Management of Common Anorectal Problems

Gaby Vargas, MD, MS
Colon and Rectal Surgeon

PUYALLUP SURGICAL CONSULTANTS
a division of Proliance Surgeons

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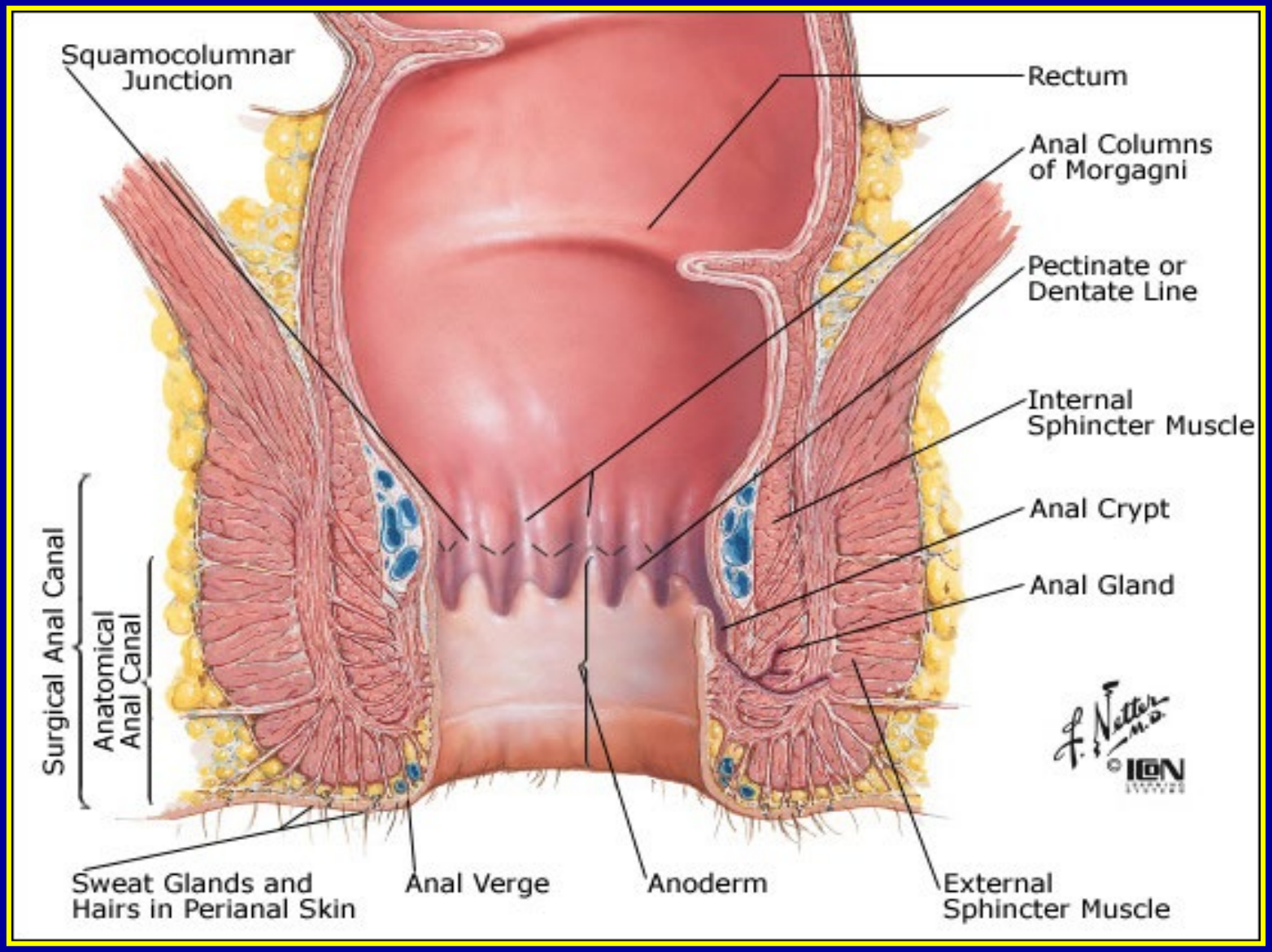
Common Anorectal Problems

- 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



Obtaining the History

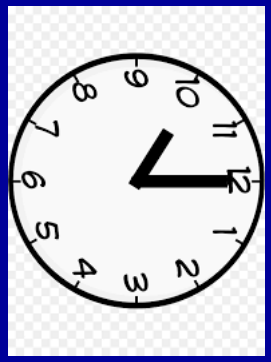
- Complete H&P
- Bleeding
  - Color
  - Frequency
  - Amount
- Pain
  - Location
  - Duration
  - Precipitants
- Bowel Habits
- Sexual habits

