Practice Parameters for the Management of Anal Fissure

PREPARED BY
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It should be recognized that these guidelines should not be deemed inclusive of all proper methods of care or exclusive of methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of all of the circumstances presented by the individual patient.

Logic for Practice Parameters

Practice parameters outline principles and provide suggestions to assist physicians in the care of patients with anal fissure. These principles should provide a rational basis for objective evaluations of patients by physicians and third-party payers. Such evaluations may make routine second opinions unnecessary. These parameters are forged from divergent opinions based on data from published articles including those on controlled trials in referred journals, textbooks, the collective experiences of clinicians, and the opinions of members of the Standards Task Force. All parameters are reviewed carefully by the Executive Council of the American Society of Colon and Rectal Surgeons prior to adoption and will be reviewed periodically and amended as necessary.

Statement of Problem

A fissure consists of a crack or tear in the vertical axis of the squamous lining of the anal canal between the anal verge and the dentate line.[1] Initially it is superficial but may deepen to reach the underlying internal sphincter, exposing circular fibers. Fissures usually occur in the posterior midline, and the second most common location is in the anterior midline (10 percent of all the fissures in women).[2] Fissures are often associated with secondary changes which may include a sentinel tag, hypertrophied anal papilla, induration of the edge of the fissure, and relative anal stenosis secondary to spasm or a fibrotic internal sphincter.[3,4] A sentinel tag may be associated with a fistula which extends from the base of the fissure to an external opening distal to the tag.

Diagnosis

Among the symptoms manifested by patients with fissures are pain during and after defecation, bleeding, discharge, swelling, and itching. The diagnosis can be made by inspection, palpation, and/or anoscopic examination. A fissure may arise from trauma to the anus (constipation, diarrhea, surgery, injection, rubber banding, sigmoidoscopy, colonoscopy, *etc.*), or it may be a manifestation of a specific underlying disease state such as chlamydia, gonorrhea, herpes, syphilis, AIDS, tuberculosis, neoplasm, Crohn's disease, or ulcerative colitis.[5] These disease entities associated with an anal fissure are suggested by the ectopic location, multiplicity, or atypical appearance of the lesion.[6] If the clinician suspects the presence of an underlying disease process, additional tests are indicated (serology, stool cultures, biopsy, or gastrointestinal workup).

Treatment

Medical. Acute (superficial) fissures can be managed by diet, bulk laxatives, short-term topical creams, and sitz baths.[7]

Surgical. Chronic fissures are managed by subcutaneous or open lateral internal sphincterotomy, posterior internal sphincterotomy with advancement flap, or manual dilatation.[8–32]

Secondary goals of fissure surgery sometimes require the removal of hypertrophied papilla and skin tag as well as the removal of inflammatory and fibrotic tissue surrounding the fissure. Concomitant fissurectomy is usually unnecessary unless extensive fibrosis is present or there is a need for biopsy.[33] It may be necessary to create mucosal or skin advancement flaps in patients with broad anal fissures associated with anal stenosis.[34] During surgery for fissure, associated symptomatic anorectal disease can be corrected.

Recurrent Fissure

If a fissure fails to heal postoperatively, then conservative treatment of the fissure may be initiated, allowing the physician to reassess the clinical picture for underlying disease processes. If anal canal pressure is elevated, repeat ipsilateral or contralateral internal sphincterotomy may be indicated.[35–37]

Complications

Complications following the surgical treatment of a fissure include abscess/fistula, postoperative hemorrhage, and urinary retention.[38,39] Varying degrees of incontinence to flatus and/or feces have been observed.[40] Internal sphincterotomy, therefore, is carried out with caution in patients with diarrhea, irritable bowel syndrome, diabetes, or other pre-existing states which predispose them to incontinence. The extent of manual dilatation required in the treatment of a fissure has yet to be determined, but caution is recommended when it is used in individuals susceptible to incontinence, especially the elderly.

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