Anal fissures

Ok, not the most glamorous subject! Sometimes our job isn't glamorous but where else will you find teaching on such mundane topics that can make such a big difference to an uncomfortable patient! What's more - we all have a 1 in 10 lifetime chance of being affected and given that patients describe it as 'feeling like passing broken glass', a GP who knows how to help must be a good thing!

Luckily for us, The DTB has recently published an excellent review on non-surgical management.

Aetiology

This section dispelled a few myths for me!

- Anal fissures are caused by a combination of variation in anatomy of anal blood vessels and high anal tone.
- Nitric oxide is the main mediator of anal relaxation and it has been suggested that a lack of nitric oxide production may result in the spasms experienced with anal fissure.
- The condition is not usually associated with constipation (really!).
- Acute fissures can be caused by passage of a hard stool or post partum – many heal without intervention – these are primary fissures.
- A chronic fissure lasts more than 6 weeks and is probably maintained by poor blood supply and a shortage of relaxing nitric oxide. These are likely to need intervention.
- Less commonly fissures indicate an underlying illness such as Crohn's, HIV, TB or syphilis – there are likely to be other features in the history/examination and they may not be midline.

Presentation and diagnosis

Patients will usually complain of:

- sharp pain on defecation
- burning pain lasting a few hours after
- bleeding during and after passage of stool.

Diagnosis can be made on the basis of history and inspection of the anus:

- Look for a fissure in the midline (posterior usually, less commonly anterior).
- Do a PR or proctoscopy if possible but anal spasm is often present making this difficult.
- Consider if examination under anaesthesia is warranted to rule out serious pathology.
- Consider secondary causes such as Crohn’s if there is other perianal pathology such as fistulae, ulcers, skin tags etc.

Treatment options

Below is a flow chart of treatments in the order we should consider them in primary care. The DTB takes its evidence for these treatments predominantly from a Cochrane Systematic Review (Cochrane 2012;2:CD003431). First a few key points:

- Conservative and medical therapy will result in healing of 50% patients with chronic fissure.
- Recurrence rates following medical treatment are 20-30%.
- Surgery is more clinically effective than all medical treatments and botox but carries a significant risk of permanent incontinence, especially for women.
- Limited economic comparisons are available but suggest GTN is most cost-effective when compared with surgery or botox.
Anal Fissures

- Common and painful!
- Most acute (<6 weeks) fissures will settle with conservative management e.g. stool softening/analgesia.
- For chronic fissures (>6 weeks) offer conservative measures with GTN ointment first line, try diltiazem ointment if headaches are a problem.
- Refer to colorectal surgeons for botox or surgery if not resolved with 6 weeks medical management.
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GP Update Limited
November 27 2013