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Guidelines to diagnose and treat peri-levator high-5 anal fistulas: Supralelevator, suprasphincteric, extrasphincteric, high outersphincteric, and high intrarectal fistulas

Pankaj Garg, Vipul D Yagnik, Sushil Dawka, Baljit Kaur, Geetha R Menon

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Abstract

Supralelevator, suprasphincteric, extrasphincteric, and high intrarectal fistulas (high fistulas in muscle layers of the rectal wall) are well-known high anal fistulas which are considered the most complex and extremely challenging fistulas to manage. Magnetic resonance imaging has brought more clarity to the pathophysiology of these fistulas. Along with these fistulas, a new type of complex fistula in high outersphincteric space, a fistula at the roof of ischioanal fossa inside the levator ani muscle (RIFIL), has been described. The diagnosis, management, and prognosis of RIFIL fistulas is reported to be even worse than supralelevator and suprasphincteric fistulas. There is a lot of confusion regarding the anatomy, diagnosis, and management of these five types of fistulas. The main reason for this is the paucity of literature about these fistulas. The common feature of all these fistulas is their complete involvement of the external anal sphincter. Therefore, fistulotomy, the simplest and most commonly performed procedure, is practically ruled out in these fistulas and a sphincter-saving procedure needs to be performed. Recent advances have provided new insights into the anatomy,

radiological modalities, diagnosis, and management of these five types of high fistulas. These have been discussed and guidelines formulated for the diagnosis and treatment of these fistulas for the first time in this paper.

Key Words: Anal fistula; Supralelevator; Suprasphincteric; Extrasphincteric; Magnetic resonance imaging

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Core Tip: These are the first published guidelines to manage the five types of peri-levator anal fistulas that involve almost the complete external anal sphincter and have, therefore, been grouped together as high-5 fistulas. These are supralelevator, suprasphincteric, extrasphincteric, and high intrarectal and fistulas at the roof of ischioanal fossa inside the levator ani muscle. The diagnosis and management of these five fistulas is quite challenging. Magnetic resonance imaging is the best modality to accurately delineate these fistulas. Once diagnosed, care should be exercised to avoid sphincter-cutting procedures (fistulotomy) in these fistulas, as the risk of incontinence would be very high. Sphincter-sparing procedures should be done. However, there is little literature available on satisfactory management of these fistulas.

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INTRODUCTION

Anal fistulas are feared by patients and surgeons alike[1]. The prime reasons for this are difficulty in understanding the pathophysiology, risk of debilitating incontinence, and high recurrence rates, especially in complex fistulas[2-5]. Amongst the category of complex fistulas, the three well-known notorious fistulas are supralelevator, suprasphincteric and extrasphincteric fistulas[6,7]. Another less known fistula is the high intra-rectal fistula which occurs by cephalad extension of the fistula between the internal anal sphincter (IAS) and conjoint longitudinal muscle (CLM). This fistula was first described by Parks *et al*[8] in 1976. Recently, another fistula, fistula at the roof of ischioanal fossa inside the levator ani muscle (RIFIL) has also joined the category of these high fistulas[9]. RIFIL fistulas are also highly complex and involve the complete external anal sphincter (EAS). The common feature of these five fistulas is that they are quite high as these reach up to the levator muscle and involve almost the complete EAS (Figure 1). Hence, these five fistulas have been grouped together as high-5 fistulas and are discussed in detail below.

The high-five anal fistulas include: (1) Supralelevator (Figures 2 and 3); (2) Suprasphincteric (Figures 4-6); (3) Extrasphincteric (Figure 7); (4) High intra-rectal (Figures 3,8 and 9)[8]; and (5) RIFIL (Figures 10-12)[9]. These fistulas are considered most dreaded because understanding their anatomy and pathophysiology, proper diagnosis, and successful safe treatment are quite challenging. All these five fistulas involve almost the complete EAS[10,11] (Figures 2-12). As the EAS plays a major role in continence, muscle-dividing procedures like fistulotomy or cutting setons are strictly contraindicated in these fistulas. In fact, fistulotomy with primary sphincter reconstruction or fistulectomy with primary sphincter reconstruction are also best avoided in these patients[1,12-14]. Therefore, the choice of procedures becomes limited. Of these, the extrasphincteric is the only type which is trans-levator, whereas the other four fistulas (supralelevator, sphincteric, high intrarectal, and RIFIL) are peri-levator fistulas which do not traverse through the levator muscle.

This article will address the major concerns of these fistulas, including the challenges in managing and diagnosing the high-5 fistulas, as well as methods to formulate management guidelines..

CHALLENGES IN MANAGING THESE FISTULAS

Confusion about pathophysiology of High-5 fistulas

There is a lot of confusion amongst surgeons about the exact anatomy, pathways of spread, and extent of these fistulas[2]. Not uncommonly, a high transsphincteric fistula is labelled as an extrasphincteric fistula and a suprasphincteric fistula is reported as a high transsphincteric fistula[2].

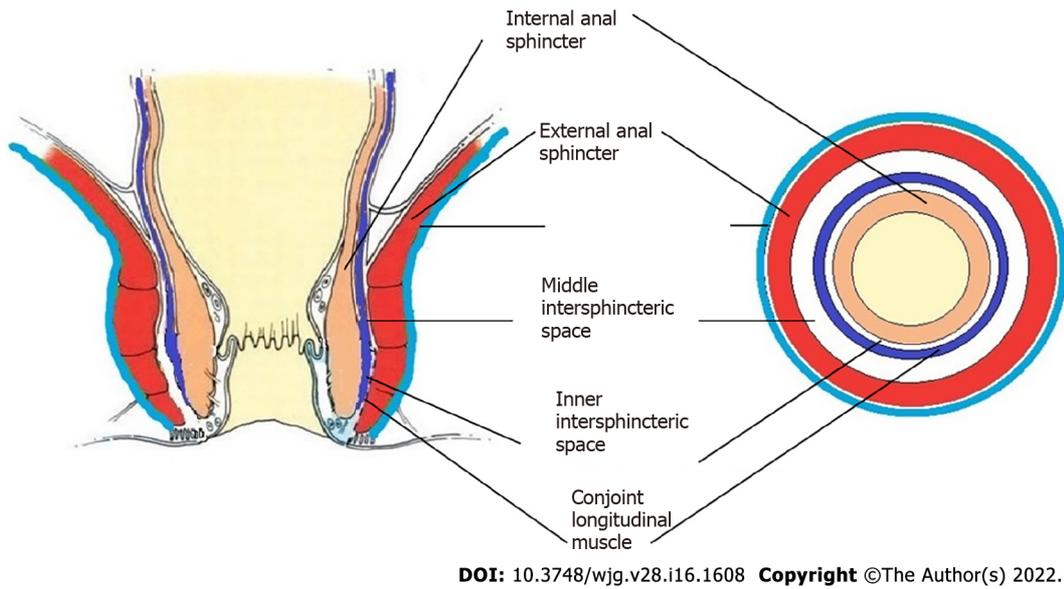


Figure 1 Normal anatomy.

