DR TREVOR CURRER
MBChB(Cape Town) FCS(S.A.) FRCS(Edin.) MMed(Surg.)(U.C.T.) FRACS
SURGEON

SUITE 9 WAHROONGA SPECIALIST CENTRE
176 FOX VALLEY ROAD
WAHROONGA NSW 2076
TELEPHONES:
ROOMS.....(02) 9487 4444
PAGER.....9962 9541
TELEFAX .....(02) 9489 7468
WEBSITE ..www.sydneygeneralsurgeon.com.au

Anal Fissure (Fissure-in-ANO)

DEFINITION

A "split or tear" occurring at the anal verge.

AETIOLOGY

A hypertonic anal sphincter (spasm/tightness) is a central factor in the genesis of an anal fissure. Precipitating factors include a change in bowel pattern such as constipation or diarrhoea.

CLINICAL PRESENTATION

Classified as "acute" and "chronic" dependent on the duration of the symptoms. The commonest symptoms include pain with a bowel movement and fresh rectal bleeding. The chronic fissures may have recurrent symptoms due to acute exacerbations over many years.

PATHOLOGY

An ulcer usually in the midline posteriorly, at the anal verge. Classified pathologically into acute and chronic dependent on the amount of scar tissue associated with the fissure. Chronic fissures may have an additional sentinel pile (fibrous polyp) at the anal verge, and a hypertrophic papilla higher in the anal canal at the level of the dentate line. These two findings are indicative of chronicity.

DIFFERENTIAL DIAGNOSIS

Acute fissures need to be differentiated from peri-anal sepsis and thrombosed internal haemorrhoids, accounting for the severity of the pain experienced by the patient.

Chronic fissures may very occasionally be a clinical presentation for Crohn's disease, other forms of inflammatory bowel disease, anal fistulas, anal cancer, and ulceration due to STD and blood dyscrasias. Biopsy of a chronic fissure may be required.

MEDICAL TREATMENT

A conservative non "interventive" approach is maintained in the majority of cases. This includes stool softeners, eg. Duphalac, topical applications, such as Rectogesic and Proctosedyl and suitable analgesics (avoid Codeine).

SURGERY

A minority of patients require surgery owing to failed conservative measures. A lateral subcutaneous sphincterotomy is a very effective curative surgical procedure. The operation relieves the anal sphincter tension and allows the fissure to heal, and there is usually a dramatic resolution of the patient's symptoms. There is a well documented risk of slight sphincter muscle impairment occurring in the longterm, as a result of the surgery. This risk is minimised by "tailoring" the procedure to the pathology and by careful patient selection for surgery.