Lateral Internal Sphincterotomy

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Indication

- Chronic anal fissure

Essential Steps

1. Rectal exam.
2. Inject local anesthetic.
3. Anoscopy.
4. Identify the fissure and curet the base.
5. Identify the intersphincteric groove and make an incision.
6. Elevate and divide fibers of the internal sphincter.
7. Achieve hemostasis.
8. Close the wound.

Note These Variations

- Prone jackknife vs. lithotomy position vs. left lateral decubitus
- Longitudinal incision into the anal canal (open technique) on occasion used

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Complications

- Bleeding/hematoma formation
- Incontinence
- Recurrence
- Urinary retention

Template Operative Dictation

Preoperative Diagnosis Chronic anal fissure

Procedure Lateral internal sphincterotomy

Postoperative Diagnosis Same

Indications This ___-year-old *male/female* had anal fissure of duration refractory to medical management. Lateral internal sphincterotomy was elected for management.

Description of Procedure The patient was brought to the operating room. Time-outs were performed using both preinduction and pre-incision safety checklists to verify correct patient, procedure, site, and additional critical information prior to beginning the procedure. *General/spinal/monitored care* anesthesia was induced. The patient was placed in the *prone jackknife/lithotomy/left lateral decubitus* position. The perineum was prepped and draped in the usual sterile fashion. Local anesthetic was injected *as a*

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perianal/pudendal nerve block. The anus was gently dilated and anoscopy performed to identify the fissure. The anoscope was replaced with a Hill-Ferguson retractor and the base of the fissure scraped with a curet.

The intersphincteric groove was identified. A short, 4- to 5-mm incision was made directly over the intersphincteric groove on the *right/left* side. A hemostat was used to dissect the internal sphincter free of anoderm and external sphincter. Fibers were then elevated into the wound using a right-angle clamp and divided with *electrocautery/sharp dissection* until the hypertrophic sphincter felt relaxed on digital exam. Hemostasis was achieved by holding pressure. The incision was left open to drain. A debriefing checklist was completed to share information critical to postoperative care of the patient.

The patient tolerated the procedure well and was *extubated and* taken to the postanesthesia care unit in stable condition.