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The Painful Truth: Anorectal Disorders

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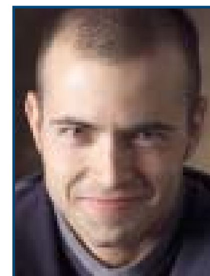
Symptoms related to the anus and rectum are among the most common complaints to family physicians. It is estimated that approximately 4.4% of the population has symptoms attributable to hemorrhoids.[1] The true incidence of anorectal disorders is impossible to ascertain since many people never seek medical advice.

The two most significant symptoms of anorectal disorders are bleeding and pain. The most common related disorders are hemorrhoids, fissures, and fistulae/abscesses. As with most areas of medicine, appropriate treatment is possible only with a correct diagnosis.

Adequate evaluation of disorders of the anus and rectum is complicated by three factors:

1. The exam is unpleasant for both patient and physician.
2. It is inconvenient, entailing the removal of undergarments.
3. It requires special instruments, which must be readily accessible and which require proper cleaning and maintenance.

Larry's case



Larry, 33, presents with a history of rectal bleeding over the past few months. He has noticed bright red blood on the toilet paper three to four times a week and, occasionally, blood dripping into the toilet bowl. He has no pain, but notices swelling or protrusion with bowel movements. He tends towards constipation and often sits on the toilet and reads for 15 minutes before having his bowel movement. He bought an inflatable donut cushion, but it has not helped.

He is otherwise healthy; he has no medical problems or allergies, and takes no medications. There is no family history of colorectal cancer or inflammatory bowel disease, though his father had problems with hemorrhoids.

An anorectal exam reveals a few small skin tags and a digital rectal exam is normal. An anoscopy reveals second-degree internal hemorrhoids, which are friable and bleed from the exam. A rigid proctoscopy to 15 cm is normal.

**What is the likely cause of his bleeding?
How would you treat him?**

For more on Larry, go to page 126.

It is worth remarking that while family physicians become quite proficient with pelvic exams during their training, they seldom develop the same proficiency when it comes to

Table 1

Medical management of common anorectal disorders

Hemorrhoids
- High-fibre diet
- Psyllium fibre supplement
- Avoidance of sitting on toilet for long periods of time and straining
- Avoidance of donut cushions

Fissures
- High-fibre diet
- Psyllium fibre supplement
- Sitz baths

Table 2

Indicators that no further investigations are necessary

- Patient is under 50
- History is typical of anal outlet bleeding
  - Blood is bright red
  - Blood is on paper or dripping
- No worrisome symptoms
  - No change in bowel habits
  - No anemia
  - No family history
- Exam finds a likely source of bleeding
  - Friable hemorrhoids
  - Fissure

examining the anus and rectum.

A quick approach to evaluating common symptoms of the anorectum will allow family physicians to initiate appropriate treatment and identify which patients should be referred to a specialist electively or urgently (Table 1).

What about rectal bleeding?

The evaluation of rectal bleeding is problematic for many family physicians. The most common causes are hemorrhoids and fissures, but we have all heard of patients who were told they had hemorrhoids and turned out to have cancer. Since no physician wants to miss a cancer diagnosis, the question arises: what is the appropriate evaluation of rectal bleeding? How aggressively should one evaluate bleeding before one can confidently attribute it to a benign cause?

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What is the nature of the bleeding?

First, clarify the type of bleeding. Is it bright red or "fresh blood"? Is it on the toilet paper? Does it drip or squirt into the bowl? Does it occur at the end of the bowel movement? Is it mixed into the stool? Is there pain? These questions help distinguish anal outlet bleeding from other causes. Bright red blood on the toilet paper or dripping into the bowl at the end of a bowel movement is typical of benign anal outlet bleeding. Suspicious symptoms are: dark or marooned blood, associated change in bowel habits, and/or blood mixed into the stool.

Is there associated pain?

Internal hemorrhoids generally do not hurt. When asked about pain, however, many patients feel it *should* be associated with bleeding, and will answer in the affirmative. It is safe to assume that if patients have to think about whether or not they have anal pain, they do not have significant problems in this regard. Pain with or after bowel movements and blood on the toilet paper are classic

Figure 1. Anoscope.

Figure 2. Sigmoidoscope.

indicators of an anal fissure. Painless bleeding, dripping into the bowl, is typical of internal hemorrhoids. Cancers rarely cause pain around the anus.

What does the examination entail?

Inspection: Inspection of the anus is a crucial part of the examination. Ask patients to bear down, as this may show prolapsing hemorrhoids. Fissures can be very subtle, and the only way to see them properly is to spread the buttocks and evert the anus slightly. A telltale sign of a fissure is pain when spreading the buttocks or a swollen tag/hemorrhoid in the midline, anteriorly or posteriorly. If a fissure or ulcer is seen off the midline, this is pathologic and requires evaluation by a specialist.

DRE: Although a digital rectal exam (DRE) is next, it is often non-contributory, even in patients with significant anorectal disease. It should be emphasized that internal hemorrhoids cannot be palpated on DRE. Any mass in the anal canal should be evaluated by a specialist. Almost all cancers of the anus are initially thought to be hemorrhoids and are treated as such for a time.[2,3]

Anoscopy: After DRE, anoscopy is carried out. This is the best way to see the anal canal, and good lighting is necessary. The anoscope (Figure 1) is inserted into the anus and rotated to visualize the anal canal in 360 degrees. Internal hemorrhoids will often be visible at the upper anal canal and may fall into the lumen, appearing red and friable. A fissure may look just like a small ulcer at the outer end of the anal canal in the six or 12 o'clock position. Many patients with fissures will find anoscopy exceedingly painful.