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

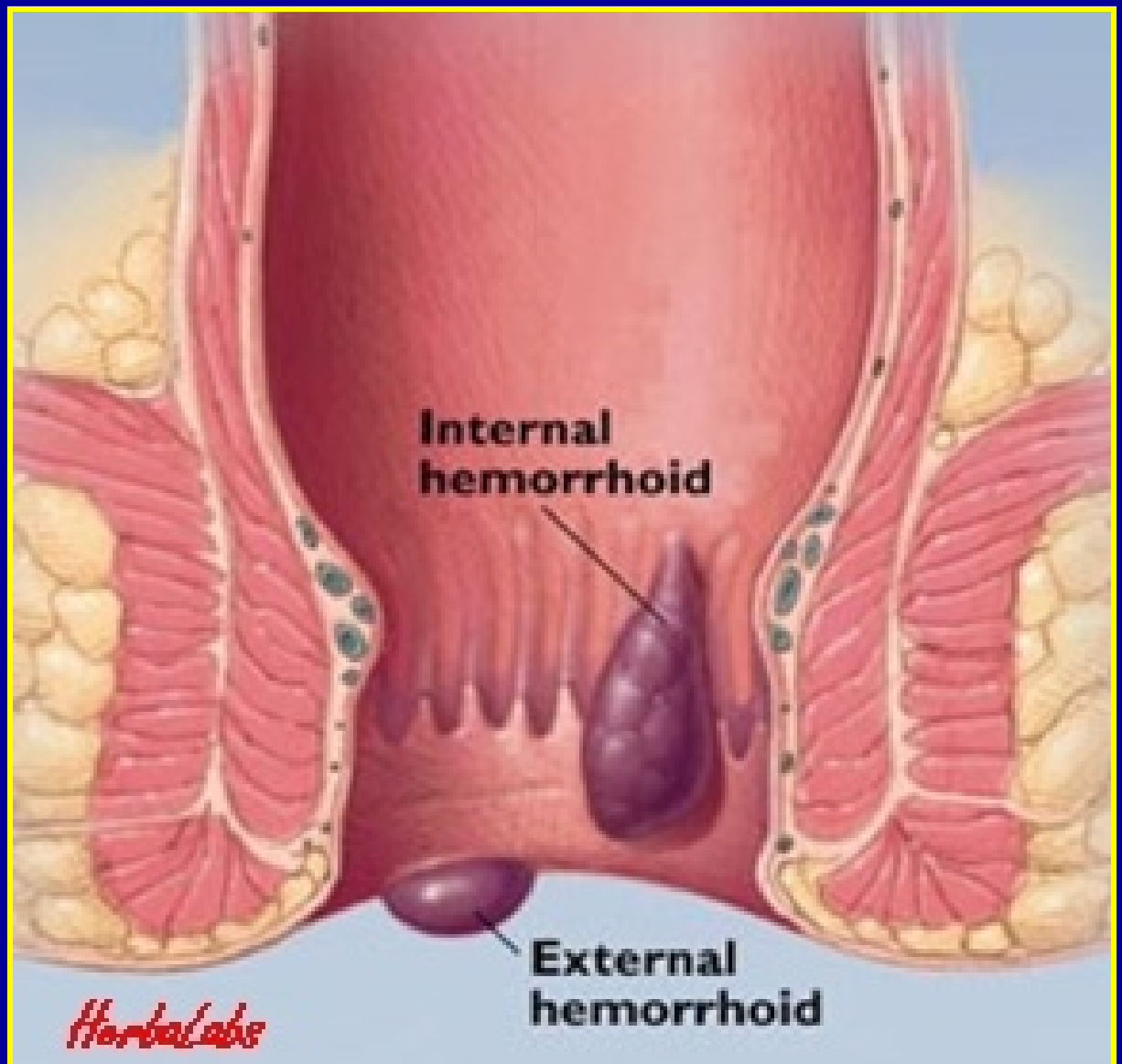

Documenting the Exam

- 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

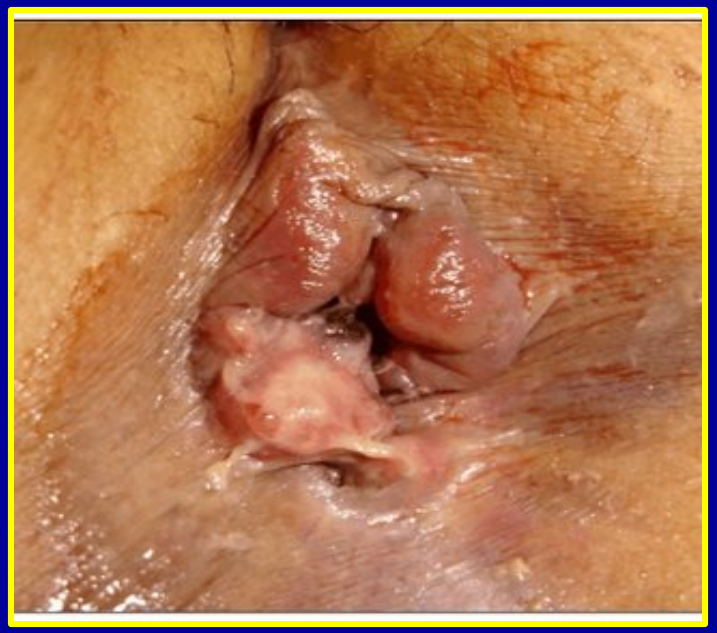
Two Types of Hemorrhoids



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



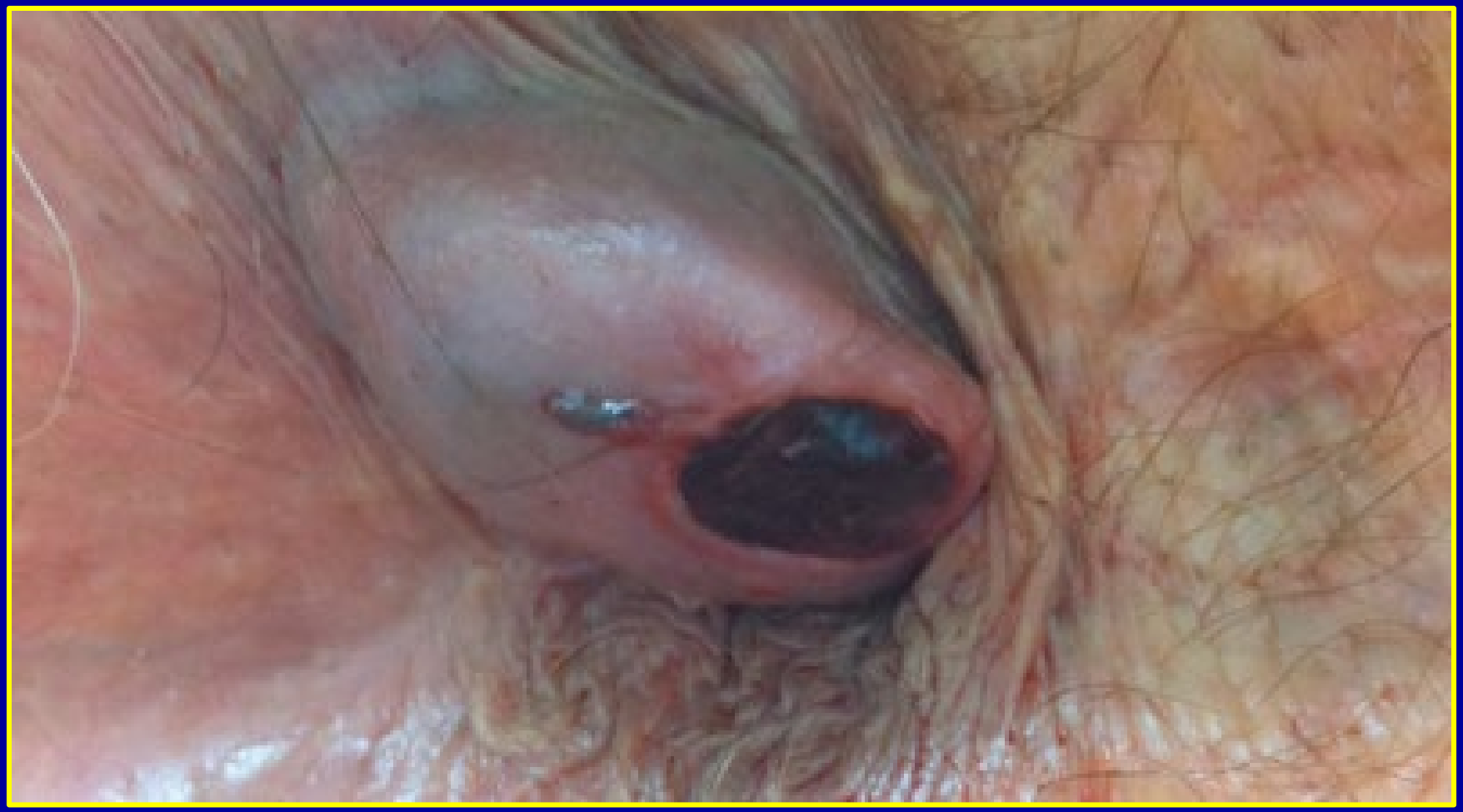
Treating External Hemorrhoids

- 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

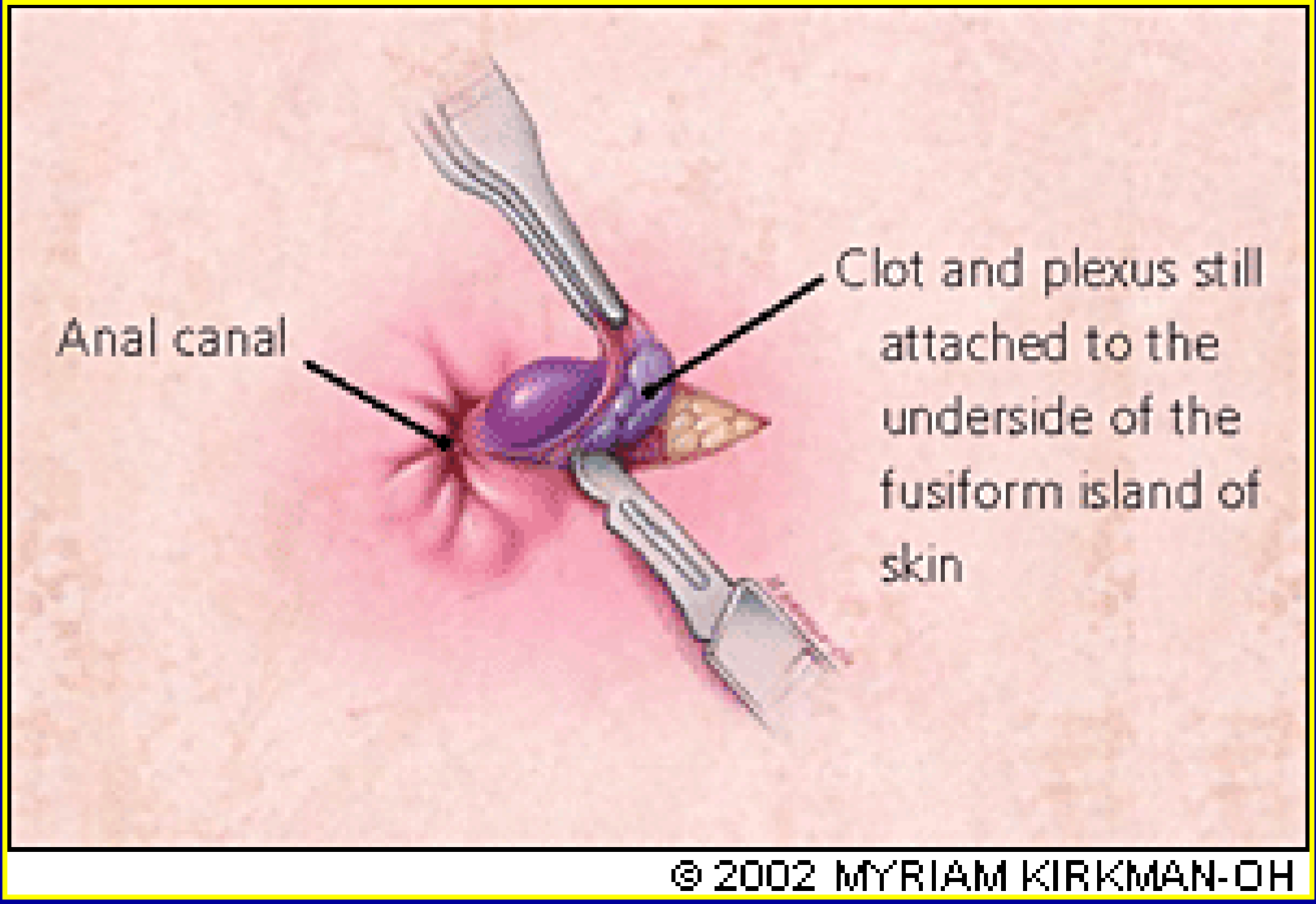
Thrombosed External Hemorrhoids

