

Treatment method selection for perianal abscesses: Bedside or operating room? a single-center retrospective study

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ABSTRACT

BACKGROUND: This study aims to evaluate the effect of the type of intervention (bedside vs. operating room incision and drainage) on clinical outcomes in the treatment of perianal abscess and to identify predictive factors that may be effective in determining the type of intervention.

METHODS: A retrospective study was conducted on 213 patients who underwent incision and drainage (I&D) for cryptoglandular perianal abscess. Patients were divided into “bedside I&D” and “operating room I&D” groups according to the type of intervention. Demographic characteristics, laboratory values, abscess size, early complications, and long-term fistula development were compared. Receiver operating characteristic (ROC) analysis was performed to determine cut-off values for white blood cell count (WBC), C-reactive protein (CRP), and abscess size; subsequently, logistic regression analyses were performed using these parameters.

RESULTS: WBC count, CRP levels, and abscess size were statistically significantly higher in the operating room group ($p < 0.001$). According to ROC analysis, cut-off values were determined as $14.68 \times 10^9/L$ for WBC, 55.7 mg/L for CRP, and 29.5 mm for abscess size. While CRP lost statistical significance in univariate regression analysis, WBC and abscess size were identified as independent predictive factors for determining the intervention site in multivariate analysis. During long-term follow-up, fistula development was observed significantly more frequently in the operating room group ($p = 0.002$).

CONCLUSION: WBC level and abscess size may be valuable predictors in deciding the type of intervention for perianal abscess treatment. Bedside I&D can be safely performed in low-risk cases, whereas operating room intervention should be preferred in patients with high inflammatory markers and larger abscesses.

Keywords: Bedside; incision and drainage; operating room; perianal abscess.

INTRODUCTION

Perianal abscesses are common anorectal conditions, with an estimated 100,000 cases of anorectal abscesses occurring annually in the United States.^[1] Although the vast majority are reported to be of cryptoglandular origin, Crohn's disease, male sex, diabetes, and smoking are among the best-defined risk factors.^[2] Treatment of perianal abscesses requires surgical intervention, usually performed through incision and drainage (I&D). However, current guidelines do not provide

a clear recommendation regarding the most appropriate intervention setting (bedside or operating room) for the treatment of perianal abscesses.^[3-5]

The predictive risk factors that should be considered when determining the type of intervention (bedside or operating room) for perianal abscess treatment have not been clearly defined in the literature.^[6] It is thought that interventions performed in the operating room (OR) setting allow greater precision, thus providing better results, such as lower ab-

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abscess recurrence and reduced fistula formation.^[7] However, although no definite difference has been demonstrated between incision and drainage procedures performed at the bedside and those performed in the OR in terms of cost and bed usage time, it has been reported that drainage procedures performed in the OR within the scope of day surgery may be more advantageous in terms of both cost and bed utilization rates.^[6,8,9] Nevertheless, the effects of both types of interventions on clinical outcomes and whether there are differences in long-term complications remain controversial in the literature.

This study aimed to compare the effects of the type of intervention (bedside vs. OR) on clinical outcomes in the treatment of perianal abscess and to identify the advantages and disadvantages of these two methods, thereby contributing to the determination of objective criteria for treatment selection.

MATERIALS AND METHODS

The data of patients who underwent perianal abscess incision and drainage at Istanbul Çam and Sakura City Hospital between September 2021 and September 2024 were evaluated retrospectively. The inclusion criteria were patients with cryptoglandular perianal abscess who were 18 years of age or older and whose data were fully accessible in the hospital database. The exclusion criteria were a history of anorectal abscess or perianal fistula; inflammatory bowel disease; diagnosis of hidradenitis suppurativa; history of anorectal trauma; anal or rectal malignancy; Fournier gangrene or complex abscess (supralelevator or horseshoe abscess); receipt of immunosuppressive therapy or presence of immunosuppressive disease; fistula detected at the time of hospital admission; and lack of blood parameters or imaging data. A total of 213 patients meeting the specified criteria were included in the study. The study was conducted in accordance with the principles of the Declaration of Helsinki and was approved by the Başakşehir Çam Sakura City Hospital Scientific Research Ethics Committee (2024-07).

