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Modern Methods of Surgical Treatment of Anal Fissures

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ABSTRACT

Currently, in the structure of coloproctological pathology, anal fissure occupies the third place, second only to hemorrhoids and colitis in prevalence [4]. According to the data of patients seeking treatment, the incidence of anal fissure is 20–23 cases per 1000 adults [6], while the proportion in the structure of colorectal diseases is, according to various authors, from 8.5 to 16%. More than half of the patients are of working age, while women get sick 1.5-1.8 times more often than men [4]. A triad of symptoms is characteristic of a fissure: pain, sphincterospasm, and poor blood flow during defecation [5]. Caused by a crack, the pain is so intense that patients lose their ability to work, sleep,

Manual uncontrolled divulsion of the anal sphincter and simple fissurectomy, which have been proposed for many years to date as monomethods for the treatment of anal fissure, do not meet the criteria for a reliable cure.

Purpose: to evaluate the options for optimal surgical treatment of anal fissures.

Material and methods. Our study was based on the analysis of the treatment of 107 patients with chronic fissure operated in 2010-2015. in the proctology department of the clinic of the Andijan State Medical Institute, which is the clinical base of the Department of General Surgery. Among them there were 67 (62.6%) women and 40 (37.4%) men aged 18 to 60 years. The patients were examined. The anamnesis was carefully collected, laboratory, digital rectal examination and endoscopic examinations were carried out at the pre-hospital stage. Of these, in 90 people (92.8%), endoscopic examination was performed under local infiltration anesthesia due to severe pain and concomitant sphincterospasm. Laboratory research methods make it possible to assess the functional state of internal organs, which influenced the choice of the method of anesthesia (local infiltration or spinal). Endoscopic instrumental research methods make it possible to make a topical diagnosis in almost 100% of cases and exclude or confirm the presence of concomitant proctological diseases (proctosigmoiditis, oncopathology, hemorrhoids, etc.). Since one of the leading places in the pathogenesis of anal fissure belongs to sphincterospasm, its condition, as well as volitional tension of all portions of the external sphincter, was assessed by digital rectal examination.

RESULTS. The leading complaint in all 97 (100%) patients was pain in the anal canal that occurs during or immediately after defecation and persists from 20 minutes to several hours. In second place in frequency, after the pain syndrome, was sphincterospasm - it was detected in 90 people (92.8%). The admixture of scarlet blood to the feces was noted in 74 patients (69.1%), moreover, in the form of a strip on toilet paper or a few drops - 16 patients (16.5%), and in the form of a trickle over the feces - in 38 (39. 2%). They had concomitant hemorrhoids during endoscopic examination. A fissure on the background of constipation (an act of defecation less than 1 time in 3 days) was in 81 patients (83.5%), on the background of diarrhea - in 6 people (6.2%), and on the background of normal stool - 10 (10, 1%). In total, a combination of chronic anal fissure and other proctological diseases was detected in 45 patients (46.4%), which