Proctoscopy: The next step in examination is proctoscopy, using a rigid sigmoidoscope (Figure 2). With respect to terminology, rigid sigmoidoscopes, as they are often called, are actually proctoscopes, and their primary use is to visualize the rectum.

Every patient with rectal bleeding requires, at minimum, a rigid proctoscopy. If a proctoscopy is anticipated, patients are asked to take an enema

A followup on Larry

Larry's bleeding is most likely caused by his hemorrhoids and no further investigation is necessary at this time.

Suggesting a high-fibre diet and starting him on a psyllium fibre supplement is recommended. He should be advised to avoid sitting on the toilet for longer than a few minutes, as this causes engorgement of his hemorrhoids and exacerbates his symptoms.

Over-the-counter hemorrhoid preparations do nothing other than lubricate the anus.

If these suggestions do not improve Larry's symptoms significantly, then a flexible sigmoidoscopy should be performed. Larry should be seen by a specialist and considered for rubber-band ligation or formal hemorrhoidectomy.

before their visit. Even if the rectum is not empty, a good evaluation is usually possible. Alternatively, presumptive therapy can be initiated and the patient can return a week later to undergo proctoscopy. Any blood in the rectum, even a small streak on the rectal wall, requires further evaluation.

Are further investigations necessary?

The findings on history and physical exam will dictate whether a flexible sigmoidoscopy or colonoscopy is necessary. Patients can be treated for their findings and no further investigations are necessary if the criteria outlined in Table 2 are met.

It is always possible that a cancer may be present more proximally, but this is probably an incidental finding rather than the cause of the original bleeding. It would be nice to detect all such cancers, but that is not so much a question of adequately investigating rectal bleeding as it is instituting an appropriate screening program.

Finally, the index of suspicion naturally increases with age. Patients over 50 should probably have at least a flexible sigmoidoscopy, even if they describe classic anal outlet bleeding and have convincing findings on physical exam. If the symptoms are worrisome in any way, then referral to a specialist and a colonoscopy are appropriate.

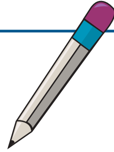
The painful anus

Evaluating the patient with a painful anus can be challenging. Important points to consider include whether the pain is primarily associated with or after bowel movements (typical of a fissure) and whether there is a lump or mass. Internal hemorrhoids are almost never painful. The most common causes of a painful anus are a fissure, thrombosed external hemorrhoid (TEH), or an abscess/fistula.[4] Patients with a mass, bleeding, and pain are diagnosed with anal canal cancer until proven otherwise.

A TEH is typically a firm, blue-tinged, tender lump outside the anus. It almost never bleeds, unless it ulcerates or is incised. Perirectal abscesses are usually obvious, with a red, inflamed, and exquisitely painful lump adjacent to the anus. Occasionally, no obvious abscess is evident, but the anus is firm and very tender. This is often indicative of an abscess in one of the deeper anal spaces, and the patient should be seen by a specialist. There is no role for antibiotics while waiting for the abscess to become drainable.

The extent of the exam will be determined by the degree of pain. Most physicians feel they have not done a proper exam if they have not performed a DRE. However, in patients with a painful anus, a DRE is almost never useful and is usually traumatic for both parties. If the patient has significant pain and a fissure is seen, it is very reasonable to treat for a fissure and complete the exam when there is less pain. When there is an obvious abscess, attempting a DRE is completely unnecessary, unless you wish to demonstrate the "chandelier sign" to a medical student. This patient simply needs incision and drainage.

Take-home message



- The two most significant signs of anorectal disorders are bleeding and pain.
- The most common related disorders are hemorrhoids, fissures, and fistulae/abscesses.
- A DRE is not necessary for patients with a painful anus. It is usually traumatizing and invariably produces no useful information.
- Every patient with rectal bleeding requires, at a minimum, a rigid proctoscopy.
- Any sort of mass in the anus or rectum should be examined by a surgeon, as a mass can represent cancers of the anal canal.
- Worrisome symptoms, such as blood mixed into the stool, change in bowel habits, or dark red/marooned blood require urgent referral to a specialist. Although the wait time for elective consultations is long, a patient with acute anal symptoms should be seen within a few days or weeks.

If no obvious explanation for acute anal pain is found, the patient requires an urgent referral to a specialist and, probably, an exam under anesthesia. Do not deter from referring such a patient to the emergency department to be seen by a surgeon. Although the pain may turn out to be something simple, further evaluation by a specialist is necessary.

Closing thoughts

The long waiting list to see a specialist for rectal bleeding or pain can be frustrating for many primary care physicians. However, if suspicious flags come up during the history or examination, a quick phone call to a specialist will usually have the patient seen within a few weeks. If not, try another specialist. Even if it turns out to just be hemorrhoids, it is the right thing to do.

Proper office evaluation of anorectal disorders is often stressful and difficult to perform adequately for family physicians. However, with some time and extra equipment, this assessment can be done well and can decrease anxiety for everyone concerned. **CME**

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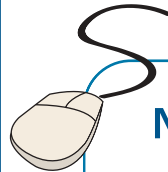

Net Reading

The American Society of Colon and Rectal Surgeons
www.fascrs.org

www.stacommunications.com

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