- 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

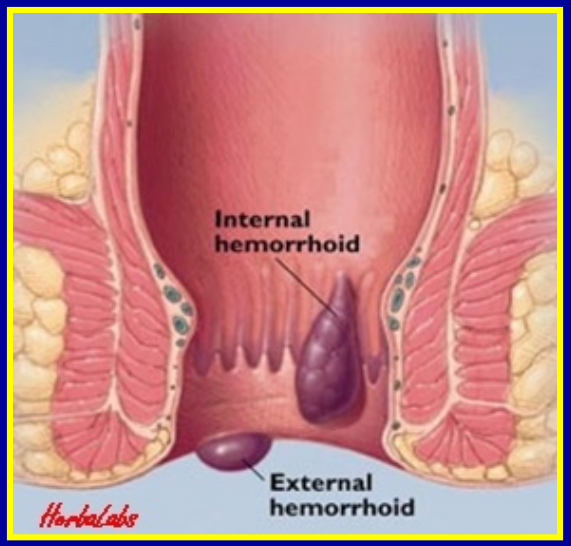


Lancing versus Excision



Two Types of Hemorrhoids

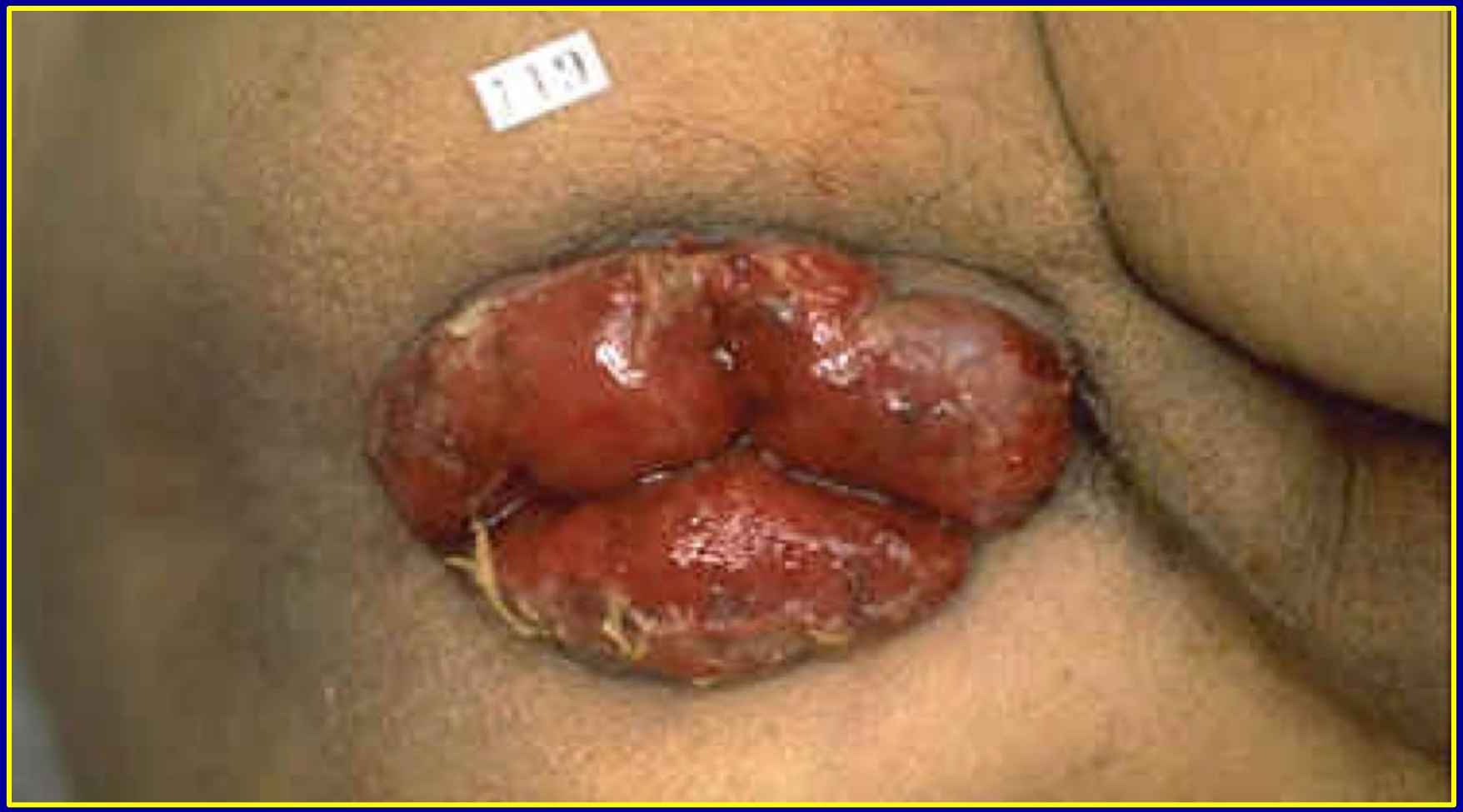
- Internal hemorrhoids
  - Submucosal vascular tissue
  - Located above the dentate line
  - Covered by mucosa
  - Major symptom are:
    - Painless bleeding
    - Bloody or mucoid discharge
    - Perianal discomfort
  - Classified from first to fourth degree depending upon extent of prolapse



