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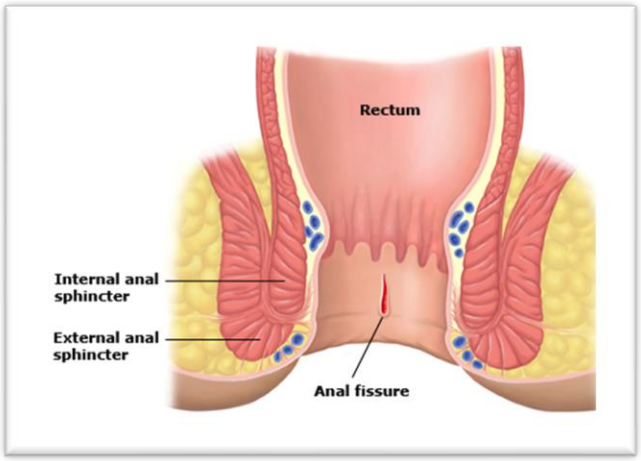
Anal fissure

Informed consent: patient information

1. What is an anal fissure?

An anal fissure is **a tear** in the lining of the anal canal. It fails to heal and becomes established as a painful ulcer associated with spasm of the anal sphincter muscle. The fissure is described as acute if it has been present for less than six weeks or chronic if present for more than six weeks.



Most anal fissures arise following trauma to the anus. The commonest trauma is that occasioned by the passage of a hard, constipated stool. However, they can occur following prolonged diarrhoea, vaginal delivery, repetitive injury, or penetration. Anal fissures are also found in patients with previous anal surgical procedures, inflammatory bowel disease (e.g., Crohn's disease), tuberculosis, infections or malignancy.

Pain is the major symptom of anal fissure. It comes on at the time of passage of a bowel motion and lasts for a variable period afterwards. Pain is due to tenderness of the fissure itself and to intense spasm of the internal anal sphincter muscle. **Bleeding** is a common symptom, especially when the fissure first develops. Sometimes a **swollen skin tag or lump** develops at the external end of the fissure.

2. How is anal fissure diagnosed?

Anal fissures can usually be diagnosed based on the symptoms described above and a physical examination. The **physical examination** involves gently separating the buttocks, allowing for visual inspection of the region around the anus. A fissure most commonly appears in the 12 or 6 o'clock position. Fissures located in other locations are more likely to be associated with an underlying disorder (e.g., Crohn disease).

If the diagnosis is unclear, **a sigmoidoscopy or colonoscopy** is usually recommended, especially if there has been rectal bleeding. A colonoscopy is preferred in patients 50 years and older and can also be used to screen for colorectal cancer. In younger patients with no risk factors for colorectal cancer or intestinal diseases, a sigmoidoscopy may suffice.

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3. What are the treatment options?

Initial treatment is medical and aimed at eliminating constipation, softening stools, and reducing anal sphincter spasm. There are several approaches to reducing anal sphincter spasm:

- High fibre supplementation (**Metamucil**) – Avoiding hard bowel movement will prevent trauma to the anal canal, promoting healing of the fissure.
- **Warm water sitz bath** – will soothe the anal spasm and increase blood flow and circulation
- Topical 0.2% Nitroglycerin (**Rectogesic ointment**) – applied around the anal opening two times daily for 4-6 weeks. It has well known side effects such as headache and dizziness. These symptoms are generally mild, last less than 30 minutes.
- **Topical 2% Diltiazem** (compounding ointment) – applied around the anal opening two times daily for 4 -6 weeks.

Surgical procedures are generally reserved for people with symptoms that have persisted despite medical treatment for 6-8 weeks or recurred soon after the treatment.

4. What is the anal sphincterotomy (Surgery)?

The procedure of choice is called a **lateral internal sphincterotomy**, which relaxes the internal anal sphincter by cutting this muscle. This is generally performed as an outpatient procedure while providing the patient a **general anaesthesia**.

A sphincterotomy involves a small cut near the anal opening, with the division of the lowest part of the internal anal sphincter muscle. The spasm is relieved, which helps the fissure to heal. Sometimes the fissure itself may be excised, together with any nearby haemorrhoids and any large or troublesome skin tags.

Prompt relief from the pain is to be expected, even though healing of the fissure may take some weeks. Healing of the fissure is to be expected in 95% of those with sphincterotomy.

5. What are the general risks of this procedure?

- pain
- bleeding
- surgical site infection

6. What are the specific risks for this procedure?

- involuntarily passing wind or loose faeces (usually temporary)
- permanent faecal incontinence (< 1%)
- recurrence (of anal fissure) – in up to 5-6%

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7. How do I prepare for the procedure?

- If you need to have an anal fissure surgery, you will be asked to eat nothing the night before the surgery. If you need to take medications, you may have a sip of water. You should have nothing at all 6 hours before the surgery. Unless you are also having a colonoscopy, the bowel preparation is not required the day before surgery.
- Your surgeon will discuss with you whether to stop taking medicines or supplements.
- You will be admitted as a day only procedure. You will receive a **fleet® enema** 1 hour prior to your operation.

8. What do I expect after the procedure?

- Following your procedure, you will recover for an hour or so until the effects of sedatives have worn off. You should not drive yourself home after your procedure and should have someone organised (a friend or relative) to accompany you.
- Spotting of blood or persistent minor oozing will occur for 5 days following your procedure, and a small surgical pad (Combine) changed once to twice daily will be needed to prevent staining of your underwear. Bleeding will typically occur after opening your bowels.
- You should remain on **simple analgesics** for a few days. You can take 2 tablets of Paracetamol (1000mg) and/or Ibuprofen (400mg) regularly three times a day. Opioid medications (Endone) may sometimes be needed but should be used sparingly as they cause constipation.
- A tablespoon of natural psyllium husk (**Metamucil®** or Fibogel®) twice daily is recommended to soften your bowel motions. You may need some laxatives (Movicol or Lactulose) in case of developing unwanted constipation.
- Twice daily **warm salt water (Sitz) bathing** to the anal region is soothing and antiseptic and should be done for 1 week following your procedure.
- You will be advised to visit your doctor when you need a frequent wound management such as change of packing gauze or dressings.
- You will be encouraged to have a **follow up appointment** with Dr Woo in 3-4 weeks.