EURASIAN HEALTH JOURNAL
Volume 18, No. 2. P. 31-42
Journal homepage: https://health-ksma.com/en
ISSN 1694-8882 / e-ISSN 1694-8890

UDC 616.352
DOI: 10.54890/1694-8882-2026-2-31

Received: 08.12.2025; Revised: 20.04.2026;
Accepted: 29.05.2026; Published: 30.06.2026

Current approaches to the diagnosis and treatment of acute paraproctitis (literature review)

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Abstract. Acute paraproctitis is a clinically significant suppurative inflammatory lesion of the pararectal tissue that requires timely diagnosis, adequate surgical drainage, and follow-up because of the risk of recurrence and anal fistula formation. The purpose of this study was to summarise current literature on the aetiology, pathogenesis, classification, diagnosis, surgical treatment, and postoperative management of patients with acute paraproctitis. A narrative literature review with elements of comparative analysis was carried out. The review established that acute paraproctitis most often develops as a manifestation of cryptoglandular infection, with polymicrobial flora and spread of pus into the perianal, intersphincteric, ischioanal, or supralevator space. For a typical superficial abscess, clinical inspection and digital rectal examination are sufficient, whereas recurrent, deep, and Crohn-associated forms require magnetic resonance imaging or endoanal ultrasonography. Timely incision and drainage remain the basic method of treatment. Primary fistulotomy was justified only for a clearly verified low fistula, whereas complex forms required a staged approach, with possible use of a draining seton. According to the reviewed sources, the rate of fistula formation after drainage was 23.0-33.9%, and, in a randomised study, omission of packing reduced pain from 38.2 to 28.2 points without a statistically significant increase in fistula or recurrence rates. Antibiotic therapy had selective value in systemic infection, cellulitis, immunosuppression, or diabetes mellitus. The optimal management strategy should be stratified according to anatomical form, fistula risk, systemic manifestations, and comorbid background. The practical significance of the study lies in substantiating a stratified algorithm for managing patients with acute paraproctitis, which differentiates simple and complex forms of the disease, identifies the need for imaging, antibacterial therapy, and staged surgical treatment in due time, and accounts for the risk of recurrence and anal fistula formation

Keywords: anorectal abscess; cryptoglandular infection; anal fistula; drainage; seton; postoperative follow-up

Introduction

Acute paraproctitis is a common emergency disorder of the anorectal region, characterised by the formation of a purulent focus in the pararectal tissue, with a risk of infection spread, recurrence, and progression to a chronic anal fistula. The clinical importance of this pathology is determined not only by the frequency of admissions to surgical and coloproctological departments but also by the need for a rapid choice between minimally sufficient drainage, extended anatomical mapping, one-stage intervention on a fistulous tract, or staged management. In the literature, acute paraproctitis is most often discussed within the cryptoglandular concept, according to which primary infection of the anal crypts and glands creates conditions for the spread of pus into the intersphincteric, perianal, ischioanal, or supralevator space. In the educational and clinical section by K.R. McQuaid [1], anorectal infections were presented as a group of conditions requiring early recognition of the localisation of the process and differentiation of superficial abscesses from deep lesions, as this determines further treatment tactics.

The relevance of the problem is strengthened by the fact that the clinical presentation of acute paraproctitis does not always correspond to the actual depth and extent of the purulent process. Superficial abscesses are usually accompanied by local pain, hyperaemia,

Likhomanov L. Current approaches to the diagnosis and treatment of acute paraproctitis (literature review). Eurasian Health J. 2026;18(2):31–42. DOI: 10.54890/1694-8882-2026-2-31

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swelling, and fluctuance, whereas deep ischioanal or supralevator lesions may present mainly with pain, intoxication, fever, and non-specific discomfort without marked external changes. C. Qi & J. Li [2] stressed the practical value of instrumental mapping in complicated forms of acute paraproctitis: according to their data, three-dimensional endoanal ultrasonography and magnetic resonance imaging have clinical value in the preoperative assessment of anal fistula, as they clarify the anatomical type of the tract and its relationship with the sphincter complex. These data are important for countries and regions where magnetic resonance imaging is not always available as the first-line instrument for preoperative mapping.

The diagnostic problem of acute paraproctitis lies in combining the speed required for emergency surgical care with sufficient anatomical accuracy. In a typical superficial form, excessive instrumental assessment may delay drainage, whereas in recurrent, deep, or complex disease, the absence of imaging clarification increases the risk of incomplete control of the source of infection. In the illustrated review by T. Hosokawa [3], the staged role of physical examination, perianal sonography, and magnetic resonance imaging was substantiated: ultrasonography was presented as an accessible method of initial assessment, and magnetic resonance imaging – as a necessary tool for deep lesions, large abscesses, or suspected complex fistulas. This approach suggests that the diagnosis of acute paraproctitis should be stratified rather than identical for all patients.