Grading of Internal Hemorrhoids

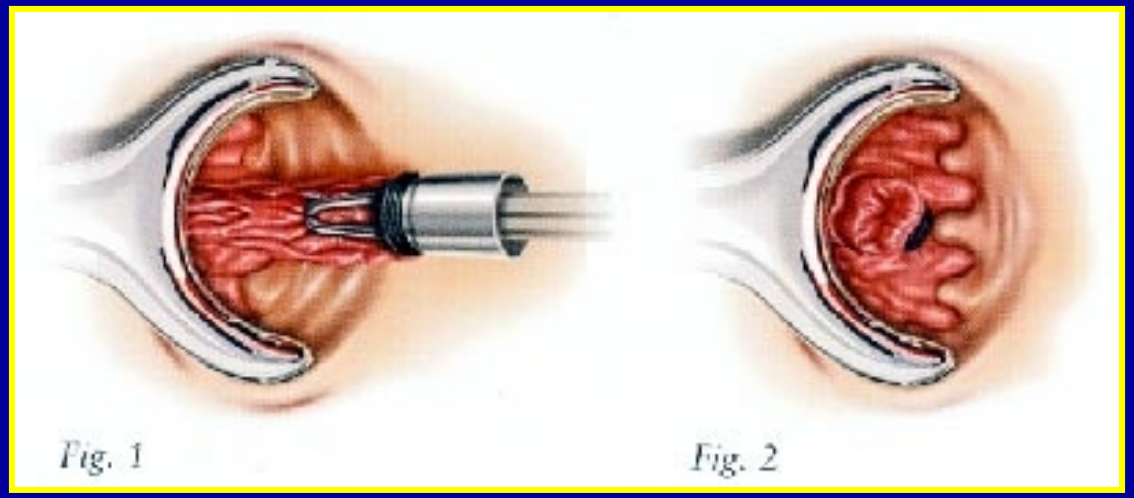
- 1° bulge into lumen but not externally
- 2° protrude and reduce spontaneously
- 3° require manual reduction
- 4° irreducible