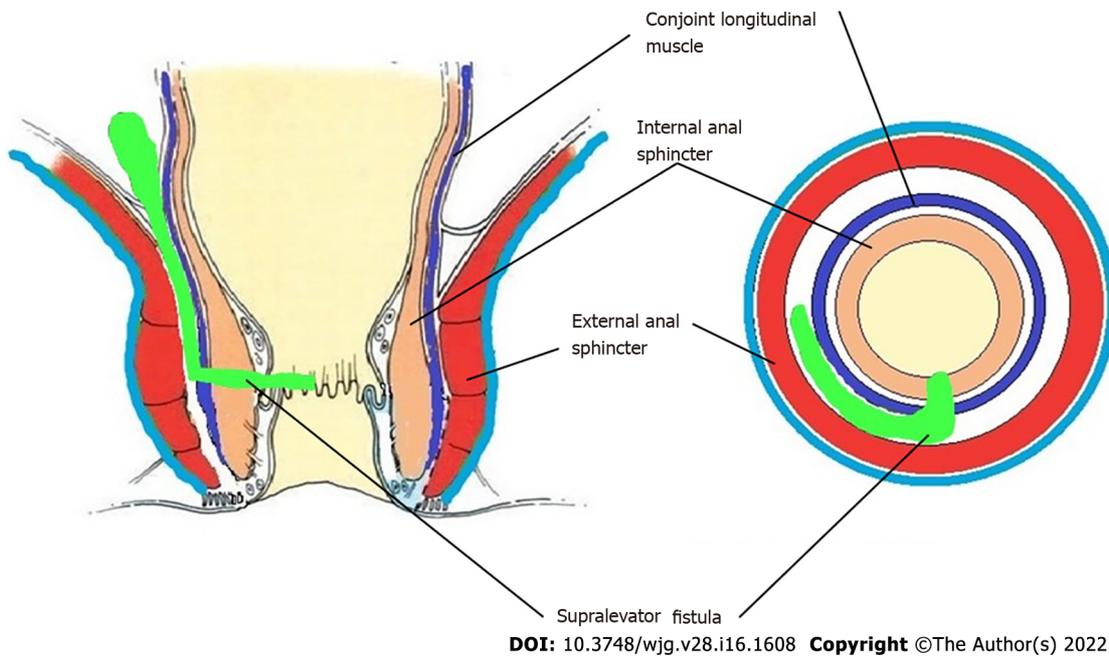
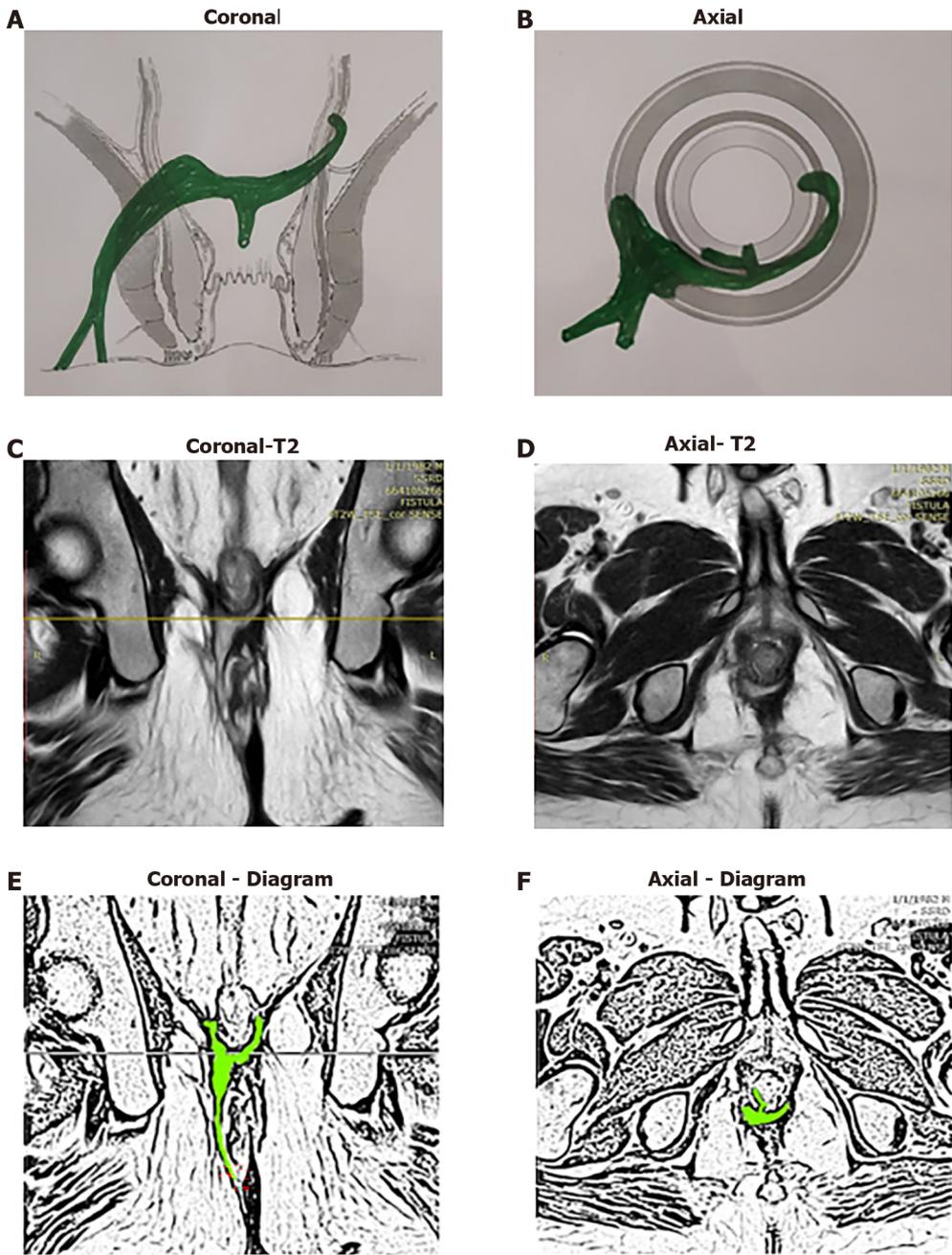


Figure 2 Supralelevator fistula.

In order to understand the pathways of extension of these fistulas, it is important to understand the anatomy of the anal canal. There are three muscle layers in the sphincter-complex in the anorectum which are downward extensions of the muscle layers of the gut. There are potential spaces between these muscle layers in which the fistula and pus can spread[9] (Figures 1, 2, 4, 7, 8 and 10).

The three muscle layers in the sphincter-complex[9] are (1) Inner circular muscle layer of gut continues downwards in the anal sphincter complex as IAS; (2) Outer longitudinal muscle layer of gut continues downwards in the anal sphincter complex as CLM; and (3) Puborectalis component of levator ani muscle continues downwards in the anal sphincter complex as EAS (Figure 1). Conventionally, it was assumed that inside the sphincter-complex, there is only one space where the fistula extends and this space between the IAS and EAS was labelled as the ‘intersphincteric space’. However, with the availability of higher resolution magnetic resonance imaging (MRI) and increasing experience, it has been demonstrated that there are three potential spaces associated with in these muscle layers through which the fistula can extend[9].

The three potential spaces in the anal sphincter-complex are (1) Inner intersphincteric space (inner space): Between IAS and CLM; (2) Middle intersphincteric space (middle space): Between CLM and EAS



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Figure 3 A 39-year-old male patient with a high transsphincteric fistula with supralelevator extension at 3 o'clock. There is a high intrarectal tract from 6 to 7 o'clock. The internal opening is at 6 o'clock position. A: Coronal section (schematic diagram); B: Axial section (schematic diagram); C: T2-weighted magnetic resonance imaging (MRI) Coronal section showing supralelevator tract; D: T2-weighted MRI Axial section; E: Sketch of MRI Coronal section highlighting fistula tract (light green color); F: Sketch of MRI Axial section highlighting fistula tract (light green color).

(conventional intersphincteric space); and (3) Outer-sphincteric space (outer space): Between the lateral muscle fibers of EAS and its covering fascia[9] (Figure 1).

The anal fistula, usually initiating at crypt glands at the level of the dentate line, can extend superiorly (cephalad) in any of these three spaces.

The fistulas traversing superiorly in (1) Inner intersphincteric space (inner space) between IAS and CLM inside the rectal wall to become a high intrarectal fistula as these fistulas are present between the muscle layers of the rectal wall[8]. At times, these are erroneously labelled as submucous fistula[8] (Figures 8 and 9); (2) Middle intersphincteric space (middle space) between CLM and EAS become a supralelevator fistula (if it continues into the supralelevator space) (Figures 2 and 3) or a suprasphincteric fistula (if pus extending superiorly in the middle space reaches up to the top of the EAS and then traverses through the junction between the EAS and puborectalis to enter the ischioanal fossa[15]) (Figures 4-6); and (3) Outer-sphincteric space (outer space) between the EAS and its lateral fascia becomes a RIFIL fistula[9] (Figures 10-12).