Clinical characteristics of the patients, including age, sex, presence of diabetes mellitus, smoking status, fever status, time from symptom onset to hospital admission, blood parameter results, imaging data, type of intervention, need for surgery due to inadequate drainage or recurrent abscess within 30 days, and development of perianal fistula during long-term follow-up, were evaluated.

The time from symptom onset to hospital admission was classified as "early admission" if it was less than 72 hours and as "late admission" if it was more than 72 hours. Patients with moderate-grade fever or higher were considered to have "high fever." White blood cell (WBC) and C-reactive protein (CRP) levels were evaluated in blood tests. Abscess size was defined as the diameter of the abscess on imaging performed before I&D.

Patients were divided into two groups according to the location where the index I&D procedure for perianal abscess was performed: bedside I&D and OR I&D. In addition, patients were grouped according to the presence or absence of early complications, and parameters were analyzed between these groups.

Surgical Procedure

All patients received intravenous antibiotics for prophylactic purposes before the procedure. Antibiotic selection was based on infection risk and patient characteristics. In all I&D procedures, the incision was made as close to the anal verge as possible to minimize the potential length of fistula formation, ensure adequate drainage, and prevent sphincter damage. Packing of the abscess cavity varied according to the surgeon's preference. All procedures were performed either by the senior surgeon or by a general surgery resident under the supervision of a senior surgeon. During the follow-up period, physical examinations were performed by senior surgeons, and dressings were performed by general surgery residents.

All patients who underwent bedside I&D had the procedure performed at the bedside in the emergency department. Patients were positioned in the Sims position during the procedure, and local anesthesia was administered after vascular access was established. After the procedure, patients' pain levels were evaluated, and intravenous analgesics were administered if necessary. All patients received oral empirical antibiotics after the procedure and were followed up in the outpatient clinic.

OR I&D procedures were performed in the lithotomy position under spinal anesthesia. All patients received empirical antibiotics and were followed up in the outpatient clinic after discharge.

Statistical Analysis

Statistical analysis of the data was performed using IBM SPSS Statistics for Windows version 25.0 (IBM Corp., Armonk, New York, USA). The normality of data distribution was evaluated using the Kolmogorov-Smirnov test. Since the variables were not normally distributed, the nonparametric Mann-Whitney U test was applied. Categorical measurements are expressed as number (n) and percentage (%), and continuous measurements are expressed as median (M), 25th percentile (Q1), and 75th percentile (Q3). The Pearson chi-square test was used for comparisons of ratios. Receiver operating characteristic (ROC) analysis was performed to determine cut-off values for parameters showing statistical significance. Parameters grouped according to ROC-derived cut-off values were included in logistic regression analysis to identify independent predictive factors for the selection of the I&D setting. Variables found to be statistically significant in univariate analysis were included in the multivariate logistic regression model. Logistic regression results are presented as odds ratios (ORs) with 95% confidence intervals (95% CI). A p-value <0.05 was considered statistically significant.

RESULTS

The median age of the patients was 38 years (range: 26-49), and 76.99% (213 patients) were male. Diabetes mellitus was present in 24.41% of patients, and 34.74% were smokers. The incidence of high fever was 4.67% in patients who underwent bedside I&D and 57.14% in those who underwent OR I&D, with the difference being statistically significant ($p<0.001$).

