

## **Anal dilatation: 'use and miss-use'**

*P. Mathur, F. Seow-Choen*

Anal dilatation had long been used in surgery. Maximal anal dilatation however was formally described nearly 30 years ago by Lord (1). However despite an initial widespread use, appropriate or inappropriate, anal dilatation had been even more widely condemned in recent years.

The premise behind anal dilatation is to decrease sphincter tone in situations where it is perceived that a raised intra-anal pressure is the cause of disease or that it will compromise postoperative recovery. However, the situation is still not as straight forward as merely stretching the sphincters; anal dilatation can be undertaken using a solid object or instrument where a uniform and constant pressure can be applied for a fixed time over a defined length of anal canal or with the surgeon's fingers where there may not be consistency or control over the degree of stretch.

This stretch may be performed with prior knowledge of anal canal physiological parameters and function before a particular procedure or without consideration for these factors. In addition, the question of whether performing anal dilatation for a particular condition or following an operation has any actual scientific merit or therapeutic benefit is still in doubt.

In the case of maximal anal dilatation, where an dilatation was used following conventional haemorrhoidectomy, dilatation was undertaken to alleviate post-operative difficulty in stool passage due to anal spasm. Four fingers were inserted in the anal canal and lateral pressure applied for a particular length of time, thereby stretching the anal sphincter complex as widely as possible. This is clearly an example of uncontrolled use; no justification for this method was made and the functional consequences of this maximal anal stretch were not taken into account, the emphasis being on pain symptom control alone. This manoeuvre will have disastrous consequences particularly in the elderly or those with lax sphincters. This practice of maximal anal dilatation for anal spasm therefore cannot be supported and should be discouraged. However some authors still advocate its use in chronic anal fissure and report favourable functional results (2), whereas others have condemned its use altogether (3).

Even to this day 'Lord's' anal stretch is still being used in various forms and disguises usually relating to the number of fingers used in the stretch and the length of time the stretch is applied for. In most instances the indication is obscure and unproven and is usually undertaken because the surgeon says that a bit of stretch will do the patient good. A perfect example of this is performing a manual anal dilatation following low anterior resection. Whether this is done to decompress the coloanal anastomosis or alleviate postoperative difficulty in defaecation is unclear. Such reasoning is not only unacceptable but also unproven and is a clear 'miss-use' of anal dilatation; and it is this uncontrolled use of anal dilatation that gives it a bad name.

Are there then any correct uses for anal dilatation or is this procedure to be condemned outright and merely recorded in historical volumes? The fact is that whether we approve of anal dilatation or not it is here to stay. This is because with the increasing number of procedures performed completely trans-anally, involving either the use of retractors or instruments, inadvertent anal dilatation becomes unavoidable and is an inherent step in many procedures. Sphincter become 'stretched' by retractors which are used to provide adequate access, e.g. trans-anal rectocele repair/polyp-

cancer resection, or as part of the operation itself, e.g. stapled haemorrhoidectomy. However in the above examples, it has been recognised preoperatively that the procedures might lead to detrimental functional consequences and it has been documented that although there was some impact on anal physiology this did not lead to problems with function (4,5). Hence in these circumstances where anal dilatation is inevitable the likelihood of some anal dysfunction should be recognised, acknowledged and recorded, avoided or minimised if possible. If anal stretch is unavoidable, the benefits of the procedure should outweigh the possible functional damage before anal stretch is allowed or used.

Perhaps the only clear benefit of anal dilatation is seen when it is utilised following haemorrhoidectomy to treat anal stenosis. This may be done using a St Mark's anal dilator. This is an instrument of fixed diameter, inserted over a given length and time which applies a constant pressure. This form of anal dilatation therefore fits into the correct use category.

Adequate access to the anal canal is only possible by stretching the anal sphincters. The majority of trans-anal operations utilise instruments of fixed diameter that apply controlled pressure only. This allows this factor to be taken into account when assessing the impact of the procedure. It is no longer acceptable to apply injudicious use of anal dilatation without regard to possible functional sequelae. Occasionally, anal dilatation may have a therapeutic effect but anal dysfunction may be too great a price to pay. Manual anal dilatation is not only an uncontrolled procedure but carries no clear indications for its use and therefore should be abandoned altogether.

## References

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