



General Surgery

CLINICAL ANALYSIS OF NEED FOR INTERVENTION IN ANAL FISSURES

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ABSTRACT **BACKGROUND:** An anal fissure is a tear of the squamous epithelium that usually extends from the dentate line to the anal verge. In most of the cases, the fissure manifests in the posterior midline of the anal canal. **OBJECTIVES:** This study was mainly done to know the need for intervention in individuals with fissure in ano based on history and examination of patients **PATIENTS AND METHODS:** Study was carried out in Department of General surgery Government general hospital kakinada between July 2021 to December 2021. 100 patients with clinical diagnosis of Fissure-in-Ano were recorded. All patients were explained about the disease and their treatment plan and followups (3 visits)-1 week, 1 month, 2 months. Surgical intervention-Lateral internal anal sphincterotomy upto the dentate line was performed. **RESULTS:** Of 100 patients, 4 patients deferred to participate in the study. Of 84 patients with chronic fissure managed conservatively 52 didn't respond and 32 patients responded. These 52 patients were advised surgical management and of them 3 patients deferred to undergo surgery and was advised local botox inj and of them 2 improved and 1 patient didn't respond. And remaining 49 patients underwent surgical intervention of them 48 improved and 1 didn't respond. **CONCLUSION:** Thus, patients with chronic fissure having multiple skin tags, hypertrophied anal papillae, visible transverse fibers, multiple fissures needed surgical intervention for improvement of symptoms and those not having those features showed improvement with conservative management. **fig1: MULTIPLE SKIN TAGS** On analysis, patients who did not respond to conservative management n=55 i.e., 52 (chronic fissure-49 with stigmata and 3 without stigmata)+3 (acute fissure). n=50 (90%) patients improved with surgical intervention and 1 patient didn't respond. Remaining 4 patients deferred from surgery and was given local botox inj of them 3 improved and 1 didn't improve.

KEYWORDS :

INTRODUCTION

Historically, an anal fissure was thought to be a result of mechanical trauma caused by a hard stool tearing the anoderm as it was passed. In addition, anal fissures have been associated with increased anal tone for many years. The fissures can be classified into 1] Acute fissure and 2] Chronic fissure in ano. Acute fissures usually are superficial and heal conservatively. Fissures lasting more than two months with features of chronicity (Sentinel skin tag, hypertrophied anal papilla, exposure of the underlying internal anal sphincter or anal cicatrization) are unlikely to heal with conservative management. Fissures due to an underlying disease (for example, perianal Crohn's disease where fissures are often multiple and situated laterally) are also unlikely to resolve with conservative management.

Pathophysiology: The cause of anal fissure is likely to be multifactorial. The passage of large and hard stools, low-fiber diet, previous anal surgery, trauma, and infection may be contributing factors. Increased resting anal canal pressures and reduced anal blood flow in the posterior midline have also been postulated as causes. **SYMPTOMS:** Patients describe the pain of anal fissures as feeling like "passing broken glass," and they commonly mention a burning pain that can remain for several hours after defecation.

Treatment:

Nonsurgical and surgical: Nonsurgical treatment is considered first-line therapy and includes modalities such as the following: High-fiber diets, Stool softeners, Warm sitz baths, Topical analgesics/anesthetics Chemical sphincterotomy (GTN, CCBs), Local injection of botulinum toxin. When nonsurgical methods fail to heal the anal fissures or relieve symptoms, however, surgical treatment may be necessary. The surgical treatment options are as follows: Internal anal sphincterotomy (open/closed) Fissurectomy Sphincter stretch Co2 laser surgery.



