

Evidence Discussion (PV 21.1)

- Anorectal fistulas most commonly arise from abscesses that originate in the anal crypts (90%). Physical exam will frequently identify these but advanced imaging is often needed to determine the course of the fistulous tract, its relationship with the sphincteric musculature and associated infection/abscess. Because of its superior resolution, MRI is the preferred modality, followed by endoscopic ultrasound and then CT.
 - Non-iatrogenic anal fistula located in atypical positions (lateral) suggest the possibility of Crohn's disease. See IBD – Perirectal/Perianal disease (AB-23.3).
1. Ziech M, Felt-Bersma R, Stoker J. Imaging of Perianal Fistulas. Clinical Gastroenterology and Hepatology. 2009;7(10):1037-1045
 2. Vogel JD, Johnson EK, Morris AM, et al. Clinical Practice Guideline for the Management of Anorectal Abscess, Fistula-in-Ano, and Rectovaginal Fistula. Diseases of the Colon & Rectum. 2016;59(12):1117- 1133

Evidence Discussion (PV 21.2)

- Pelvic infections can take the form of intraperitoneal abscesses or perineal wall infections.
 - Refer to Abdominal Sepsis (AB-3-1) for intraabdominal pelvic abscess.
 - History and physical can usually identify perineal (perirectal and perianal) abscesses. Due to a high rate of recurrence due to associated fistulous tracts, advanced imaging with MRI (preferred because of its improved resolution), endorectal ultrasound or CT scan. Primary treatment is surgical drainage.
1. Abcarian H. Anorectal infection: abscess-fistula. Clin Colon Rectal Surg 2011; 24:14.
 2. Ziech M, Felt-Bersma R, Stoker J. Imaging of Perianal Fistulas. Clinical Gastroenterology and Hepatology. 2009;7(10):1037-1045.
 3. Vogel JD, Johnson EK, Morris AM, et al. Clinical Practice Guideline for the Management of Anorectal Abscess, Fistula-in-Ano, and Rectovaginal Fistula. Diseases of the Colon & Rectum. 2016;59(12):1117- 1133.
 4. Hancock KJ, Gajjar AH. Anorectal Disorders. Obstetrics & Gynecology. 2020;136(3):642-642.
 5. Levy AD, Liu PS, Kim DH, et al. ACR Appropriateness Criteria® Anorectal Disease. Journal of the American College of Radiology. 2021;18(11):S268-S282.

Evidence Discussion (PV 21.3)

- MRI has been established as a method of delineating vaginal fistulas. This is secondary to its excellent soft tissue resolution, allowing identification of acute inflammatory changes, post-surgical fibrosis, neoplastic tissue and abscesses¹. It also has the benefit of lacking ionizing radiation, but may have limited access as compared with CT. MRI is also contraindicated by the presence of metallic foreign body or MRI-incompatible devices, such as some pacemakers¹. Studies have shown a positive predictive value of 92% for delineation of anorectal vaginal fistulas².
 - CT can also be utilized in the visualization of fistulas^{1,3}. It does have lower contrast resolution than MRI¹ and does carry the risk of ionizing radiation. It may be beneficial in emergent situations given the wide availability or in situations where an MRI is contraindicated. CT-urography/cystography is also a mainstay in evaluation of the urinary tract and can be utilized to evaluate urinary vaginal fistulas¹.
1. Tonolini M. Elucidating vaginal fistulas on CT and MRI. Insights into Imaging. 2019;10(1). doi:10.1186/s13244-019-0812-9
 2. VanBuren WM, Lightner AL, Kim ST, et al. Imaging and Surgical Management of Anorectal Vaginal Fistulas. RadioGraphics. 2018;38(5):1385-1401. doi:10.1148/rg.2018170167
 3. Levy AD, Liu PS, Kim DH, et al. ACR Appropriateness Criteria® Anorectal Disease. Journal of the American College of Radiology. 2021;18(11):S268-S282. doi:10.1016/j.jacr.2021.08.009

Evidence Discussion (PV 21.4)

- Pilonidal cysts most frequently arise in the natal cleft, the groove between the buttocks overlying the sacral area. Asymptomatic disease usually does not require any treatment. Acute and chronic infections can be evaluated sufficiently with history and physical alone. Advanced imaging is limited to concern for complicated disease (See Infection/Osteomyelitis - MS-9.1).
1. Johnson EK, Vogel JD, Cowan ML, Feingold DL, Steele SR. The American Society of Colon and Rectal Surgeons' clinical practice guidelines for the management of pilonidal disease. *Dis Colon Rectum*. 2019;62:146-157.
 2. Doll D, Friederichs J, Boulesteix AL, et al. Surgery for asymptomatic pilonidal sinus disease. *Int J Colorectal Dis* 2008; 23:839.