Research Paper MEDICAL

RESULTS OF MANAGEMENT OF PATIENTS WITH PRIMARY CHRONIC ANAL FISSURE WITH DILTIAZEM2%topical VERSUS LATERAL SPHINCTEROTOMY

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KEYWORDS

introduction

Anal fissure is most frequent and painful anal disease and its clinical management is still controversial

Aim

Aim is to compare results with 2% topical Diltiazem versus Lateral sphincterotomy on patients coming to the dept of surgery ,ggh,Kakinada with primary chronic anal fissure.

DEFINiTION,EPIDEMIOLOGY AND ETIOLOGY

Anal fissure is defined as linear ulcer of the anoderm distal to dentate line , generally located in the posterior midline.

Classification

Anal fissures are considered to be acute if present for <6weeks, superficial , having well demarcated edges.

Anal fissures are called chronic , if they have been present for more than 6weeks, having cartiginous edges, sentinel pile , hypertrophied anal papillae.

Primary anal fissure : if not caused by underlying chronic disease.

Secondary anal fissure : if associated with chronic inflammatory intestinal disease, HIV, Tuberculosis, Syphilis and Neoplasm.

Primary anal fissure is most frequent in young adults of both sex, 80 -90 % located in posterior midline.

95%-in males

80% in females

Etiologically -generally due to passage of hard faeces, constipation.

Others causes are like inappropriate diet,previous anal surgery ,childbirth, laxative abuse

High anal pressures –ischemia--- ulceration-fissure.

Treatment modalities include Dietary habits

Laxatives

Topical applicaions– nitroglycerine ,calcium channelblockers

botulinum injections

Lignocaine preparations

Material and methods

50 patients are observed presenting to the OP with intense pain during or after defaecation (100%) , bleeding (20%).

Duration more than 6 weeks

Confirmed by inspection of commisure of the anus; majority at level of posterior commisure (80 – 90 %).

Other findings--Slime/mucus and itching

Proctoscopy done to rule out hemorrhoids and secondary causes of fissure after applying xylocaine 2% jelly but few cases required sedation.

Few cases with multiple fissures are only selectively evaluated with sigmoid/colonoscopy .

25 cases were advised Diltiazem 2% topical application twice daily.

25cases were treated with Lateral sphincterotomy done by conventional closed technique with excision of sentinel pile if present.

Both patients are supplemented on oral laxatives for a period of 2 weeks

Sitz baths were given to patients for a period of 1 week

Patients are examined every week for a period of 2 months

Treatment response was recorded by decrease of pain ,feeling of well being,

incontinence,
bleeding,
healing of fissure.

Pain response was graded by faces pain scale



Patients treated with 2% Diltiazem topical ointment responded on average after 2weeks with complete pain response , until which they needed oral analgesic supplementation.

Pain upto 2 wks between 2-6 faces pain scale

Healing of ulcer took more than 6 weeks of treatment.

Patients treated by lateral sphincterotomy had response to pain with in <1 week and healing of ulcer by 4 weeks.

Pain between 2-6 faces pain scale

2cases had incontinence for liquids/ gases and none for solids.

- **2%diltiazem topical**
- Pain reponse started aweek after
- Pain absence after 2 weeks
- No bleeding

- Analgesic requirement for 2wks
- Laxatives for 2 weeks
- No incontinence
- Healing of ulcer by 6 weeks

- **Lat sphincterotomy**
- Pain decreased with in first week
- Painless after 1 week

- Bleeding 1-2 days postop
- Only for 1week
- Laxativesfor 2 weeks
- Incontinence for liquid/flatus
- Healing of ulcer by 4 weeks

Conclusion

- Treatment for primary chronic anal fissure equally holds good with topical ointment or Lateral internal sphincterotomy.

- Topical treatment may be given as first line management followed by surgical option so that complications of surgery can be avoided.