Treatment

Treatment

After confirmation of the diagnosis and exclusion of secondary causes of anal ulceration, conservative management should result in the healing of almost all acute and the majority of chronic fissures. Emphasis must be placed on normalisation of bowel habits. The addition of fibre to the diet to bulk up the stool, stool softeners and adequate water intake are simple and helpful measures. Warm baths and topical local anaesthetic agents relieve pain. Patients with normal bowel function and excessive straining at defecation might benefit from anorectal biofeedback to correct it. The mainstay of current conservative management is the topical application of pharmacological agents that relax the internal sphincter. If simple measures fail, treatment can be escalated to ‘chemical sphincterotomy’ using agents that induce smooth muscle (internal sphincter) relaxation. Glyceryl trinitrate (GTN) (0.2% applied two or three times per day to the anal margin) is a nitric oxide donor while diltiazem (2% applied twice daily) is a calcium channel antagonist. Botulinum toxin (10–100 units) injected into the internal sphincter in either divided or a single dose reduces Burrill Bernard Crohn , 1884–1983, gastroenterologist, Mount Sinai Hospital, New Y ork, NY , USA. Moritz Kaposi , 1837–1902, Professor of Dermatology , Vienna, Austria, described pigmented sarcoma of the skin in 1872. neuromuscular junctions. Temporary incontinence occurs in up to 10% of patients. The cure ra te is approximately 50%, although GTN can be associated with headaches, which limits its acceptability to patients. Diltiazem and botulinum toxin have similar e ffi cacy with fewer side e ff ects. Summary box 80.3 Anal fissure /uni25CF /uni25CF - Symptoms: /uni25CF /uni25CF - /uni25CF /uni25CF

Acute or chronic ulcer in the midline of the anal canal Ectopic site suggests a more sinister cause Pain on defecation Bright-red bleeding Mucus discharge Constipation

Treatment

Symptomatic treatment begins with dietary measures to ensure a soft, formed stool. For hygiene, cotton wool or moist tissue should be substituted for toilet paper. Soap is avoided and replaced by water alone, and the area pat-dried rather than rubbed. These measures, combined with wearing cotton underwear and the application of calamine lotion or zinc oxide barrier cream, are su ffi cient in many cases. In patients with dermatitis topical application of 0.5% or 1% hydrocortisone cream is beneficial. - Summary box 80.10 Pruritus ani /uni25CF /uni25CF /uni25CF /uni25CF -

Common Numerous causes, including skin diseases, parasites (threadworm), anal discharge, allergies, diabetes Treat the cause if possible Symptomatic treatment is the mainstay

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Treatment

In the early stages, general measures, including weight reduc tion and antiseptic soaps, may be helpful. Antibiotics may induce remission but often the disease relapses and progresses, at which point surgery is indicated. Inadequa te treatment may lead to prolonged morbidity , but any surgery should be less debilitating than the condition. Surgical intervention ranges from simple incision and drainage of acute sepsis to radical excision of all apocrine gland-bearing skin. Careful laying open of all tracts, possibly as a staged procedure according to anatomical location, is an option that appeals to many patients. Radical excision requires closure by skin graft or rotation flap and, occasionally , a defunctioning colostomy to allow healing. Treatment

Because of the field e ff ect endowed by viral skin infection, long - term resolution can be problematic. Careful serial application of 25% podophyllin to discrete warts on the perianal skin is excision under local, regional or general anaesthesia involves raising and separating the lesions with local infiltration of dilute adrenaline, which allows more accurate scissor or electro cautery excision to maximise the preservation of normal skin. Treatment

Non-operative treatment is recommended for mild stenosis. The use of stool softeners and fibre supplements helps aid the passage of stools. Dilatation Anal dilatation can be performed under general anaesthesia and then by the patient, using an anal dilator. For anal and many rectal strictures, dilatation at regular intervals is all that is required. Anoplasty For severe anal stenosis, an anoplasty is used to replace loss of anal tissue. The stricture is incised and a rotation or advance - ment flap of skin and subcutaneous tissue replaces the defect and enlarges the anal orifice (Figure 80.41). This technique is particularly useful for postoperative strictures. Colostomy Colostomy must be undertaken when a stricture is causing intestinal obstruction and in advanced cases of stricture complicated by fistulae- in - ano . In selected cases, this can be followed by restorative resection of the stricture-bearing area. If this step is anticipated, a loop ileostomy is constructed. Rectal excision and coloanal anastomosis Rectal excision is required when the strictures are at, or just above, the anorectal junction and are associated with a normal anal canal, but irreversible changes necessitate removal of the area. Coloanal anastomosis can restore function but is contra - indicated in Crohn’s disease. Benign anal stricture /uni25CF /uni25CF /uni25CF /uni25CF

May be iatrogenic, e.g. after haemorrhoidectomy Biopsy must be taken to rule out malignancy Can usually be managed by regular dilatation Severe anal stenosis may require an anoplasty

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Revision #1
Created 2025-12-31 15:29:25 UTC by Omar Ayman
Updated 2025-12-31 15:29:25 UTC by Omar Ayman