Anal Fissure surgery

Important information

Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

Please bring with you any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies).

Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.

About Anal Fissure surgery

Mr Jourdan has recommended that you undergo an operation to treat your anal fissure. Surgery is required where other forms of treatment have not been able to control the symptoms. An anal fissure is a small tear of the skin of the anus. Although the tear is small, it can be very painful because the anus is very sensitive. The pain tends to be worse when you pass faeces (sometimes called stools or motions) and for an hour or so after passing faeces. Often an anal fissure will bleed a little. The majority of fissures will heal spontaneously or with simple conservative measures including laxatives and the application of topical agents such as Rectogesic. For fissure which become chronic (persistent for greater than 6 weeks) and fail to respond to these simple measures then a visit the operating theatre may be required. There are two procedures which can be undertaken in theatre. The first is the injection of Botox into the anal sphincter (the muscle which keeps the anus closed). This injection causes the muscle to relax and makes it less traumatic for stool to pass through the anal canal. The effects last for about three months in which time about 60% of fissures will have healed. For those in whom Botox has failed or is not appropriate then surgical division of the innermost ring of anal sphincter muscle (internal sphincter) can be divided (Lateral sphincterotomy). This permanently reduces the pressure in the anal canal and allows the anal fissure to heal in over 90% of cases.

Intended benefits of surgery

The operation is aimed at allowing the anal fissure to heal and thus settle any pain associated with the passage of stool

Before your admission

Before your operation you will need to attend the pre-assessment clinic, which is usually run by

specialist nurses; occasionally this process can be conducted by telephone. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time. You may have a blood test and ECG performed, and also swabs for MRSA.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you.

This procedure involves the use of anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

Day of surgery

Most people who have this type of procedure have it performed as a day case procedure. You may need to stay overnight if you have other medical problems.

You will be admitted on the day of your surgery. Just before surgery the nurse may give you an enema to empty the bowel.

It may be necessary during the procedure to shave your thigh to allow attachment of a pad for the electrical diathermy machine (used to seal blood vessels), so that the pad sticks to your skin to achieve the best and safest performance.

During the procedure

At the start of your procedure, you will be given the necessary anaesthetic and/or sedation

Mr Jourdan will first examine the anal canal to confirm the presence of the anal fissure and exclude any other pathologies that may be present including tumours, polyps and haemorrhoids.

If you planned for Botox injections then a fine needle will be used to deploy the botox into the sphincter muscle. The fissure will be cleaned and injected with local anaesthetic.

If you are planned for a Lateral Sphincterotomy then a tiny incision is made at the edge of the anus and the fibres of the internal sphincter are divided with a scalpel blade. Again the fissure and the surgical site are injected with local anaesthetic.

After the procedure

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

Eating and drinking: You may eat and drink normally, and we recommend a high fibre diet and fluid intake of at least six to ten glasses of water daily.

Getting about after the procedure: We will encourage you to get up and walk about within one to two hours after your operation. This helps improve your recovery and reduces the risk of certain complications. If you have any mobility problems, we can arrange nursing or physiotherapy help.

Leaving hospital. Discharge from hospital will be the same day (for planned daycase surgery) or the following day. You may be given a copy of your discharge summary which contains documentation of your admission. You will be given necessary tablets or medicines to take home with you – for example, painkillers and laxatives. You should expect to have your bowels open within two to three days and this will be uncomfortable at first. Please use the laxative you will be given to help reduce any discomfort on having your bowels open.

Special measures after the procedure: A small amount of bleeding is expected. Over the first few weeks you may notice some change in your ability to control wind; this will resolve. Provided you feel comfortable, there are no restrictions on activity and you may lift, drive and go back to work.

Pain relief and wound care: In order to minimise the pain associated with your operation, a number of measures will be taken:at the time of surgery, local anaesthetic is usually injected. This will provide pain relief for much of the day.you will be given painkillers to take by mouth. you will be given a laxative for two weeks after the operation to prevent constipation. There is usually very little pain after this operation and in most cases the pain is far less than the anal fissure was producing before surgery. The wound of a lateral sphincterotomy is very tiny and usually heals within a few days. The fissure itself should heal over within a month.

Check-ups and results: You will be seen at 4 weeks after surgery but if there are problems before this date then you can call the hospital or Mr Jourdan's secretary for advice.

Significant, unavoidable or frequently occurring risks of this procedure

Anal fissure surgery is generally a very safe operation with few risks, but, as with any surgical procedure, complications do occasionally occur; Some patients may initially experience a reduced control of flatus but in most cases this will settle. Major incontinence is a rare complication and one that Mr Jourdan has never seen in his practice. In about 5% of patients the fissure will fail to heal. Most often this occurs because not enough fibres of the internal sphincter have been divided.

If you suffer form urinary symptoms due to a large prostate you might be at increased risk of urinary problems after surgery.

In the period following your operation you should contact your ward or GP if you notice any of the following problems:
increasing pain, redness, swelling or discharge
severe bleeding
constipation for more than three days despite using a laxative
difficulty in passing urine
high temperature over 38º or chills
nausea or vomiting.

Alternative procedures that are available

A lateral sphincterotomy is offered where the conservative measures mentioned above have failed to work. There is no other surgical procedure commonly practiced for this condtion.

The Anaesthetic

Anaesthesia means 'loss of sensation'. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness**.
Sometimes different types of anaesthesia are used together.

Before your operation: Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery.
To inform this decision, he/she will need to know about:
your general health, including previous and current health problems
whether you or anyone in your family has had problems with anaesthetics
any medicines or drugs you use
whether you smoke
whether you have had any abnormal reactions to any drugs or have any other allergies
your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and may review your test results.

Pre-medication: You may be prescribed a 'premed' prior to your operation. This a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

Before starting your anaesthesia the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted and you may be asked to breathe oxygen through a face mask.

The Anaesthetic: During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body

temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

Mr Jourdan will inject some local anaesthetic into the surgical site. This will give excellent pain control in the hours following surgery. When the effects of the local anaesthetic wear off your pain will need to be controlled with pain-killers taken in tablet form.

After the Anaesthetic: Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.
Very common (1 in 10 people) and common side effects (1 in 100 people)
Feeling sick and vomiting after surgery Sore throat
Dizziness, blurred vision Headache
Bladder problems
Damage to lips or tongue (usually minor) Itching
Aches, pains and backache Pain during injection of drugs Bruising and soreness Confusion or memory loss

Uncommon side effects and complications (1 in 1000 people)
Chest infection Muscle pains
Slow breathing (depressed respiration) Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)

Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications
Damage to the eyes
Heart attack or stroke
Serious allergy to drugs
Nerve damage
Death

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.