Management of Common Anorectal Problems

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Common Anorectal Problems

- Hemorrhoids
- Abscess
- Fistula-in-ano
- Anal fissure
- Pruritus ani
- Pilonidal Disease
- Proctalgia fugax

- Proctitis
- Fecal Impaction
- Fecal Incontinence
- Anal warts and other neoplasms
  - Anal
  - Rectal
  - Perianal
General Anatomic Considerations

- Squamocolumnar Junction
- Rectum
- Anal Columns of Morgagni
- Pectinate or Dentate Line
- Internal Sphincter Muscle
- Anal Crypt
- Anal Gland
- Surgical Anal Canal
- Anatomical Anal Canal
- Sweat Glands and Hairs in Perianal Skin
- Anal Verge
- Anoderm
- External Sphincter Muscle
Obtaining the History

- Complete H&P
- Bleeding
  - Color
  - Frequency
  - Amount
- Pain
  - Location
  - Duration
  - Precipitants
- Bowel Habits
- Sexual habits
Examining the Anorectum

- **Inspection**
  - Asymmetry
  - Discoloration
  - Skin integrity
  - Masses or lumps

- **External palpation**
  - Induration
  - Fluctuance
  - Tenderness

- **Internal palpation**
  - Masses
  - Pain
  - Presence of blood
Documenting the Exam

• Describe the position the patient was examined in
  – Refrain from using clock hands to describe findings
Documenting the Exam

• Describe findings in the perineum and external inspection
  – “The perineum was dry/soiled with a normal/abnormal appearing anal verge.”

• Describe DRE findings
  – ”There were/were no appreciable masses, no blood.”
  – If there is an abnormal finding note the location
Hemorrhoids

- Normal tissue
- Integral part of the continence mechanism
- Venous plexuses with arteriolar communications
- Vascular cushions
  - right anterolateral
  - right posterolateral
  - left lateral
Two Types of Hemorrhoids
Two Types of Hemorrhoids

• External hemorrhoids
  – Dilated venules of the inferior hemorrhoidal plexus
  – Arise **below** the dentate line
  – *Covered by skin*
  – Usually small and asymptomatic
  – Painful only when acutely thrombosed or inflamed
  – A skin tag (not a hemorrhoid)
    • fold of skin
    • arise from the anal verge
    • end result of thrombosis or repeated inflammation
External Hemorrhoids vs. Skin Tags
Treating External Hemorrhoids

- Acute inflammation will respond to conservative treatment within a few days
  - Sitz baths every 4-6 hrs.
  - Increased fiber AND water
  - OTC or Rx hemorrhoid creams/suppositories
  - Consider stool softener
  - Minimize straining
  - Avoid loitering on the commode
Thrombosed External Hemorrhoids

- Most common presentation is acute severe pain
- Treatment depends on timing of presentation
  - Symptoms are worst in the first 72 hrs.
    - This is the time period that excision should be entertained
    - Beyond 72 hrs., conservative management is usually best
Thrombosed External Hemorrhoid
Lancing versus Excision

Clot and plexus still attached to the underside of the fusiform island of skin

Anal canal
Two Types of Hemorrhoids

• **Internal hemorrhoids**
  – Submucosal vascular tissue
  – Located above the dentate line
  – Covered by mucosa
  – Major symptom are:
    • Painless bleeding
    • Bloody or mucoid discharge
    • Perianal discomfort
  – Classified from first to fourth degree depending upon extent of prolapse
Grading of Internal Hemorrhoids

- **1°** bulge into lumen but not externally
- **2°** protrude and reduce spontaneously
- **3°** require manual reduction
- **4°** irreducible
Treatments for Internal Hemorrhoids

- **Banding**

- **Excision**
  - Stapled hemorrhoidectomy
  - Closed or open hemorrhoidectomy
Hemorrhoidectomy
Hemorrhoidectomy
Preventing Symptomatic Hemorrhoid Recurrence

• Lifestyle modifications
  – Diet
    • Fiber
    • Water
  – Avoid
    • Straining
    • Reading on the commode
  – Exercise
How much fiber should we recommend?

25-35 grams DAILY
How much water should we be drinking?

6-8 eight ounce glasses
Anal Fissure

- Second most common anorectal disorder
- A small tear in the anal skin
- Causes significant pain, especially with bowel movements
- Bright red blood is common
- Frequently misdiagnosed as hemorrhoids
Anal Fissure

- Most heal on their own without treatment
- May be caused by constipation or diarrhea
- Young adults most frequently affected
- Majority occur in the posterior midline
  - Likely caused by decreased blood flow
- Anterior fissures in 10% of women and 1% of men
  - Fissures in other locations atypical and should raise suspicion for other disorders (IBD, HIV, STD, etc)
Anal Fissure

- Physical examination confirms the diagnosis
  - Most fissures are best seen by separating the buttocks
  - A sentinel skin tag should alert the examiner to the likely presence of a chronic fissure
  - *Digital and endoscopic examinations not appropriate*
  - When significant anal pain cannot be diagnosed definitively, examination under anesthesia is warranted
Anal Fissure

- **Acute anal fissure**
  - symptoms present for only days or < 8 weeks
  - these fissures are more likely to heal without surgery

