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Role of homoeopathy in the management of anal fissure

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Abstract
Anal fissure is one of the most painful anorectal diseases which makes the patient seek medical help. The textbooks of modern medicine classify anal fissures into acute and chronic depending on the duration. The position of the fissure and also other underlying diseases if present, predispose the fissure towards chronicity. According to Hahnemannian classification of diseases, anal fissures are tubercular in origin. Combined with Sycotic miasm, the condition becomes aggravated and difficult to cure. Homoeopathic medicines like *Aesculus hippocastanum*, Causticum, Graphites, Hydrastis, Ignatia amara, Lachesis, *Natrum muriaticum*, Nitric acid, *Paeonia officinalis*, *Ratanhia peruviana*, Sepia, Sulphur, Silicia, Thuja, are helpful in this condition when selected on the basis of totality of symptoms. Surgery is required if the fissure does not heal with medication or it becomes the cause for secondary symptoms- the so-called complications.

Keywords: Anal fissure, homoeopathic medicines, miasmatic diagnosis

Introduction
Anal fissures are one of the most common anorectal problems encountered in the surgical out patient departments. The incidence is equal in males and females, being as much as 30.7% in the Indian population. These are seen in all age groups, with a slight young and middle-age group preponderance. Anal fissures can be acute or chronic [1, 2]. Fissures lasting for 1-2 weeks are acute whereas those persisting for more than 8 to 12 weeks are considered chronic according to modern medicine [3]. Approximately 40% of anal fissures are chronic [4]. According to Homoeopathy, anal fissures are classified under chronic disease with miasmatic origin.

Etiopathogenesis
An anal fissure is a superficial tear in the anoderm distal to dentate line. The dentate line is an irregular line present at the junction of the superior two thirds and inferior one third of the anal canal. The blood supply, innervation and lymphatic drainage of the anal canal grossly vary with respect to the dentate line. The area above the dentate line is sensitive only to stretch while the area below has somatic innervation and is sensitive to touch, pain and temperature making anal fissures one of the most painful anorectal problems. The area below the dentate line is highly sensitive to insults like microtrauma, pressure, and ischemia and gets torn easily. Passage of hard stools, constipation, injury, repeated episodes of diarrhoea (less frequently) form common aetiologies for anal fissures. Acute fissures can develop after repeated vaginal childbirth due to damaged pelvic floor and loss of support to anal mucous membrane. Anal cancer can be a cause in the elderly. Severe spasm of the internal anal sphincter is seen in acute fissures. Bowel movements and attempts at defecation result in more pain, augmenting the sphincter spasm and thereby diminishing anal blood supply. The patient withholds passing stools and this exacerbates the constipation. This cycle continues and hampers the healing process. Persistent sphincter spasm, anal hypertonicity, repeated trauma and decreased perfusion to the posterior commissure predispose the fissure to turn to chronicity [5, 6].
Anal fissures are most commonly located in the posterior midline of the anal canal since this region receives the least blood supply. Exaggerated shearing forces acting at the posterior midline during defecation, relatively less elasticity of the anoderm and increased density of longitudinal muscle extensions at this site contribute to increased rate of occurrence of fissures at the posterior midline.

When anal fissures occur at other sites like the lateral walls, a suspicion of underlying diseases like tuberculosis, HIV, sexually transmitted diseases, inflammatory bowel disease, squamous cell carcinoma should arise. These conditions also predispose the fissure to chronicity. Anterior fissures are rare, associated with external anal sphincter dysfunction and seen during repeated vaginal deliveries [7, 8, 9].

