
# Anal Fissure

An anal fissure is a painful linear tear or crack in the distal anal canal (back passage).
Most (85-90%) fissures occur in the posterior (back) midline of the anus with about 10-15% occurring in the anterior (front) midline. A small number of patients may actually have fissures in both the front and the back locations (kissing fissures).

Fissures develop with equal frequency in both sexes; they tend to occur in younger and middle-aged people. The exact aetiology of anal fissures is unknown, but the initiating factor is thought to be trauma from the passage of a particularly hard or painful bowel movement or the rapid uncontrolled evacuation of a hard stool. Very occasionally, exceptionally prolonged episodes of loose stool/diarrhoea can cause fissures.

Clinical presentation:
Typically, patients report severe pain during a bowel movement, with the pain lasting several minutes to hours afterward. The pain recurs with every bowel movement, and patients commonly becomes afraid or unwilling to have a bowel movement, leading to a cycle of worsening constipation, harder stools, and more anal pain. Approximately 70% of patients note bright-red blood on the toilet paper or in the pan.
After a while, patients may notice a small anal skin tag developing outside the anal canal (sentinel pile). Along with the fissure this can become swollen, cause intense irritation and even bleed.

Management:
Initial therapy for an anal fissure is medical in nature, and more than 80% of acute anal fissures resolve without further therapy.
First-line medical therapy consists of a combination of stool-bulking agents, such as fibre supplementation; increasing the intake of fluid to 2.5 litres a day and stool softeners.
Suggested natural fibre supplements include linseeds and flaxseeds (available form supermarkets).
Laxatives can be used as needed to maintain regular bowel movements.
Sitz baths (hot; warm or cold) after bowel movements provide symptomatic relief because they relieve some of the painful internal sphincter muscle spasm.
Recurrence rates are in the range of 30-70% if the high-fibre diet is abandoned after the fissure is healed. This range can be reduced to 15-20% if patients remain on a high-fibre diet.

Second-line medical therapy consists of intra-anal application of a cream, twice a day for 3 months. Two creams are commonly used:
• 0.4% Nitroglycerin (also called glycerol trinitrate - Rectogesic®) ointment directly to the fissure. The main adverse effects are headache and dizziness when first used, but this subsides after a few days usage.
• Diltiazem ointment is slightly less effective than Rectogesic but with fewer adverse effects.
Failure of medical therapy is an indication for surgical therapy.

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Surgical therapy:
Surgery involves an Examination under General Anaesthetic, minimal surgery to the fissure and injection of Botox® (Medical Botulinum Toxin A). The Botox® provides temporary relaxation of part of the sphincter muscle, thereby allowing the fissure to heal. If a sentinel pile is present, this can be removed or used to cover the fissure depending on the size of it.
Risks associated with Botox® injection are rare but can cause loss of ability to maintain continence to gas (and very rare reports of loss of control to stool). This is self limiting as the effects of Botox® wear off after 3 months.
The recurrence or non-healing rates for anal fissures after surgical treatment are in the range of 1-10%.
Postoperatively, pain relief; stool softness and a short course of antibiotics will be prescribed. Follow up will be in 6 - 8 weeks.

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