Three Column Prolapse



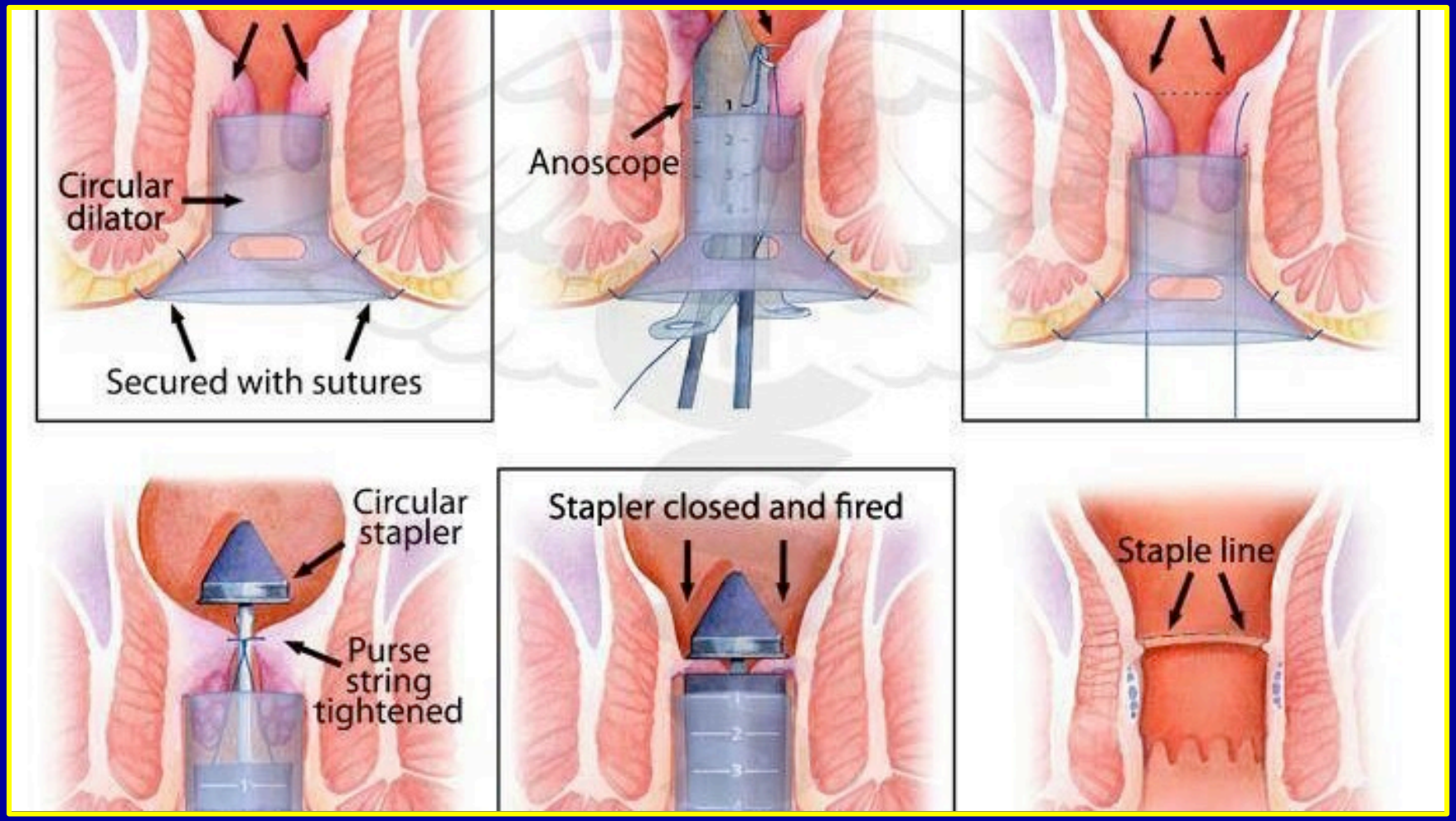
Treatments for Internal Hemorrhoids

- Banding

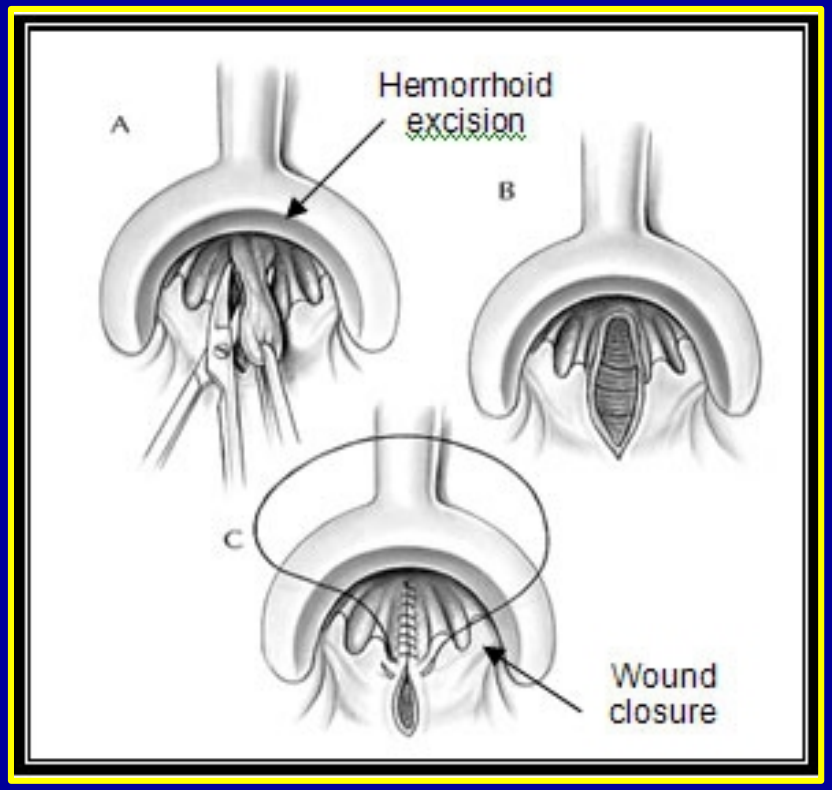


- Excision
  - Stapled hemorrhoidectomy
  - Closed or open hemorrhoidectomy

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)

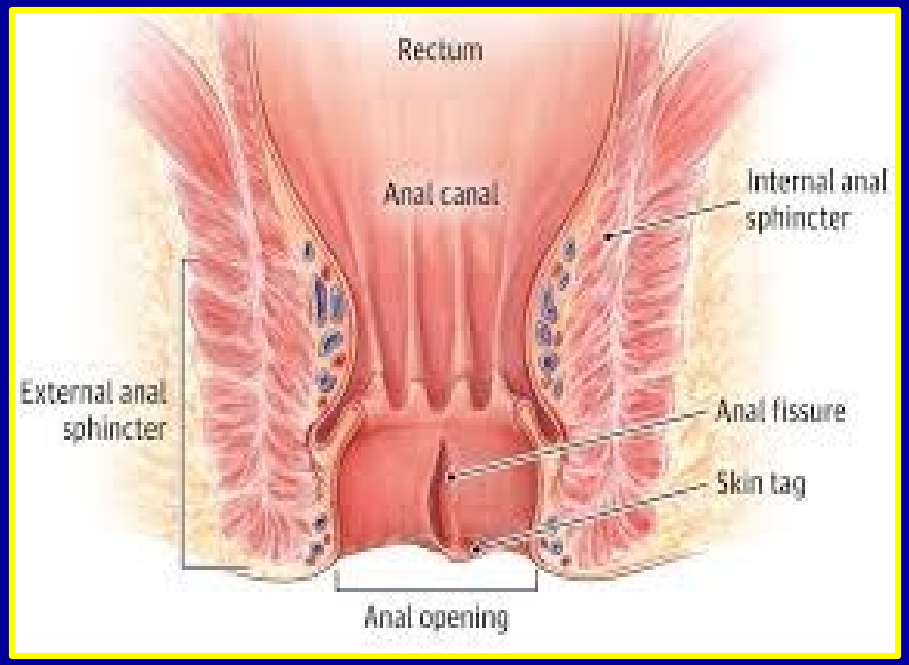
Anal Fissure

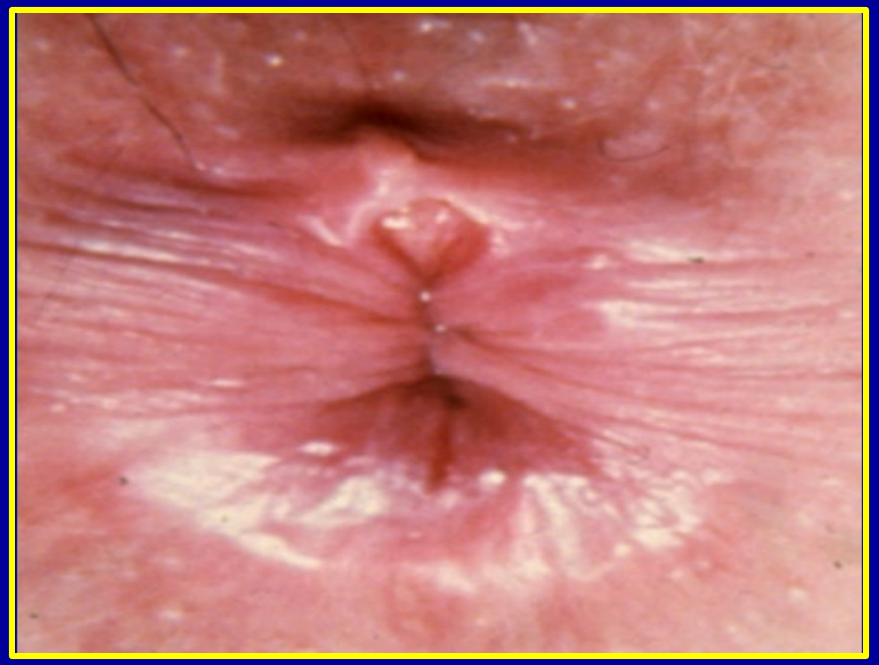
- Physical examination confirms the diagnosis
  - Most fissures are best seen by separating the buttocks
