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Disability Due To Enter cutaneous Fistulas

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Clinical Image Description

Enter cutaneous fistulas constitute one of the most complicated problems that the surgeon must face and involves the application of knowledge such as fluid and electrolyte management, metabolic and nutritional support, and complex diagnostic and surgical techniques [1,2].

Fistula is an abnormal communication between two epithelialized surfaces, usually with granulation tissue.

Classification: Due to their anatomical location, intestinal fistulas are classified as internal or external. The internal ones communicate two organs and the external ones do so directly or indirectly with the body surface. They can be simple with a single connection or complicated, with several tracts or connected to an abscessed cavity; when talking about physiological classification, it refers to flow; High flow ones are those that drain more than 500 ml/day, and low flow ones drain less than 500 ml/day. Stiges-Serra and Schein proposed classifying them based on their location and whether they drain through a large abdominal wall defect [3-5].

Classification of Postoperative Enter cutaneous Fistulas [4].

Group 1: Esophageal, gastric, small intestine and ileocolic.

Group 2: Fistulas that drain through a large abdominal wall defect.

Group 3: Appendiceal and colonic fistulas.

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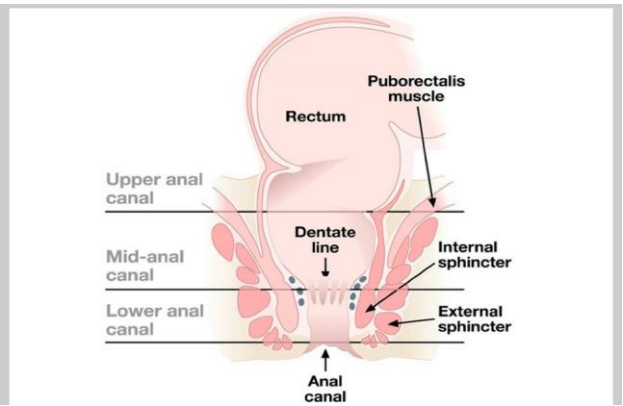

Figure 1: Anatomy and classification of the anal canal.

The suprasphincteric enter cutaneous fistula does not affect the worker's fecal continence. But assuming a communication of the digestive tube in its last section with the epidermal area, exudation of fecaloid and sometimes purulent material occurs when it becomes superinfected. This very frequently causes the formation of abscesses, that is, an accumulation of pus without its release, which produces pain, inflammation and fever, causing the patient's loss of functional capacity. The presence of this type of chronic pathology, which has exhausted the therapeutic possibilities, requires the worker to maintain exquisite hygiene of the perianal area. Working in areas with high temperatures, such as in your usual workplace, facilitates the formation of abscesses more frequently, since the high temperature facilitates bacterial growth. The repetitive flexo-extension movements of the lumbosacral area are stimulated by the friction of the Seton with the epidermal surface, which facilitates irritation, inflammation and the penetration of bacteria from the outer surface to the interior and the release of purulent-fecaloid material from the lumbosacral area. The inside to the outside through the fistula.

Figure 2: Anatomical model of the anal canal.

This pathology was presented by a worker in a battery factory. The worker was diagnosed more than 10 years ago [6], this fistula appears suddenly without relation with Crohn´s disease. He was evaluated by the Surgery service where he was intervened on five times without a definitive solution to the problem. Finally, the patient was placed with a permanent drain to avoid false closure and the production of abscesses. The patient had to resort to multiple long-term sick leave due to not being able to do his job properly. Unexpectedly, the occupational health doctor did not revoke his fitness for his job. This meant litigation by the worker himself for recognition of his incapacity for his job.

One of the functions of the occupational doctor is the assessment of the worker´s physical fitness for the work activity he or she performs. A personalized assessment must be carried out depending on the characteristic of the job and the psychophysical health status of the worker. This must be carried out depending on the characteristics of the job and the psychophysical health status of the worker. Otherwise, harm could happen not only to the worker, but also to his co-workers, to the company and to production.

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