Introduction

A fistula-in-ano is a hollow tract lined with granulation tissue connecting a primary opening inside the anal canal to a secondary opening in the perianal skin. Secondary tracts may be multiple and from the same primary opening ***(Loungnarath et al., 2004).***

Fistula-in-ano can result from a number of clinical conditions. Majority of the patients give positive past history of perianal abscess. In fact, perianal abscesses are fairly common in the community due to poor personal hygiene and hot and humid climate. Multiple fistulas can occur due to other reasons like, Crohn's disease, actinomycosis, malignancy etc ***(Mangual, 2004)***.

Anal and perianal disease, especially fistula-in-ano by their nature are embarrassing to the patient. This disease not only stresses the patient through soiling and foul smelling discharge but also causes panic. On the contrary, over enthusiastic operative treatment results in ever embarrassing faecal incontinence ***(Mangual, 2004)***.

Fistula-in-ano is a common and easily treatable surgical problem. However, injudicious and overambitious surgery may convert a relatively straight forward fistula into a catastrophe. To diminish the postoperative occurrence of fecal incontinence and to keep the recurrence rate as low as possible, the surgeon

must understand the exact relationship of the fistula to the perianal anatomic structure and space **(Stoker *et al., 2008).***

High fistula-in-ano is difficult to treat since the conventional laying-open will lead to division of most of the anal sphincter muscles resulting in incontinence. The ultimate goal of fistula surgery is to eradicate it without disturbing or disturbing minimally the anal sphincter mechanism. To achieve the objective in high anal fistula, different surgical techniques have been described in literature from time to time. These include Park's fistulotomy, insertion of a Seton, two stage-fistulotomy, advancement flaps, and repair of fistula using fibrin adhesive glue and rerouting the fistula. The number of procedures mentioned indicates that there is no single established way of treating these high fistulas ***(Qureshi et al., 2002).***

The successful surgical management of fistula-in-ano depends upon accurate assessment of the course of the primary fistulous track ,the presence and the site of any secondary extension or abscess ***(Seow-Choen and Nicholls, 1992).***

Over the last 30 years, many authors have presented new techniques and case series in an effort to minimize recurrence rate and incontinence complications. Despite of this, Fistula-in-ano remains a perplexing surgical disease ***(Loungnarath et al., 2004).***

Many radiological modalities are used to evaluate perianal fistula such as, conventional x-ray fistulography which was used for many past years as the only radiological technique, ***(Halligan and stoker, 2006).***

New modalities such as Magnetic resonance imaging with endoanal coil using T2 weighted images ***(Schaeftr et al., 2004),*** and three dimensional transrectal ultrasonographyy with the injection of hydrogen peroxide into the fistulous tract, ***(Rachel et al., 2004).***

Both magnetic resonance imaging and three dimensional transrectal ultrasonography are equally adequate radiological modalities that give an accurate idea about the level, the course, the side branches of the fistulous tract and the perianal soft tissue abnormalities. No specific benefits for either technique over the other and no patient preference for either procedures. ***(West et al., 2005).***

Fistulotomy continues to be the gold standard to which other therapies must be compared; also preservation of continence is an important goal ***(Singer et al., 2006)***.