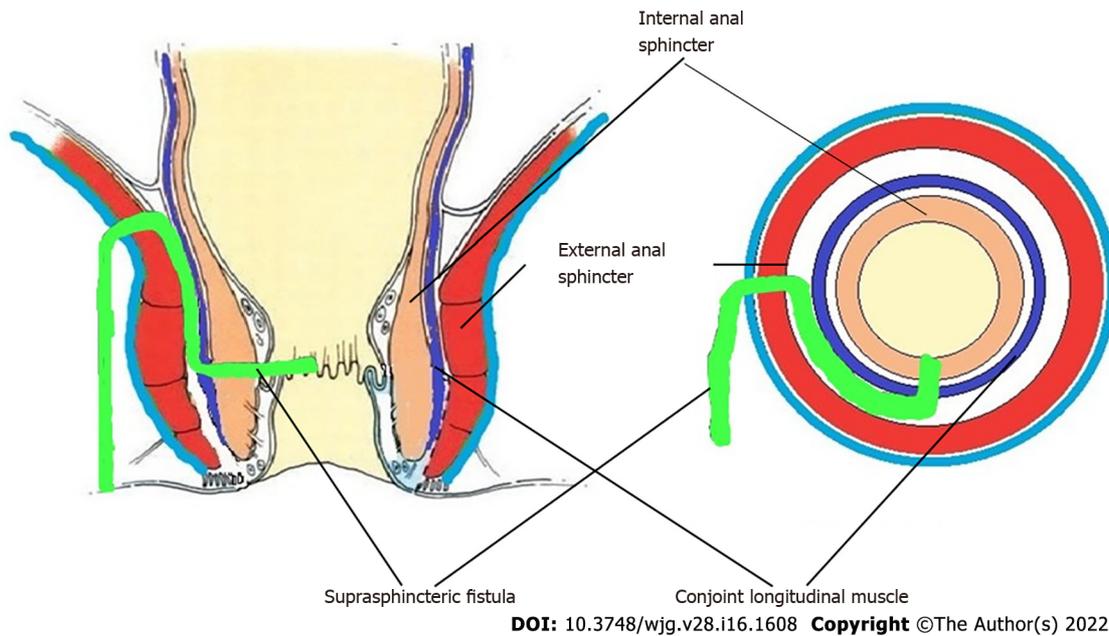


Figure 4 Suprasphincteric fistula.

Thus, the definition of these five fistulas is: (1) Supralelevator (Figures 2 and 3): These fistulas traverse in the middle intersphincteric space to enter the supralelevator space. The fistula may open into the rectum through an additional high rectal opening in the supralelevator space (Figures 3 and 6); (2) Suprasphincteric (Figures 4-6): These fistulas extend superiorly in the middle intersphincteric space to reach up to the top of the EAS and then traverses through the junction between the EAS and puborectalis to enter the ischioanal fossa; (3) Extrasphincteric (Figure 7): These fistulas traverse through the ischioanal fossa and enter the supralelevator space penetrating the levator muscle. They generally do not traverse through the sphincter-complex (EAS and IAS), which is why they are labelled as 'extra-sphincteric' fistulas; (4) High intra-rectal (Figures 8 and 9): These fistulas traverse cephalad between IAS and CLM in the rectal wall and is thus present between the muscle layers of the rectal wall; and (5) RIFIL (Figures 10-12): These fistulas traverse the EAS but do not enter the ischioanal fossa. They extend cephalad between the EAS and its lateral fascia to continue on the undersurface of puborectalis and levator ani muscle[9].

Incidence: In recently published large cohorts, the prevalence of these high-5 fistulas has been highlighted[9,16]. The incidence of these fistulas in a cohort of 419 consecutively operated patients over a 2-year period were RIFIL-10% (42/419), supralelevator-9.5% (40/419), suprasphincteric-5.5% (23/419) and extrasphincteric-0%[9,16].

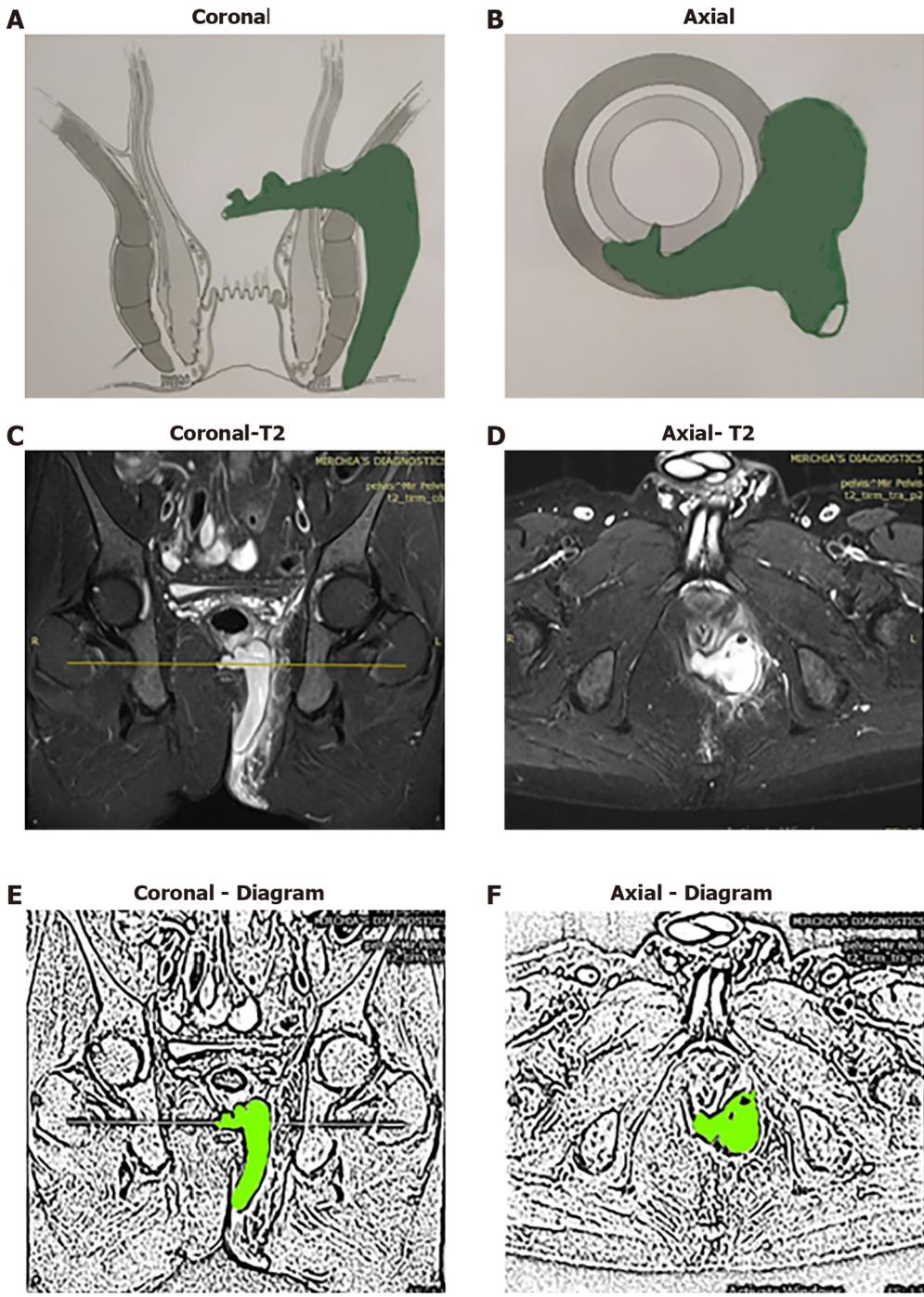
Difficulty in diagnosis

As these fistulas are deep and high, they are extremely difficult to diagnose on clinical examination. It usually requires advanced imaging modalities, MRI, or transrectal ultrasound (TRUS), to diagnose these fistulas[17-21]. Both MRI and 3D-TRUS are very effective in delineating various parameters of these fistulas, including the internal opening, primary tracts, and secondary extensions[17-20,22], though MRI has a slight edge over TRUS. It is really impressive that in the pre-MRI era, doyens in the field like Parks *et al*[8] could describe these deep fistulas with a reasonably high level of accuracy.

MRI helps to clearly differentiate between supralelevator, suprasphincteric, high intrarectal, and RIFIL fistulas[23]. Rather it would not be wrong to say that MRI is mandatory to properly diagnose these fistulas. Therefore, whenever a fistula has recurred several times, or a tract or side branch of the main fistula is seen extending superiorly during surgery, an MRI should be done to rule out these fistulas[23].

