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التوثيق الالكتروني والميكروفيلم

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MANAGEMENT OF CHRONIC ANAL FISSURE COMPARATIVE STUDY OF SOME LINES OF TREATMENT

THESIS

Submitted to the Faculty of Medicine Tanta University in Partial fulfillment of the Requirements of Master Degree

In

General Surgery

By

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2000

بسم الله الرحمن الرحيم

« البقرة ٣٢ »

صدق الله العظيم

ACKNOWLEDGEMENT

First of all and above all, great thanks to **ALLAH** *for Creation, Islam and for being a surgeon.*

I wish to express my deep gratituide to **Prof. Dr. Mostfa Abd-El Kader Eltablawy** *Professor of Gastrointestinal and Endoscopic Surgery, The Head of the Department of General Surgery, Faculty of Medicine, Tanta University, for his kind help experienced guidance and meticulous supervision that made the completion of this work possible.*

My sincere thanks and special appreciation to **Prof. Dr. Usama Abd-El Samea Baza** *Professor of Gastrointestinal and Endoscopic Surgery, Faculty of Medicine, Tanta University, for his helpful suggestions, instructive supervision and experienced guidance throughout the whole work.*

My great thanks and indebtedness to **Dr. Gamal Ibrahim Mousa** *Lecturer of Gastrointestinal and Endoscopic Surgery, Faculty of Medicine,Tanta University, for his kind assistance, continuous help and close supervision during this work.*

Special appreciation to **Dr. Medhat Fouda** *Assistant Prof. of Pharmaceutics, Faculty of Pharmacy Tanta University for his great help in preparing the nitroglycerine ointment.*

I Would like to extend may thanks to my patients, my colleagues and to the nurses and workers in the General Surgery department who all participate sincerly in completing this work.

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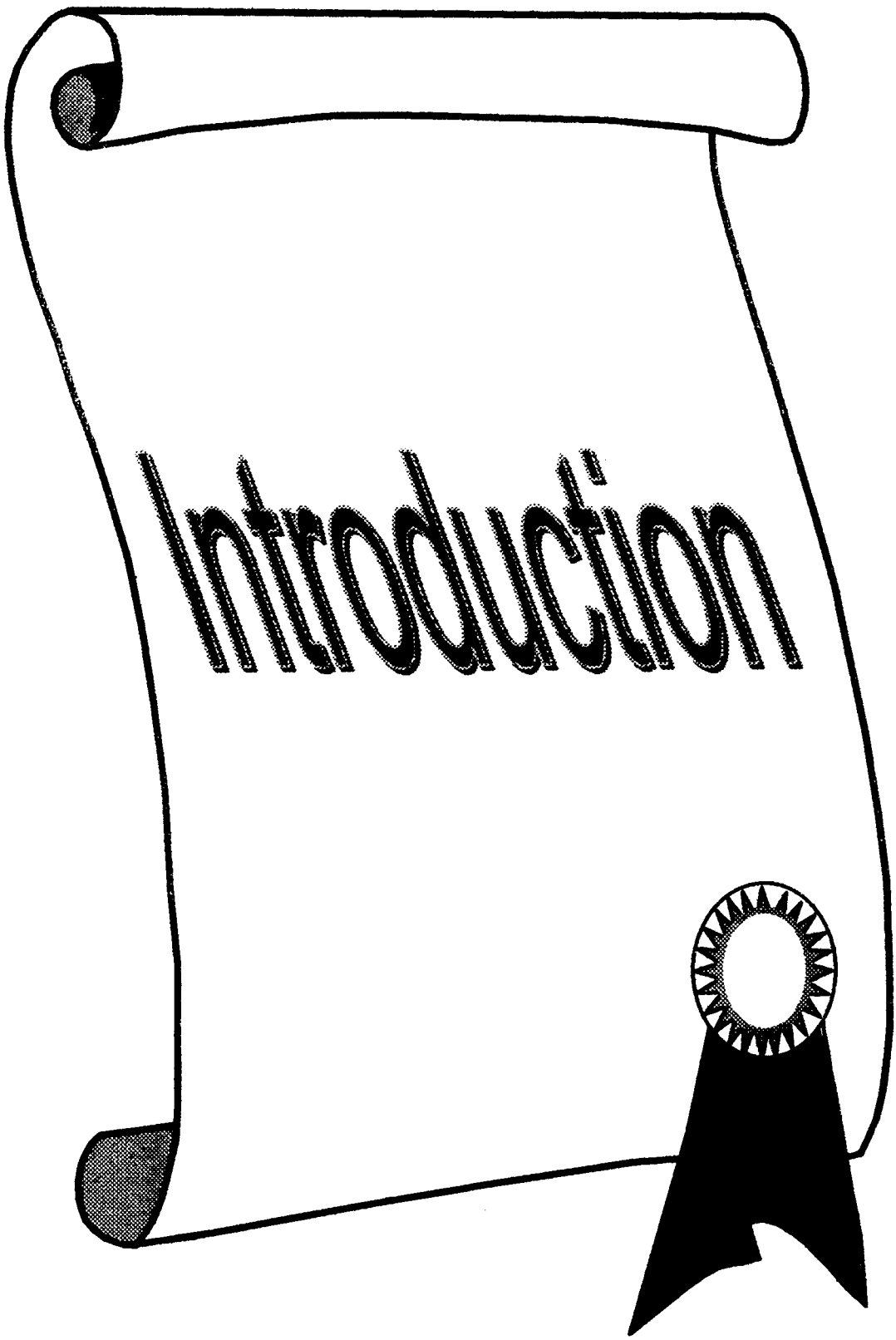

Introduction

INTRODUCTION

Anal fissure remains one of the most common proctologic problems. Fissures are seen in all age-groups, although the majority of patients are relatively young to middle aged adults. Fissures cause considerable pain disproportionate to the size of the lesion, resulting in significant morbidity and disability. Therefore worthwhile to explore effective preventive measures and attempt to identify the most effective treatments for this disease (Oh et al., 1995).

The etiology of anal fissure is unclear and probably multifactorial. It has been postulated that trauma, anal canal anatomy, sphincter dysfunction, and ischemia may be contributory. But patients tend to have a high anal maximum resting pressure which if reduced leads to fissure healing and increased blood flow to the fissure ulcer (Schouten et al., 1994, Farouk et al., 1994).

Surgical sphincterotomy is an excellent procedure for the long-term cure of chronic anal fissure it probably works by reducing resting anal pressure by as much as 50 percent (Watson et al., 1996).

For many years internal anal sphincterotomy has generally been considered to be the standard operation for an anal fissure (Eisenhammers, 1959).

Nitric oxide has recently been shown to be an important inhibitory neurotransmitter in the internal anal sphincter. Organic nitrates are degraded by cellular metabalism, releasing nitric oxide. Glyceryl trinitrate ointment applied to the anus causes a fall in maximum anal resting pressure amounting to a reversible chemical sphincterotomy (Lund et al., 1996).


Review
Of Literature

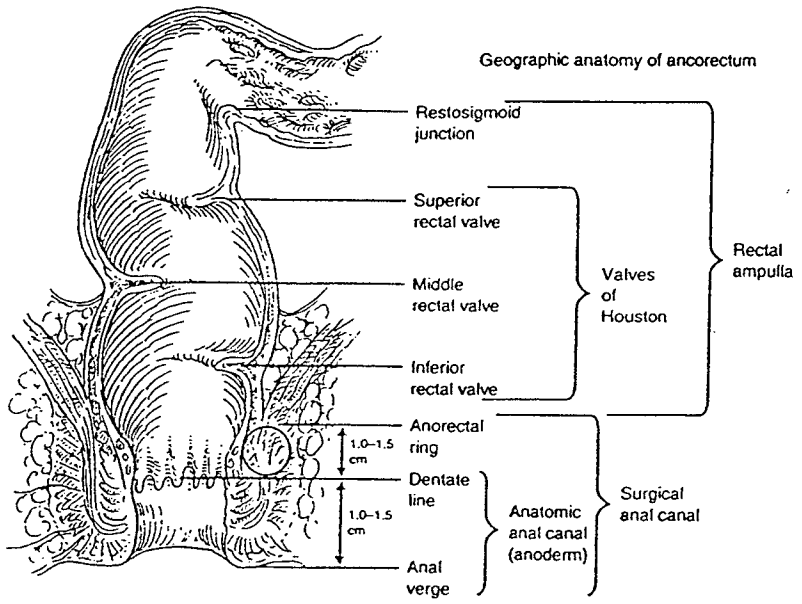
REVIEW OF LITERATURE

SURGICAL ANATOMY

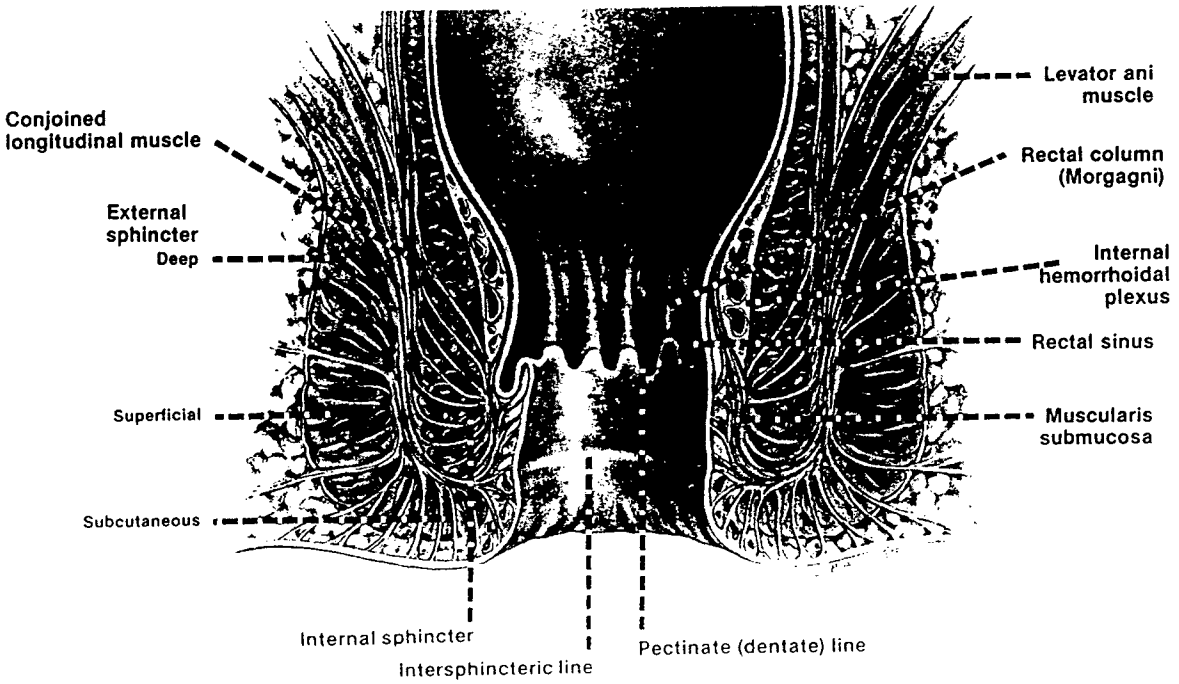
The anatomy and physiology of the anorectum (the terminal portion of the alimentary tract that maintains enteric continence and facilitates defecation) although intensely investigated, continues to be the subject of debate and speculation. Several dogmatic versions of anatomy, and more particularly physiology have been modified as a result of newer research using novel methodology that quantifies not only parameters of anorectal motility but also the function of the pelvic floor muscles (Pemberton and Meagher. 1996).

The anatomic anal canal extends from the anal verge to the dentate line. For practical purposes, however, surgeons usually define the surgical anal canal as extending from the anal verge to the anorectal ring, which is the circular lower border of the puborectalis that is palpable by digital rectal examination (Kodner et al., 1999).

The anal canal begins one inch infront of and slightly below the tip of the coccyx where the rectal ampulla suddenly narrows, passing down and backwards to the anus. It is about 4cm long in adults, its anterior wall being slightly shorter than its posterior, when empty its lumen is a sagittal or triradiate longitudinal slit (Warwick and Williams 1992).



Figer (1): Anatomy of the anus and rectum (Maingot 1997).



Figer (2): Anatomy of the anal region (Corman, 1993).