A significant difference was also observed between the two groups in terms of abscess size. Abscess size was larger in the OR I&D group (median 35 mm, Q1: 29.75, Q3: 40) compared to the bedside I&D group (median 22 mm, Q1: 17, Q3: 28) ($p<0.001$). In blood parameters, WBC count and CRP levels were significantly higher in the OR I&D group compared to the bedside I&D group ($p<0.001$). The early complication rate was similar between the bedside I&D and OR I&D groups, with no statistically significant difference ($p=0.542$). However, during long-term follow-up, perianal fistula development was more common in the OR I&D group (45.23% vs. 21.63%, $p=0.002$). Comparisons of clinical features and

outcomes between patients who underwent bedside and OR I&D are summarized in Table 1. The most commonly used imaging method was transperineal ultrasonography, which was performed in 90.61% (193 patients) of patients. The median hospital stay of patients who underwent OR I&D was one day (Q1: 1, Q3: 1.25). No unexpected situations were encountered after bedside I&D procedures.

ROC analysis was performed to determine cut-off values for WBC count, CRP level, and abscess size (Fig. 1, Table 2). The cut-off value for WBC was $14.68 \times 10^9/L$, which was statistically significant, with 85% sensitivity and 84.9% specificity (area under the curve [AUC]=0.917; $p<0.001$). The cut-off value for CRP was 55.7 mg/L, with 70% sensitivity and 69.8% specificity (AUC=0.759; $p<0.001$). The cut-off value for abscess size was 29.5 mm, which was statistically significant, with 80% sensitivity and 77.4% specificity (AUC=0.818; $p<0.001$). These cut-off values were used to categorize the metric variables, which were then subjected to logistic regression analysis.

Table 1. Comparison of clinical characteristics and outcomes of patients undergoing bedside and operative incision and drainage (I&D)

	Total (n=213)	Bedside I&D (n=171)	Operative I&D (n=42)	p value
Age# (Years)	38 (26-49)	38 (26-50)	39.5 (26-46.25)	0.823
Sex* (Male)	164 (76.99)	128 (74.85)	36 (85.71)	0.134
Symptom onset* (Early presentation)	116 (54.46)	96 (56.14)	20 (47.61)	0.32
Diabetes* (Yes)	52 (24.41)	41 (23.97)	11 (26.19)	0.765
Smoking status* (Current smoker)	74 (34.74)	60 (35.08)	14 (33.33)	0.831
High fever* (Present)	32 (15.02)	8 (4.67)	24 (57.14)	<0.001
Abscess size# (mm)	24 (18-32)	22 (17-28)	35 (29.75-40)	<0.001
WBC# ($10^9/L$)	12.88 (10.29-15.19)	11.99 (9.88-14.09)	16.68 (15.38-17.71)	<0.001
CRP# (mg/L)	44.5 (23.42-70.82)	41.8 (21-60.07)	86.9 (45.6-151.62)	<0.001
Early complications* (Present)	34 (15.96)	26 (15.2)	8 (19.04)	0.542
Perianal fistula* (Present)	56 (26.29)	37 (21.63)	19 (45.23)	0.002

*n (%); #median (Q1-Q3); WBC: White blood cell count; CRP: C-reactive protein.

Table 2. Receiver operating characteristic (ROC) analysis of factors influencing the choice between bedside and operative incision and drainage (I&D)

	AUC (95%)	p value	Cut-off value	Sensitivity (%)	Specificity (%)
WBC ($10^9/L$)	0.917 (0.874-0.961)	<0.001	14.68	85	84.9
CRP (mg/L)	0.759 (0.668-0.851)	<0.001	55.7	70	69.8
Abscess size (mm)	0.818 (0.743-0.893)	<0.001	29.5	80	77.4

WBC: White blood cell count; CRP: C-reactive protein; AUC: Area under the curve.