- **Chronic anal fissure**
  - symptoms present for months or years
  - these are more likely to require surgery
Acute Anal Fissure
Chronic Anal Fissure
Anal Fissure

• Medical treatments highly successful
  – Ointments, sitz baths, and fiber
  – Healing may take up to 3 months but symptoms usually improve within 7-10 days of treatment
• Medical treatment
  – Nitroglycerine ointment
  – Nifedipine or Diltiazem ointment
  – Botox injection
• Heal more than 75% of acute anal fissures
• Surgery highly successful
  – Advocated for patients with chronic anal fissures
  – Associated with minor incontinence in some patients
Perirectal Abscess

- Rectum
- Supralevator
- Ischorectal
- Intersphincteric
- Perianal
Perirectal Abscess

- **Pain**
  - Pain escalates over time
- **Mass**
  - Develops gradually and enlarges with time
- **Fever**
Abscess and Fistula

- Infection arising from obstruction of anal glands/crypts
- Extend to the potential spaces around the anal canal
  - Perianal, intersphincteric, ischiorectal, deep post anal, suprarelevator spaces
  - Alone or in combination
- Usually polymicrobial
  - *Bacteroides fragilis* predominant anaerobe
  - *Escherichia coli*
  - *Proteus*
  - *Streptococcus*
Abscess and Fistula

- **Mortality/Morbidity**
  - Fistula formation in 25-50% of cases
  - Bacteremia and sepsis may result if:
    - Immunocompromised
    - Diabetic
    - Obese
  - Urinary retention occurs in 5%
  - Fournier’s gangrene

- **No racial predilection**
- **Men affected more frequently**
- **Treatment involves drainage with or without fistulotomy**
Rectal Prolapse

• Intussusception of rectum through anus
  – Full Thickness
  – Circumferential

• Symptoms
  – Pain
  – Bleeding
  – Mucoid discharge
  – Incontinence

• Treatment
  – Reduction
  – Fiber and water
  – Laxatives
  – Avoid straining and loitering

• Surgery indicated but not urgent/emergent
Rectal Prolapse
Rectal Prolapse vs. Prolapsed Hemorrhoids
Proctitis

- Proctitis is inflammation of the rectal mucosa.
- May be acute or chronic
  - Multiple causes
    - Side effect of medical treatments (i.e.: radiation therapy or antibiotics)
    - Inflammatory bowel disease, trauma, & bacterial infection
    - STD (i.e.: gonorrhea, herpes, & chlamydia)
Proctitis
Proctitis

• Most common symptom:
  – “Tenesmus” - frequent or continuous sensation or urge to have a bowel movement

• Other symptoms include:
  – Bleeding
  – Constipation
  – Feeling of rectal fullness
  – Lower abdominal pain
  – Anorectal pain
  – Passage of mucus
Radiation Proctitis

• *Acute radiation proctitis* — symptoms occur in the first few weeks after therapy
  
  – diarrhea, tenesmus, bleeding
  – usually resolves without treatment after several months
  – symptoms may improve with salicylate enemas
  – due to direct damage of the mucosa
Radiation Proctitis

- *Chronic radiation proctitis* — symptoms begin as early as several months after therapy but occasionally not until several years later
  - Symptoms include diarrhea, bleeding, pain, and obstruction
  - Fistulas may also develop to skin or bladder
  - Results from damage to the blood vessels
Proctitis

- Ulcerative Proctitis
  - Inflammatory bowel disease limited in extent to the rectum
  - Usually requires biopsy for definitive diagnosis
  - Need to exclude small bowel or proximal colon disease
  - Can be treated with salicylate or steroid enemas or suppositories
  - May require combined oral and rectal treatment
Proctitis

- Infectious Proctitis
  - Gonorrhea
  - Herpes
  - Chlamydia
  - Campylobacter
  - Entamoeba histolytica
  - Salmonella
  - Shigella

- Treatment
  - Antibiotics
  - Probiotics
Pruritus Ani

• **Chronic perianal itching**
  – Most common after BM or at night
  – Irresistible urge to scratch

• **Etiology**
  – Overly aggressive hygiene
  – Too much moisture
  – Dietary Excess
    • Caffeine
    • Alcohol
    • Chocolate
    • Tomatoes
Pruritus Ani

• Treatment
  – Avoid further trauma
    • Do not scrub
    • Do not scratch
  – Avoid moisture in the anal area. This includes creams/ointments.
  – Avoid all medicated, perfumed and deodorant powders
    • Cleanse only with warm water
  – Elimination diet for 2 weeks
Pilonidal Disease

- Chronic skin infection in the buttock crease
- Sinus or pit in skin with impacted hair
- More common in men than women
- Frequently occurs in early adulthood
- More common in obese and those with thick hair
Pilonidal Disease
Pilonidal Treatment

• Acute abscess:
  – Needs incision and drainage of pus
  – Reduces inflammation
  – Relieves pain
  – Can be performed in the office

• A chronic sinus usually needs surgical excision
Conclusion

• Not all rectal bleeding and pain is hemorrhoids
• There are numerous possibilities, and colorectal neoplasm must be excluded
• Many of these diseases can be managed in the office