

Operations to augment the anal sphincters

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If the degree of sphincter disruption or weakness is such that restoration of function cannot be achieved by direct means, the sphincter can be augmented by using muscle transposed from nearby (gluteus maximus or gracilis) or by using an artificial sphincter. Transposition of the gracilis muscle around the anal canal is followed by electrical stimulation, with conversion from a fast-twitch to a less fatigable slow-twitch muscle by an Sir Norman S Williams, contemporary, Emeritus Professor of Surgery, The Royal London Hospital, London, UK. implanted pacemaker (Williams) (Figure 80.16). Because of its magnitude this technique is performed only in highly selected and motivated patients, most of whom have had more conventional treatment that has failed to cure their incontinence. Despite all currently available treatments presented and discussed above, each patient requires individualised management. The evidence unfortunately is not robust, and decision making relies on expert opinion. The surgeon is only a small part of the multidisciplinary team of specialists necessary to manage these patients. An end-stoma may be appropriate for patients with severe end-stage incontinence in whom all available treatments have failed. While a stoma is associated with significant psychosocial issues and stoma-related complications, it can allow patients to resume normal activities and improve their quality of life.

Figure 80.17 The appearance of an anal fissure. If the buttocks are gently parted, the presence of an anal fissure can usually be detected as an ulcer of variable depth with the skin tag and an

anal papilla.

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