Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Simple painkillers such as paracetamol and ibuprofen may be required after surgery. Simple bowel medication such as senna and lactulose may be required after surgery. It is suggested that you discuss with your pharmacist and have a seven day supply of these medications at home to take as you need according to the instructions.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.

- Please call the colorectal specialist sisters on 01223 217923 if you have any questions or concerns about this procedure.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know
Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health.

Anal fistula, CF0130, V8, November 2018
However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

**About surgery for anal fistula**

Your surgeon has recommended that you undergo an operation for anal fistula. Since few fistulas heal spontaneously, surgery is required for almost all patients with this condition.

A fistula is an abnormal connection between the anus and the skin. On the surface of the skin around the anus there may be one or more holes evident: these are the external openings of thin passages which tunnel down towards the anal canal. A fistula is usually the result of a previous abscess in the area which has been drained but does not fully heal. This results in persistent or intermittent discharge of pus, blood or mucus. There is not usually much pain, although an abscess can sometimes recur.

**Intended benefits**

1. To identify the nature of the anal fistula.
2. To perform surgery (often in stages) that will control and/or cure the fistula with minimal side effects.

**Who will perform my procedure?**

This procedure will be performed by a suitably qualified and experienced surgeon, or a trainee surgeon under the direct supervision of a suitably qualified and experienced surgeon.

**Before your procedure**

You will need to attend the pre-assessment clinic, which is usually run by specialist nurses. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time. We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy.

**Hair removal before an operation**

For most operations, you do not need to have the hair around the site of the operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head. On the day of the surgery, please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

Anal fistula, CF0130, V8, November 2018
It may be necessary during the procedure to shave another area of your body e.g. your thigh to allow attachment of a pad for the diathermy machine (used to seal blood vessels), so that the pad sticks to your skin to achieve the best and safest performance.

**During the procedure**

Fistula surgery may be simple or complex according to the nature of the fistula. Sometimes it is not possible to see the full extent of the fistula before surgery and so decisions are made whilst you are anaesthetised. Simple fistulas can be 'laid open' by cutting a small amount of the anal skin and muscle to open up the track. Fistulas that are situated more deeply (complex fistulas) cannot be treated like this because it would involve cutting too much muscle and could result in incontinence. Here a variety of other treatments are available and your surgeon will discuss the options with you individually. Complex fistulas are difficult to treat and the surgery may be planned in several stages over a period of weeks, months or even years.

**Finding the fistula track** – it is crucial to identify the course of the fistula(s) to enable correct treatment to be given. Usually this can be achieved by passing a probe through the external opening down to the internal opening within the anal canal. Occasionally the track is difficult to find if it is narrow or winding.

**Laying open of the track** - for superficial fistulas the best treatment is to open up the track by cutting through the skin directly onto the probe placed in the track. Sometimes this involves cutting a small amount of the anal sphincter muscle but the risk of any significant alteration of continence is very low. This creates a small raw area that will heal without the need for any special dressings. A dissolvable suture (stitch) is often placed around the edge of the wound to aid healing.

**Deeper fistulas** – if the internal opening is deeper inside it is often best not to cut the anal sphincter muscle and instead explore the use of alternative strategies. The part of the track away from the muscle can still be laid open, however, the surgeon may decide to insert a **seton**. A seton is a piece of suture material or a rubber sling that can be passed from the skin opening along the line of the fistula, through the internal opening and out through the anus. It is then tied to form a loop that can stay in place for some weeks or months. Most people find a seton fairly comfortable – you can go to the toilet and wash normally quite safely. A **loose seton** is most commonly used. This acts as a wick to promote drainage of any infected material and allows the fistula track to heal gradually around the seton, leaving mature scar tissue. This is often the first part of treatment requiring several stages.

**Secondary surgery** – once a seton is in place the fistula is usually controlled but this does not result in cure and some discharge will remain. Further surgery may be needed and there are a variety of options available. The choice is dependent on the type of fistula, the underlying cause and patient and surgeon preferences.
Amongst the options are:

(a) remove the seton and hope the fistula closes or discharges a minimal amount
(b) try to close the fistula with fibrin glue – this is appealing but success is not guaranteed
(c) use a **cutting seton** which is slowly tightened over several weeks so that it gradually cuts through the muscle allowing healing but with a smaller risk of alteration of continence than occurs with a single surgical cut
(d) core out the fistula track and close the internal opening using a section of the lining of the rectum (‘mucosal flap advancement’).
(e) close the fistula track with a biological plug, called an anal fistula plug.
(f) **LIFT procedure** (ligation of the intersphincteric fistula tract). LIFT is a fairly new technique used for fistulas that cross both the internal and external anal sphincter muscles. The space between these circular muscles is opened up to reveal the cord-like fistula tract. This tract is then cut and the fistula stitched (ligated) either side.
(g) **Over the scope Clip** – this is a new procedure where a special metal clip is placed over the internal opening (in the anus) of the fistula track. It closes slowly and the idea is that it seals this opening and then the fistula track itself heals later

None of these methods are guaranteed to succeed at the first attempt, and sometimes multiple operations may be required to eventually achieve healing of the fistula. The advantage of these methods is that there is a very low risk of becoming incontinent because the anal muscle is not cut open.

**After the procedure**

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

**Eating and drinking.** You may eat and drink normally, and we recommend a high fibre diet and fluid intake of at least six to ten glasses of water daily.

**Getting about after the procedure.** We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. Within one to two hours of your operation, you will be encouraged to get up and walk around.
Leaving hospital. Discharge from hospital will be the same day (for planned day-case surgery) or the following day.

Resuming normal activities including work. After a few days, provided you feel comfortable, there are no restrictions on activity and you may lift, drive and go back to work.

Special measures after the procedure.

