

months(range 0.5-42). AlloDerm<sup>®</sup> was utilized in 20 patients (cryptoglandular (n=8), rectovaginal (n=5), Crohn's (n=2), rectourethral (n=3), pouch (1) and urinary cutaneous (n=1)). Three patients had a failed prior repair. EAF without AlloDerm<sup>®</sup> was utilized in forty-one patients (cryptoglandular (n=23), rectovaginal (n=9), Crohns (n=3), operative trauma (n=3), vaginal abscess (n=1) and hidradenitis (n=1)). Fifteen patients had prior repairs. Four patients were lost to follow-up. 18/20 patients (90%) in the AlloDerm<sup>®</sup> group had complete resolution of their fistula, compared to 22/41 (55%) without AlloDerm<sup>®</sup> (p=0.035). All patients with prior failed repair who had EAF with AlloDerm<sup>®</sup> healed, compared to 7/15(47%) without AlloDerm<sup>®</sup> (p=0.04). There were no differences in rates of smoking or Crohn's disease between groups. In patients with successful closure with either repair, there were no statistical differences in history of previous repair, BMI, smoking rate or Crohn's disease

**Conclusions:** When using EAF to repair complex anorectal fistulas, successful outcome is improved by the addition of AlloDerm<sup>®</sup>.

#### FISTULA LASER CLOSURE (FILAC): AN EXPERIMENTALLY NEW SPHINCTER-CONSERVING TREATMENT FOR ANAL FISTULA.

(P35)

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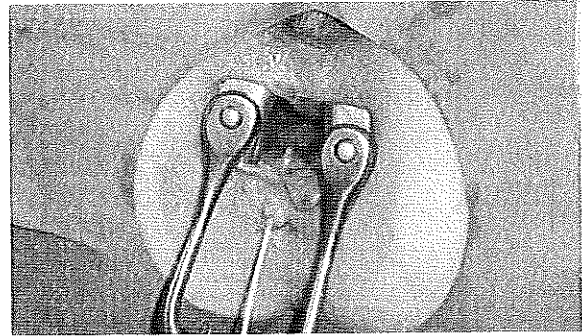
**Purpose:** Complex high and recurrent fistulas remain a surgical challenge. Fistulotomies and even seton placements are often responsible for fecal incontinence. Various surgical options for these fistulas have shown disappointing results. The authors describe a new method to seal complex fistula tracts with 980nm diode laser fibre. To assess the results of Fistula Laser Closure(FiLaC), a prospective pilot clinical study was undertaken

**Methods:** With patients in the lithotomy position both the external and internal opening of the fistula tract are identified. A disposable laser fibre delivering radiant energy at 360 degrees is introduced in the fistula through a Seldinger maneuver. Starting from the internal opening, 10W of laser radiant energy is delivered in a continuous mode while pulling the fibre out of the tract. Laser radiation causes a progressive shrinkage of tissue and primary closure of the fistula.

**Results:** Ten patients with a median age of 43 (range 28-71) with high or recurrent fistulas were included in the study and treated with FiLaC. Two patients had setons in the fistula tract at the time of operation. Postoperative evaluation included proctoscopy, anal ultrasound, QOL survey and incontinence score evaluation. At a median length of follow-up of 10 (range 3-18) months, 8 of 10 fistulas had healed(80%). In two patients the fistula recurred. One of these patients was successfully treated

again with FiLaC.

**Conclusions:** Fistula primary closure with laser is easy to perform and has a satisfactory success rate. It preserves the integrity of sphincters, has a low morbidity rate and high patients satisfaction.



#### IDENTIFICATION OF AN INTERNAL ANAL OPENING AND SETON PLACEMENT IMPROVES OUTCOME IN THE MANAGEMENT OF DEEP POSTANAL ABSCESSSES.

(P36)

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**Purpose:** Adequate drainage of any deep postanal (DPA) abscesses is crucial in its management. A seton is often placed through the internal opening but its identification is not always possible. The aim of our study was to determine if seton placement at the initial procedure improves the outcome in DPA abscesses.

**Methods:** A retrospective review of 32 patients who underwent drainage procedures for DPA abscesses from December 2002 to August 2010 was performed. All DPA abscesses were confirmed on endoanal ultrasonography.

**Results:** Twenty-four (75.0%) patients underwent drainage procedures with successful seton insertion. This group underwent a total of 55 operations with the majority of them having 2 (n = 16, 66.7%) or 3 (n = 6, 25.0%) procedures. Twenty patients underwent definitive procedures such as fistulotomy, advancement flap procedure, LIFT procedure and sphincterotomy. One patient declined further surgery while the other three underwent further drainage procedures but declined subsequent operations. The median time taken from the initial to the final surgery was 5 (2-18) months with 16/23 having their final procedures within 6 months. There were 8 (25.0%) patients who did not had any seton inserted initially as the internal opening was not identified. They underwent a total of 26 surgeries with the majority of them (n = 5, 62.5%) undergoing 3 to 4 procedures. The median duration from the initial surgery to the final definitive operation was 11 (3 - 24) months. These included advancement flap procedure, LIFT, fibrin glue and fistulotomy. Only two (25.0%) patients had their final definitive pro-