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influenced the choice of the method of surgical intervention. In 72 patients (74.2%), the size of the fissure ranged from 0.8-1.0 cm in d, and the localization of its lower edge was 1.0 cm from the anoperianal junction (above the Hilton line). All these cracks had posterior localization (6 o'clock according to the conventional dial). In this case, the V-Y plasty technique was used with bringing down a trapezoidal mucosal flap to cover the wound defect (Fig. 1) [21]. Picture. 1. V-Y plastic with bringing down a trapezoidal mucosal flap to cover the wound defect. In 19 patients (19.6%), the fissure was located distal to the Hilton line (almost at the level of the anoperianal junction), and its dimensions did not exceed 0.8 cm. In 9 patients (9.3%), the fissure was located 12 hours conditional dial (all women), and in 10 (10.3%) it was localized at 6 o'clock. With this localization, the crack was excised with two elliptical incisions in the transverse direction, the mucosa was mobilized proximal to the wound defect by 2-2.5 cm and also sutured in the transverse direction according to the "hemi-Whitehead" type of operation. With high and large cracks (d> 2.0 cm), usually localized at the level of the dentate line, the operation was limited to economical excision of the edges and curettage of the wound bottom with suturing its edges to the bottom with synthetic absorbable suture material [6] There were 2 such cases (2.06%). Both cracks were localized at 6 o'clock on the conventional dial. In case of a combination of a fissure with pronounced cicatricial changes in the anal canal with the formation of a stricture of the anal canal of I-II degree, rigid mucosa, a deep "anal funnel", we performed the technique of moving a skin-subcutaneous fat flap from the perianal tissues to close the wound defect. When a chronic anal fissure was combined with anal polyps canal and large polyps of the lower ampullar rectum, the first stage was polypectomy followed by intervention on the anal fissure using one of the above methods. Before each surgical intervention, a mandatory divulsion of the anal sphincter with a mirror was performed. 71 (73%) patients were operated under spinal anesthesia, and in 26 (27%) patients the intervention was performed under local infiltration anesthesia. The operation ended with the introduction of a tampon with betadine, 3% hydrogen peroxide and Oflomelide ointment into the rectum. In the postoperative period, all patients were prescribed strict bed rest for 1 day with activation of patients the next day. The ointment swab was removed from the rectum on the 2nd day, during the dressing. Postoperative analgesia included the use of analgesics for 2-3 days. Antibacterial therapy orally and parenterally was not prescribed. Local treatment included the toilet of the anal area, daily dressings (Oflomelide, Cathegelgel), the introduction of suppositories with belladonna and sea buckthorn 2 r / day. In patients with chronic anal fissure, we have developed an algorithm for combined treatment methods depending on its size and location, as well as the presence of concomitant cicatricial changes in the projection of the CAT and pronounced, palpable hypertonicity of the internal sphincter. According to the results of clinical observation, it was established that the situational use of one of the surgical techniques in combination with drug treatment (use of a trapezoidal flap, or a semilunar incision with wound closure according to the "hemi-Whitehead" type of operation, suturing the edges of the wound to the bottom and moving the skin-subcutaneous fat flap) in combination with local drug treatment (application of "Oflomelid" ointment on the perianal area) significantly improves the recovery period. The function of the sphincter in the postoperative period was not impaired (there were no cases of incontinence of gases and feces, as there was no obvious, palpation determined, hypertonicity of the internal sphincter). In all cases, on the 3rd day after the operation, an independent semi-formed stool was observed. At the same time, 92 (94.8%) patients did not require the use of analgesics after defecation. On the 2nd day, a tampon was removed for all patients and a laxative was prescribed (30.0 ml of castor oil at night once or twice, and with a tendency to constipation - peristalide syrup - until discharge and for another 1-1.5 months after it). The anal canal was treated daily with antiseptic solutions (Dekasan, chamomile) followed by finger massage-bougienage of the anal canal to prevent cicatricial strictures. After discharge from the hospital for a follow-up examination, the patients were examined after 10 days, 1, 2 months and 1 year

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after surgery. All those who came showed healing of wounds with a thin elastic scar. No recurrence of the disease was noted.

CONCLUSION. In all cases, with the existence of an anal fissure for more than 6 weeks, the absence of positive clinical dynamics with its conservative treatment for 6-8 weeks, the presence (during anoscopy) of dense cicatricial edges, a pronounced “sentinel tubercle” and hypertrophied fibrously altered anal papilla, a fissure should be regarded as chronic and all of the above elements should be excised. At the same time, we consider it inappropriate to leave an open surgical wound in the anal canal, counting on its gradual epithelialization. The wound surface should be, if possible, closed by suturing its edges, bringing down the mucosal flap or moving the flap on a feeding leg, and in case of its large size, reduced by suturing the edges of the wound to the bottom.

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