Status of extrasphincteric fistulas

Increasing experience with MRI in fistulas has highlighted that extrasphincteric fistulas do not occur or are extremely rare[24]. It stands to reason that it is almost impossible for a fistula in the ischioanal fossa to penetrate through the strong levator plate when it can extend with ease in the surrounding fat of the ischioanal fossa[24]. The only likely possibility for an extrasphincteric fistula to occur is iatrogenic when an artery forceps in a high transsphincteric fistula is pushed through the levator muscle. Even this seems improbable as it would require a lot of force by the operating surgeon. Moreover, due to increased awareness amongst surgeons of iatrogenic injuries, better understanding of regional anatomy, and easy availability of advanced radiological modalities, these iatrogenic blunders seem exceedingly



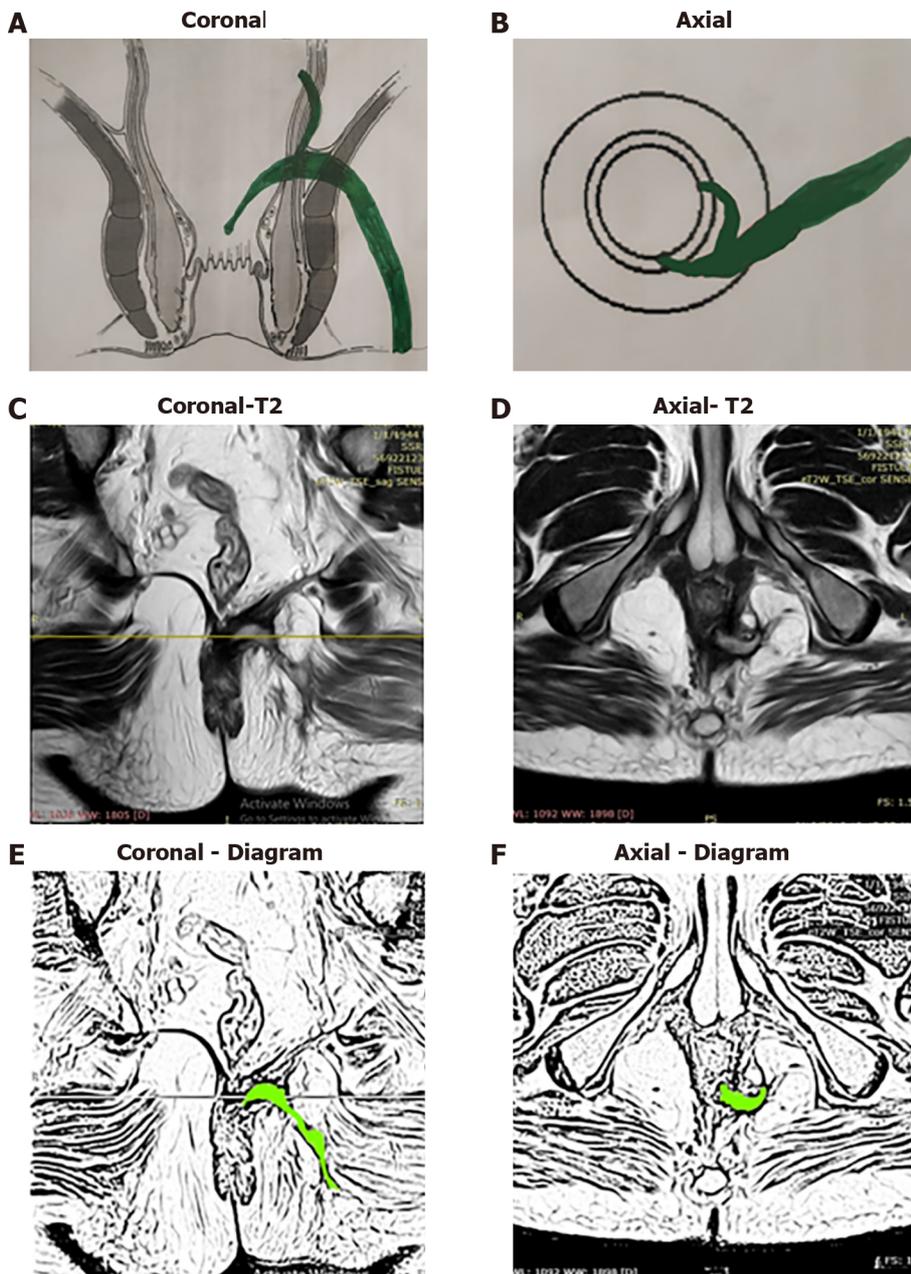
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Figure 5 A 40-year-old male patient with a suprasphincteric fistula and abscess on left side. The internal opening is at 6:30 o'clock position. A: Coronal section (schematic diagram); B: Axial section (schematic diagram); C: Short Tau Inversion Recovery (STIR) magnetic resonance imaging (MRI) Coronal section showing suprasphincteric tract and abscess; D: STIR MRI Axial section; E: Sketch of MRI Coronal section highlighting suprasphincteric fistula tract and abscess (light green color); F: Sketch of MRI Axial section highlighting fistula tract and abscess (light green color).

unlikely. Due to this, extrasphincteric fistulas are not seen (or are extremely rare) these days[24]. It is quite possible that the fistulas diagnosed as extrasphincteric fistulas in the pre-MRI era were perhaps supralelevator or RIFIL fistulas. Understandably, in the absence of MRI, it is extremely difficult to differentiate between an extrasphincteric fistula and other deep fistulas. So, a diagnosis of extrasphincteric fistula should be made only after due deliberation and detailed analysis of MRI[24].

Complete involvement of EAS

The main challenge in these five fistulas is that they involve almost the complete EAS (Figures 2, 4, 7, 8 and 10). The EAS plays a major role in maintaining continence and risk of damage to the EAS is very high in these fistulas. Because this risk of incontinence is so high, these fistulas are extra concerning[4,5,



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Figure 6 A 47-year-old male patient with a suprasphincteric fistula on left side and supralelevator tract and high rectal opening at 3 o'clock. The internal opening is at 6 o'clock position. A: Coronal section (schematic diagram); B: Axial section (schematic diagram); C: T2-weighted magnetic resonance imaging (MRI) Coronal section showing suprasphincteric tract; D: T2-weighted MRI Axial section; E: Sketch of MRI Coronal section highlighting supralelevator fistula tract (light green color); F: Sketch of MRI Axial section highlighting fistula tract (light green color).

25]. The most commonly performed procedure, fistulotomy, is contraindicated in these fistulas[25]. There is little published data and there are no standard guidelines to manage these fistulas. Therefore, the fear of managing these fistulas amongst surgeons is easy to understand.

Presence of ASRO (additional supralelevator rectal opening)

One of the features that make these fistulas more challenging is the presence of an ASRO along with a primary internal opening at the dentate line[6]. In a large cohort, ASRO was present in 2.8% (23/836) anal fistulas, but in supralelevator fistulas, the incidence was 16.6% (23/138)[6]. At times, the presence of ASRO is detected accidentally during surgery (intraoperatively) when a colored solution injected into the external opening comes out through the primary internal opening at the dentate line as well as through the ASRO[6]. In many cases, a granulation polyp or a papilla can be seen at the site of the ASRO. However, ASRO can be diagnosed preoperatively with the help of MRI in almost every case[6]. MRI is an excellent tool to diagnose ASRO with a high level of accuracy[6].

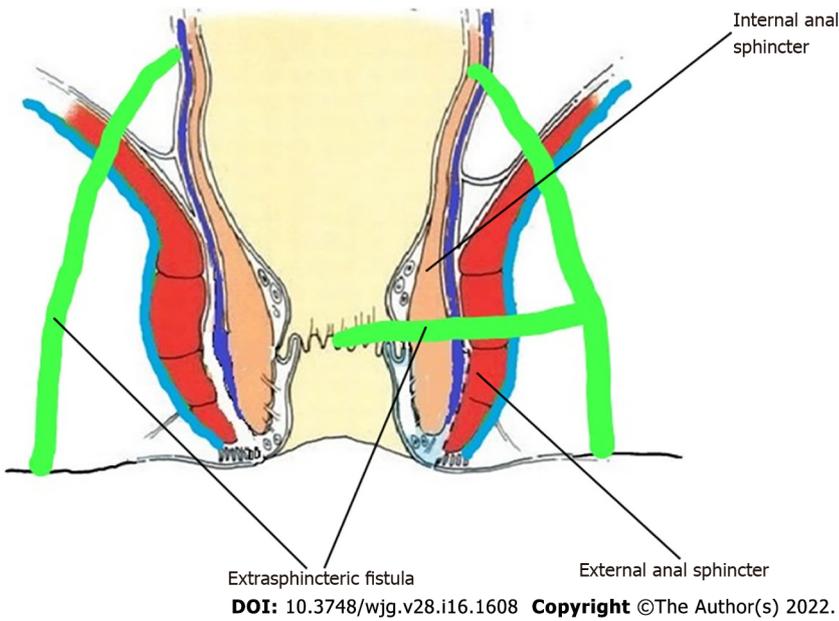


Figure 7 Extrasphincteric fistula.