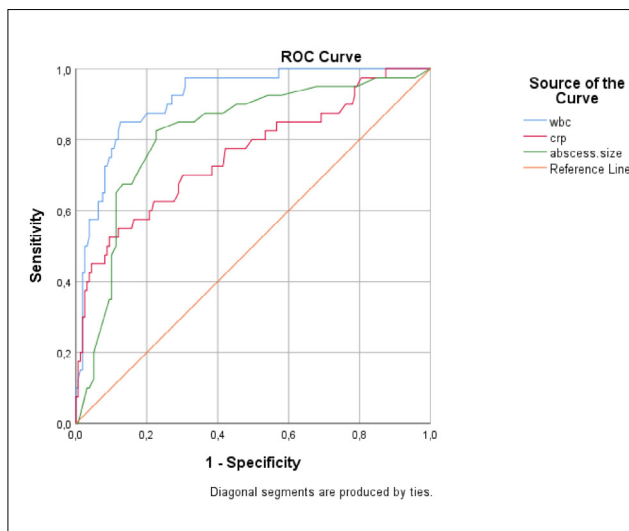


Figure 1. Receiver operating characteristic (ROC) curves of white blood cell count, C-reactive protein, and abscess size in determining the choice between bedside and operative incision and drainage (blue line: white blood cell count, red line: C-reactive protein, green line: abscess size).

In univariate analysis, high WBC (hazard ratio [HR]: 35.04, 95% CI: 13.38–91.77, $p < 0.001$), high CRP (HR: 5.44, 95% CI: 2.56–11.60, $p < 0.001$), and large abscess size (HR: 11.12, 95% CI: 5.01–24.65, $p < 0.001$) were significant predictors for OR drainage selection. However, in multivariate Cox regression analysis, the CRP group was no longer statistically significant (HR: 1.92, 95% CI: 0.69–5.36, $p = 0.214$). High WBC (HR: 20.88, 95% CI: 7.16–60.87, $p < 0.001$) and large abscess size (HR: 8.47, 95% CI: 2.99–23.95, $p < 0.001$) were identified as independent significant predictors. These findings indicate that WBC count and abscess size are clinically important independent determinants in choosing the setting for drainage (Table 3).

The clinical characteristics of patients with early complications are summarized in Table 4. In the group with early complications, WBC values were statistically significantly higher [12.2 (9.89–14.54) vs. 14.78 (13.38–16.07), $p < 0.001$]. No statistically significant differences were found in the other evaluated parameters.

Table 3. Univariate and multivariate logistic regression analysis of study parameters

	HR (95% CI) Univariate	p value Univariate	HR (95% CI) Multivariate	p value Multivariate
WBC ($>14.68 \times 10^9/L$)	35.04 (13.38–91.77)	<0.001	20.88 (7.16–60.87)	<0.001
CRP (>55.7 mg/L)	5.44 (2.56–11.6)	<0.001	1.92 (0.69–5.36)	0.214
Abscess size (>29.5 mm)	11.12 (5.01–24.65)	<0.001	8.47 (2.99–23.95)	<0.001

HR: Hazard ratio; WBC: White blood cell count; CRP: C-reactive protein.

Table 4. Comparison of clinical features of patients with and without early complications

	No early complications (n=179)	Early complications (n= 34)	p value
Age# (Years)	38 (26-49)	36.5 (26.5-50.5)	0.883
Sex* (Male)	134 (74.86)	30 (88.23)	0.089
Symptom onset* (Early presentation)	101 (56.42)	15 (44.11)	0.187
Diabetes* (Yes)	43 (24.02)	9 (26.47)	0.761
Smoking status* (Current smoker)	64 (35.75)	10 (29.41)	0.476
High fever* (Present)	24 (13.4)	8 (23.52)	0.13
Abscess size# (mm)	23.5 (18-30.25)	27 (20-38.5)	0.065
WBC# (10 ⁹ /L)	12.2 (9.89-14.54)	14.78 (13.38-16.07)	<0.001
CRP# (mg/L)	45 (23.67-68.82)	42.9 (21-91.32)	0.735
Perianal fistula* (Present)	47 (26.25)	9 (26.47)	0.979

*n (%); #median (Q1-Q3); WBC: White blood cell count; CRP: C-reactive protein.

