Dear Editor,

We read with great interest the article by Mert [1] outlining the importance of infection in etiopathogenesis and hence the efficacy of topical metronidazole in the treatment of acute anal fissures. We have been working on the same concept for the last several years [2–6] and would like to highlight a few pertinent points as per our experience with LOABAC (local plus oral antibiotics with avoidance of constipation) regimen to manage fissure conservatively.

First, for local application on anal fissure, the addition of povidone-iodine cream increases the efficacy of local metronidazole cream [4, 7]. This is expected because unlike metronidazole which is effective against mainly anaerobes, povidone-iodine has an action against a broad spectrum of microorganisms which include aerobes (both gram-positive and gram-negative), fungi, protozoa, tubercle bacilli, viruses, and bacterial spores. A small proportion of patients (<5%) experience a burning sensation after the application of povidone-iodine cream in whom this cream may be withheld.

Second, the addition of a short course of oral antibiotics covering gram-negative and anaerobes (ciprofloxacin and metronidazole) also increases the efficacy of this conservative management. In the presence of pain especially in the acute anal fissure, the local cream application is difficult and painful due to which the compliance of the patients falls significantly. Therefore, an addition of a short course (5 days) of oral antibiotics, by eradicating infection in anal fissure, gives much-needed immediate relief in pain and spasm. This results in the subsequent easier application of local antibiotics cream on anal fissure inside the anal canal.

Third, while outlining the inclusion criteria, the author defined acute anal fissure as an anal fissure present for less than 8 weeks, lesions limited to the epithelium on physical examination, and no findings suggestive of chronic anal fissure (such as skin tag in the anal region) [1]. Though the duration of the existence of anal fissure is taken as one of the criteria to differentiate acute from chronic anal fissure, it is prudent that the presence or absence of anal spasm should also be included as a main parameter [4]. Because the presence of spasm would require appropriate management for complete healing of the anal fissure. Therefore, like other chronic disorders, anal fissure should be categorized as acute anal fissure, chronic anal fissure, and acute-on-chronic anal fissure (Table 1) [4]. This classification takes both duration of existence of anal fissure as well as the spasm into consideration. Once this is done, the management of each category becomes quite clear and avoids unnecessary confusion [4].

The anal fissure should be classified based on the duration of onset of symptoms and clinically assessed anal tone (Table 1) [4]; acute fissure of <6 weeks duration with high anal tone (spasm); chronic fissure of >6 weeks duration with normal/low anal tone (no spasm); and acute-on-chronic fissure of >6 weeks duration with high anal tone (spasm). The management of anal fissure in each category is outlined in Table 1.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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Table 1. Proper classification of anal fissures and their treatment

| Category of anal fissures | Duration (wk) | Spasm | Creams for relieving spasm (diltiazem and nifedipine) | Local*oral antibiotics | Stool softeners | Sitz bath |
|--------------------------|--------------|-------|------------------------------------------------------|------------------------|-----------------|----------|
| Acute                    | <6           | ++++  | Yes                                                   | Optional               | Yes             | Yes      |
| Chronic                  | >6           | –     | No                                                    | Yes                    | Yes             | No       |
| Acute-on-chronic         | >6           | ++++  | Yes                                                   | Yes                    | Yes             | Yes      |

*Metronidazole + povidone-iodine cream. *Ciprofloxacin + metronidazole, 5 days.

AUTHOR CONTRIBUTIONS

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