The issue of surgical tactics remains equally important because acute paraproctitis requires timely control of the purulent focus while preventing recurrence, fistula formation, and functional damage to the sphincter apparatus. The basic method of treatment is incision and adequate drainage of the abscess, yet the extent of the primary intervention depends on the anatomical form of the process, the presence or probability of a fistulous tract, systemic manifestations of infection, and the availability of specialised coloproctological care. In this context, regional data from A. Kussainova *et al.* [4], obtained during analysis of the clinical and organisational features of paraproctitis management in the Abai region of Kazakhstan, showed that the outcome of treatment depends not only on the operative method selected but also on timely patient routing, access to specialised care, and organisation of postoperative follow-up. The development of sphincter-preserving approaches reflects an effort to minimise the risk of continence disorders in patients with pathology of cryptoglandular origin. E. Karacan & E.M. Yılmaz [5], for example, discussed laser ablation of the fistulous tract as a minimally invasive option for high anal fistulas; this is relevant not as direct justification for the treatment of an acute abscess, but as an example of a broader shift towards function-sparing surgery in complex fistulous forms.

The international literature also discusses the role of surgeon specialisation and organisation of emergency care. G.A. Turner *et al.* [6] analysed 408 patients with acute perianal abscess treated in an emergency surgery department; colorectal surgeons more often detected a fistula during the primary operation, although surgeon specialisation was not associated with a statistically significant improvement in recurrence rates or subsequent fistula formation. M.A. Casas *et al.* [7] reported a similar problem: colorectal surgeons more often performed definitive treatment of a concomitant fistula, but recurrence, readmission, reoperation, and incontinence rates did not differ substantially between groups. This indicates that quality of treatment is determined not only by specialisation, but also by timely drainage, appropriate selection of patients for extended intervention, and the presence of an algorithm for postoperative follow-up.

The evidence base concerning the choice of the optimal treatment method remains heterogeneous. In a retrospective study by J. Hu *et al.* [8], an intersphincteric approach with an internal incision and counter-drainage was compared with standard incision and drainage for deep perianal abscesses. The authors highlighted the clinical importance of adequate drainage of deep spaces and prevention of premature closure of the drainage opening. In a randomised single-blind study by L. Ghahramani *et al.* [9], the use of ciprofloxacin and metronidazole after incision and drainage of a simple perianal abscess was associated with a lower risk of fistula formation. A review by H.C. Kim & V.V. Simianu [10] described complex anorectal fistulas as a condition requiring anatomically grounded selection of surgical tactics, assessment of recurrence risk, and preservation of sphincter function. These data strengthen the position that sphincter-preserving and staged approaches are needed in complex cryptoglandular forms. The clinical problem of acute paraproctitis is the need to coordinate three tasks: timely elimination of the acute purulent focus, accurate determination of anatomical complexity, and prevention of recurrence or chronic fistula without unjustified risk to anal continence. Existing sources share the basic principle of surgical infection control, but differ in their assessment of the role of imaging, the extent of primary intervention, antibiotic therapy, and postoperative management. A synthesis of the literature is needed to develop a differentiated model of patient management. This study aimed to analyse current approaches to the diagnosis and treatment of acute paraproctitis based on literature data.

Materials and Methods

The study was conducted as a narrative literature review with elements of comparative analysis of current approaches to the diagnosis and treatment of acute paraproctitis. The methodology was aimed at analytical and synthetic comparison of data on aetiology, pathogenesis, classification, diagnostic algorithms, surgical

tactics, the role of antibacterial therapy, and postoperative management of patients with anorectal abscesses. The review format was selected because the problem covers different types of sources: clinical guidelines, position papers of professional societies, systematic reviews, randomised studies, retrospective cohort studies, clinical reviews, and individual publications on complicated forms of the disease.

The literature base for the review was formed by searching publications in open scientific databases and resources, including PubMed, PubMed Central, Google Scholar, ScienceDirect, SpringerLink, Wiley Online Library, BMJ Open, World Journal of Emergency Surgery, and the websites of professional societies and publishers where clinical guidelines on coloproctology and emergency surgery are available. The indicative search terms were acute paraproctitis, anorectal abscess, perianal abscess, anal fistula, diagnosis, surgical treatment, antibiotic therapy, and postoperative management. These terms were used to identify publications covering aetiology, classification, instrumental diagnosis, surgical drainage, prevention of recurrence, and postoperative management of patients with acute paraproctitis. The search focused mainly on publications from 2019-2026 (for 2026, sources available at the time of preparing the review were included), which covered a seven-year period and included the most recent clinical guidelines and studies. The most relevant publications covering current approaches to the aetiology, pathogenesis, classification, diagnosis, surgical treatment, and postoperative management of patients with acute paraproctitis were selected for the study. Publications from 2019-2026 addressing current approaches to the diagnosis, classification, surgical treatment, and postoperative management of acute paraproctitis were included. Preference was given to clinical guidelines, systematic reviews, randomised studies, cohort studies, and retrospective studies of clinical relevance for developing patient management tactics. Sources without a direct connection to acute paraproctitis, general publications without practical value, and works devoted to chronic fistulas without a connection to acute abscess were not included.