DISCUSSION

In this study, we evaluated different treatment strategies used in the management of perianal abscess. The literature describes various approaches regarding where and under what conditions I&D should be performed for the treatment of perianal abscesses.^[6,8] Current guidelines recommend drainage of the abscess but do not clearly specify whether this procedure should be performed at the bedside in the emergency department or under anesthesia in the OR.^[3-5] We believe that the most critical step in making this decision is a detailed examination and clinical evaluation of the patient by the surgeon. The fundamental approach is to guide the decision by requesting additional blood tests and imaging studies, particularly in cases with signs of sepsis, additional risk factors, or atypical presentations.^[3,5] Our findings show that higher WBC counts, larger abscess size, and increased CRP levels are significantly associated with operative I&D. In multivariate regression analysis, WBC count and abscess size emerged as independent predictors, whereas CRP lost its statistical significance.

In the current literature, studies directly comparing bedside and OR I&D are quite limited.^[6] Most existing studies compare outpatient incision and drainage procedures, usually performed as day surgery, with surgical drainage methods requiring hospitalization.^[8-10] It has been reported that even day surgery contributes significantly to reducing healthcare system costs.^[8-9] In a study by Swift et al.^[9] conducted in England, a total of 42,568 bed days were used for emergency perianal abscess surgery, with a mean hospital stay of 1.2 days. The study also predicted that if a targeted 90% transition to day surgery was achieved, approximately 28,114 bed days could be saved over three years.^[9] In our study, no statistically significant difference was found between the groups in terms of early complication rates. This finding suggests that I&D procedures performed at the bedside in the emergency department may be a safe and advantageous option in carefully selected cases. It should be emphasized that patients with complex abscesses, severe systemic disease, or signs of sepsis were excluded from this study. In a study by Sho et al.,^[10] it was reported that even among patients undergoing day surgery, reoperation and rehospitalization rates were not negligible.

Our study is among the first in the literature to focus on identifying parameters that predict the type of intervention (bedside or OR) in the treatment of perianal abscess. WBC level and abscess size were identified as independent predictors of intervention type in multivariate regression analysis. In particular, a WBC level above $14.68 \times 10^9/L$ was significantly associated with OR I&D (odds ratio [OR]: 4.91, 95% CI: 2.2–10.9) and emerged as an independent variable in the regression model. This finding suggests that leukocytosis reflects not only systemic inflammation but also the local severity of disease. Although no studies in the current literature have evaluated leukocytosis as a determinant of intervention type

(bedside vs. OR) in perianal abscess treatment, leukocytosis has been shown to be associated with disease severity and with both early postoperative and long-term complications.^[11,12] In a study by Dong et al.,^[11] a significant association was found between larger abscess cavity size and higher WBC levels. In the same study, although a statistically significant association was observed between WBC levels and postoperative recurrence in univariate analysis, WBC was not identified as an independent risk factor in multivariate analysis.^[11] Similarly, Elhadidi et al.^[12] reported that WBC levels of $18 \times 10^9/L$ or higher were significantly associated with severe anorectal sepsis.

As with WBC levels, studies directly assessing the impact of abscess size on the choice of intervention type (bedside vs. OR) are rare. The current literature reports that abscess cavity size is associated with postoperative recurrence, and an increase in abscess diameter has also been identified as an independent predictor of conservative treatment failure in the pediatric population.^[11,13] These findings indicate that abscess size is a parameter that should not be overlooked when deciding on the type of intervention. Our study demonstrates that abscess size can be considered a guiding factor not only for treatment success but also in the surgical decision-making process regarding intervention type (bedside vs. OR).

Although CRP level showed a statistically significant association in univariate analysis for determining the type of intervention in the treatment of perianal abscess, it was not identified as an independent risk factor in multivariate regression analysis. While there are no definitive studies in the current literature evaluating CRP levels in selecting the intervention type, elevated CRP has been reported to be associated with anorectal sepsis and fistula development.^[12,14]

One of the important findings of our study is that early complication rates were similar between the two groups, whereas perianal fistula formation was more frequently detected in the OR group during long-term follow-up. Considering that larger and potentially more complex abscesses undergo OR I&D, as emphasized by Narayanan et al.,^[7] the baseline risk of perianal fistula is already higher in these cases and may be associated with the higher detection rate of fistulas during OR I&D. In addition, the identification of minor fistula tracts during more detailed exploration in the OR and their subsequent clinical detection during follow-up may be another reason for the higher fistula frequency observed in the group that underwent OR surgery. Although some studies in the literature suggest that treating intraoperatively detected fistulas with fistulectomy reduces inadequate drainage and abscess recurrence, other studies have reported conflicting results, indicating that an early aggressive approach may increase the risk of sphincter damage or other complications.^[10,15] This contradiction highlights the complexity of perianal anatomy and underscores the need to tailor diagnostic and treatment strategies to individual patient factors.

