What to do for a patient with a fissure *in ano*

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An anal fissure is a common anorectal problem that can occur at any age. Here, Dr Peter Stewart discusses the management of this painful condition.

Remember

- Think of a fissure *in ano* in a patient presenting with moderate to severe anal pain of sudden onset occurring with and immediately after defaecation, often in association with rectal bleeding.
- An anal fissure is a very common anorectal condition, and may be acute or chronic.
- A fissure is usually caused by the passage of a hard motion which causes a tear in the delicate, pain sensitive anal mucosa. The exposed internal sphincter fibres spasm, causing pain and local ischaemia that delay healing.
- A fissure *in ano* may occur at any age but is most common in young adults.
- Anal fissures are equally common in males and females. In men, fissures are almost always located posteriorly; in women, up to 10% of fissures are in the anterior position.
- An anal fissure may be a consequence of frequent defaecation and diarrhoea. It may also occur in association with inflammatory bowel disease as well as with infective conditions, such as tuberculosis or syphilis and other sexually transmitted diseases.
- If a fissure is not in the usual posterior position (or anterior position in a woman) or has an atypical appearance, consider the possibilities of Crohn's disease and neoplasm.

Assessment

- A diagnosis is often made on the history alone. The characteristic symptoms are pain and bleeding, with and immediately after defaecation. Bleeding is usually minimal, and generally visible only on the toilet paper.
- A chronic fissure may cause less pain and bleeding than an acute fissure.

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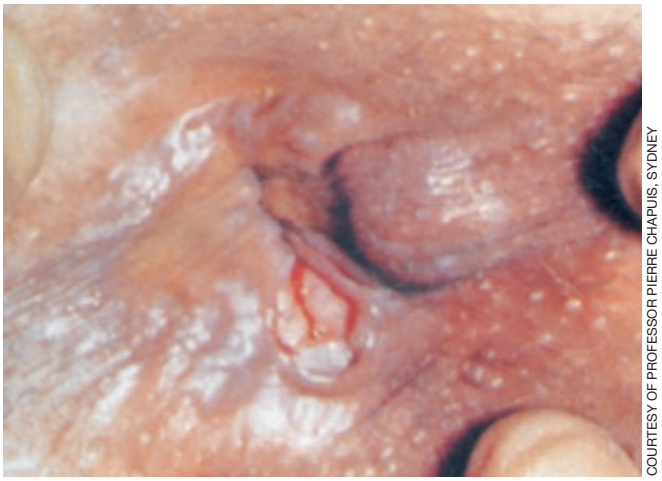

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Figure. A typical posterior midline fissure *in ano*.

- Inspection with gentle buttock retraction of the perianal skin may be all that is required to view the open wound. If buttock spasm is present, the diagnosis is almost certain.
- Proctoscopy is usually not possible in patients with an acute fissure but may be tolerated if the fissure is chronic.
- A chronic fissure may give the sensation of a lump at the anus (a sentinel tag or pile which may be up to 3 or 4 cm in size), visible at the lower end of the anus.

Management

- Acute fissures are usually managed nonoperatively with a bulking agent (such as psyllium [Metamucil, Mucilax]), stool softener (such as docusate sodium [Coloxyl Tablets]), a high fibre diet and salt baths. Avoid stimulant cathartics and preparations containing mineral oil.
- Topical proprietary medications containing local anaesthetic and steroid offer temporary relief. Suppositories tend not to work.
- Topical 0.2% glyceryl trinitrate cream (Rectogesic) has been proven to be effective. The patient should be instructed to wear a glove during application because the cream is absorbed through the skin and can result in headache.
- Patients should be encouraged to maintain a high fibre diet well after symptoms have resolved.
- If the fissure has not resolved within about three weeks of conservative treatment, surgery should be offered. The standard procedure is a lateral internal sphincterotomy, which has a small incidence of postoperative abscess. Minor incontinence may occur in 10% of patients who undergo surgery.
- Results of recent studies using botulinum toxin (Botox) injected into the intersphincteric plane have been promising and may prove to be an alternative to surgery. MT