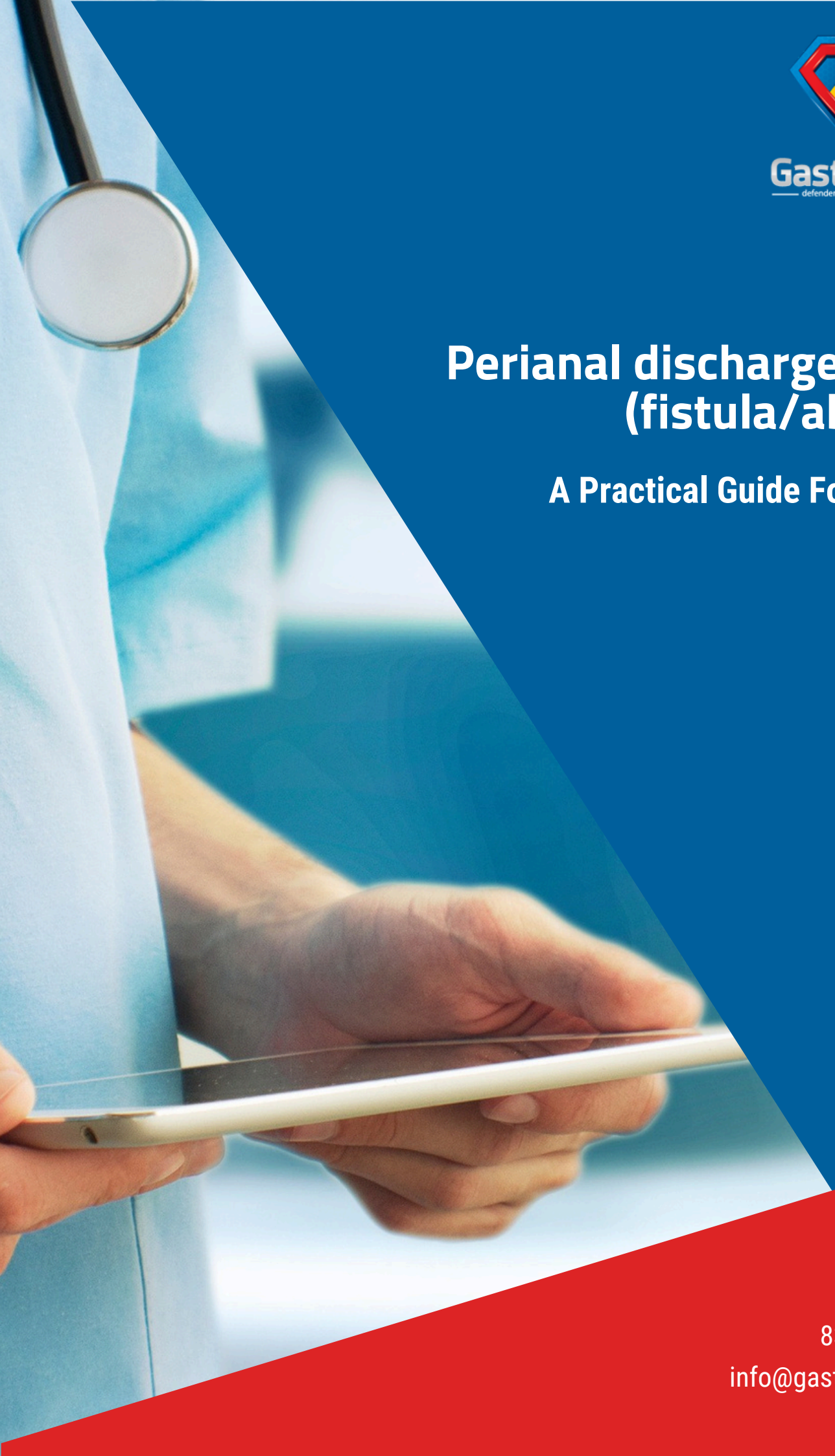
GastroDoxs
defenders of the digestive system