Our study has certain limitations. First, the single-center, retrospective design carries a potential risk of selection bias. Second, because perianal abscess I&D is a painful procedure, patients' pain scores and discomfort levels during the procedure could not be compared between groups due to missing data. Furthermore, the more severe clinical presentation of patients in the OR I&D group limits direct comparison between the groups. In addition, reliance on clinical examination and imaging for perianal fistula detection may have resulted in a higher reported perianal fistula rate in this group due to easier identification of subclinical tracts during more detailed examinations in the OR.

CONCLUSION

Our results suggest that bedside I&D may be a safe and effective option in selected cases; however, more comprehensive evaluation and OR I&D may be required for patients with pronounced inflammatory findings or larger abscesses. In this context, incorporating WBC level and abscess size into clinical decision-making algorithms may support an individualized and resource-efficient approach. Future multicenter prospective studies are needed to strengthen the generalizability of these findings.

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Ethics Committee Approval: This study was approved by the Başakşehir Çam Sakura City Hospital Scientific Research Ethics Committee (Date: 25.09.2024, Decision No: 2024-07).

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REFERENCES

1. Turner SV, Singh J. Perirectal Abscess. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025.
2. Newton K, Dumville J, Briggs M, Law J, Martin J, Pearce L, et al. Postoperative packing of perianal abscess cavities (PPAC2): randomized clinical trial. *Br J Surg* 2022;109:951–7. [\[CrossRef\]](#)
3. Tarasconi A, Perrone G, Davies J, Coimbra R, Moore E, Azzaroli F, et al. Anorectal emergencies: WSES-AAST guidelines. *World J Emerg Surg* 2021;16:48. [\[CrossRef\]](#)
4. Vogel JD, Johnson EK, Morris AM, Paquette IM, Saclarides TJ, Feingold DL, et al. Clinical practice guideline for the management of anorectal abscess, fistula-in-ano, and rectovaginal fistula. *Dis Colon Rectum* 2016;59:1117–33. [\[CrossRef\]](#)
5. Reza L, Gottgens K, Kleijnen J, Breukink S, Ambe PC, Aigner F, et al. European Society of Coloproctology: Guidelines for diagnosis and treatment of cryptoglandular anal fistula. *Colorectal Dis* 2024;26:145–96. [\[CrossRef\]](#)
6. Maniskas SA, Jebbia MI, Nasir D, Akopian G, Kaufman HS, Golan JY. "Emergency room incision and drainage of perirectal abscess is equivalent to incision and drainage in the operating room". *Am Surg* 2024;90:2609–13. [\[CrossRef\]](#)
7. Narayanan S, Althans AR, Reitz KM, Allen LH, Kurukulururiya C, Larkin TM, et al. Drainage of anorectal abscesses in the operating room is associated with a decreased risk of abscess recurrence and fistula formation. *Am J Surg* 2023;225:347–51. [\[CrossRef\]](#)
8. Yang PF, Builth-Snoad L, Ng KS, Gu E, Errington B, McBride KE, et al. Optimizing theatre utilization for abscess drainage: going beyond priority categories. *ANZ J Surg* 2024;94:648–54. [\[CrossRef\]](#)
9. Swift S, Ceney A, Eve-Jones S, Skueus M, Clark CI. Emergency day case surgery for abscess drainage: time for change? *Ambulatory Surgery* 2015;21:172–6.
10. Sho S, Dawes AJ, Chen FC, Russell MM, Kwaan MR. Operative incision and drainage for perirectal abscesses: what are risk factors for prolonged length of stay, reoperation, and readmission? *Dis Colon Rectum* 2020;63:1127–1133. [\[CrossRef\]](#)
11. Dong S, Chen B, Zhang J. Study on the factors influencing the prognosis after perianal abscess surgery. *BMC Gastroenterol* 2023;23:334. [\[CrossRef\]](#)
12. Elhadidi A, Al-Katary M, Abdelhalim M, Negm A, Shouma A. Complicated anorectal sepsis: Validation of scoring system for predicting anorectal sepsis severity. *Medicine (Baltimore)*. 2024;103:e37377. [\[CrossRef\]](#)
13. Baltrak Y, Sogut S, Varlikli O. Treatment outcomes of perianal abscess in the children younger than 1 year of age. *EJMI* 2020;4:453–8 [\[CrossRef\]](#)
14. Skovgaard DM, Perregaard H, Dibbern CB, Nordholm-Carstensen A. Fistula development after anal abscess drainage—a multicentre retrospective cohort study. *Int J Colorectal Dis* 2023;39:4. [\[CrossRef\]](#)
15. Malik AI, Nelson RL, Tou S. Incision and drainage of perianal abscess with or without treatment of anal fistula. *Cochrane Database Syst Rev* 2010;7:CD006827. [\[CrossRef\]](#)

