



Are we following an algorithm for managing chronic anal fissure? A completed audit cycle[☆]



Nicholas Farkas¹, Kohmal Solanki¹, Adam E. Frampton^{*}, John Black, Ashish Gupta²,
Nicholas J. West²

Department of General & Colorectal Surgery, Epsom & St. Helier University Hospitals NHS Trust, St. Helier Hospital, Wrythe Lane, Carshalton, Surrey, SM5 1AA, UK

HIGHLIGHTS

- A retrospective audit regarding management of chronic anal fissure (CAF).
- Adherence to ACPGBI standards reduces the need for potentially unnecessary surgery.
- Conservative management of CAF provides an effective treatment strategy.
- Following change, re-audit demonstrated significant improvement in management of CAF.

ARTICLE INFO

Article history:

Received 29 October 2015

Accepted 22 November 2015

Keywords:

Chronic anal fissure (CAF)

Audit

Management

GTN

Diltiazem

Botox

Surgery

ABSTRACT

Background: Anal fissure is one of the commonest proctological diseases with considerable national variation in sequential treatment. We aimed to audit our compliance of chronic anal fissure (CAF) management with national guidance provided by the Association of Coloproctology of Great Britain and Ireland (ACPGBI).

Methods: We retrospectively audited patients presenting to outpatient clinics with CAF over a 6-month period. Using electronic patient records, notes and clinic letters, we compared their management with ACPGBI algorithm. A prospective re-audit was then performed.

Results: Forty-one patients were included in the analysis (59% male). Sixty-eight percent (n = 28/41) of patients were appropriately started on conservative dietary therapy, of whom only 7.1% (n = 2/28) had treatment success. Eighty-nine percent (n = 25/28) were then appropriately treated with either topical diltiazem 2% or GTN 0.4%. Overall, 43.9% (n = 18/41) of all patients' entire management strategy adhered to the ACPGBI guidelines. In total, 48.8% (n = 20/41) patients had surgical treatment (excluding Botox), of which only 15% (n = 3/20) had undergone ACPGBI-compliant management. After local dissemination of results and education, the re-audit of 20 patients showed significant improvement in adherence to the guidelines (43.9% vs. 95%; P = 0.0001).

Conclusions: Topical creams were the most successful treatments (50%; n = 9/18) in ACPGBI-compliant strategies. Importantly, these data suggests that compliance with the ACPGBI algorithm leads to healing without surgery in 83.3% (n = 15/18) of patients, compared to 26.1% (n = 6/23) with non-compliant methods (P = 0.0004). This highlights the benefit of early conservative and medical management of CAF, before attempting surgery.

© 2015 The Authors. Published by Elsevier Ltd on behalf of IJS Publishing Group Limited. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

[☆] This work was presented as an oral presentation at the Association of Surgeons of Great Britain and Ireland International Surgical Congress 2015, Manchester, UK.

^{*} Corresponding author.

E-mail addresses: nickfarkas@doctors.org.uk (N. Farkas), kohmalsolanki@yahoo.co.uk (K. Solanki), a.frampton@imperial.ac.uk (A.E. Frampton), jbjohnyblack126@gmail.com (J. Black), Ashish.Gupta@esth.nhs.uk (A. Gupta), Nicholas.West@esth.nhs.uk (N.J. West).

¹ These first authors contributed equally.

² These senior authors contributed equally.

1. Introduction

Chronic fissure-in-ano is a proctological condition often ignored or misdiagnosed by clinicians, both in the community and by junior doctors in colorectal surgical clinics [1]. Simple measures have been shown to be effective in treating the condition thereby avoiding surgery [2]. Often, managing benign proctology conditions can be more challenging than the complex cancer cases.

An anal fissure is a linear ulcer of the squamous epithelium within the anal canal distal to the dentate line. Anal fissures are common, with an incidence of 1 in 350 and a lifetime incidence of up to 11.1% [3]. Fissures most commonly present in the 2–4th decades with an equal propensity between sexes. The majority of fissures are sited posteriorly (90%), and present with pain on defecation and/or per rectal bleeding, due to hypertonia of the internal anal sphincter, resulting in ischemia [4].

A number of management strategies are used to treat chronic anal fissure (CAF) focussing on the reduction of anal tone [5]. Initial treatment is centred on conservative management with general measures, such as topical analgesics, increasing dietary fibre, laxatives and maintaining appropriate fluid intake. Medical management utilises topical glyceryl trinitrate (GTN) 0.4% and diltiazem 2% creams, whilst Botulinum toxin (Botox) has also been shown to be effective [6]. Surgical treatment is often necessary if conservative and medical managements are ineffective [7]. A variety of procedures are employed including lateral sphincterotomy, fissurectomy and anal advancement flap.

There is considerable national variation in the sequential treatment of CAF [8]. Management strategies have been provided as national guidance by the ACPGBI [9] in 2008 (Fig. 1). The ACPGBI position statement is based on Level 1, Grade “A” evidence.

2. Aims

To review the management of CAF within our two hospitals in accordance to the ACPGBI guidelines.