The selected sources were analysed in three thematic areas. The first area covered the aetiology, pathogenesis, and classification of acute paraproctitis, including the cryptoglandular mechanism of infection, the polymicrobial nature of the process, and anatomical variants of abscess spread. The second area concerned diagnostic approaches: clinical examination, laboratory assessment of the systemic inflammatory response, and the use of imaging methods in deep, recurrent, or complicated forms. The third area focused on treatment and postoperative management, including surgical drainage, tactics for concomitant fistula, use of a draining seton, antibacterial therapy, postoperative wound care, and management of patients with risk factors for a complicated course. The material was summarised using theoretical analysis, synthesis, comparison, clinical-logical generalisation, and structural systematisation. Theoretical analysis was applied to identify key provisions on the aetiology, pathogenesis, classification, and clinical course of acute paraproctitis from clinical guidelines, position papers, and reviews [11-16]. Synthesis combined data from these sources into an integrated understanding of the cryptoglandular mechanism of disease development, the polymicrobial character of infection, anatomical variants of abscess spread, and the risk of anal fistula formation.

Comparative analysis was used to compare the diagnostic informativeness of clinical examination, magnetic resonance imaging, endoanal ultrasonography, transrectal or transperineal sonography, and computed tomography. Diagnostic methods were assessed with regard to their clinical availability, suitability for superficial and deep forms of abscess, ability to detect supralevator spread, value in mapping a fistulous tract, and importance for surgical planning. Sources [17-21], which discussed the role of magnetic resonance imaging, endoanal sonography, and computed tomography in complex, recurrent, Crohn-associated, and extensive forms of anorectal infection, were used for this purpose.

A stratified treatment approach was substantiated using clinical-logical generalisation depending on abscess localisation, the presence or probability of fistula, systemic manifestations of infection, comorbid background, and risk of impaired anal continence. Treatment approaches were compared according to timeliness of source control, adequacy of drainage, risk of recurrence, probability of fistula formation, preservation of sphincter function, need for antibacterial therapy, and postoperative care features [22-23]. Specific disputed issues in treatment were assessed using sources with different levels of evidence. The role of antibacterial therapy after drainage was analysed using a meta-analysis, a protocol for a randomised study, and a retrospective study [24-26]. The appropriateness of postoperative packing of the cavity after abscess incision was assessed using the results of the randomised study by K. Newton *et al.* [27]. Rates of anal fistula formation, recurrence risk, and postoperative outcomes were reviewed using the studies presented in [28-30].

Structural systematisation was used to distinguish specific clinical situations in which the standard algorithm for a simple superficial abscess requires modification. These situations included Crohn-associated lesions, deep and extensive purulent processes, phlegmon, necrotising perineal infections, diabetes mellitus, immunosuppression, and other risk factors for a complicated course. Data from E. Shehi *et al.* [31], H. Zhang *et al.* [32], I.M. Shevchuk *et al.* [33] were used for their analysis. The quality and relevance of sources were considered descriptively, without a formal meta-analysis, because the selected publications differed in design,

clinical groups, endpoints, and level of evidence. Clinical guidelines and position papers were used to define general management principles, whereas randomised, cohort, and retrospective studies, together with clinical cases, were used to clarify specific questions of diagnosis, treatment, and postoperative follow-up. Statistical processing of original empirical data was not performed because the paper is a review and did not involve forming a primary clinical sample of patients. Quantitative indicators presented in the results were taken from the literature sources analysed and were used only to illustrate the frequency of specific clinical outcomes, including anal fistula formation after perianal abscess drainage. The limitation of the analysis was the heterogeneity of the included sources in terms of design, samples, duration of follow-up, criteria for fistula diagnosis, and local surgical approaches, which complicates direct quantitative comparison of results.

Aetiology, pathogenesis, and classification of acute paraproctitis

The review indicates that, in coloproctological practice, acute paraproctitis should be understood not only as a local suppurative inflammatory lesion of the pararectal tissue but also as an acute clinical form of anorectal infection, the course of which is shaped by the interaction of the cryptoglandular mechanism of infection, anatomical routes of pus spread, the microbiological composition of the inflammatory focus, and patient-specific risk factors. The synthesis of clinical guidelines, position papers, and reviews by W.B. Gaertner *et al.* [11], A. Tarasconi *et al.* [12], A. Kata & J.S. Abelson [13], E. Polyzou *et al.* [14], A. Amato *et al.* [15], and J.N. Conner *et al.* [16] allowed identifying a shared position: acute anorectal abscess and anal fistula are interrelated manifestations of one pathological continuum. This has clinical relevance, as primary abscess drainage does not always end the pathological process; in some patients, after the acute purulent focus has been eliminated, a fistulous tract persists or forms and requires further follow-up and, when indicated, delayed surgical treatment.