  - A sentinel skin tag should alert the examiner to the likely presence of a chronic fissure
  - *Digital and endoscopic examinations not appropriate*
  - When significant anal pain cannot be diagnosed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

Anal Fissure

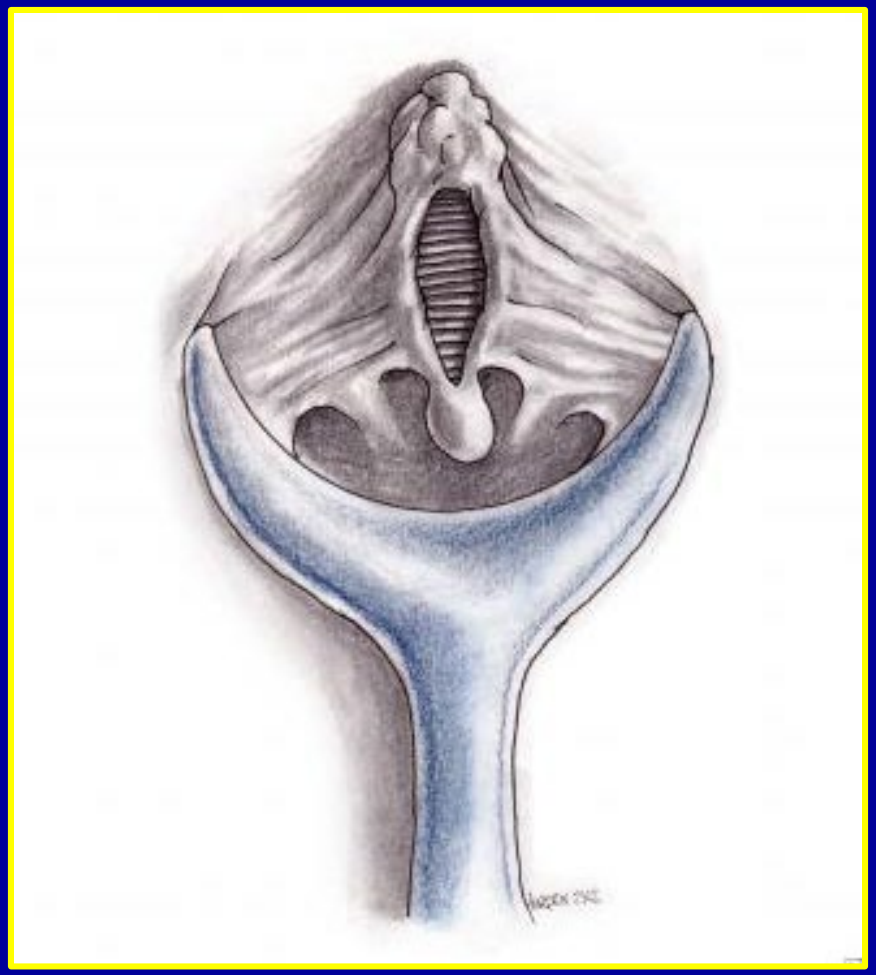
- Acute anal fissure
  - symptoms present for only days or < 8 weeks
  - these fissures are more likely to heal without surgery
- Chronic anal fissure
  - symptoms present for months or years
  - these are more likely to require surgery