Perianal discharge or pus (fistula/abscess)

A Practical Guide For Patients



832-632-4070
info@gastrodoxs.com

TABLE OF CONTENTS

01 Introduction

02 What Causes Perianal discharge or pus (fistula/abscess)?

03 Symptoms

04 Diagnosis

05 Diet

06 Medications

07 Therapies

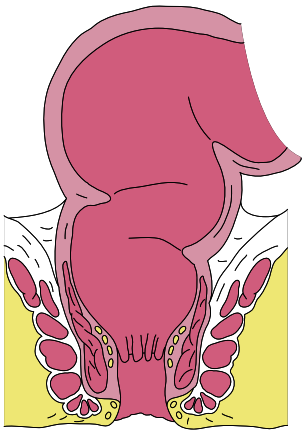
08 Coping

09 FAQs

10 Take Action

Introduction: Perianal discharge or pus (fistula/abscess)

Perianal discharge or pus can come from a draining anorectal abscess or from an anal fistula - a small tunnel between the anal canal and the skin near the anus. Drainage may be intermittent or persistent and can be yellow, white, blood-tinged, or foul-smelling. Skin irritation, tenderness, swelling, or throbbing pain may occur, and fever can signal active infection. Because a fistula often develops after an abscess and usually does not close on its own, ongoing or recurrent drainage should be medically evaluated.



Key Takeaways

• Perianal pus or drainage: may come from an abscess that has opened or from a persistent anal fistula.
• Anal fistula: is an abnormal tunnel that commonly develops after an anal abscess drains.
• Typical drainage: may be foul-smelling, blood-tinged, or associated with wetness and skin irritation.
• Abscess warning signs: include increasing pain, swelling, redness, warmth, fever, or feeling unwell.
• Crohn's disease: can increase the risk of complex or recurrent perianal fistulas and abscesses.
• Diagnosis: usually starts with examination; MRI, CT, ultrasound, or examination under anesthesia may be used for deeper or complex disease.
• Treatment: may involve abscess drainage and a procedure for the fistula, chosen to control infection while protecting sphincter function.

What Causes Perianal discharge or pus (fistula/abscess)

Known Causes

Perianal discharge has several possible explanations. Some cases come from an abscess that has opened and drained, while persistent or recurrent drainage may indicate an anal fistula—an abnormal tract between the anal canal and nearby skin. This distinction matters because ongoing drainage from a fistula or undrained infection usually requires evaluation rather than simply treating the moisture or irritation.

- Anal fistula: A fistula commonly develops after an anal abscess and may cause persistent or intermittent pus, foul-smelling fluid, or blood-tinged drainage from an opening near the anus.
- Draining perianal abscess: An abscess may release pus if it opens or partially drains, but continued pain, swelling, redness, fever, or recurrent drainage can indicate persistent infection that needs medical assessment.
- Crohn's-related perianal disease: Crohn's disease increases the likelihood of perianal abscesses and fistulas, particularly when drainage is recurrent, comes from multiple openings, or occurs with other bowel symptoms.



Common Signs & Symptoms

Discharge may be the most noticeable sign of a fistula, while an active abscess often causes more pain, swelling, warmth, and tenderness. Symptoms can fluctuate as a tract drains and then temporarily closes.

Core Symptoms Include:

- Pus or fluid draining from an opening near the anus
- Foul-smelling or blood-tinged discharge
- Wetness, staining, or recurrent drainage in underwear
- Skin irritation, itching, or soreness around the opening
- Persistent or throbbing anal pain
- Swelling, redness, or a tender lump when an abscess is present



Severe cases can also cause:



- Fever, chills, or feeling markedly unwell
- Rapidly increasing pain, swelling, redness, or warmth
- New difficulty passing urine
- Persistent bleeding or worsening drainage
- Severe pain with sitting or bowel movements

Diagnosis & Medical Testing

Evaluation usually begins with a history and careful examination of the perianal skin. A clinician looks for active drainage, an external fistula opening, swelling, redness, tenderness, or signs of an abscess. Imaging is not required for every patient, but it can help when disease is deep, recurrent, complex, associated with immune suppression, or linked to Crohn's disease.