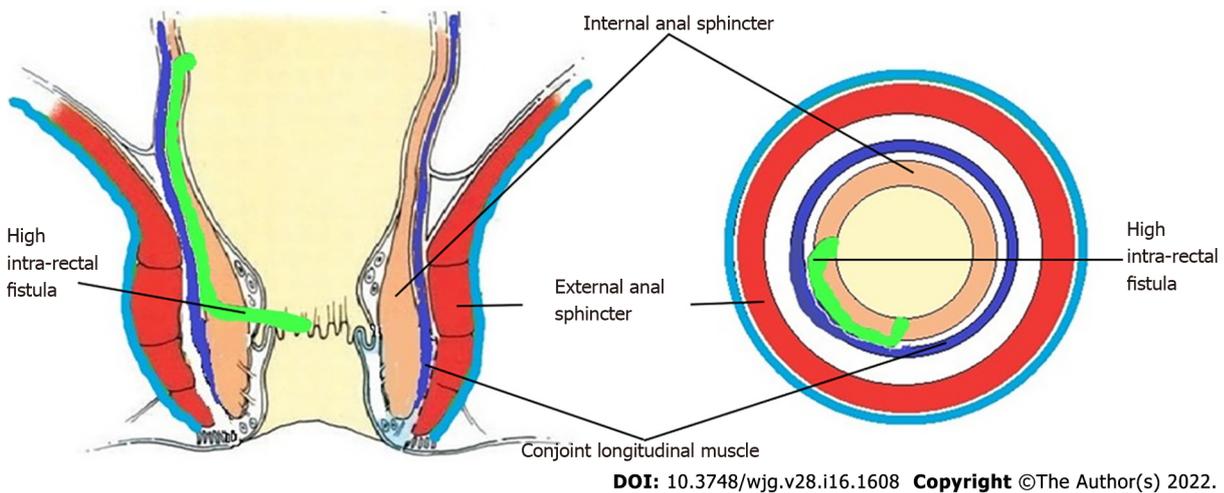


Figure 8 High Intrarectal fistula.

The management of ASRO seems challenging. Closure of an opening high up in the rectum which, at times, is even difficult to reach through the transanal route is not easy. However, there is a sliver of relief in these otherwise complex fistulas. A recent study has demonstrated that even if nothing is done to ASRO, there is no impact on ultimate fistula healing[6].

There is an explanation for this surprising finding. Anal fistulas usually initiate in crypt glands located at the dentate line. The fistula then can extend in different directions from here. Some fistulas or abscesses extend superiorly and enter the supralelevator space[6]. In a small subset (16%) of these supralelevator abscesses, the pressure generated by the supralelevator abscess is so high that the abscess ruptures into the rectum, thus creating an ASRO. In such situations, the flow of infection (and bacteria) in ASRO is from the supralelevator space into the rectum[6]. This continues in the same manner because, unlike in the anal canal where intraluminal pressure rises during defecation, pressure in the mid-rectum is quite low (as the rectum is primarily a storage organ). Therefore, the bacteria usually enter the fistula tract from the primary internal opening at the dentate line, bacterial multiplication leads to suppuration, and then the pus egresses through the external opening and the ASRO (if present)[6]. Hence, ultimate healing of the fistula depends primarily on successful closure of the primary internal opening at the dentate line. Once the primary internal opening at the dentate line heals, the fistula heals irrespective of whether the ASRO is closed or open[6]. Therefore, it is a reassuring fact that ASRO left untreated does not affect the ultimate fistula outcome[6].

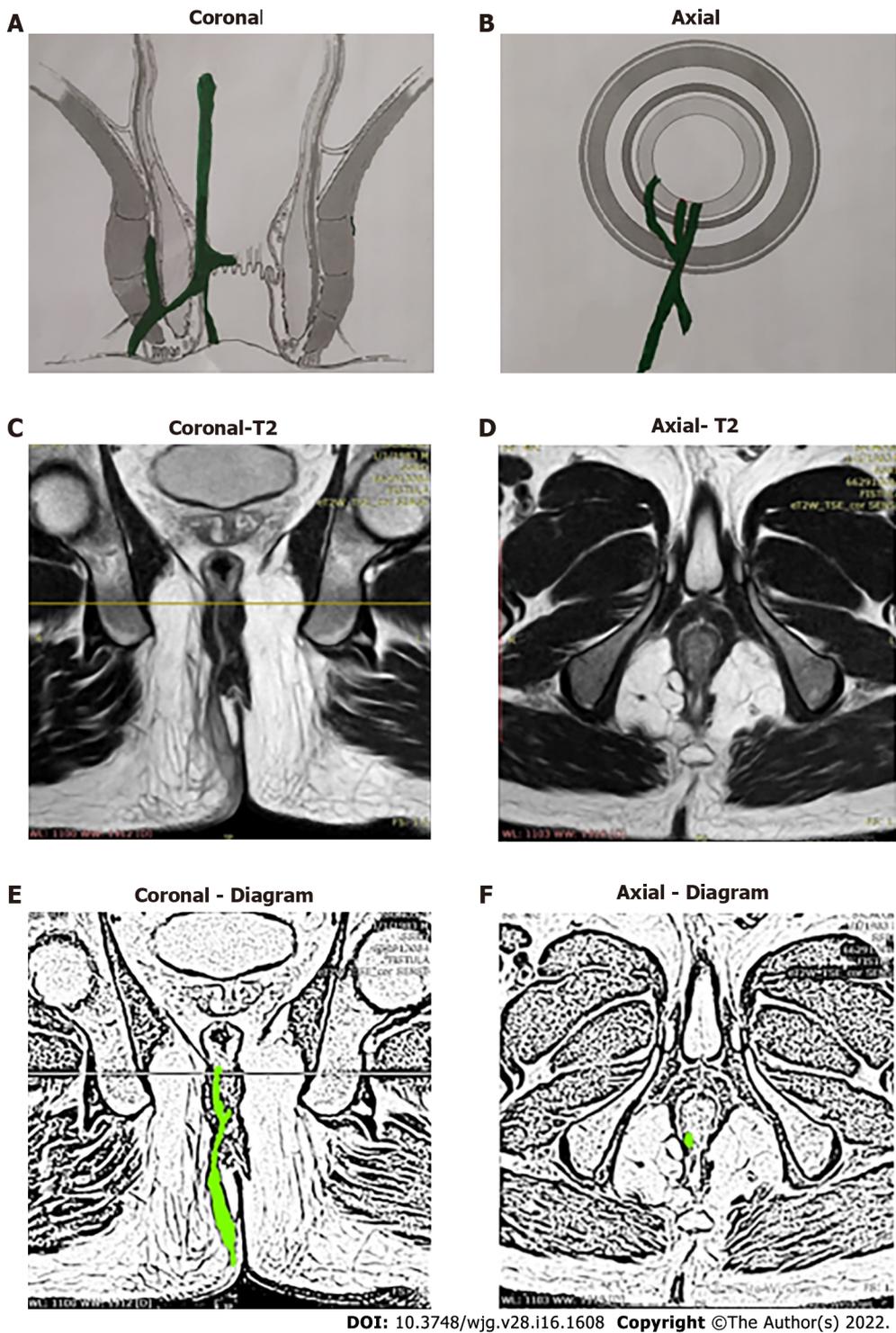


Figure 9 A 36-year-old male patient with a high intrarectal fistula at 7 o'clock. A: Coronal section (schematic diagram); B: Axial section (schematic diagram); C: T2-weighted magnetic resonance imaging (MRI) Coronal section showing high intrarectal fistula tract; D: T2-weighted MRI Axial section; E: Sketch of MRI Coronal section highlighting high intrarectal fistula tract (light green color); F: Sketch of MRI Axial section highlighting fistula tract (light green color).

