Dr. Ferguson

I would like now to call on Dr. Patrick Hanley.

Dr. Hanley

"Unroofing" of an abscess is a bad term to use in describing the treatment of anorectal abscess and fistula. It may be understood to imply unnecessary excision of skin over the abscess. To me, "unroofing" means making an incision in the posterior midline to drain a deep postanal abscess adequately with no excision of anal skin. I thoroughly enjoyed Dr. Friend's paper. In Dr. Friend's method of treatment, a posterior fistulotomy and multiple radial incisions about the anus over the fistulous tract have obtained good results, as illustrated by his slides. However, I wish to emphasize that in patients with horseshoe fistulas the fistulotomy from the primary opening toward the coccyx in the posterior midline opening the deep postanal space is the most important factor in achieving a cure. The secondary openings of the fistulous tract should be enlarged with a scalpel to permit thorough curettage of the granulation tissue from the tracts with a sharp bone curette forceps. It is not necessary to excise the tracts completely because, after fistulotomy in the posterior midline, the secondary-intention healing process will close the communication between the levator and the superficial external sphincter and the tracts distal to the postanal space will resolve spontaneously.

In a ten-year period, 1963–1973, we had 41 patients treated by posterior fistulotomy. For acute abscesses, para-anal incision and drainage over the anterior extension of the abscess was also done. With chronic fistulas, when feasible, excision of the T portion of the tract is done, with curettage of the remaining portion of the tracts (Fig. 1). In some cases curettage only is done, and

Fig. 1. In chronic horseshoe fistula-in-ano, the "T" portion of the tract is excised.
in a few cases, the tracts can be excised without severing the superficial external sphincter muscle.

The Program Chairman asked that I discuss patients with complicated fistulas and the type of incisions recommended in treating them. The first patient is a man with a rectovesical supralevator abscess. This slide demonstrates that initially the abscess was intersphincteric, with the primary opening in a crypt (Fig. 2) that ruptured in the rectovesical space. The treat-

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**Fig. 2.** Large rectovesical pelvic abscess from intersphincteric abscess fistula.

**Fig. 3.** Chronic intersphincteric supralevator abscess, anal fistula with urinary retention.