3. Methods

Patients were identified with CAF through a database search using clinical coding and ICD-10 codes over a 6-month period (February–July 2014). Electronic patient records, notes and clinic

letters were assessed retrospectively. Basic demographic information was collected using a proforma along with treatment strategies employed in patient care. Comparison was then made to the standards of care recommended in the ACPGBI guidelines (Fig. 1). Consecutive patients from January 2015 onwards were identified in the same manner.

4. Standards

Six key standards were highlighted to assess management within our two hospitals against the ACPGBI statement (Table 1).

5. Results

5.1. Initial audit

There were 534 patients identified using ICD-10 codes between February and July 2014, of which 41 patients (17 females, 24 males) with CAF were included. Of these, 31 were seen in colorectal clinic, 8 in general surgical clinic and 2 in gastroenterology clinic.

Compliance and non-compliance to the ACPGBI management algorithm is demonstrated in Table 2 and via flow diagram in Fig. 2. Conservative therapy was initiated appropriately in 28 patients, with 13 patients not receiving these simple measures. Of the 28 patients, 2 were treated successfully, whilst 1 was inappropriately administered Botox without having a trial of topical creams. Topical GTN 0.4% and Diltiazem 2% creams were correctly prescribed for the 25 patients compliant with the algorithm, successfully treating 9 patients. Eight patients were non-compliant with the algorithm and underwent surgical intervention before further non-surgical management (i.e. Botox). The procedures performed were lateral sphincterotomy ($n = 5$), creation of anal advancement flap ($n = 1$), anal dilatation ($n = 1$), and fissurectomy ($n = 1$).

The remaining 8 patients compliant with the algorithm were given Botox, of which 4 were treated successfully, 3 went on to have appropriate surgical intervention and 1 patient was treated inappropriately with anal dilatation.

Overall, 43.9% ($n = 18/41$) of all patients' entire management strategy adhered to the ACPGBI guidelines. Topical diltiazem/GTN was the most successful treatment in ACPGBI-compliant strategies, leading to success in 50% ($n = 9/18$). In total, 20 patients had surgical treatment (excluding Botox), of which only 35% ($n = 7/20$) had undergone ACPGBI-compliant management. Compliance with the ACPGBI management guidelines leads to treatment success without surgery in 83.3% ($n = 15/18$) of patients, compared to 26.1% ($n = 6/23$) with non-compliant methods (Fisher's exact test $P = 0.0004$).

5.2. Implementation of change

Results from the initial audit were presented locally to the department of general surgery. This presentation also included a detailed overview regarding the ACPGBI management guidelines.

5.3. Re-audit

A re-audit was carried out to assess whether practice within our trust had changed. Having completed and presented our initial audit in December 2014 we identified and analysed the next 20 patients with CAF from 01/01/2015 to 31/03/2015. The same methodology used in the initial study was applied to the re-audit.

The results of the re-audit are presented in Table 2 and in the flow diagram in Fig. 3. Of the 20 patients analysed, 19 were seen in colorectal clinic and 1 in a general surgical clinic. The male to female ratio was 12:8. Conservative management was initiated in 100% of patients ($n = 20/20$). Topical diltiazem or GTN was

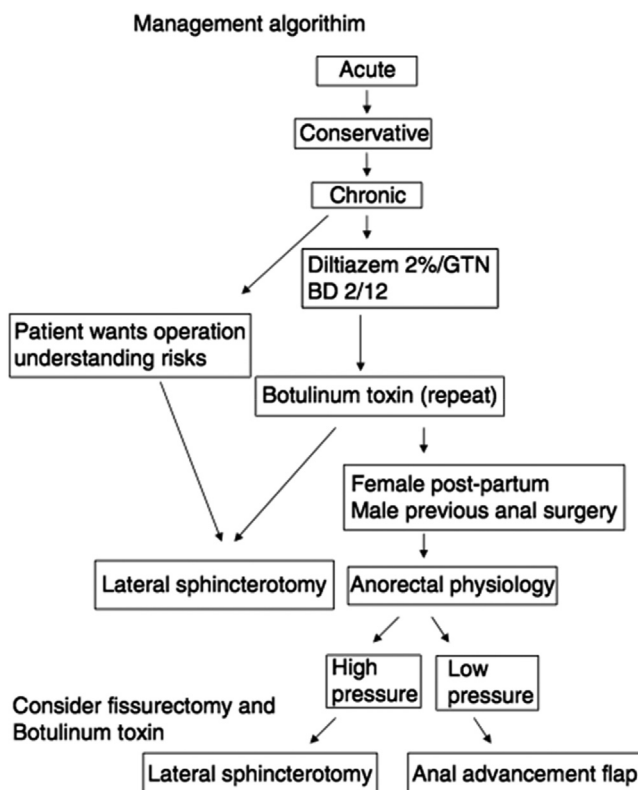


Fig. 1. ACPGBI management algorithm.

Download English Version:

<https://daneshyari.com/en/article/4195290>

Download Persian Version:

<https://daneshyari.com/article/4195290>

[Daneshyari.com](https://daneshyari.com)