Detection of underlying secondary pathology

The high-5 fistulas are more complex and refractory to treatment as compared to other fistulas. The incidence of associated complicating pathology like Crohn’s disease and tuberculosis is higher in these fistulas[24,26,27]. Therefore, it is important that these diseases should be ruled out whenever any of these high fistulas are diagnosed or suspected.

In regions where Crohn’s disease is common, a colonoscopy should be done in all cases of high fistulas[28]. On the other hand, in regions where tuberculosis is common, polymerase chain-reaction (PCR) should be done in samples from the fistula (pus or fistula tract wall or tract lining)[24,29]. In a large series published from a TB-endemic region (India), tuberculosis was detected in 10% (133/1336) of

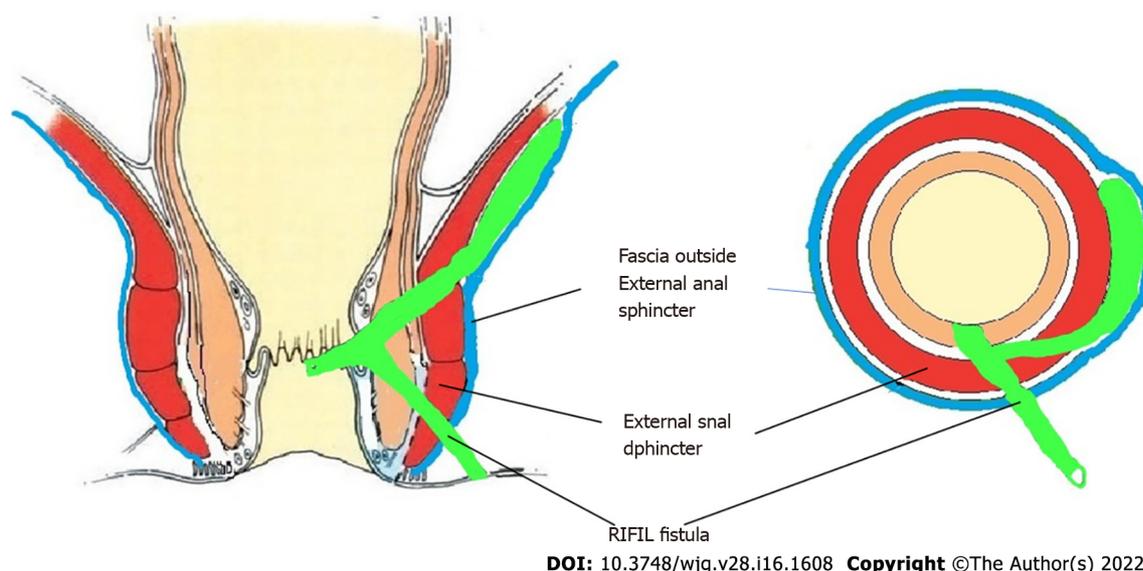


Figure 10 Roof of ischiorectal fossa inside the levator ani muscle fistula. RIFIL: Roof of ischiorectal fossa inside the levator ani muscle.

tested samples (fistula tract lining or pus)[29]. The detection rate of tuberculosis was 12.5% (129/1034) by PCR, 1.5% (3/197) by histopathology, and 0.9% (1/105) by GeneXpert tests[29]. Therefore, PCR is significantly more sensitive than histopathology or GeneXpert to detect tuberculosis[29]. However, in spite of high sensitivity, it is not uncommon that tuberculosis is missed and goes undetected in the first sample. Therefore, in regions where tuberculosis is endemic, it is recommended that repeated samples should be sent for testing, especially in more complex refractory fistulas[29].

METHODS USED TO FORMULATE MANAGEMENT GUIDELINES

A search was performed on MEDLINE, PubMed, EMBASE, and the Cochrane Database of Collected Reviews from January 1975 to September 2021. Keyword combinations using MeSH terms included supralelevator, suprasphincteric, extrasphincteric, intrarectal, abscess, fistula, fistula-in-ano, anal, rectal, perianal, perineal, seton, fistula plug, fibrin glue, advancement flap, tuberculosis, Crohn's disease, ligation of intersphincteric tract, ligation of intersphincteric fistula tract (LIFT), fistulectomy with primary sphincter reconstruction (FPR), fistulectomy with primary sphincter repair, transanal opening of the intersphincteric space (TROPIS) and stem cells.

Various guidelines, such as GRADE[30,31], RIGHT[32] AGREE[33] were evaluated, but considering the rarity of the disease condition (Hi-5 fistulas) in the study, the Levels of Evidence for Therapeutic Studies developed by Centre for Evidence-Based Medicine, <http://www.cebm.net>. (Oxford, United Kingdom) (Table 1) and Grade Practice Recommendations recommended by American Society of Plastic Surgeons (Table 2) were utilized[34]. Each diagnostic and therapeutic intervention was assigned a 'level of evidence' from 1A to 5 (1A being the strongest evidence and 5 being the weakest) (Table 1) and then a 'grade of recommendation' was awarded ranging from 'A' to 'D' ('A' being a strong recommendation and 'D' being a weak option) (Table 2).

Authors (PG, VDY) reviewed all English language articles and tabulated all the evidence available and allotted the level of evidence. After that, the grade of recommendation was decided with consensus of all the authors.

MANAGEMENT GUIDELINES

Diagnostic evaluation of Hi-5 fistulas

MRI or TRUS are preferred modalities to evaluate Hi-5 fistulas. MRI is better than TRUS to evaluate high secondary extensions. Level of Evidence-2B. Grade of recommendation-B.

MRI and TRUS are the diagnostic modalities of choice to evaluate complex anal fistulas[17,19-21]. MRI and 3D-TRUS have comparable efficacy in outlining the internal opening and primary tracts; however, MRI is significantly more effective than 3D-TRUS in detecting deep secondary extensions[35]. The sensitivity of 3D-TRUS to detect deep secondary extensions was 73.9% while MRI had sensitivity of 97% ($P = 0.041$)[35]. Therefore, MRI is the preferred modality to diagnose high fistulas especially the high-5 fistulas[10,36].

Table 1 Levels of evidence for therapeutic studies[49]

Level	Type of evidence	
1	A	Systematic review (with homogeneity) of RCTs
	B	Individual RCT (with narrow confidence intervals)
	C	All or none study
2	A	Systematic review (with homogeneity) of cohort studies
	B	Individual Cohort study (including low quality RCT, <i>e.g.</i> , < 80% follow-up)
	C	“Outcomes” research; Ecological studies
3	A	Systematic review (with homogeneity) of case-control studies
	B	Individual Case-control study
4		Case series (and poor-quality cohort and case-control study)
5		Expert opinion without explicit critical appraisal or based on physiology bench research or “first principles”

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RCTs: Randomized controlled trials.

Table 2 Grade practice recommendations¹

Grade	Level of Recommendation	Qualifying evidence	Implications for clinicians
A	Strong recommendation	Level I evidence or consistent findings from several studies of levels II, III, or IV	These recommendations should be followed unless an alternative approach with clear and compelling rationale is present
B	Recommendation	Consistent evidence of levels II, III, or IV	These recommendations should be followed but clinicians should understand that there is scope of improvement and these may be slightly modified as <i>per</i> patient preferences
C	Option	Levels II, III, or IV evidence, but findings are inconsistent	These guidelines are broad guidelines and clinicians should be flexible in their decision-making regarding appropriate practice keeping patient preferences in mind
D	Option	Level V evidence: Little or no substantial evidence	These recommendations may be referred but clinicians should consider all other available options while making decisions

