DISEASES OF THE COLON & RECTUM

Fissurectomy for Treatment of Chronic Anal Fissures

To the Editor—The paper by Pelta *et al.*[1] reflects the outcome of several debates about the surgical treatment option for anal fissures. Although controversially discussed, lateral sphincterotomy is associated with a higher incidence of fecal incontinence (30–45 percent),[2,3] depending on preceding obstetric trauma and proctologic operations and, therefore, has been abandoned in many European centers or described as an overtreatment. Especially in older patients with weak internal anal sphincter muscle or even sphincter defects, lateral sphincterotomy might deteriorate sphincter function. Recurrence rates after lateral sphincterotomy are between 5 and 11 percent according to previously published data.[4] Major concerns of recurrent anal fissures after lateral sphincterotomy are the residual hypertrophied anal papilla, the sentinel tag, and the underlying fistula tract, which remain untouched with this technique. Unfortunately, only a few authors confirmed the existence of subcutaneous fistula tracks (*e.g.,* in 80 percent of the fissurectomy specimens[5]) corresponding to the "undrained smouldering infection" theory described in the paper by Pelta *et al.*[1]

In our own series from January 1983 to May 1996, 162 patients with chronic anal fissures (80 men; mean age, 42 years) were treated by fissurectomy alone (n=118) or by lateral sphincterotomy (n=44). During fissurectomy, we routinely remove the frequent underlying fistula and the concomitant lesions (*i.e.*, lateral margins of the fissure, sentinel tag, and hypertrophied anal papilla) *in toto* and with consecutive conservative treatment (sitzbaths, stool softeners), a secondary wound healing is achieved.

In our study, undisturbed wound healing was achieved in both groups. Recurrent anal fissures developed in 8 percent of the patients treated by fissurectomy alone and 2 percent within the lateral sphincterotomy group ($P>0.05$). Regarding fecal incontinence, only 2 percent of the patients in the fissurectomy group experienced any incontinence events during the long-term follow-up compared with 5 percent of the patients in the lateral sphincterotomy group ($P>0.05$, unpublished data). Although both parameters (fecal incontinence, recurrence rate) did not reach statistical significance, we assume that lateral sphincterotomy is an overtreatment in chronic anal fissures with the risk of causing fecal incontinence. Therefore, we abandoned this technique in 1996. Moreover, we hypothesize that the increased resting tone of the internal anal sphincter muscle is rather a consequence than a cause of anal fissures.

In conclusion, we share the authors' opinion that laying open the subcutaneous fistula track, which frequently underlies a chronic anal fissure, introduces a new debate relating to the etiology of anal fissures. The data presented in this study fully confirm our experience of many years with fissurectomy in chronic anal fissures and make routine internal sphincterotomy unnecessary.

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