# Anorectal Evaluations: Are You Willing to Look?

Just over a year ago, I established a solo colorectal surgery clinic within a comprehensive academic medical center hospital system and have since seen a variety of cases: benign anorectal conditions, acute and chronic diseases, complex defecatory dysfunction, and colorectal surgery pre- and postop patients. I also manage a colorectal cancer survivorship clinic. As a PA in this field, I very much appreciated the November 2017 CE/CME, "Anorectal Evaluations: Diagnosing & Treating Benign Conditions" (*Clinician Reviews*. 2017;27[11]:28-37). The article offered useful highlights and clinical pearls for diagnosing common anorectal conditions. It supplied corresponding images for quick reference, discussed the need for a thorough history, and detailed the finesse of the often-dreaded-yet-so-important physical exam, reassuring providers that the majority of anorectal complaints are, indeed, benign and often treatable on first visit. However, the latter is contingent on one key factor: Are you willing to look?

Primary care is typically a patient's first stop when experiencing anorectal symptoms. If you see a high volume of these cases and are comfortable and confident in your exam skills, the patient is likely well-served. But because it is not expected of general practitioners to have the experience or knowledge to recognize or discern the more minute features of anorectal atypia, I fully advocate the "when in doubt, refer it out" mentality without hesitation or judgement—and I quickly learned the importance of a quality referral network when I established my own clinic.

What concerns me, though, is how often a referral is made with no mention of an anorectal exam in the office note. I can certainly make a rare exception for the exam that mistakenly did not get recorded, but ultimately, if it wasn't documented, it didn't happen, right? And when questioned, most of these patients report that the referring provider didn't look!

The greater issue therein occurs when a provider who doesn't perform a physical exam recommends a course of treatment. For example—I see this on a weekly basis—a provider may prescribe a rectal preparation ointment for a patient complaining of "hemorrhoids." Sometimes, that initial appointment is the only one before the patient is referred to my office; more often, the patient is subject to multiple office visits and excessive trials of prescription and/or homeopathic remedies before a referral is finally made. And all of this occurs without a proper exam!

The patient being treated for a presumed diagnosis of hemorrhoids may have a completely different problem altogether—if only the provider had looked. Optimistically, the patient may have an anal fissure, and the only downfall is a delay in appropriate treatment and symptom resolution. Unfortunately, grimmer outcomes can—and often do—result. I have diagnosed several cases of anal squamous cell cancer from referrals of this nature.

What's more, recent studies have found that the incidence of anal cancer (all ages) and of colorectal cancer (adults ages 20-54) is on the rise.[1,2] And because both may manifest with mild or seemingly benign symptoms, such as rectal bleeding, anorectal pain, or a change in bowel habits, making an early and accurate diagnosis can be challenging.

These data reinforce my belief that referral to a trusted colorectal specialist with whom you can easily communicate is the best option if any doubt exists. As a provider, I would rather see a patient who is urgently referred for what turns out to be a benign condition than diagnose a serious problem, such as cancer, in a patient who has been lost in the shuffle.

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Of course, the key in all this is the relationship you establish with your patients. In my case, building relationships with my patients encourages them to more freely discuss anorectal concerns and allows me to regularly perform necessary exams. Since I've created my own clinic, I also have the "luxury" (I would call it the responsibility) of maintaining a flexible schedule. Many practice settings accommodate same-day or urgent appointments, but I can assure you that patients with anorectal complaints offer a unique expression of urgency when they call with colorful phrases to describe their pain. My referral coordinator, schedulers, and triage nurses can reach me anytime during the workday; I even see patients during non-clinic time if I'm available and it is appropriate. I know that not everyone can implement this practice the way I can, but putting patients first is part of providing quality care—and it often requires flexibility.

At the very least, I encourage you to read the CE/CME article that sparked this commentary. Incorporate the techniques into your patient care when someone presents with anorectal discomfort. In short, be willing to look. You never know when you might save a life! **CR**

## REFERENCES

1. American Cancer Society. Key Statistics for Anal Cancer. www.cancer.org/cancer/anal-cancer/about/what-is-key-statistics.html. Accessed May 10, 2018.
2. Siegel RL, Miller KD, Jemal A. Colorectal cancer mortality rates in adults aged 20 to 54 years in the United States, 1970-2014. *JAMA.* 2017;318(6):572-574.