PLASTIC SURGERY OF THE ANO-PERINEAL REGION FOR BENIGN DISEASES

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Why?

The colorectal surgeon may use techniques proper to plastic surgery to obtain an adequate reconstruction of the ano-perineal region, to accelerate healing and finally to limit the functional consequences that may develop postoperatively, especially after extended operations.

What?

Many techniques can be used to remodel the anorectal and the perineal region. Advancement or rotation muscular flaps or mucosal flaps are often employed to remodel the anal canal.
Middle to full thickness skin grafts accelerate healing after wide excisions in the perineal region, while type Y-V, Z and other techniques of reconstruction are used to treat strictures.

When?

In some cases of ***complex anal fistulae*** the use of a flap allows to spare as much sphincter muscle as possible and limit to a minimum the occurrence of mild to severe fecal incontinence.
When indicated, a flap of anal mucosa comprising a portion of circular musculature can be lifted to close the site of the fistulous track after its removal (1).
In ***recto-vaginal fistulae*** the bulbocavernous muscle, a small striated muscle situated along the labia majora, may be dissected and placed between the rectal and the vaginal suture to improve the blood supply to the region and act as a barrier between the sutures (2).Alternatively the gracilis muscle can be mobilized from the inner side of the thigh and interposed without causing any functional impairment (3).
Many plastic techniques are described for the treatment of ***pilonidal disease***. Respect to the open technique the closure of the skin through flaps impressively reduces both recovery and the period of working invalidity (4).
In rare cases where circumferential prolapse of ***hemorrhoids*** is so severe that conventional haemorroidectomy does not seem reasonably sufficient to warrant a satisfactory result, Park's reconstructive haemorroidectomy may represent an option.
The surgical treatment of **anal stenosis** (the narrowing of the anal canal) is probably the most important application of plastic surgery to proctology.
Anal stenosis is often related to previous hemorroidectomy, especially when poor surgery leaves inadequate mucocutaneous bridges or in case of hypertrophic scarring at the anal margin. Another cause of anal stenosis is the chronic use of laxatives. The patient usually suffers dramatic problems during evacuation and pain. Again in such cases type Y-V plasty, Z plasty or other advancement flaps are used to restore an adequate caliber of the anal canal (5).

Who?

Many colorectal surgeons have an adequate experience to safely perform a reconstruction of the ano-perineal region. For the reconstruction of wider excisions and in complex cases the plastic surgeon has to be involved.

Riferimenti bibliografici:

1. *Miller GV & Finan PJ (1998) Flap advancement and core fistulectomy for complex rectal fistula. Br J Surg 85:108-110*
2. *Reisenauer C, Huebner M,Wallwiener D (2009)The repair of rectovaginal fistulas using a bulbocavernosus muscle-fat flap. Arch Gynecol Obstet 279:919-22*
3. *Zmora O, Tulchinsky H,Gur E,Golman G,Klausner JM,Rabau M (2006)Gracilis muscle transposition for fistulas between the rectum and urethra or vagina. Dis Colon Rectum 4:;1316-21*
4. *Kitchen PRB (1996) Pilonidal sinus : experience with the Karydakis flap. Br J Surg 83:1452-55*
5. *Keighley MRB (1999) Management of anal stenosis. In: Keighley MRB, Williams NS (eds) Surgery of the anus, rectum and colon. Saunders,London, pp 412-4*