Bowel function: please feel free to use a laxative to help your bowels open comfortably after surgery if you wish.

Pain relief: in order to minimise the pain associated with your operation, a number of measures will be taken at the time of surgery, local anaesthetic will be injected to provide pain relief after surgery you will be given painkillers to take by mouth you may have sitz baths (a 15 minute bath in water as warm as you can tolerate) several times daily or as often as you require them. These are very soothing and provide several hours of pain relief.

Check-ups and results: Before you leave hospital, we will give you an appointment for an outpatient clinic or for the results of your surgery. At this time, we can check your progress and discuss any further treatment.

Significant, unavoidable or frequently occurring risks of this procedure

Surgery of anal fistula is generally a very safe operation with few risks, but as with any surgical procedure, complications can occur.

The maintenance of anal continence is of paramount importance in the decision-making concerning the nature of the surgery performed. For the majority of patients, laying open of the fistula does not involve cutting a significant portion of the anal muscles and continence is not at risk. Nevertheless, any disturbance of the anal sphincter muscles can lead to some degree of change in ability to control wind, liquid and, very occasionally, solid stool from the back passage.

In the period following your operation you should contact your GP or the ward if you notice any of the following problems:

- increasing pain, redness, swelling or discharge
- severe bleeding
- constipation for more than three days despite using a laxative
- difficulty in passing urine
- high temperature over 38° or chills
- nausea or vomiting.

If you suffer from urinary symptoms due to a large prostate you might be at increased risk of urinary problems after surgery.
Alternative procedures that are available

It is extremely rare for a fistula to heal without surgery and at present there are no non-surgical alternatives to this recommended treatment.

Information and support

You might be given some additional patient information before or after the procedure, for example leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including the doctor or ward staff.

If you have further questions please contact one of the colorectal specialist sisters on 01223 217923.

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

Moving to the operating room or theatre

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage.
If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

**Local anaesthesia**

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted and some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

**Sedation**

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain, the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.
What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

**Very common (1 in 10 people) and common side effects (1 in 100 people)**
- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)
Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications

- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists' website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1 Creutzfeldt Jakob Disease ('CJD')

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of Tissue

As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & dignity
Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:
If you would like this information in another language or audio, please contact Interpreting services on telephone: 01223 256998, or email: interpreting@addenbrookes.nhs.uk For Large Print information please contact the patient information team: patient.info@addenbrookes.nhs.uk.

Document history
Authors: Consultant Colorectal & General Surgeon, Eilis Rahill
Department: Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk
Contact number: 01223 245151
Publish/Review date: November 2018 /November 2021
File name: Anal_fistula.doc
Version number/Ref: 8/CF0130/1808
Surgery for anal fistula

A Patient’s side  left / right  or  N/A

Consultant or other health professional responsible for your care

Name and job title: ..........................................................

☐ Any special needs of the patient (e.g. help with communication)? ..........................................................

Please use ‘Procedure completed’ stamp here on completion: ..........................................................

B Statement of health professional (details of treatment, risks and benefits)

1 I confirm I am a health professional with an appropriate knowledge of the proposed procedure, as specified in the hospital’s consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure (please state)

- To identify the nature of the anal fistula.
- To perform surgery (often in stages) that will control/cure the fistula with minimal side effects.

b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient.

Anal fistula is generally a very safe operation but as with any surgical procedure, complications can occur: For the majority of patients, laying open the fistula does not involve cutting a significant portion of the anal muscle, nevertheless, any disturbance of the anal sphincter muscles can lead to some degree of change in ability to control wind, liquid and, very occasionally, solid stool from the back passage; Please contact your GP or the ward if you notice any increased pain, redness, swelling or discharge, severe bleeding, constipation of more than three days, difficulty in passing urine, high temperature or chills or nausea or vomiting; If you have a large prostate, possibility of increased risk of urinary problems.

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Surgery for anal fistula

d) any extra procedures that might become necessary during the procedure such as:

☐ Blood transfusion  ☐ Other procedure (please state)

2 The following information leaflet has been provided:

Surgery for anal fistula

Version, reference and date:  Version 8, CF0130, November 2018

or  ☐ I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:

☐ General and/or regional anaesthesia  ☐ Local anaesthesia  ☐ Sedation  ☐ None

Signed (Health professional): ____________________________ Date: ____________________________

Name (PRINT): ____________________________ Time (24hr): ____________________________

Designation: ____________________________ Contact/bleep no: ____________________________

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.  ☐ Yes  ☐ No

2 Photography, Audio or Visual Recording
a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.  ☐ Yes  ☐ No

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.  ☐ Yes  ☐ No

3 Students in training
I agree to the involvement of medical and other students as part of their formal training.  ☐ Yes  ☐ No

Patient safety – at the heart of all we do

Addenbrooke’s Hospital | Rosie Hospital
Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research. □ Yes □ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records. □ Yes □ No

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ............................... Date: D.D./M.M./Y.Y.Y.Y.
Name of patient (PRINT): ...........................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: ................................................................. Date: D.D./M.M./Y.Y.Y.Y.
Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .......................................................... Date: D.D./M.M./Y.Y.Y.Y.
Name of witness (PRINT): ...........................................
Address: .................................................................
Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): ................................. Date: …D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ......................................................... Job title: ..........................................................

Please initial to confirm all sections have been completed:

Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .................................................. Date: …D.D./M.M./Y.Y.Y.Y.

Name (PRINT):

Or, please note the language line reference ID number:

Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ................................. Date: …D.D./M.M./Y.Y.Y.Y.

Signed (Health professional): ................................. Date: …D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ......................................................... Job title: ..........................................................

Patient safety – at the heart of all we do

Addenbrooke’s Hospital | Rosie Hospital

Anal fistula, CF0130, V8, November 2018