Anal Fissure: Is it becoming a medical disorder?  
Review Article

All Al-shaham, CABS*. Kadhim Jawad, CABS**, Serene A.A. MS***

ABSTRACT
An anal fissure which does not heal with conservative measures as sits baths and laxatives is a chronic anal fissure. Physiologically, it is the high resting tone of the internal anal sphincter that chiefly interferes with the healing process of these fissures. Until now, the gold standard treatment modality is surgery, either digital anal dilatation or lateral sphincterotomy. However, concerns have been raised about the incidence of faecal incontinence after surgery. Therefore, pharmacological means to treat chronic anal fissures have been explored.

A Medline and pub med database search from 1986-2012 was conducted to perform a literature search for articles relating to the non-surgical treatment of chronic anal fissure.

Pharmacological sphincterotomy using Glyceryl trinitrate, isosorbide dinitrate or calcium channel blockers are exciting alternative treatment, that relaxes the anal sphincter and, therefore, promote healing, the drawback of such medications are headache and poor compliance. With the introduction of Botulinum toxin as mean of chemical sphincterotom, topical injection of Botulinum toxin reduces the anal hypertonia which lasts for few months, allows the fissure to heal, thus eliminating the need for surgery without incidence of incontinence. Cure rates are over 60%, and the procedure can be repeated safely. Therefore, Botulinum toxin is a reasonable first-line management of chronic anal fissure and the relapses can be managed by surgery.

Keywords: Non-surgical treatment of anal fissure, fissure in ano, sphincterotomy, botulinum toxin, anal fissures, Glyceryl trinitrate. Chemical sphincterotomy, pharmacological sphincterotomy.

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A Kindy College Medical Journal 2014: Vol.10 No. 2  
Page: 1-4

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Received 24th Dec 2014, accepted in final 10th May 2015  
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A nal fissure is a longitudinal tear in the mucosa of anal verge upon passage of hard stool, and the patients usually present with fresh per rectal bleeding and anal pain during defecation. Although the acute anal fissures usually respond to conservative management with Sits baths and laxatives, the chronic one does not. Until now, surgery has been necessary for treatment of these fissures, that do not respond to conservative therapy. However, there are exciting new advances in non-operative management that change the concept of management of this surgical disease into medical one, the introduction of many pharmacological agents that can treat anal fissures successfully without risk of anal incontinence and no hospitalization is required.

Pathogenesis
In a patient with constipation, the passage of hard stool can injure the mucosa and skin of the anal canal. This anal injury triggers a spasm of the internal anal sphincter (IAS). A permanently elevated resting pressure of IAS impairs the intrasphincteric blood flow and consequently causing ischemia to the anoderm that delays healing of these fissure, resulting in chronicity of these fissures as shown in Figure 1.

The reason for high incidence of posteriorly located anal fissures (90%) is that the posterior anus is already less perfused with blood than other parts of the anal canal and hence it is more vulnerable to sustain disease.

The principle concept in the management of chronic anal fissure is reducing hypertonia of the IAS: It follows that a relief of IAS spasm will improve the blood supply to the anoderm and promote healing process.

Methodology: A Medline and pub med database was conducted during 26 years from 1986-2012 to perform a literature search for articles relating to the non-surgical treatment of chronic anal fissure.

Surgical treatment: The two most popular procedures are digital anal dilatation and lateral sphincterotomy. In anal dilatation, the surgeon stretches the sphincter to extend that the IAS becomes temporary paralyzed for several days. While in a lateral sphincterotomy, the surgeon divides the lowermost fibers of the IAS so that these fibers lose their spasm, and improve the blood supply with consequent healing of the fissure.

After anal dilatation, fissures heal in 93% of patients. Nevertheless, because of the sphincter damage, as many as 38% of patients can have transient incontinence and a small number of patients have a degree of permanent incontinence. Since anal dilatation may cause incontinence, many surgeons prefer lateral internal sphincterotomy, which often considered the procedure of choice for anal fissure. The sphincterotomy is simple to perform, and provides immediate relief of pain. Healing occurs in 96% of patients. Although incontinence is rare, it does occur, and may be permanent.

Chemical sphincterotomy:
Both surgical anal dilation and sphincterotomy are associated with irreversible damage to the IAS and the possibility of long term incontinence. This complication of surgery can be quite distressing, and therefore researchers have investigated nonsurgical methods of reducing IAS spasm. They have discovered drugs that reduce this spasm and help in healing of the fissure, with no incidence of sphincter damage. The use of pharmacological agents for this purpose is called chemical sphincterotomy.