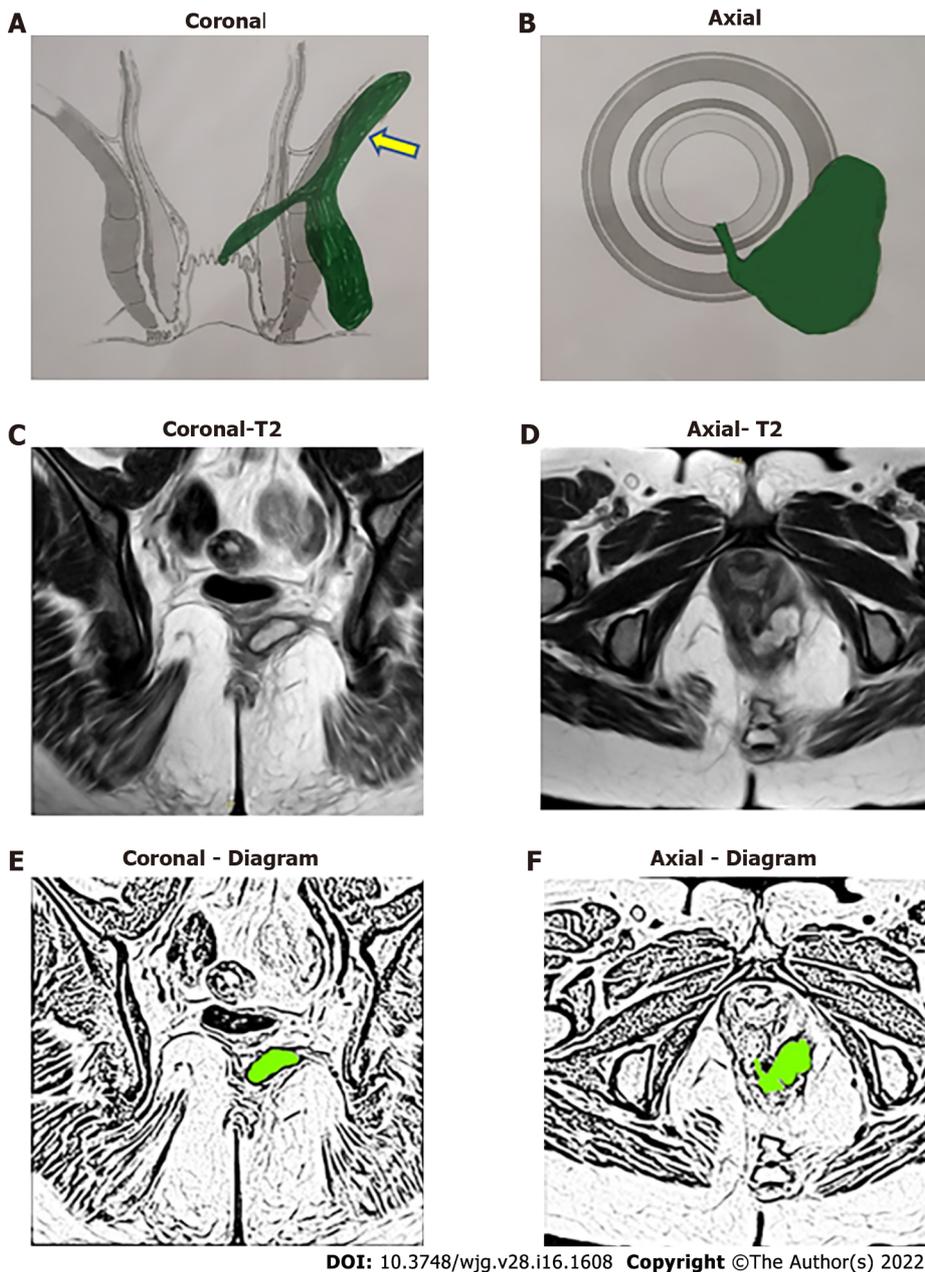
¹Based on the American Society of Plastic Surgeons[34].

Surgical procedure

Due to the challenging factors discussed above, the management of high-5 fistulas is quite difficult and far from satisfactory. Apart from the associated complex parameters, the additional problem is minimal experience or published data on the management of these fistulas. Due to this, the quality of data is of a low evidence level.

As discussed earlier, due to complete involvement of EAS, the most commonly performed procedure, fistulotomy, is contraindicated in these fistulas[25] unless it is coupled with primary sphincter repair. The newer sphincter-sparing procedures, like video-assisted anal fistula treatment[24], fistula laser closure[24], over-the scope clip (OTSC)[37-39], anal fistula plug (AFP)[40], stem cells[28] *etc*, have dismal success rates in complex fistulas. In fact, there are hardly any studies that have analyzed the success rates of these newer procedures in high-5 fistulas. Therefore, the sphincter-preserving procedures, such as LIFT, FPR, advancement flaps, and TROPIS, seem more suitable procedures for high-5 fistulas.

TROPIS provides a ray of hope, as it has been shown to have satisfactory results in these fistulas[2,3,16,24,41]. In the TROPIS procedure, the intersphincteric space is laid open in the anal canal and the resultant wound is allowed to heal by secondary intention[16,24]. The transsphincteric tracts (tracts lateral to the EAS in the ischioanal fossa) are thoroughly curetted and cleaned[3,41]. Thus, the tracts on both sides of the EAS are managed separately (tracts inner to the EAS are laid open into the anal canal and tracts outside the EAS in the ischioanal fossa are curetted and cleaned) and the EAS is not cut or damaged at all[16,24]. Due to this, it has been shown that there is no deterioration in continence after the TROPIS procedure[16,24].



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Figure 11 A 33-year-old female patient with a roof of ischiorectal fossa inside the levator ani muscle fistula on left side at 5 o'clock and internal opening at 6 o'clock position. A: Coronal section showing roof of ischiorectal fossa inside the levator ani muscle (RIFIL) fistula (yellow arrow) (schematic diagram); B: Axial section (schematic diagram); C: T2-weighted magnetic resonance imaging (MRI) Coronal section showing RIFIL fistula tract; D: T2-weighted MRI Axial section; E: Sketch of MRI Coronal section highlighting RIFIL fistula tract (light green color); F: Sketch of MRI Axial section highlighting fistula tract (light green color).

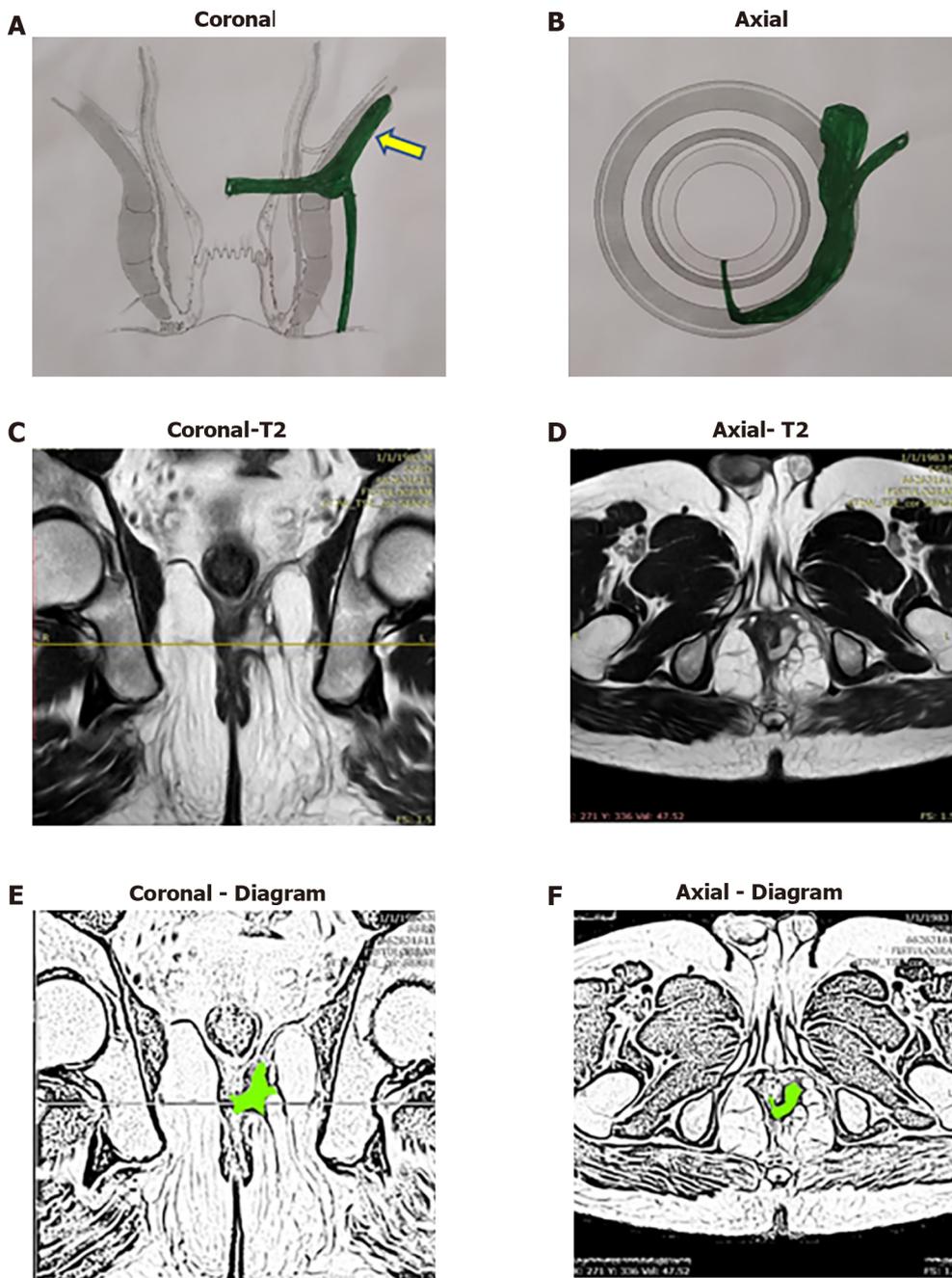
The reason for the higher success rate of the TROPIS procedure could be that, unlike other procedures, TROPIS adequately tackles the sepsis in the intersphincteric space[3,41]. It is now understood that the pus/sepsis in the intersphincteric part of the fistula tract is like an abscess in a closed space[24]. Therefore, this sepsis is best managed in the manner an abscess anywhere else in the body is managed-deroofting the abscess cavity and allowing it to heal by secondary intention[24].