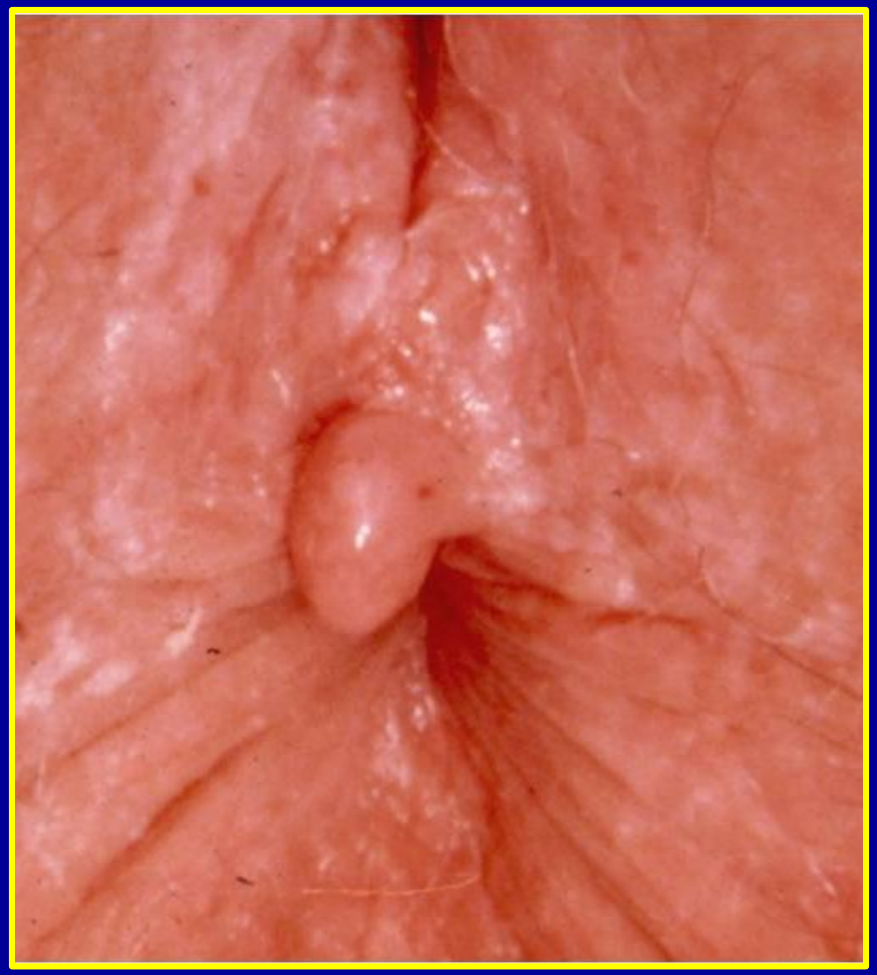
Acute Anal Fissure





Chronic Anal Fissure

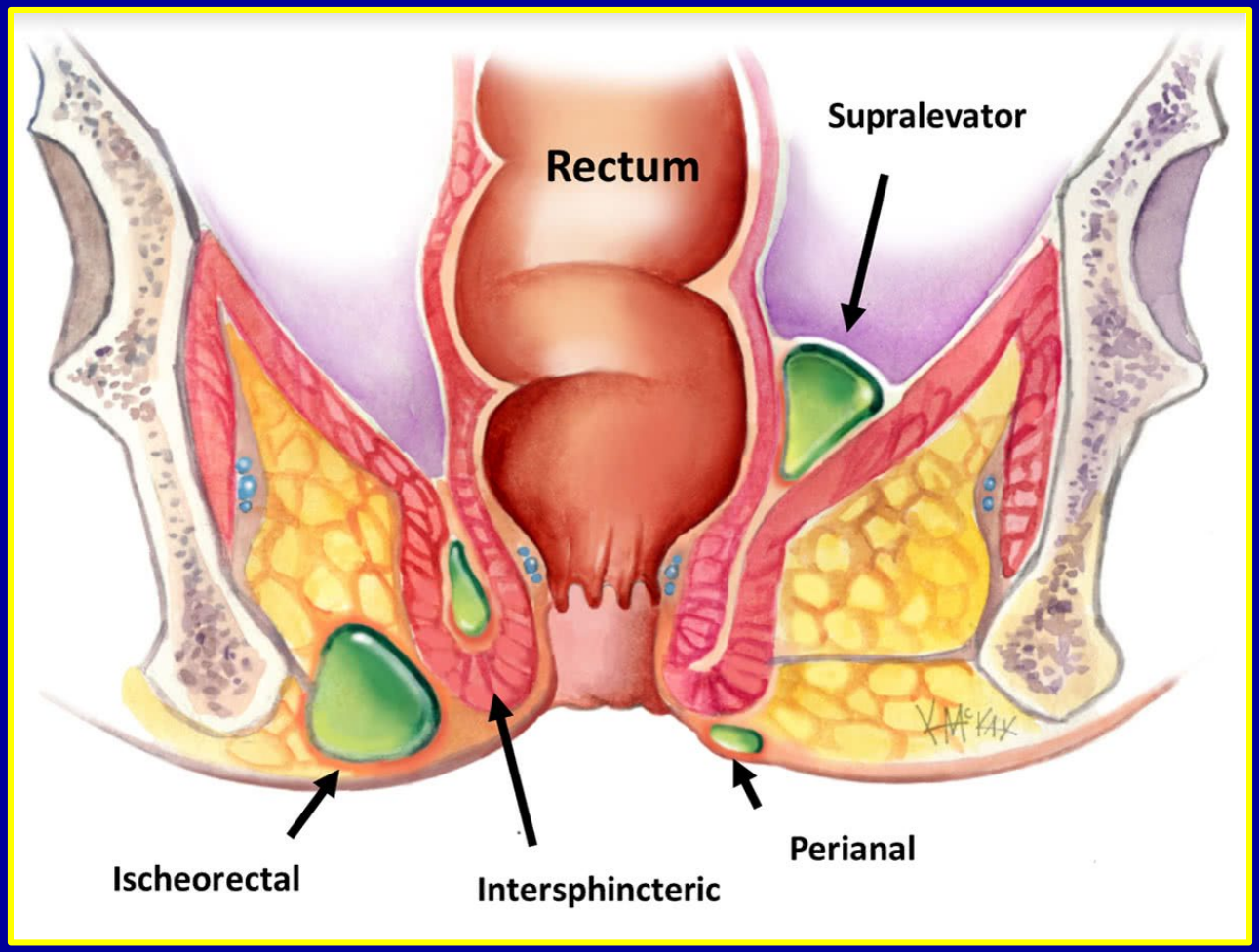




Anal Fissure

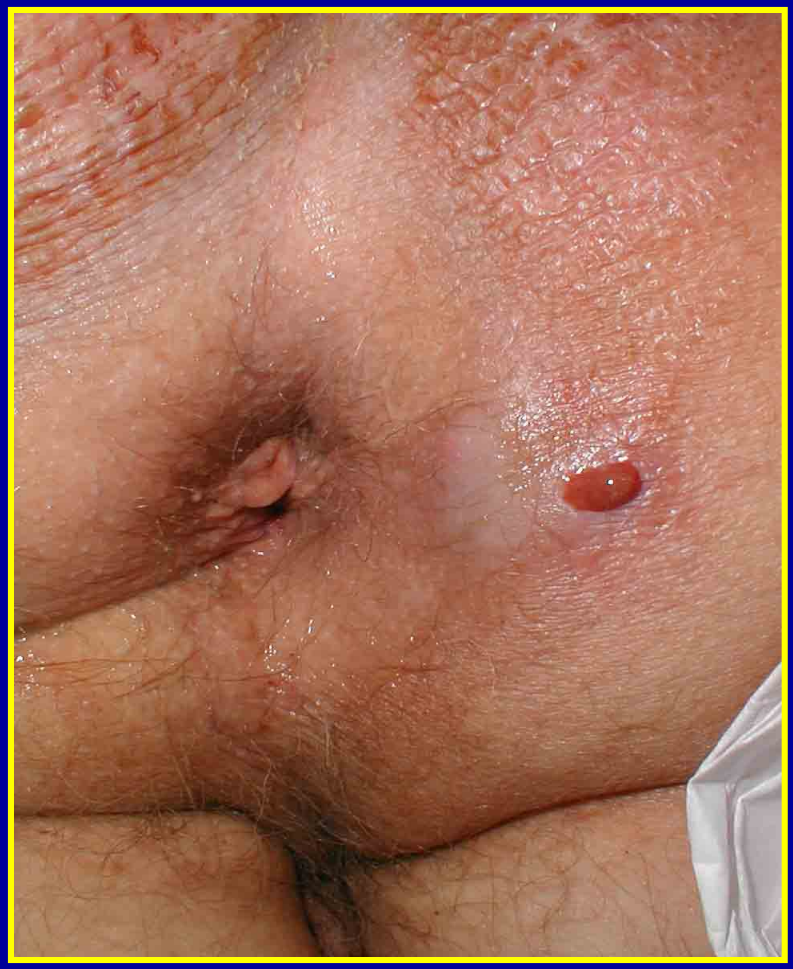
- Medical treatments highly successful
  - Ointments, sitz baths, and fiber
  - Healing may take up to 3 months but symptoms usually improve within 7-10 days of treatment
- Medical treatment
  - Nitroglycerine ointment
  - Nifedipine or Diltiazem ointment
  - Botox injection
- Heal more than 75% of acute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

Perirectal Abscess



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, supralevator spaces
  - Alone or in combination
- Usually polymicrobial
  - *Bacteroides fragilis* predominant anaerobe
  - *Escherichia coli*
  - *Proteus*
  - *Streptococcus*