Diagnostic Tools

- **Medical history:** reviews the timing and pattern of drainage, pain, fever, previous abscesses, bowel symptoms, Crohn's disease, diabetes, immune suppression, and prior anorectal procedures.
- **Physical examination:** checks for drainage, swelling, redness, tenderness, scars, and an external fistula opening.
- **Digital rectal examination:** may help identify tenderness or deeper swelling when tolerated.
- **Anoscopy or proctoscopy:** may be used to inspect the anal canal when the diagnosis is unclear.
- **Pelvic MRI, CT, or ultrasound:** may be considered for occult abscesses, recurrent or complex fistulas, or suspected perianal Crohn's disease.
- **Examination under anesthesia:** may be used by a colorectal surgeon to define complex anatomy and treat an abscess or fistula when appropriate.



Diet

Diet and hydration can support comfort and bowel regularity, but they do not drain an abscess or close an anal fistula. The main goal is to keep stools soft, reduce straining, support healing, and avoid foods that clearly worsen diarrhea or irritation. Nutrition should be individualized when Crohn's disease, diabetes, poor appetite, or malnutrition is also present.

Key Insights

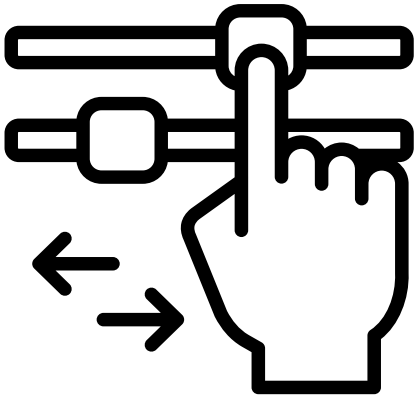
• Drink enough fluids to help keep stools soft and reduce straining.
• Include fiber from fruits, vegetables, whole grains, and legumes when tolerated.
• Increase fiber gradually if constipation is present to limit bloating or discomfort.
• Choose softer, easy-to-digest foods if pain, fever, or poor appetite makes normal meals difficult.
• Include adequate protein and calories to support tissue healing after infection or procedures.
• Use smaller, more frequent meals if Crohn's disease, diarrhea, nausea, or reduced appetite limits intake.
• Avoid foods that repeatedly worsen diarrhea or cause frequent urgent bowel movements.
• Limit highly processed, low-fiber foods if hard stools and constipation are a problem.
• Avoid unnecessary restrictive diets unless recommended for an underlying gastrointestinal condition.

Medications & Treatment Options

There is no single medicine that reliably cures a formed anorectal abscess or closes most anal fistulas. Prompt drainage is the main treatment for an acute abscess, while fistulas often need a colorectal procedure. Antibiotics are used selectively when there is surrounding cellulitis, systemic illness, immune suppression, or another specific indication.

Treatment Options

- **Incision and drainage:** the primary treatment for a formed anorectal abscess to release pus, relieve pressure, and control infection.
- **Antibiotics:** may be added for cellulitis, fever or systemic infection, immune suppression, or other clinician-defined risk factors; they generally do not replace drainage.
- **Pain management:** appropriate pain-relieving medicines may be used during recovery based on medical history and clinician guidance.
- **Fistula treatment:** persistent or recurrent drainage from a fistula commonly requires surgical or procedural management.
- **Crohn's disease treatment:** perianal disease related to Crohn's often needs coordinated gastroenterology and colorectal surgical care.



