A quick guide to **managing anal fissures**

Anal fissures: tear-inducing tears

Anal fissures are small tears in the epithelium of the anus that can be intensely painful.

Most anal fissures are caused due to straining during bowel movements, constipation or repeated diarrhoea. They are equally common in both sexes, and most frequently affect people aged 15 – 40 years.[1] Women giving birth are at increased risk of developing anal fissures due to pressure on the perineum. Spasm of the anal sphincter or local ischaemia can predispose people to, or worsen, anal fissures.

Atypical anal fissures may develop in people with Crohn's disease, sexually transmitted diseases (particularly HIV, syphilis and herpes simplex), anal cancer, local trauma (anal intercourse), tuberculosis or receiving chemotherapy.[2, 3]

Spontaneous resolution occurs in one-third of people, usually within six weeks. Anal fissures that persist longer than this are considered chronic and should be managed more intensively. Topical glyceryl trinitrate is now available, fully subsidised, with Special Authority, as a treatment option for people who have had an anal fissure for at least three weeks. Where medical management fails to resolve symptoms and help heal the fissure, referral to secondary care for surgery or botulinum toxin treatment is usually required.

Symptoms and history usually indicate anal fissures

Anal fissures can usually be diagnosed based on the patient's description of their condition and a brief history, although an examination is also required.

Intense pain during defecation that often persists for one to two hours afterwards is the primary symptom of an anal fissure.[1] Patients will usually also have noticed the presence of blood on the toilet paper, and may report a tearing sensation during bowel movements.

Complications may occur in some people, including: failure to heal/chronic fissure, an anorectal fistula, infection and/or abscesses may develop or faecal impaction can occur due to intense and intolerable pain during defecation.

Perform an examination to help confirm a diagnosis

Anal fissures are not always visible on examination; however, examination is useful for ruling out other causes of pain and bleeding such as haemorrhoids, abscesses and viral ulcers. In 90% of cases, anal fissures form on the posterior midline of the anus. Typical features of a chronic anal fissure include an ulcerated lesion, a sentinel pile at the base of the fissure (resulting in a permanent skin tag) and enlargement of the anal papillae.

The management of anal fissures

Initial management involves lifestyle changes and symptomatic relief

Advise the patient to increase dietary fibre and fluid intake to keep bowel motions soft. The importance of correct anal hygiene and the need to keep the anal area dry should be emphasised. Regular sitz baths (sitting in warm water up to the hips) can help to relax the sphincter.[1] The patient should also be advised to avoid undue straining during bowel movements.

If lifestyle and dietary interventions are insufficient, or if the fissure is severe, a stool softener, e.g. oral docusate sodium, and mild local analgesia, e.g. lidocaine (not subsidised), may be prescribed.[1]

More intensive treatment may be required in some patients

If the fissure fails to heal within three to six weeks, topical nitrates or topical calcium channel blockers should be used. All topical treatments for anal fissures should be applied for at least six weeks to allow re-epithelialisation of the fissure.[1]

A topical nitrate, e.g. glyceryl trinitrate 0.2% ointment (see opposite), should be considered if the fissure has been present for at least three weeks. The patient should insert 1 – 1.5 cm of ointment into the anal canal, three times daily.[1] Nitrate ointment increases blood flow to the anus and reduces pain on defecation.[1] Dose escalation is not recommended as it does not increase the healing rate and may lead to more adverse effects.[4] Headache is the most common adverse effect,[5] and advising the patient to stop the medicine for a day or two if headaches become intolerable is recommended.[5]

Topical calcium channel blockers are also commonly used to manage anal fissures, although this is an unapproved use.[1] If the use of topical nitrates has not improved symptoms or where the adverse effects of nitrates are intolerable, topical diltiazem 2% (requires pharmacy preparation), two to three times daily, may be used.[1] The most common adverse effect is headache, although this has a lower incidence than with topical nitrates.[3, 4]

What to do if medical management fails to resolve symptoms

If the fissure has not healed after six to eight weeks of topical treatment and dietary changes, the patient should be referred to secondary care to assess the appropriateness of other treatments, usually botulinum toxin or surgery.

Subsidy changes to glyceryl trinitrate

Topical glyceryl trinitrate ointment is now available, fully subsidised, as of 1 April, 2013, for use in adults with anal fissures. The medicine can be prescribed by any General Practitioner, under Special Authority. The Special Authority criteria limit the use of the medicine to adults who have an anal fissure that has persisted for longer than three weeks.[6]

Topical glyceryl trinitrate is available as a 0.2% ointment, in 30 g packs. This medicine was previously available, but was not subsidised for anal fissures.

Botulinum toxin injected into the internal anal sphincter is used to paralyse the sphincter for several months. This treatment is most useful for females where the anal sphincter has been damaged following childbirth.[1]

Surgical techniques commonly used for anal fissures which aim to relax the internal sphincter include; open lateral sphincterotomy, closed lateral sphincterotomy and posterior midline sphincterotomy.[3] Surgery is consistently superior to medical management options, although it should only be considered in people with chronic, non-healing anal fissures where medical treatments have failed.[3] There is a slight risk of flatus and faecal incontinence following surgery.[4]

References

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