

should raise suspicion for other causes, including tuberculosis, syphilis, Crohn's disease, and malignancy.

Presentation and Evaluation A fissure can be easily diagnosed on history alone. The classic complaint is pain, which is strongly associated with defecation and is relentless. The bright red bleeding that can be associated with a fissure is less extensive than that associated with hemorrhoids. On examination, most fissures are located in either the posterior or anterior position. A lateral fissure is worrisome because it may have a less benign nature, and systemic disorders should be ruled out. A chronic fissure is indicated by the presence of a hypertrophied anal papilla at the proximal end of the fissure and a sentinel pile or skin tag at the distal end. Often the circular fibers of the hypertrophied internal sphincter are visible within the base of the fissure. If anal manometry is performed, elevation in anal resting pressure and a sawtooth deformity with paradoxical contractions of the sphincter muscles are pathognomonic.

TREATMENT

Anal Fissure

The management of the acute fissure is conservative. Stool softeners for those with constipation, increased dietary fiber, topical anesthetics, glucocorticoids, and sitz baths are prescribed and will heal 60–90% of fissures. Chronic fissures are those present for >6 weeks. These can be treated with modalities aimed at decreasing the anal canal resting pressure including nifedipine ointment applied three times a day and botulinum toxin type A, up to 20 units, injected into the internal sphincter on each side of the fissure. Both treatments are associated with a fissure healing rate of >80%. Surgical management includes anal dilatation and lateral internal sphincterotomy. Usually, one-third of the internal sphincter muscle is divided; it is easily identified because it is hypertrophied. Recurrence rates from medical therapy are higher, but this is offset by a risk of incontinence following sphincterotomy. Lateral internal