




Editorial Comment on “Could local antibiotics be included in the treatment of acute anal fissure?”

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I read the article by Karapolat (1) with great interest and congratulate the author for conducting a randomized controlled trial on such a relevant topic. Because we have conducted extensive and pioneering work in the conservative treatment of fissure-in-ano [Local and Oral Antibiotics with Avoidance of Constipation (LOABAC)](2, 3), we would like to add few points and share our experience.

There is a reason that antibiotics are effective in providing relief in patients with fissure-in-ano. The deepening of the fissure mostly due to persistent trauma of hard stools leads to the formation of a subcutaneous tract in which indolent sub-clinical infection gets superimposed (2-4). This is much more likely to happen in patients with chronic fissure-in-ano. Therefore, although the authors used the LOABAC concept in acute fissure-in-ano, it is even more effective in chronic fissure-in-ano (2, 3).

Like several other chronic diseases, fissure-in-ano has also been categorized into three types (2): acute (spasm present, duration <6 weeks), chronic (spasm absent, duration >6 weeks), and acute-on-chronic (spasm present, duration >6 weeks)(2). This classification explains the pathophysiology of fissure-in-ano in a simpler manner. Acute fissure-in-ano is abrupt in onset and occurs most commonly due to trauma by a hard fecalith. Marked spasm due to severe pain is usually the main complaint. Chronic fissure-in-ano is a long-developing illness with lesser intense pain and minimal spasm. The main symptoms (mild to moderate pain, burning, and itching) in chronic fissure-in-ano are due to low-grade infection. Any superimposed insult to the anoderm by a hard fecalith in a patient with chronic fissure-in-ano leads to the development of acute-on-chronic fissure-in-ano (2).

This classification simplifies the treatment. For the acute component (main issue: hypertonicity/spasm), the primary treatment is sphincter relaxation (sitz bath plus diltiazem cream)(2, 3). For the chronic component (main issue: low-grade infection), the primary treatment is antibiotics (local plus oral). For acute-on-chronic fissure-in-ano, both sphincter relaxation and antibiotics are very effective (2, 3).

Lateral internal sphincterotomy (LIS) is considered a safe and gold-standard surgery for the treatment of fissure-in-ano. However, a recent meta-analysis of LIS with long-term follow-up (>2 years) showed an incontinence rate of 14% (5). Therefore, the importance and necessity of the non-surgical management of fissure-in-ano cannot be undermined.

In our experience with 505 patients over the last 6 years, LOABAC (local antibiotic cream-metronidazole + povidine-iodine locally for 1 month, oral course of antibiotics-Ciprofloxacin 500 mg + Ornidazole 500 mg twice a day for 5 days, and avoidance of constipation) cured >90% of patients with chronic fissure-in-ano (2, 3). Topical nifedipine/diltiazem and sitz bath were prescribed when there was associated spasm in patients with acute or acute-on-chronic fissure-in-ano (2, 3). Botulinum toxin was needed in only two patients in whom the spasm did not get relieved after LOABAC treatment. The only patients who required surgery were the ones in whom the fissure had deepened into a small intersphincteric fistula. Once a deep tract had formed, conservative treatment was not effective.

To conclude, a vast majority of all patients with fissure-in-ano can perhaps be treated without surgical intervention. Like any other surgery, surgery for fissure-in-ano (LIS) has its side effects. Therefore, surgery should be reserved for a minority of patients with fissure-in-ano who do not respond to medical management.

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