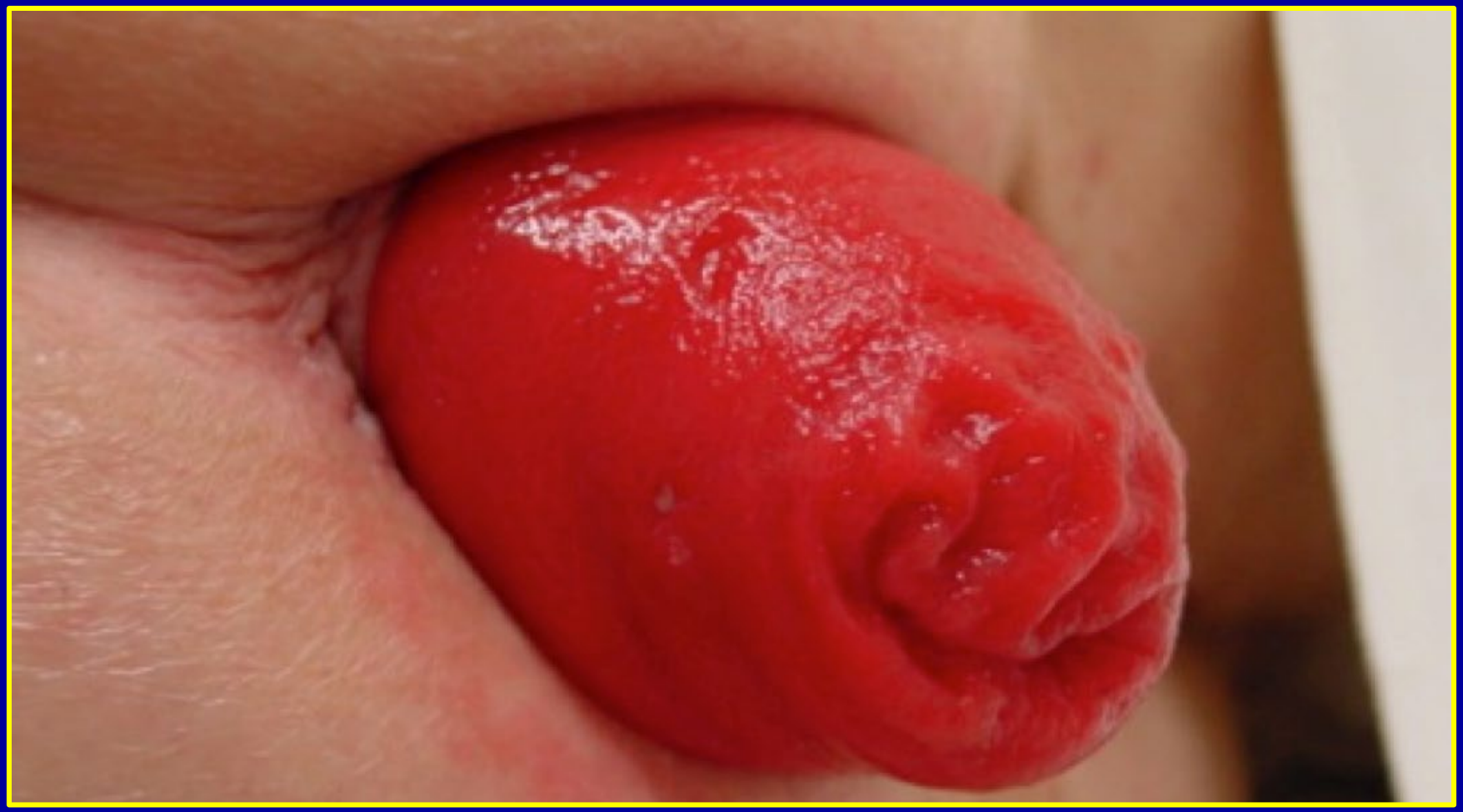
Abscess and Fistula

- 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

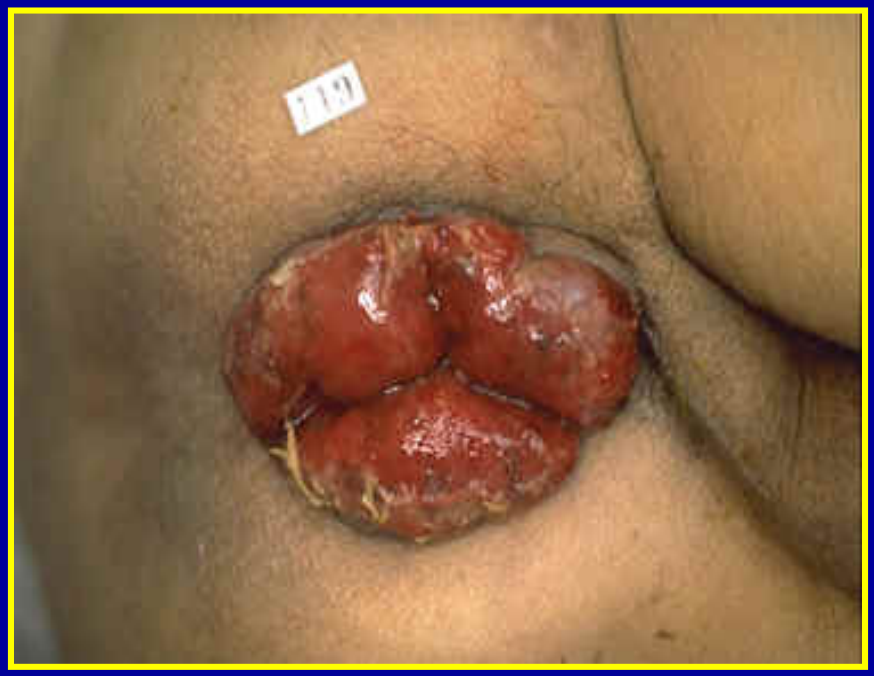
Rectal Prolapse

- 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



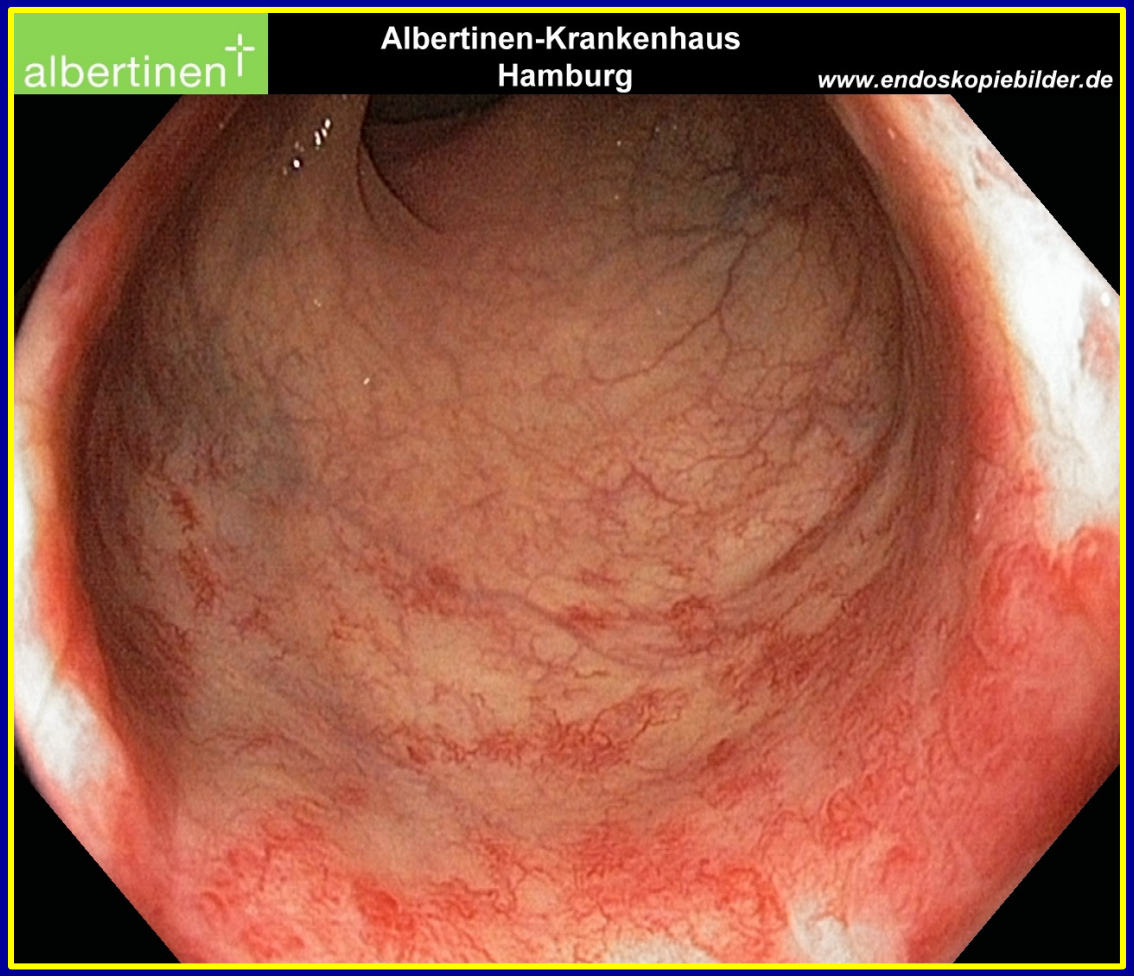
Rectal Prolapse vs. Prolapsed Hemorrhoids



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


albertinen
Albertinen-Krankenhaus
Hamburg
www.endoskopiebilder.de

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

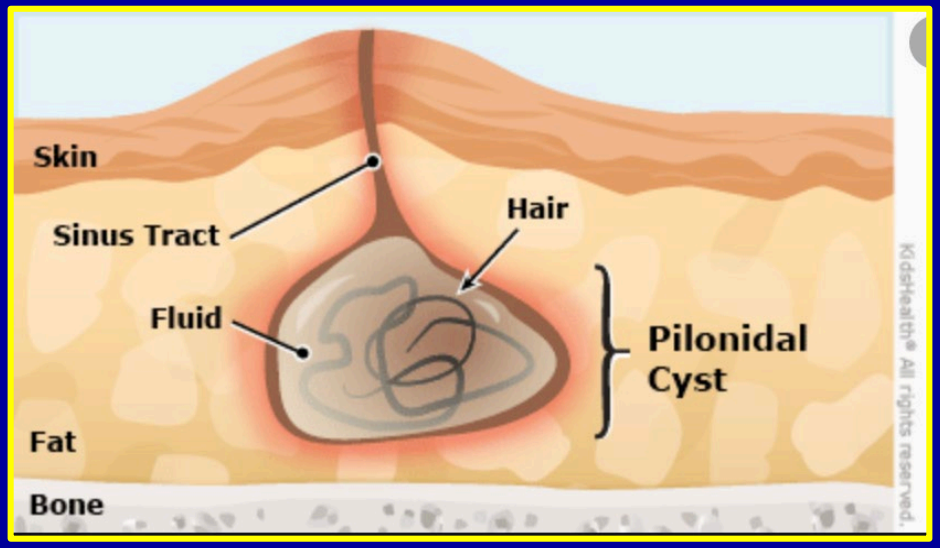
Pruritus Ani

- 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