



Letter to the Editor: Comments on “Outcomes of Loose Seton Followed by Fistulotomy in Transsphincteric Perianal Fistulas”

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Dear Editor,

We read with great interest the article by Bük et al.¹ entitled “Outcomes of Loose Seton Followed by Fistulotomy in Transsphincteric Perianal Fistulas: A Retrospective Study,” published in the Turkish Journal of Colorectal Disease. The authors should be commended for addressing an important clinical question and reporting favorable continence outcomes in a relatively large cohort.

However, we would like to raise a methodological concern that may influence the interpretation of the results: the absence of systematic preoperative magnetic resonance imaging (MRI) for fistula classification. Although all patients are reported as having transsphincteric fistulas, it is unclear whether MRI was performed in every case. Differentiation between simple and complex fistulas is difficult on clinical examination alone, particularly after an abscess or inflammation, and a lack of routine MRI risks misclassification.²

This point is clinically relevant because many intersphincteric and low transsphincteric fistulas can be safely managed with primary fistulotomy without the need for prolonged loose seton placement.³ The low incontinence rate and universal healing reported in this series, therefore, raise the possibility that some patients labeled “transsphincteric” may have had

simple fistulas amenable to straightforward fistulotomy. In a retrospective cohort, such uniformly favorable outcomes should be interpreted cautiously in light of potential case selection and baseline classification.

Consequently, the excellent functional outcomes observed may reflect underlying fistula anatomy rather than the intrinsic superiority of a staged loose-seton strategy. MRI is the most accurate preoperative imaging modality for delineating tracts and extensions and can influence operative planning and outcomes.⁴ Radiologic consensus statements likewise recommend MRI as a core component of systematic fistula evaluation to avoid misclassification.⁵

In a large operative-MRI correlation study, Garg et al.⁶ reported that 34% of clinically simple fistulas were upgraded after MRI, whereas MRI revealed additional complex parameters in 52.5% of fistulas already considered complex on clinical examination, with direct implications for operative decision-making. These findings underscore that MRI modifies the perceived anatomical extent of disease and highlight the risk of both over- and under-classification in the absence of standardized preoperative imaging.^{6,7} In this context, the absence of standardized preoperative MRI in the current study may limit generalizability and



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could overestimate the benefit of loose seton use in transsphincteric fistulas.

Moreover, the manuscript does not clarify how fistulas initially classified as transsphincteric became suitable for fistulotomy during follow-up, and no objective reassessment (clinical or imaging based) is reported to confirm true anatomical “downgrading.” In an MRI before–after study of trans- and suprasphincteric fistulas, Verkade et al.² found no significant distal migration relative to the external sphincter/puborectalis and observed downgrading in only 1/40 tracts (3%), concluding that loose silicone seton drainage should not be offered as a strategy to downgrade (simplify) a complex fistula.

We believe this study reinforces the importance of preoperative MRI as a determinant of strategy and patient selection. We suggest that future studies incorporate routine preoperative MRI to ensure accurate classification and valid outcome comparisons.

Footnotes

Authorship Contributions

Concept: S.L., D.Z., Design: E.E., D.Z., Data Collection or Processing: E.E., Analysis or Interpretation: E.E., D.Z., Literature Search: E.E., Writing: E.E., D.Z.

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