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ANAL FISSURE

This document is designed to provide general background information. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It may not cover some areas that concern you. These can be dealt with individually.

You are free to ask about any aspect of your care. All questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

What is an anal fissure?

An anal fissure is a tear in the lining of the anus, or in the skin around it. The usual cause of an anal fissure is straining to pass a hard stool. The most common symptoms are sharp pain and bleeding when a stool is passed. Following the passage of the stool the sharp pain disappears, but a persistent ache may last for several hours. Sometimes the irritation results in the development of a 'sentinel' pile. This thickened skin may protrude from inside to outside the anus. It may itch and bleed from time to time.

When a hard stool passes the fissure it irritates the internal sphincter muscle underneath it. The muscle then goes into spasm. This means the anus does not relax when the next hard stool is passed. This makes matters worse! Because of the pain patients avoid opening their bowels. This may make the stool harder, which irritates the tear further. This vicious cycle stops the fissure healing.

Treatment of anal fissures.

The treatment of anal fissures is aimed at breaking this vicious cycle. The initial treatment is non-surgical. Every effort should be made to soften the stools. This can be achieved by increasing the fibre in your diet and drinking at least 1.5 litres of water per day. In the short-term a stool softener, which can be purchased from a chemist, may be helpful. Options include Lactulose, Benefibre, Metamucil and other bulk laxatives. They all require a high fluid intake to work properly.

You may also be prescribed Rectogesic, an ointment containing 0.2% Glyceryl Trinitrate. This ointment will help the sphincter muscle to relax. A pea-sized amount should be applied to the edge of the anus, and ideally slightly into the anus, two or three times a day

and, if possible, about one hour before you open your bowels. About 20% of patients will develop a headache with this ointment. If that occurs, halve the quantity of Rectogesic used. If you still get a headache you will have to abandon this treatment. Rectogesic will result in healing in 50-70% of anal fissures.

An alternative non-surgical option is the use of Botox. When injected the internal sphincter is paralysed (as when injected in facial muscles). The spasm then goes. Botox also obtains healing in about 70% of cases. In Australia Botox is not licensed for the treatment of anal fissure and patients have to meet the full cost of the injection.

There is considerable cross over in that many who well with Rectogesic do well with Botox, and vice-versa. Other medical treatments include the use calcium channel blockers, either topically or by orally. Some are not available in Australia. There is little evidence that these are any better than Rectogesic.

Lateral sphincterotomy

If the fissure does not heal with Rectogesic a small operation, called a lateral sphincterotomy, will be required. This operation, performed under general anaesthetic, divides the lower most fibres of the internal anal sphincter. It is a small operation that is performed as a day-case. It results in healing in 98% of patients.

Although the vast majority of patients have no long-term consequence there is a small risk that minor incontinence may develop later in life. This is usually quoted at 5 – 15%, but is based on data when the lateral sphincterotomy was extended up to the dentate line and about 1.5 cm of the internal sphincter was divided. Lateral sphincterotomies performed now are normally only extended to the top of the fissure itself, about 0.5 cm. The expectation is that long term incontinence will be less, but as yet there is no data to support this. Women who have had several vaginal deliveries, or a traumatic vaginal delivery, are at greatest risk of long term problems.

The skin incision of a lateral sphincterotomy is about 0.5cm. It requires no special management other than regular baths, especially after defaecation. It is not necessary to use salt; this may sting and dries out the skin.