The cryptoglandular theory remains the leading concept for explaining most cases of acute paraproctitis. According to this concept, primary infection occurs in the anal crypts and glands that open into the anal canal. Obstruction of the excretory duct of an anal gland creates conditions for secretion accumulation, bacterial proliferation, increased intratissue pressure, and formation of a purulent cavity. Subsequent spread of infection is determined by the anatomical boundaries between the internal and external sphincters, the ischioanal tissue, the submucosal layer, and the space above the levator ani muscle. The same aetiological basis may be realised in different clinical forms, from a superficial perianal abscess to a deep supralevator or horseshoe purulent process. The clinical significance of the cryptoglandular theory lies in its explanation of the relationship between acute abscess and subsequent risk of anal fistula. If the infected crypt or internal opening of the pathological tract persists after drainage, an anatomical prerequisite for chronicity is formed. Treatment of acute paraproctitis should not be assessed only by evacuation of pus and reduction of pain in the early postoperative period. The risk of later fistula formation must be considered, especially in deep, recurrent, ischioanal, intersphincteric, and Crohn-associated forms. This approach distinguishes contemporary management from a purely local view of the abscess as an isolated collection of pus.

The microbiological aspect of acute paraproctitis also has clinical importance. Synthesis of data from E. Polyzou *et al.* [14] and E. Sanchez-Haro *et al.* [34] confirmed that anorectal abscesses and anal fistulas usually have a polymicrobial character. The structure of infection includes combinations of aerobic and anaerobic flora of intestinal origin, including *Escherichia coli*, bacteria of the genus *Bacteroides*, enterococci, streptococci, staphylococci, and other representatives of mixed microbial associations. This microbiological profile explains why, in systemic manifestations, extensive cellulitis, or a necrotising process, antibacterial therapy should cover both aerobic and anaerobic components. The polymicrobial nature of infection does not change the basic position: a formed abscess requires surgical drainage, because an anatomically limited purulent cavity cannot be reliably eliminated by systemic medication alone.

The anatomical classification of acute paraproctitis has practical rather than merely descriptive value. It determines the probability of clinical detection of an abscess, the need for imaging, the type of surgical access, and the risk of recurrence or fistula. The sources distinguish perianal, ischioanal, intersphincteric, supralevator, and submucosal abscesses [12,16]. A perianal abscess is located superficially near the anal margin and is usually accompanied by local swelling, hyperaemia, tenderness, and fluctuance. This form can most often be diagnosed clinically without mandatory preoperative imaging. An ischioanal abscess spreads laterally into the ischiorectal tissue and may cause more pronounced pain, intoxication, and less obvious superficial manifestations. An intersphincteric abscess is located between the internal and external anal sphincters, so its clinical picture may be less typical. A supralevator abscess forms above the levator ani muscle and has the greatest importance for differential diagnosis, as it may be related either to ascending cryptoglandular disease or to a pelvic or other secondary source of infection.

The aetiology, pathogenesis, and classification of acute paraproctitis are directly linked to diagnosis and treatment. Cryptoglandular origin explains the risk of fistula; the polymicrobial character of infection – the selective role of antibiotic therapy; anatomical routes of spread – the need for differentiated imaging; and localisation-based classification guides the choice of surgical

access and the extent of postoperative follow-up. For this reason, a review analysis should treat pathogenesis not as a theoretical description, but as the basis of a clinical algorithm for patient management.

Clinical stratification of diagnostic assessment of patients

Diagnosis of acute paraproctitis should be based on stratification, meaning that the extent of examination is selected according to the clinical form, depth of the process, systemic response, and risk of complex anatomy. Synthesis of data from W.B. Gaertner *et al.* [11] and A. Tarasconi *et al.* [12] indicates that, in a typical superficial perianal abscess, the main methods remain clinical inspection, digital rectal examination, and assessment of the general condition. In this situation, local pain, swelling, hyperaemia, fluctuance, and increased pain when sitting or defecating are usually sufficient for diagnosis and for deciding on drainage. Excessive waiting for instrumental findings in an obvious superficial form may be inappropriate because it delays control of the source of infection.

Laboratory indicators have auxiliary rather than decisive value in diagnosing acute paraproctitis. Leucocytosis, elevated C-reactive protein, procalcitonin, lactate, or impaired renal function do not confirm the anatomical localisation of an abscess, but they help assess infection severity, septic risk, systemic inflammatory response, and the need for hospitalisation or more intensive monitoring. This is important in diabetes mellitus, immunosuppression, suspected phlegmon, necrotising infection, or spread beyond a local perianal focus.

Imaging methods should not be applied uniformly to all patients. Their value is highest when the clinical picture does not match a typical superficial abscess or when a deep, recurrent, or complex form is suspected. Synthesis of the works by E. Anand *et al.* [17], H. Habeeb *et al.* [18], and M.P. Kawecki *et al.* [19] supports magnetic resonance imaging of the pelvis as the leading method of anatomical mapping in complex perianal pathology. It is appropriate in recurrent disease, suspected supralevator spread, multiple tracts, internal fistula opening, perianal Crohn's disease, or the need to plan staged sphincter-preserving treatment. The practical value of magnetic resonance imaging lies in confirming the presence of a purulent focus and defining its spatial relationship with the sphincter complex, the levator ani muscle, and possible secondary tracts.