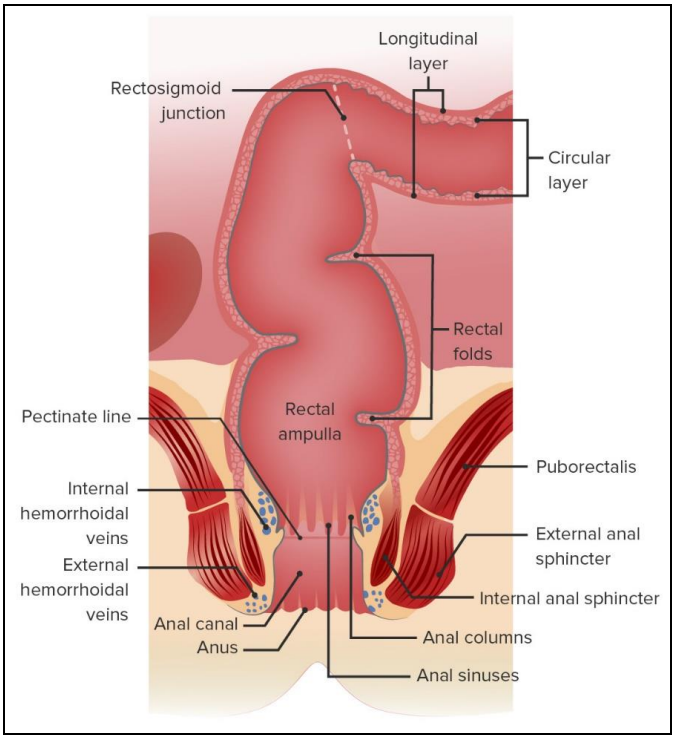

Fig 1: Anatomy of Rectum and Anal canal

Clinical features and examination

1. Pain (severe tearing type) worse during and after defecation, persisting for hours after defecation.
2. Bleeding per rectum, drops or streaks of fresh blood with passage of stools.
3. Constipation and hard pellet like stools are commonly associated.
4. Chronic fissures may be associated with itching.
5. Patients with inflammatory bowel diseases will present with intermittent and chronic anal pain while defecation over a period of months to years.
6. The best position to examine anal fissures is the jack-knife position where the patient lies prone and the bed is folded so that there is flexion at hips.
7. On spreading the buttocks apart, a superficial laceration or a longitudinal tear extending proximally is visible. This may be associated with a tag of thickened and hypertrophied skin near the lower end of the fissure called the sentinel pile in chronic fissures. Hypertrophic anal papilla is seen on the inner side of the fissure.
8. Per rectal examination can be done with local anaesthetics. Digital examination should be kept to the minimum; Sphincter spasm can be appreciated here. Instrumentation and visualisation of the anal canal with scopes is contraindicated due to the extreme painful nature of anal fissure. However, instrumentation can be tried under anaesthesia.

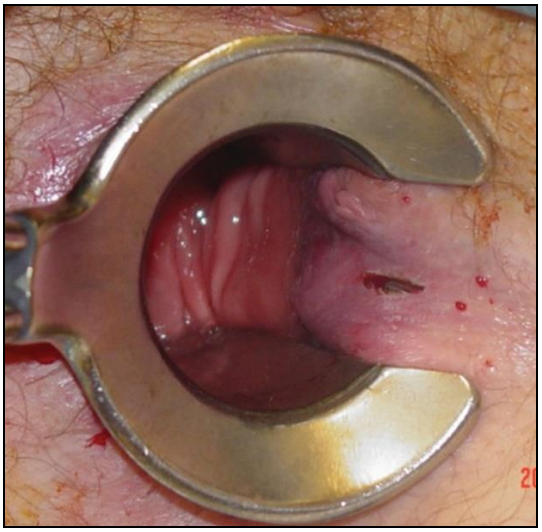

Fig 2: Classical anal fissure (Courtesy of W. Brian Sweeney, MD)

Miasmatic diagnosis of anal fissure

Anal fissures are manifestations of chronic miasmatic disease, tubercular in origin [10]. It has the constriction and constipation of Psora and the ulceration of Syphilis. When combined with Sycosis the condition becomes much aggravated and difficult to cure.

Management of anal fissure

Almost 50% of acute fissures heal with conservative management. Addition of fibre to the diet and increased water intake can aid resolve constipation and soften the stools. Warm sitz bath helps in relaxation of the internal anal sphincter spasm and fastens recovery. Acute fissures heal within 6-8 weeks [11]. Surgery is considered in patients not responding to conservative and medical management and when the fissure becomes cause for secondary set of symptoms. Along with surgery proper homoeopathic treatment has to be administered to cure the morbid vital processes and restore health. The gold standard surgery for anal fissure is lateral internal sphincterotomy where the lateral sphincters are incised to reduce sphincter pressure and aid healing.

Though Homoeopathy primarily deals with disease per se and not the tangible products of the disease [12], homoeopathic medicines selected on basis of totality of symptoms are known to cure anal fissures.

Some of the Remedies for anal fissure [13, 14, 15, 16, 17] are as follows-

***Aesculus hippocastanum*:** Rectum feels full of sticks raw and sore. Complaints associated with backache affecting sacrum and hips. Stools followed by sensation of fullness of rectum. Pain like a knife sawing backward and forward in the anus. Burning in anus with chills up and down the back. Complaints worse during climacteric period. Irritability is marked.

Causticum: Burning, rawness and soreness in anus. Hard stools covered with mucus, shining, expelled after much straining or only on standing. Fissures with tendency to dry up with dark brown or purple edges. Walking aggravates the condition. Patient is intensely sympathetic, complaints from sudden emotions. Thinking of complaints aggravates. Mainly suited for broken down seniles.

