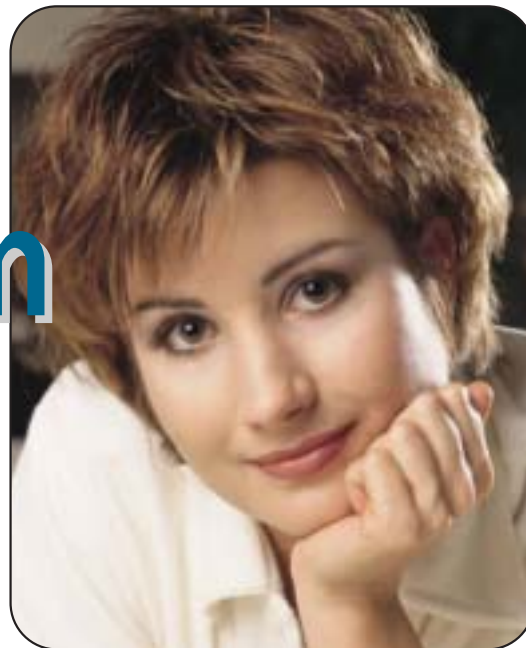


Getting to the Bottom of Pain



By Daniel S. Mishkin, MDCM; and
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A 36-year-old female patient presents to your office with intermittent rectal pain and a sensation of incomplete evacuation over the past eight months. This pain is sensed as an uncomfortable sensation of pressure that is worse after prolonged sitting, and is slowly relieved with walking around. Its frequency varies from one to four times per week and it usually lasts between two and four hours. The patient denies any melena, hematochezia, constipation, diarrhea, or any constitutional symptoms. She has had no relief with the use of NSAIDs, a sitz bath or “hemorrhoidal” cream. She has consulted a gastroenterologist who performed a flexible sigmoidoscopy, which was normal to the splenic flexure. She was told there was nothing abnormal and that her discomfort was most likely related to a psychiatric problem. She now comes to you for help and advice.

What's Your Diagnosis?

On examination, she appears healthy and in no apparent distress. Her blood pressure is 120/68 mmHg with a pulse of 72 beats per minute and an oral temperature of 37.2 C. The head and neck, respiratory, cardiac, abdominal, and musculoskeletal exams are all within normal limits. Rectal exam is diffusely tender, grossly normal sphincter tone and the stool is negative for occult blood.

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WHAT'S YOUR DIAGNOSIS?

Answer

The symptoms this patient has described are quite typical for Levator Ani Syndrome, a subgroup of functional disorders of the anus and rectum. It is estimated that it occurs in 6% to 7% of the general population, with a slight female predominance.^{1,2}

Of these individuals, only 29% consulted a physician for the pain. More than half of all affected patients are aged 30 to 60. In one report, 12% of patients with Levator Ani Syndrome also reported having proctalgia fugax, another type of painful functional disorder of the anal rectum.

The pain is often described as vague — a dull ache or pressure-sensation high in the rectum — often worse with sitting or lying down. It can last anywhere from hours to days. Without objective findings, this becomes a clinical syndrome of “highly likely” or “possible” diagnosis. Confidence in your diagnosis, however, is substantially increased if posterior traction on the levator ani muscle causes tenderness or pain. This tenderness is predominantly right-sided. Massaging this muscle will generally elicit the characteristic discomfort.

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WHAT'S YOUR DIAGNOSIS?

It is hypothesized that this syndrome is a result of spastic or overly-contracted pelvic floor muscles. The etiology, however, remains unknown, and an association has been suggested with psychological stress, tension and anxiety.

Therapy is directed at reducing anal canal and levator ani tension. The use of digital massage of the muscle, warm sitz baths, muscle relaxants, belladonna and opium suppositories, electrogalvanic stimulation and biofeedback have been attempted with good results. Surgical division of the puborectalis muscle is to be avoided. **Dx**

References:

1. Wald A: Functional anorectal and pelvic pain. *Gastroenterol Clin North Am* 2001; 30:243-51.
2. Grant SR, Salvati EP, Rubin RJ: Levator Syndrome: An analysis of 316 cases. *Dis Colon Rectum* 1975; 18:161-3.
3. Whitehead WE, Wald A, Diamant NE, et al: Functional disorders of the anus and rectum. *Gut* 1999;45 (suppl II): 1155-9.

Diagnostic criteria include:

At least 12 weeks, which need not be consecutive, in the preceding 12 months of:³

- Chronic or recurrent rectal pain or aching;
- Episodes that last 20 minutes or longer; and
- Other causes of rectal pain that have been excluded (i.e., ischemia, inflammatory bowel disease, cryptitis, intramuscular abscess, fissure, hemorrhoids, prostatitis and solitary rectal ulcer).



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