Endoanal, transrectal, or transperineal ultrasonography has a different area of use. According to S. Kumar *et al.* [20], endoanal sonography may be useful for assessing the internal and external sphincters, detecting low intersphincteric or transsphincteric tracts, and clarifying lesion localisation in centres with appropriate experience. Ultrasonographic methods have the advantages of availability and rapid performance, although their informativeness depends on operator expertise, technical conditions, and tolerability of the procedure during the acute inflammatory phase. In supralevator, multiple, or complex lesions, magnetic resonance imaging remains more suitable for complete mapping of the process. Computed tomography has an advantage in another clinical scenario, when rapid assessment of infection spread is required. According to L.A. Barbu *et al.* [21], computed tomography is appropriate when phlegmon, gas in tissues, pelvic or retroperitoneal spread, systemic intoxication, or signs of sepsis are suspected. It provides less detail of the sphincter complex than magnetic resonance imaging, but is useful in emergencies when the extent of infection must be determined quickly and a decision on surgical revision is needed. When a necrotising process is suspected, imaging should not delay operative intervention (Table 1).

Table 1. Diagnostic appropriateness of the main examination methods in acute paraproctitis depending on the clinical scenario

Clinical situation	Most appropriate method	What it clarifies	Method limitations	Practical conclusion for patient management
Typical superficial perianal abscess with local tenderness, hyperaemia, and fluctuance	Inspection of the perianal region, digital rectal examination, assessment of the general condition	Presence of a superficial purulent focus, local inflammatory signs, fluctuance	Does not always detect intersphincteric, ischioanal, or supralevator abscesses	In a typical clinical picture, drainage should not be delayed because of non-mandatory imaging
Suspected intersphincteric or low transsphincteric process	Endoanal or transperineal ultrasonography	Relationship of the process to the internal and external sphincters, possible low fistulous tract	Dependence on operator experience; pain during the acute phase	Appropriate in centres with relevant experience, especially for clarifying low lesions
Recurrent abscess, suspected complex fistula, or multiple tracts	Magnetic resonance imaging of the pelvis	Secondary branches, internal opening, relationship with the sphincter complex, supralevator spread	Lower availability, time requirement, higher cost	Appropriate for preoperative mapping and planning of staged tactics

Clinical situation	Most appropriate method	What it clarifies	Method limitations	Practical conclusion for patient management
Suspected perianal Crohn's disease	Magnetic resonance imaging of the pelvis; endoanal ultrasonography if needed	Inflammatory activity, abscesses, fistulas, secondary tracts, response to treatment	Requires interpretation in the context of the gastroenterological diagnosis	Should be used not only for initial diagnosis, but also for monitoring response to therapy
Signs of sepsis, phlegmon, necrotising infection, or spread into pelvic/ retroperitoneal spaces	Computed tomography; emergency surgical revision when indicated	Gas in tissues, spread of phlegmon, pelvic or retroperitoneal involvement	Provides less detail of the sphincter complex than magnetic resonance imaging	Imaging should not delay emergency surgery in a necrotising process

Source: created by the author based on analysis of data from [11-12,17-21]

Diagnosis of acute paraproctitis should follow the principle of clinical sufficiency. In a simple, superficial form, timely recognition and drainage are central. In a deep, recurrent, complex, or Crohn-associated form, imaging becomes an instrument for planning treatment tactics. In a systemically complicated course, computed tomography or other methods for assessing spread should be used in a way that does not delay surgical control of the source of infection.

Surgical treatment and source control

The main shared conclusion of the analysed clinical guidelines and surgical studies is that timely incision and adequate drainage remain the basic treatment for acute paraproctitis. According to W.B. Gaertner *et al.* [11], A. Tarasconi *et al.* [12], and A. Kata & J.S. Abelson [13], drainage provides source control, evacuation of pus, reduction of local tissue pressure, and conditions for healing. Delayed surgery in a formed abscess may promote the spread of infection into adjacent tissue spaces, intensification of the systemic response, and a higher risk of complications. Drainage technique should correspond to the anatomical form of the abscess. In superficial perianal collections, a local incision with evacuation of pus, breakdown of septa, and provision of outflow may be sufficient. In ischioanal, horseshoe, intersphincteric, or supralevator abscesses, access must be defined more precisely because incomplete drainage of a deep space may lead to recurrence. This is important when external manifestations are less marked, and the extent of the purulent process exceeds the clinically visible lesion area.

One-stage treatment of a concomitant fistula during primary drainage remains limited to selected indications. Synthesis of data from W.B. Gaertner *et al.* [11], A. Amato *et al.* [15], and L. Reza *et al.* [22] suggests that primary fistulotomy may be considered only when a clearly identified simple low fistula is present and does not involve a substantial part of the external sphincter. This approach may reduce the risk of recurrent abscess or later intervention, but it should not be used as a routine strategy for all patients. During acute inflammation, the tract anatomy may be unclear, tissues oedematous, and the risk of damage to the sphincter apparatus increased. In fistulas involving a substantial portion of the sphincter complex, complex fistulas, anterior fistulas in women, cases with unclear anatomy, or suspected Crohn-associated disease, one-stage fistulotomy should not be used as a routine approach.