GRAPH 1:

Category I: (n=45 i.e., 83.3%) No. of pt with stigmata showed improvement with surgery
Category II: (n=7 i.e., 12.9%) improved with conservative management
Category III: (n=2 i.e., 3.8%) no improvement

Graph 2: Category 1: Males Category 2: Females

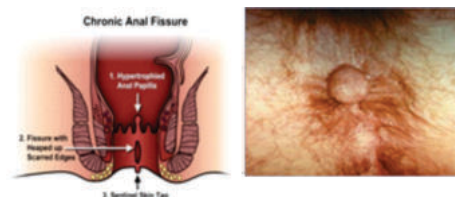


Fig 2: FISSURE WITH FISTULA

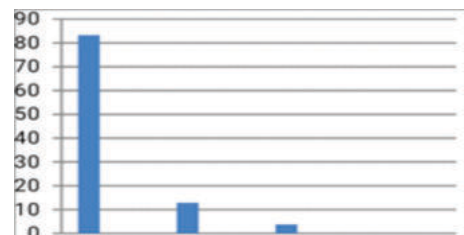


Fig3: chronic fissure in ano

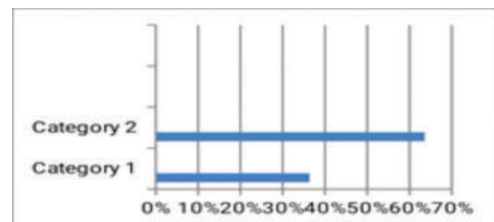


fig 4: HYPERTROPHIED ANAL

CASES: There were 100 patients examined in this study. Of which 4 deferred to participate in the study out of 96 patients 84 patients had different features of chronic fissure and other associated complications

and remaining 12 patients presented with features of acute fissure

METHODS: Study was carried out in Department of General surgery, Osmania General Hospital, Hyderabad, Telangana between July 2021 to December 2021. 100 patients with clinical diagnosis of Fissure-in-Ano; whose age, sex, any previous treatment taken were recorded. All patients were explained about the disease and their treatment plan and followups (3 visits)-1 week, 1 month, 2 months. Treatment failure based on the persistence of symptoms/pain while defecation (pain score--VAS), VAS 6 OR GREATER recurrences, wound infection

RESULTS:

Of 100 patients who came to opd in Government general hospital in surgery dept in unit V and were diagnosed as fissure in ano 4 patients deferred to participate in the study. So n=96(96%) of cases were taken into the study. Of them 12(12.5%) patients presented with features of acute anal fissure and remaining 84(87.5%) presented with features of chronic anal fissure. All the patients who participated in study were initially managed conservatively. Of 12 individuals with acute fissures 9 responded to conservative management and remaining 3 individuals did not show any improvement so were advised surgical management. Of these 3 patients, 2 patients showed improvement with surgery and 1 patient deferred from surgery and was given local botox injection and responded. Of 84 patients with chronic fissure managed conservatively 52 dint responded and 32 patients responded. These 52 patients were advised surgical management and of them 3 patients deferred to undergo surgery and was advised local botox inj and of them 2 improved and 1 patient dint responded. And remaining 49 patients underwent surgical intervention of them 48 improved and 1 dint responded. Males were 36.4%(n=35) and females 63.6%(n=61) with age varying between 22yrs -54yrs. All cases studied dint underwent previous treatment. Of (n=84)-- 35.7%(n=30) presented without indications of interventions mentioned above (fibrosed ulcer, ulcer with granulation tissue). 27 patients improved with conservative management and remaining 3 improved with surgical intervention. 64.3%(n=54) presented with stigmata i.e., multiple skin tags alone or also had hypertrophied anal papillae or with visible transverse fibers at the floor of fissure or with multiple fissures/anterior or lateral fissures. 49 patients were advised surgical management of them 46 underwent surgery and 45 improved and 1 dint respond. Remaining 3 deferred surgery and local botox injection was advised of them 2 improved and 1 dint improved. Remaining 12.5%(n=12) presented with acute fissure. Thus, 83.33% (n=45) Individuals with chronic fissure and having stigmata (multiple skin tags, hypertrophied anal papillae, visible transverse fibers, multiple fissures) showed improvement with surgical management successfully after failed conservative management.

CONCLUSION:

Thus, in patients with stigmata (multiple skin tags, hypertrophied anal papillae, visible transverse fibers at the base of fissure, multiple fissures) conservative management might be a wastage of resources which may add to loss of working hours adding to the cost burden on the patient. So patients with these stigmata should be directly advised surgical management

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