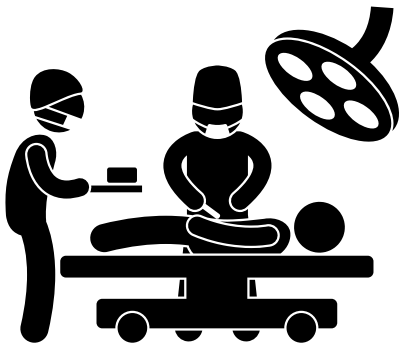


Advanced Therapies & Procedures

Procedure choice depends on whether the problem is an active abscess, a simple fistula, a complex fistula, or fistulizing Crohn's disease. The goals are to control infection, eliminate the fistula tract when possible, and protect anal sphincter function.

Therapy Options

- **Surgical drainage:** incision and drainage is the main treatment when an anorectal abscess has formed.
- **Fistulotomy:** may be appropriate for carefully selected simple, low fistulas when the expected benefit outweighs the risk to continence.
- **Draining seton:** may be used to maintain drainage in complex fistulas or as part of staged treatment, including selected patients with Crohn's disease.
- **Sphincter-sparing procedures:** techniques such as LIFT or an endorectal advancement flap may be considered for selected fistulas when preserving sphincter muscle is important.
- **Crohn's disease management:** fistulizing disease is commonly managed with a combination of medical therapy and surgical drainage or seton strategies.



GastroDoxs
defenders of the digestive system

Coping With Perianal discharge or pus (fistula/abscess)

Ongoing drainage can affect comfort, sitting, exercise, sleep, work, and confidence. Practical care focuses on protecting the skin, managing moisture, avoiding self-drainage, and watching for signs that infection is worsening or returning.

Practical Strategies

- Track the amount, color, odor, and frequency of drainage.
- Note whether pain, swelling, or a lump returns when drainage slows or stops.
- Watch for increasing redness, warmth, tenderness, fever, or chills.
- Use clean gauze or an absorbent pad to protect clothing if drainage is ongoing.
- Gently clean the area and pat dry; avoid harsh scrubbing.
- Use warm sitz baths if recommended by your clinician for comfort and hygiene.
- Avoid squeezing, puncturing, probing, or trying to drain the area yourself.
- Keep stools soft with fluids and appropriate fiber when tolerated.
- Avoid constipation and excessive straining during bowel movements.
- Take prescribed medicines exactly as directed.
- Attend follow-up after abscess drainage or fistula procedures.
- Report recurrent drainage, new openings, or worsening symptoms promptly.

FAQS About

Perianal discharge or pus (fistula/abscess)



Q1: Why is pus or fluid draining from near the anus?
A: Drainage may come from an abscess that has opened or from an anal fistula, a tunnel that often remains after an abscess drains. Persistent or recurrent drainage should be examined.

Q2: What is the difference between an abscess and a fistula?
A: An abscess is a collection of infected pus. A fistula is an abnormal channel between the anal canal and nearby skin. A fistula may develop after an abscess and can cause repeated swelling and drainage.

Q3: How is a fistula or abscess diagnosed?
A: Diagnosis usually starts with medical history and examination. MRI, CT, ultrasound, proctoscopy, or examination under anesthesia may be used when the problem is deep, recurrent, or complex.

Q4: When should perianal drainage be evaluated urgently?
A: Seek prompt medical care for fever, chills, rapidly worsening pain or swelling, spreading redness, difficulty urinating, or feeling significantly unwell. These can suggest an active or spreading infection.

Take Action

Persistent or recurrent pus, foul-smelling drainage, swelling, or pain around the anus deserves medical evaluation. An active abscess may require prompt drainage, while repeated drainage can signal an anal fistula that needs specialist assessment. Fever, chills, rapidly worsening pain or swelling, spreading redness, difficulty urinating, or feeling very unwell should be evaluated promptly.

Visit **GastroDoxs.com** to schedule an appointment and access more resources on digestive health.



Your health matters
take the next step
today!

SCHEDULE AN APPOINTMENT

832-632-4070

info@gastrodoxs.com

GastroDoxs
defenders of the digestive system