A draining seton is relevant in the staged management of complex or high-risk cases. According to T. Erol *et al.* [23], use of a draining seton can maintain outflow, prevent premature closure of the external opening, and reduce the risk of repeated accumulation of pus. Its use is most justified for high-lying, complex, recurrent, or incompletely verified fistulas, where immediate division of the tract may carry an unacceptable risk of impaired anal continence. A seton should not be treated as a mandatory procedure in every case of acute paraproctitis. If a fistula is not verified and the abscess is simple and superficial, adequate incision and drainage may be sufficient. A staged surgical approach is important in recurrent, Crohn-associated, and anatomically complex forms. The logic of this approach is that acute infection is controlled at the first stage, whereas definitive fistula treatment is deferred until inflammation decreases, the anatomy of the pathological tract becomes clearer, and the risk of sphincter injury is lower. This approach combines two key goals: timely sanitation of the purulent focus and preservation of the function of the anal sphincter complex.

Antibiotic therapy and postoperative management of patients with acute paraproctitis

Antibacterial therapy in acute paraproctitis should be viewed in two different clinical contexts. The first is the treatment of complicated infection. According to W.B. Gaertner *et al.* [11] and A. Tarasconi *et al.* [12], antibiotics are indicated in cellulitis, systemic signs of infection, fever, immunosuppression, diabetes mellitus, septic risk, spread of infection beyond the local abscess, or suspected necrotising disease. In this situation, antibacterial therapy is a component of comprehensive treatment, supplementing surgical source control but not replacing it. Its purpose is to act on extensive

cellulitis, the systemic bacterial response, and the polymicrobial component of infection.

The second context is prophylactic use of antibiotics after drainage to reduce the risk of anal fistula formation. Data presented by V. Mocanu *et al.* [24], J.Y. van Oostendorp *et al.* [25], J. Alabbad *et al.* [26], V. Polaino Moreno *et al.* [35], and A.A. Alam *et al.* [36] indicated that this issue remains debated. Individual studies and meta-analytic summaries suggest a possible reduction in fistula risk when antibiotics are used after drainage, although the evidence base is heterogeneous and protocols for new randomised studies point to the absence of a final consensus. Antibiotics should not be prescribed routinely for all patients with a simple superficial abscess. Their use should be justified by the severity of the clinical condition, the presence of a systemic response, extensive cellulitis, immune status, metabolic risk factors, and the quality of surgical drainage.

Postoperative management after drainage should include pain control, local care, maintenance of outflow, prevention of constipation, assessment of healing, and observation for signs of recurrence or fistula formation (Table 2). Routine packing of the abscess cavity after drainage remains a separate issue. Packing has traditionally been used to prevent premature wound closure, but contemporary data question its obligatory use. In the randomised study by K. Newton *et al.* [27], omission of routine packing of the postoperative cavity after perianal abscess drainage was associated with less pain and no statistically significant increase in recurrence or fistula rates. Similar conclusions were supported by systematic summaries by D.L. Crook & O. Padfield [37] and D.R. Kim *et al.* [38], in which prolonged packing did not demonstrate a convincing advantage in preventing recurrence or fistula, but was associated with greater pain and discomfort.

Table 2. Quantitative indicators characterising postoperative outcomes of perianal abscess treatment according to the analysed sources

Design/sample	Analysed indicator	Main quantitative result	Clinical significance for the review
Retrospective study, 109 patients	Anal fistula formation after drainage	Fistula developed in 33.9% of patients; 37.8% of fistulas were diagnosed within ≤6 months	Confirms the need for delayed follow-up after primary drainage, not only short-term assessment of healing
Randomised multicentre study, 433 patients, 50 centres	Postoperative pain with and without packing	Pain on a 100-point scale: 38.2 in the packing group versus 28.2 in the non-packing group; difference 9.9 points, $p < 0.0001$	Substantiates avoidance of routine traumatic packing of the cavity after drainage
Randomised multicentre study, 433 patients, 50 centres	Fistula rate after drainage	Fistula: 15% in the packing group versus 11% in the non-packing group; $p = 0.20$	Shows that non-packing was not accompanied by a statistically significant increase in fistula rate
Randomised multicentre study, 433 patients, 50 centres	Abscess recurrence	Recurrence: 6% in the non-packing group versus 3% in the packing group; $p = 0.20$	Indicates that omission of packing requires follow-up, but did not produce a statistically significant increase in recurrence in the study
Systematic review and meta-analysis, 6 studies	Effect of antibiotics after drainage on fistula risk	Antibiotic therapy was associated with a 36% reduction in the odds of fistula formation	Supports further assessment of the role of antibiotics, but is not sufficient grounds for routine prescription to all patients

Source: created by the author based on analysis of data from [24,27-28]

Postoperative care should be directed not towards mechanical repetition of traditional procedures, but towards clinically justified aims: adequate outflow, pain control, hygienic support, timely detection of prolonged discharge, recurrent induration, or an external fistula opening. Omission of routine traumatic packing does not mean omission of follow-up; rather, it requires organised monitoring of the wound and clinical dynamics.