1. Glyceryl trinitrate and isosorbide dinitrate: Glyceryl trinitrate (GTN) and isosorbide dinitrate (ISD) relax smooth muscle. They reduce resting anal pressure, and improve blood flow to the region. The resting anal pressure falls immediately after topical anal application of GTN/ISD ointment. GTN ointment promotes healing of anal fissures in 33% to 88% of patients in different trials. Moderate to severe headaches are commonly encountered
Table 1: The incidence of incontinence after lateral internal sphincterotomy.

<table>
<thead>
<tr>
<th>Authors</th>
<th>No.</th>
<th>Incontinence to flatus%</th>
<th>Incontinence to faces %</th>
<th>Incidence of soiling %</th>
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<tbody>
<tr>
<td>Nyam and Pemberton\textsuperscript{10}</td>
<td>487</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Mélange et al\textsuperscript{11}</td>
<td>76</td>
<td>17</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Khubchandani and Reed\textsuperscript{12}</td>
<td>829</td>
<td>35</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Littlejohn and Newstead\textsuperscript{13}</td>
<td>287</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Hananel and Gordon\textsuperscript{14}</td>
<td>312</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

2. Calcium antagonists: Nifedipine and diltiazem are calcium channel blockers. Topical application of both nifedipine\textsuperscript{22} and diltiazem\textsuperscript{23} have been evaluated. The reduction in anal pressure is a modest 28%, and the effect lasts for 3-5 hours after application.

With both drugs (80% patients)\textsuperscript{19} and compliance is a major issue.\textsuperscript{20,21} These side effects, along with tachyphylaxis, limit the utility of topical GTN/ISD ointment in the treatment of anal fissure.\textsuperscript{19}
3. Botulinum toxin: Botulinum toxin is a lethal biologic neurotoxin released by *Clostridium botulinum*. It binds rapidly and strongly to presynaptic cholinergic nerve terminals, and prevents the release of acetylcholine into the neuromuscular junction. This decreases the activity within parasympathetic and sympathetic cholinergic synapses, and produces a flaccid paralysis of skeletal muscle.

Botulinum toxin is a versatile tool and is used in disorders of striated muscles, e.g. spasmodic torticollis, strabismus, blepharospasm, and hemifacial spasm. The toxin can be used to weaken smooth muscle in the gastrointestinal tract as in inachalis and infantile hypertrophic pyloric stenosis.

In the treatment of anal fissure, botulinum toxin has greater clinical potential than GTN or the calcium antagonists. The advantage of using botulinum toxin injections in patients with anal fissure is that the ensuing reduction in anal pressure lasts for three or more months. This prolonged relaxation of the IAS allows the fissure to heal properly, thus eliminating the need for surgery without the risk of permanent incontinence or hospitalization.

Typically, 0.4 ml (20 units) of botulinum toxin is injected around the fissure. Some patients may need re-injection after two months. After injection of botulinum toxin, there is a significant decrease in resting anal pressure by 18-30%. The therapeutic effect of sphincter relaxation occurs within a few hours after injection, relieving pain almost immediately. Another benefit over surgery is that no hospitalization, sedation or anesthesia is required during the procedure. It is safe, easy to perform constantly with good cure rate. A transitory incontinence for flatus occurs in about 3% of patients. As shown in Table 2.

### Table 2: Treatment of chronic anal fissure using botulinum toxin injection

<table>
<thead>
<tr>
<th>Author</th>
<th>No.</th>
<th>Temporary incontinence (%)</th>
<th>Healing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria et al.</td>
<td>57</td>
<td>2</td>
<td>68</td>
</tr>
<tr>
<td>Fernandez et al.</td>
<td>76</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td>Miguez et al.</td>
<td>69</td>
<td>0</td>
<td>63</td>
</tr>
</tbody>
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In a randomized trial, Nasr et al showed that fissure healing occurred in 25/40 patients after use of botulinum toxin, as compared to 36/40 patients after lateral sphincterotomy. Permanent incontinence does not seem to occur with the use of botulinum toxin.

We believe that botulinum toxin injection should be the first line treatment in patients with chronic anal fissure before surgery is considered. Over sixty percent of patients will heal without the morbidity or side effects of surgery.

In Conclusions, although surgical sphincterotomy is the gold standard procedure in patients with fissure in ano, the use of pharmacological means to treat chronic anal fissure is an interesting alternative. Attrial with botulinum toxins therapy is appropriate before any surgery for the following advantages: it is safe, effective, less expensive and easier to perform as an outpatient procedure and does not require anesthesia or hospitalization. No adverse effects or permanent sphincter damage. Botulinum toxin is strongly indicated in patients having high surgical risk and patients with high risk of future incontinence.

References:


