INTRODUCTION

An anal fissure is an elongated ulcer in the long axis of the lower anal canal. The site of election for an anal fissure is mid line posteriorly (90 pre cent over all) . The next most frequent situation is the midline anteriorly .*(Norman S. ,2004)* .

Anal fissures affect people of all ages particularly young and otherwise health people, they are equally common in men and women. Sometimes an anal fissure and hemorrhoids develop at the same time. *(Jones and Scholefield , 1999)* .

The etiology of anal fissure is unknown, but fissure are associated with increased resting pressure which prevent healing . It is also associated with alteration in bowel habit, particularly an episode of constipation. *(Keighley , 1997)* .

The classic symptoms are intense pain on or after defaecation and anal bleeding .*(Mann et al , 1995)* .

An anal fissure is either acute or chronic . The upper internal end of the fissure stops at the dentate line . Because the fissure occur in the stratified sensitive epithelium of lower

half of the anal canal , pain is the most prominent symptoms . ***(Norman S.,2004)*** **.**

Acute anal fissure are superficial and are not normally associated with skin tag formation. Chronic anal fissure is associated with development of both anal tags and polyps as a result of inflammatory reaction . ***(Nelson , 2004)*** **.**

The prominent symptoms is sever pain in the anal canal especially during defecation. Bleeding is common but slight and a mucoid discharge produce perianal irritation and there is constipation. The condition is more common in women and generally occur during the meridian of life . ***(Sailer M,Bass D , 1998)*** **.**

The principles of medical management are to avoid constipation and relief internal anal sphincter spasm by means of high-fiber diets and stool softeners, combined with topical local anaesthesia . ***(Norman S. ,2004)*** **.**

There are different surgical modalities for treatment of chronic anal fissure. Lateral internal sphincterotomy is widely accepted as the procedure of choice in the management of anal fissure. It promises, rapid relief of pain simple to perform, and most patients express satisfaction with the result. Lateral sphincterotomy may be performed using an open or a closed

technique under general or local anaesthesia .*(Garcia – Aguilar et al 1998)* .

Anal dilatation as a method for treatment of anal fissure has a relatively high recurrence rate and may cause un-controlling tearing of the sphincter with resulting disturbed continnce . It is considered to be an efficient simple procedure with rapid and effective symptomatic relief . However , it should be performed under general anaesthesia with gentle and controlled technique . ***(Sohn et al , 1992)***

Fissurectomy with posterior internal sphinterotomy is considered less effective than lateral sphinterotomy , of the needed longer period of wound healing and a higher incidence of disturbed continence . ***(Nyam et al , 1995)***

Pharmacological or chemical sphinterotomy using , topical 2% Diltiazem ointment or 0.2 percent Glyceryl trinirate (G.T.N) ointment and injection of Botulinum toxin into the internal sphincter , has been tried . This treatment has potential advantage that there is no permanent damage to the internal anal sphincter as it occurs with surgical sphinterotomy , however further evaluation of this new non surgical treatment is needed as it promises good results . ***(Lund et al , 1998)***