Specific clinical scenarios and risk factors

Assessment of the effectiveness of acute paraproctitis treatment should not be limited to the early postoperative period. Pain relief, effective drainage, and reduction of local inflammatory signs are important short-term outcomes, but they do not exclude subsequent anal fistula formation. Long-term follow-up after drainage should be an integral element of contemporary management.

In the study by Z.A.I.Y. Hasan *et al.* [28], the rate of anal fistula formation after drainage of pyogenic perianal abscess was 33.9%, and 37.8% of these fistulas were diagnosed within the first six months. In the papers of D.M. Skovgaards *et al.* [39], O.H. Ali & A.A. Hamza [40], and E. Supatrakul *et al.* [41], the fistula rate after drainage in different clinical groups ranged approximately from 23% to 33.9%. This variability may be related to differences in study design, duration of follow-up, anatomical structure of abscesses, local approaches to drainage, and criteria for fistula diagnosis. The shared conclusion of these works is that the risk of fistula after drainage is clinically significant and requires planned postoperative monitoring. The clinical significance lies in the need to change the criteria for assessing treatment success. If the result of drainage is assessed only during the first days after surgery, some delayed

complications remain unnoticed. A more grounded approach is to inform patients after drainage about possible signs of fistula: persistent or recurrent discharge, repeated induration, pain, formation of an external opening, or recurrent abscess. Special attention should be given to patients with deep, ischioanal, intersphincteric, recurrent, and Crohn-associated forms due to the higher risk of chronicity in these groups.

Certain clinical scenarios require modification of the standard management algorithm for a simple superficial abscess. Patients with Crohn's disease are the most specific category. The findings of H. Habeeb *et al.* [18], M.P. Kawecki *et al.* [19], M. Adamina *et al.* [42], and J.J. Lee *et al.* [43] indicate that perianal abscess in these patients may be a manifestation of transmural chronic inflammation rather than only local cryptoglandular infection. This changes the treatment logic: drainage of the purulent focus remains primary, but further tactics should include magnetic resonance mapping, possible placement of a draining seton, coordination with gastroenterological therapy, and limitation of intervention radicality in view of the poor healing and impaired continence risk. Diabetes mellitus, immunosuppression, and obesity are risk factors for a complicated course. H. Zhang *et al.* [32], X. Zeng *et al.* [44], and S. Ye *et al.* [45] point to an association between metabolic disorders and the risk of anorectal suppurative inflammatory diseases, with a potentially more complex course. In practice, patients with diabetes, obesity, immunosuppressive states, or repeated episodes of anorectal infection require closer assessment of systemic manifestations, a lower threshold for antibiotic therapy when indicated, more careful wound monitoring, and longer follow-up for recurrence or fistula.

Recurrent abscesses should be regarded as a signal of possible complex anatomy, incomplete primary drainage, persistence of an internal opening, or background pathology. In such cases, repeated simple drainage without anatomical clarification may be insufficient. Magnetic resonance imaging or specialised ultrasonography, assessment of the fistulous tract, and planning of staged treatment become appropriate. If recurrence is combined with a systemic response, diabetes, immunosuppression, or suspected Crohn's disease, the management strategy should be expanded. Necrotising complications, extensive phlegmon, and suspected Fournier's gangrene form a separate emergency group. According to L.A. Barbu *et al.* [21] and E. Shehi *et al.* [31], in such cases, the course does not correspond to the algorithm for a simple perianal abscess. Treatment should include emergency surgical debridement, wide drainage, systemic antibacterial therapy, intensive monitoring, correction of organ dysfunction, and repeated revisions when indicated. Imaging and laboratory assessment should be integrated into emergency tactics, but must not delay control of the necrotising source of infection.

