Lateral Internal Partial Sphincterotomy Technique for Chronic Anal Fissure: an Avoidable Risk to the Surgeon's Finger

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Dear Editor,

We have read the original article “Lateral internal partial sphincterotomy technique for chronic anal fissure” by Nessar and Topbas published in June 2017, issue of Indian Journal of Surgery. The authors have described their technique for lateral internal partial sphincterotomy which entails division of only part of the width of internal anal sphincter (IAS) below dentate line by a closed technique. The authors have reported relief of pain in 40/43 patients after initial operation; only one patient developed incontinence for flatus. Though the patients were followed up for 6 months, the rate of complete healing of anal fissure and recurrence rate—the usual outcome measures—has not been mentioned by the authors.

There is a discrepancy in the article regarding the width of sphincter to be divided. Under “Material and Methods,” the authors mentioned that not more than half of the sphincter's width below dentate line is to be divided. On the other hand, under “Discussion,” the authors state that the sphincterotomy is performed by dividing one fourth of the sphincter. The authors may clarify exactly how much thickness of the sphincter is to be divided in this technique.

The authors recommend closed technique for division of part of the thickness of IAS, from lateral side to medial side controlled by the index finger, to obviate soiling and fecal incontinence. Normal IAS is usually 2–3-mm thick. To divide with precision one fourth or one half of thickness of such a thin structure in a blind manner is a tall order. Further, this technique exposes surgeon's finger to risk of sharp injury in a

highly contaminated field. In our opinion, this risk is not worth taking.

In a number of patients, mild degree of anal incontinence may be related to underlying pathology rather than being the sequel of sphincterotomy. Minor fecal incontinence was documented before surgery in 16 of 108 (14.8%) patients with chronic anal fissure [1]. Conservative sphincterotomy up to the level of apex of fissure, as compared with traditional sphincterotomy up to dentate line, is associated with lower anal incontinence (2.17 versus 10.86%) [1].

Ultrasound evaluation of patients with persistent fissures after sphincterotomy revealed lack of division of IAS in almost 70% of patients [2]. In this context, the open technique for sphincterotomy seems to be more precise as the sphincter is divided under direct vision. However, in a recent meta-analysis, open and closed sphincterotomy appears to be equally efficacious [3].

Open lateral internal sphincterotomy under vision, restricting division of the IAS to the length of fissure rather than to the dentate line, can be performed with the help of an anal speculum under local anesthesia in majority of the patients.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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