SYMPTOMS AND TREATMENT OF INTOLERABLE FISSURE OF THE ANUS.

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You have perhaps noticed in our ward a young man of 25, of a robust appearance, who sometimes seems to enjoy perfect health, and sometimes groans and writhes in his bed, complaining of the most violent pains in the region of the anus. These pains are of a character which of itself suffices to diagnose the disease. While defecating, the patient, who is usually constipated, feels a sudden pain; it seems as though a red-hot knife passed through his rectum. But this pain, though rather severe, is not intolerable and quickly subsides. In about a quarter or half an hour after defecation, however, atrocious pains come on, which cause him to cry out in anguish; these pains may last four, five or six hours.

With these facts before us, the diagnosis of fissure of the anus is easy. If, now, we examine the patient in a convenient position, we will find at the posterior margin of the anus, in the median line, a small ulcer. This lesion is a very small affair; it is merely an elongated fissure, not deep, not roughened, not oozing, and with the edges scarcely indurated. But it is only necessary to touch it in order to cause violent pain.

Rectal examination reveals another important fact to explain the pains: the contraction of the sphincter. This examination is very painful; quite an effort is required to overcome the resistance of the sphincter. Upon seizing the sphincter between the thumb and index finger, there is a sensation as of a ring of extreme hardness. This spasmodic contraction seems to be the principal cause of the great pain and sufferings in this disease; whence the name *fissural sphincteralgia* that was proposed for it.

This contraction is often caused by extremely small fissures, by a simple hemorrhoidal ulceration, or by a simple eczematous erosion. On the other hand, it is remarkable that syphilitic, tubercular or epitheliomatous ulcers never give rise to it. The pain and contraction, though very distressing, are still very reassuring in regard to general prognosis.

Fissures resulting from hemorrhoids or eczema may also exist without severe pain or spasm of the sphincter. Gosseline has described this form under the name of *fissure tolerante*, in contradistinction to the intolerably painful fissures. In the tolerable fissures, the patient feels a smarting pain at the time of defecation, but this smarting is only momentary. The co-existence of syphilis or tuberculosis may then be thought about; but the appearance of the fissure and the non-intensity of the lesion scarcely leave any room for doubt.

In regard to treatment it is essential to distinguish between the two forms of the disease. In the tolerable form, sitz-baths, washes and various ointments quickly bring about a cure, especially if constipation be avoided. On the other hand, dilatation of the anus, which is of such marvelous efficacy in the intolerable form, is not of the slightest use in the mild form.

In intolerable fissures, all other measures besides dilatation are perfectly useless. Some time ago I saw a foreign young woman who had been treated in vain for two years for fissure of the anus, with all sorts of medicines; topical applications of many kinds, mineral waters, cauterizations, excision of hemorrhoids, but all to no effect. Dilatation of the sphincter gave her relief in a few hours.

In performing this painful operation, I employ anæsthesia by chloroform; I am afraid of interstitial injections of cocaine, especially in this region, which have been recommended. The only preliminary step necessary is to empty the rectum by a gentle purgative, given the day before the operation; a light diet and an enema before operating. The patient lies on his side, the lower leg being extended and the upper one flexed and the buttock raised by an assistant. I perform the dilatation by introducing the two index fingers into the rectum, and using the thumbs only when the resistance is very great. I never use a dilating speculum. It is necessary to avoid a blind and brutal dilatation; we should above all, avoid the practice which recommends that the thumbs be separated until they touch the ischia. We should dilate until we feel that the resistance of the sphincter has been overcome, but we should not go beyond that; at the same time the fissure should be watched so as to see that no tearing takes place. Tearing of the fissure, and even of the sphincter, which often happens when a dilating speculum is used, is not a very serious accident, but it is worth avoiding.

The after treatment in cases of dilatation is almost nothing. If the fissure be slightly torn, an ointment containing iodoform might be used.

Relief is usually very prompt, almost immediate. However, you must bear in mind that in hemorrhoidal subjects, if the pain from the fissure ceases in a day or two after the operation, it is frequently replaced for about a week by another pain, due to turgescence of the hemorrhoidal plexus following the traumatism. It is well to remember the possibility of such an incident.

Failures are very rare. I have seen only one, in a neuropathic young man not hemorrhoidal. In such a case, division of the sphincter would result in cure. The line of incision should be through the fissure, and the whole thickness of muscle should be divided. The thermo-cautery should be used to divide the sphincter. Cicatrization is a little slower than after the use of the bistoury, but you avoid troublesome hemorrhage, and you also diminish the risks of infection. Divisions of the sphincter causes in