ORİJİNAL ÇALIŞMA - ÖZ

Perianal apseler için tedavi yöntemi seçimi: yatak başında mı ameliyathanede mi? tek merkezli, retrospektif çalışma

AMAÇ: Bu çalışmanın amacı perianal apse tedavisinde müdahale tipinin (yatak başı, ameliyathane insizyon ve drenaj) klinik sonuçlar üzerine etkisini değerlendirmek ve müdahale tipinin belirlenmesinde etkili olabilecek prediktif faktörleri saptamaktır.

GEREÇ VE YÖNTEM: Kriptoglandüler perianal apse nedeniyle insizyon ve drenaj (İ&D) uygulanan 213 hasta retrospektif olarak değerlendirildi. Hastalar müdahale türüne göre "yatak başı İ&D" ve "ameliyathane İ&D" gruplarına ayrıldı. Demografik özellikler, laboratuvar değerleri, apse boyutu, erken komplikasyonlar ve uzun vadeli fistül gelişimi karşılaştırıldı. Beyaz kan hücresi (WBC), C-reaktif protein (CRP) ve apse boyutu için cut-off değeri belirlemek amacıyla ROC analizi yapıldı; ardından bu parametreler üzerinde lojistik regresyon analizleri yapıldı.

BULGULAR: WBC, CRP düzeyleri ve apse boyutu, ameliyathane grubunda istatistiksel olarak anlamlı şekilde daha yüksek bulundu ($p<0.001$). ROC analizine göre belirlenen cut-off değerleri; WBC için $14.68 \times 10^9/L$, CRP için 55.7 mg/L ve apse boyutu için 29.5 mm olarak tespit edildi. Univariyantal regresyon analizinde CRP istatistiksel anlamlılığını kaybederken, çok değişkenli analizde WBC ve apse boyutunun müdahale yerini belirlemede bağımsız prediktif faktörler olduğu saptandı. Uzun dönem takipte, fistül gelişimi ameliyathane grubunda anlamlı olarak daha sık gözlemlendi ($p=0.002$).

SONUÇ: WBC düzeyi ve apse boyutu, perianal apse tedavisinde müdahale türüne karar vermede değerli öngörücüler olabilir. Yatak başı İ&D düşük riskli vakalarda güvenle gerçekleştirilebilirken, yüksek inflamatuvar belirteçleri ve büyük apse boyutu olan hastalarda ameliyathane müdahalesi tercih edilmelidir.

Anahtar sözcükler: Ameliyathane; insizyon ve drenaj; perianal apse; yatak başı.

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