Generalised model for the management of patients with acute paraproctitis

Synthesis of the results of the review allowed forming a stratified model for managing patients with acute paraproctitis. For a simple superficial form, the basis is clinical diagnosis, timely incision, and adequate drainage without mandatory preoperative imaging. In this group, the key issue is not the expansion of the examination, but the prevention of delay in surgical source control. Postoperative follow-up should focus on pain, healing, discharge, and possible signs of fistula. In a complex, recurrent, deep, or Crohn-associated form, the tactics should differ. In this group, anatomical mapping with magnetic resonance imaging or specialised sonography, assessment of the presence of a fistulous tract, determination of the risk to the sphincter apparatus, and planning of staged treatment are appropriate. Primary fistulotomy is possible only in a low, simple fistula with clear anatomy. For complex, recurrent, anatomically uncertain, or continence-risk fistulas, drainage, possible placement of a draining seton, and delayed definitive intervention are preferable. In a systemically complicated course, extensive cellulitis, phlegmon, immunosuppression, diabetes mellitus, or suspected necrotising infection, treatment should include emergency source control, antibacterial therapy, correction of concomitant disorders, and intensive monitoring. In this group, diagnostic imaging should assess the spread into pelvic, retroperitoneal, or fascial spaces, in addition to localising the abscess. The clinical importance of aetiopathogenetic views of acute paraproctitis lies in their direct influence on diagnostic and treatment tactics. The optimal management strategy for patients with acute paraproctitis is not universal: it should be built on clinical stratification, in which the extent of diagnosis, surgery, antibacterial therapy, and follow-up is determined by abscess localisation, fistula risk, systemic response, and comorbid background.

Conclusions

An analysis of current literature data established that acute paraproctitis should be regarded as an acute form of cryptoglandular anorectal infection, the course of which is determined by localisation of the purulent focus, direction of inflammatory spread, presence or absence of a fistulous tract, systemic inflammatory response, and comorbid state of the patient. The main anatomical and clinical forms remain perianal, ischioanal, intersphincteric, supralevator, and submucosal abscesses, with deep, recurrent, and atypical forms requiring the most careful preoperative clarification. It was presented that diagnostic tactics should be stratified. In a typical superficial perianal abscess, clinical inspection, digital rectal examination, and assessment of the general condition are sufficient, whereas suspected deep, supralevator, recurrent, or Crohn-associated disease requires magnetic resonance imaging, endoanal

ultrasonography, or computed tomography for emergency indications. Laboratory markers have no independent diagnostic value, but are useful for assessing infection severity, septic risk, and the need for hospitalisation.

The generalisation of treatment data confirmed that timely surgical incision and adequate abscess drainage remain the basic method. Primary fistulotomy may be considered only in a clearly verified low simple fistula and low risk of sphincter injury. For complex or incompletely verified fistulas, a staged approach with possible placement of a draining seton is more appropriate. Antibacterial therapy should not replace surgical source control and should be used selectively, in cellulitis, systemic manifestations, immunosuppression, diabetes mellitus, or a necrotising course. Postoperative management should focus on pain control, maintenance of outflow, avoidance of unjustified traumatic packing, and follow-up for recurrence or fistula formation. Further studies should address standardisation of diagnostic algorithms, identification of patient groups most likely to benefit from antibiotic therapy, comparison of sphincter-preserving strategies, and development of unified criteria for postoperative monitoring after drainage of acute paraproctitis.

Acknowledgements

None.

Funding

None.

Conflict of Interest

None.

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Современные подходы к диагностике и лечению острого парапроктита (обзор литературы)

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Аннотация. Острый парапроктит представляет собой клинически значимое гнойно-воспалительное поражение параректальной ткани, требующее своевременной диагностики, адекватного хирургического дренирования и последующего наблюдения в связи с риском рецидива и образования анального свища. Целью данного исследования было обобщение современных данных литературы по этиологии, патогенезу, классификации, диагностике, хирургическому лечению и послеоперационному ведению пациентов с острым парапроктитом. Был проведен описательный обзор литературы с элементами сравнительного анализа. Обзор показал, что острый парапроктит чаще всего развивается как проявление криптогландулярной инфекции с полимикробной флорой и распространением гноя в перианальное, межсфинктерное, седалищно-анальное или надлеваторное пространство. Для диагностики типичного поверхностного абсцесса достаточно клинического осмотра и пальцевого ректального обследования, тогда как рецидивирующие, глубокие и ассоциированные с болезнью Крона формы требуют магнитно-резонансной томографии или эндоанальной ультрасонографии. Своевременное вскрытие и дренирование остаются основным методом лечения. Первичная фистулотомия была оправдана только при явно подтвержденной низкой фистуле, тогда как сложные формы требовали поэтапного подхода с возможным использованием дренирующего сетона. Согласно проанализированным источникам, частота образования фистул после дренирования составляла 23,0-33,9%, а в одном рандомизированном исследовании отказ от тампонады позволил снизить уровень боли с 38,2 до 28,2 баллов без статистически значимого увеличения частоты образования фистул или рецидивов. Антибиотикотерапия имела выборочное значение при системной инфекции, целлюлите, иммуносупрессии или сахарном диабете. Оптимальная стратегия ведения должна быть дифференцирована в зависимости от анатомической формы, риска образования фистулы, системных проявлений и сопутствующих заболеваний. Практическая значимость исследования заключается в обосновании стратифицированного алгоритма ведения пациентов с острым парапроктитом, который позволяет дифференцировать простые и сложные формы заболевания, своевременно определять необходимость визуализации, антибактериальной терапии и поэтапного хирургического лечения, а также учитывать риск рецидива и образования анального свища

Ключевые слова: аноректальный абсцесс; криптогландулярная инфекция; анальный свищ; дренирование; сетон; послеоперационное наблюдение