Supralelevator fistulas

A supralelevator abscesses can be drained into the rectum with a moderate success rate[7,42-44]. The level of evidence for this is 2B with a grade of recommendation of B. For example, Garcia-Granero *et al*[7] drained the supralelevator abscess into the rectum in four patients and all of them healed.

This not only leads to resolution of the acute symptoms, but also leads to fistula healing in many cases[7,44].

Fistulectomy with or without advancement flap may be done in selected cases with a moderate success rate[44]. The level of evidence is a -4, with the grade of recommendation a-D. Van Onkelen *et al*



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Figure 12 A 38-year-old male patient with a roof of ischiorectal fossa inside the levator ani muscle fistula on left side at 3 o'clock and internal opening at 6 o'clock position. A: Coronal section showing roof of ischiorectal fossa inside the levator ani muscle (RIFIL) fistula (yellow arrow) (schematic diagram); B: Axial section (schematic diagram); C: T2-weighted magnetic resonance imaging (MRI) Coronal section showing RIFIL fistula tract; D: T2-weighted MRI Axial section; E: Sketch of MRI Coronal section highlighting RIFIL fistula tract (light green color); F: Sketch of MRI Axial section highlighting fistula tract (light green color).

[44] performed advancement flap in three patients after draining the supralelevator abscess. All patients healed but multiple surgeries were required in order to achieve fistula healing[44].

Supralelevator fistula can be managed with laying open of the supralelevator extension into the rectum through the transanal route (TROPIS) procedure with a satisfactory healing rate[6,16]. The level of evidence for this is 2B with a grade of recommendation of B. The success rate was 84.6% (11/13) in the initial series and 82.1% (92/112) on long-term follow-up (median 30 mo) in the same series[16].

LIFT and FPR can also be done in selected cases with good success rates (80%-91%) in high complex fistulas (the studies included supralelevator fistulas)[45,46]. The level of evidence for this is 5 with a grade of recommendation of D. However, data for these two procedures specific to supralelevator fistulas is not available.

Suprasphincteric fistulas

Advancement flap, fistulotomy/fistulectomy with primary sphincter repair and stem cells have moderate success rates, with a success rate range from 70%-85%, though the sample size was quite small [47]. The level of evidence for this is 2B with a grade of recommendation of D. Perez *et al*[47] compared advancement flap *vs* fistulotomy with sphincter reconstruction in suprasphincteric fistulas and the healing rate was 80% (4/5) and 83.3% (5/6) respectively[47]. However, the risk of cutting the entire EAS and then repairing the same seems a difficult option to most surgeons. Also, in the rare eventuality of suture dehiscence, the risk of incontinence would be very high.

Fibrin glue has a poor success rate in suprasphincteric fistulas. The level of evidence for this is 2B with a grade of recommendation of C. Garcia-Olmo *et al*[48] compared the healing rate of fibrin glue *vs* adipose stem cells in suprasphincteric fistulas. The healing rate in the fibrin glue group was 8% (2/16) while it was 71% (10/14) in the stem cells group[48].

The TROPIS procedure has had promising results with a good success rate with minimal impact on continence. The level of evidence for this is 4 with a grade of recommendation of C. Out of 14 suprasphincteric fistulas, 78.6% (11/14) patients were cured with no deterioration in continence levels after surgery on long-term follow-up (median 30 mo)[16].

LIFT can be done in selected cases but is technically difficult. The level of evidence for this is 2B with a grade of recommendation of C.

There are studies in which LFT has shown a good success rate (80%-91%) in high complex fistulas[45, 46]. but data for LIFT exclusive to supralelevator fistulas is not available. It is also expected that performing the LIFT procedure in suprasphincteric fistulas (ligating the intersphincteric tract high up in the intersphincteric plane) would be a technically demanding procedure.

Extrasphincteric fistulas

Temporary colostomy with management of the primary pathology can be used for extrasphincteric fistulas. The level of evidence for this is 5 with a grade of recommendation of D.

Extrasphincteric fistulas are extremely rare these days, which means there is little data available on the management of these fistulas. As most of these fistulas are caused by secondary pelvic pathology or iatrogenic factors, a diverting stoma along with management of the underlying cause would be the mainstay of treatment[8].

High intra-rectal fistulas

Intra-anal fistulotomy (TROPIS procedure) has a high success rate with minimal impact on continence. The level of evidence for this is 4 with a grade of recommendation of B. These fistulas are perhaps the easiest to treat. Simple intra-rectal fistulotomy (laying open the fistula tract into the anorectum) would cure these fistulas with a high success rate (> 90%)[8,16].

RIFIL fistulas (fistula at the roof of ischioanal fossa inside the levator ani muscle)

TROPIS has a moderate success rate with minimal impact on continence in RIFIL fistulas. The level of evidence for this is 2B with a grade of recommendation of B. RIFIL fistulas are challenging to manage because access to the RIFIL component might become difficult. TROPIS has shown a moderate success rate in RIFIL fistulas[9]. The healing rate in RIFIL fistulas by the TROPIS procedure was 69.4% (25/36) with a follow-up (median) of 12 mo[9]. There was no negative impact on continence following surgery.

LIFT and FPR are expected to have a moderate success rate; however, since RIFIL fistulas have been recently described[9] and till now, there are no studies of LIFT or FPR procedure in RIFIL fistulas. Conceptually it is expected that these procedures would also prove at least moderately effective for these fistulas. The level of evidence for this is 5 with a grade of recommendation of D.

CONCLUSION

Anal fistulas that reach up to the levator muscle and involve almost the complete EAS have been grouped together as high-5 fistulas. These comprise supralelevator, suprasphincteric, extrasphincteric, high intrarectal, and RIFIL fistulas. The diagnosis as well as the management of these five fistulas is quite challenging. Advanced radiological modalities, preferably MRI, are needed to accurately delineate these fistulas. Once diagnosed, care should be exercised to avoid sphincter-cutting procedures like fistulotomy or cutting seton in these fistulas as the risk of incontinence would be very high. Sphincter-sparing procedures like TROPIS or LIFT should be carried out in these fistulas. These guidelines may help improve understanding and outcomes in the management of these complex fistulas.

FOOTNOTES

Author contributions: Garg P conceived and designed the study, collected and analyzed the data, revised the data,

approved and submitted the final manuscript (guarantor of the review); Dawka S critically analyzed the data, reviewed and edited the manuscript, and approved and submitted the final manuscript; Kaur B and Yagnik VD collected and analyzed the data, revised the data, and approved and submitted the final manuscript; Menon GR analyzed the data, revised the data, and approved and submitted the final manuscript.

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