Graphites: Great anti-psoric remedy, suited to women with tendency to obesity and suffering from habitual constipation. Anal fissure with stools large, hard, difficult and knotty with lumps covered with mucous or contains shreds of mucous. Burning and soreness in anus after stools < when sitting. There is no constriction of anus which differentiates it from other remedies. Offensive flatus with distension of abdomen. Chilly patient, indecisive and timid by nature.

Hydrastis canadensis: Anal fissure with burning and smarting in anus during and after stools, Pain lasting for hours after stool. Constipation with dry, large, lumpy stools with sinking feeling in stomach and dull headache. Colic and faintness. Constriction and spasm of rectum.

Ignatia amara: Itching and stitching pain in the anus with painful constriction after stools. Bleeding per rectum < when stool is loose. Pressure in the rectum as from a sharp instrument from within outward. Pains return at the same hour each day, < from standing or walking. Complaints especially in smokers and coffee drinkers. Weeping disposition.

Lachesis: Constriction in anus with constipation. Sensation of little hammers pecking in the fissure. Constant urging in the rectum, but not for stools. Itching in the anus, < after sleep. Pain shooting up the rectum on sneezing or coughing.

***Natrum muriaticum*:** Anal fissure with burning and stitching pain in the anus after stools. Constipation, stools dry, hard and crumbling. Sensation of constriction in the rectum. Great debility and weakness especially in the morning. Consolation aggravation with Psychic causes of disease.

Nitric acid: Suited to thin persons with nervous temperament. Anal fissure with piercing (as from sticks) and spasmodic pain during and after stools lasting for hours. Lancinating pain even after soft stools. Strong smelling urine, cold when it passes. Chronic anal fissure, could be secondary to inflammatory bowel disease. Thinks his condition will never improve.

***Paeonia officinalis*:** Anal fissure with constant oozing, thus keeping the anus damp and disagreeable. There is intense pain after each stool. Burning in the anus after stool followed by internal chilliness. Tendency for ulceration in general with burning and itching.

***Ratanhia peruviana*:** One of the leading remedies for anal fissure. Great constriction of the anus. Anal fissure with burning for hours after stool. Pain, > by cold water. has to strain hard for stools. Pricking pain after stools in anus as if full of broken glass. Bursting pain in the head after stools. Frequent and Ineffectual desire for urination.

Sulphur: Anti-psoric remedy, for chronic relapsing complaints resulting from suppressed eruptions. Constipation, with frequent, ineffectual desire for stools. Stools hard, knotty, unsatisfactory, dry as if burnt. Burning in the anus after stools. Constipation frequently alternates with diarrhoea.

Silicia: Persons who are psoric, nervous and irritable. Constipation, stools when partly expelled, recedes again. Anal fissure with spasmodic pain in rectum. Rectum feels paralysed and stools remain in the rectum for long time. Constipation before and during menses.

Sepia officinalis: Sensation of ball in the rectum with constipation. Stools dark brown, round balls glued together with mucous. Anal fissure with bleeding and pain shooting up the rectum and vagina. There is constant oozing from the anus. Tubercular patients with complaints < by working in water.

Thuja occidentalis: Anal fissures with edges trimmed with polypoid excrescences or true rectal polypus. Constipation with intense rectal pain- burning and stitching. Pain < sitting, associated with urinary complaints.

Differential diagnosis of anal fissure

Acute fissures are most commonly mistaken for haemorrhoids and this can result in delayed diagnosis of fissures. However, only thrombosed external haemorrhoids are painful. The other differential diagnosis includes acute proctitis, anorectal abscess, diverticulitis, fistula in ano, skin abscess/ furuncle, folliculitis, pruritis ani, inflammatory bowel disease, squamous cell carcinoma, syphilitic fissures, tuberculous ulcers, AIDS and proctalgia fugax [2, 5, 18].

Complications

Although, most acute fissures resolve on their own within 1-2 weeks, they, being very painful cause tremendous emotional stress. This leads to a reduced quality of life in the patients. Anal fissures can get infected and lead to abscess formation. These abscesses can lead to fistula formation. Fistulas and incontinence are relatively serious complications of anal fissures. These can present as discharge from the ulcer in case of infected fissures. Discharge from an inter-sphincteric fistula indicates a complication which has arisen through infection penetrating via the base of the fissure. Lateral internal sphincterotomy is associated with a very high risk of faecal incontinence, with almost 45% of the patients experiencing incontinence in the immediate post operative period. Other complications of the surgery include excessive bleeding, perianal abscess formation and keyhole deformity of the anus [19].

Conflict of Interest

Not available

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