History Can Help Identify Cause of Anal Pain

Information about medication, bleeding, and even sexual practices can help nail down a diagnosis.

BY SHARON WORCESTER
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FORT LAUDERDALE, FLA. — Patients presenting with anal pain pose a diagnostic challenge, but a careful, detailed history will lead to the correct diagnosis in 90% of cases, Dana R. Sands, M.D., said at a symposium on pelvic floor disorders sponsored by the Cleveland Clinic Florida.

Ask patients about the quality of their pain, as well as the location, the presence of radiating pain, and the duration of pain, advised Dr. Sands, associate staff surgeon at the Cleveland Clinic Florida, Weston.

Also, associated symptoms—such as changes in bowel habits and bleeding, a history of similar pain, medication use, and information about sexual practices—can help in nailing down a diagnosis.

Among the differential diagnoses are:

► **Hemorrhoids.** Most patients presenting with anal pain have been referred for, or believe they have, hemorrhoids. In some cases hemorrhoids are the cause of the pain, but it is important to keep in mind that only external thrombosing hemorrhoids or prolapsed internal hemorrhoids will cause pain. The pain may be described as acute in onset, short-term, and associated with occasional bright red bleeding and the sensation of a lump around the anal canal, Dr. Sands said.

If the pain is severe, excision can usually be accomplished in the office setting, but prolapsed, irreducible internal hemorrhoids can become gangrenous and pose a surgical emergency.

► **Anal abscesses.** Pain associated with anal abscesses is insidious in onset and is usually associated with fever, swelling, and drainage. Patients may have a history of a previous abscess. Evaluation and treatment is entirely dependent on the location of the abscess, as various spaces around the anal canal can harbor abscesses.

Physicians should pay careful attention to the posterior midline, which is the location where rectal cancer very often is missed.

The most common type is a perianal abscess, which can usually be drained easily. Unexplained anal pain is often attributed to internal hemorrhoids or fissures, but may be due to an internal abscess. Such pain warrants examination of the patient under anesthesia, Dr. Sands stressed.

► **Fissures.** Patients with anal fissures describe severe pain, bright red blood from the rectum, and pain for 3-4 hours following a bowel movement. There is no associated fever and usually no drainage. Patients may describe being afraid to move their bowels, and the history may include an episode of diarrhea or constipation. Many patients have had long-term anal pain, indicating chronic fissures.

Patients with fissures are in agony—and are "terribly afraid and extremely anxious" about undergoing an anal examination, Dr. Sands said.

In most cases, the diagnosis can be made by visual inspection of the anal verge with the patient in the prone jackknife position. The digital examination usually cannot be tolerated and can be reserved for after the patient has been treated and the pain is improved or resolved.

► **Tumors.** Pain associated with anal cancer is insidious in onset. Patients do not complain of fever or prolapse, but may describe a recent change in bowel habits. A lesion may be noted on the anal margin, or digital examination may reveal a palpable mass.

Low-lying rectal cancers can also cause anal pain, and may be associated with fecal urgency, bloody stool, swelling, weight loss, and a change in the caliber of the stool. The tumor may be palpable on digital examination; pay careful attention to the posterior midline, which is the location where rectal cancer is most often missed, Dr. Sands noted at the meeting.

Patients with unexplained anal pain and no obvious benign condition who cannot tolerate an office examination should be examined under anesthesia, she said.

► **Stenosis.** This painful condition has a slow onset and can result from overly aggressive anal surgery, such as hemorrhoidectomy. Radiation injury to the anal canal and Crohn's disease also can cause stenosis. The patient complains of painful bowel movements and a change in the caliber of the stool, but not of fever or prolapse.

► **Infection.** Sexually transmitted diseases are a common cause of anal pain. Ulcerations around the anal canal may signal an STD. Ask about potential exposures during the history, examine external genitalia for additional clues to the diagnosis, and follow up with appropriate cultures and biopsies, Dr. Sands advised.

► **Proctalgia.** This is a diagnosis of exclusion in patients presenting with rectal pain and pressure. They describe increased pain after bowel movement, but not of bleeding or fever. They may describe long-term pain.

"I find this is reproducible on palpation of the levator muscles," said Dr. Sands, noting that patients may also have associated anal hypertonia.

A good endoscopic evaluation is important in these patients, and once organic pathology is ruled out, a diagnosis of proctalgia is appropriate, she said. ■

Rectal Prolapse Requires Individualized Approach to Therapy

BY SHARON WORCESTER
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FORT LAUDERDALE, FLA. — The key to successful treatment of true rectal prolapse is an individualized approach, and in many cases that means a multidisciplinary approach, Eric G. Weiss, M.D., said at a symposium on pelvic floor disorders sponsored by the Cleveland Clinic Florida.

That's because the majority of women with rectal prolapse have concomitant genital prolapse and/or urinary incontinence. In addition, expanding knowledge of pelvic floor function—and the evolution of the concept of the pelvic floor as a single functioning unit with anterior and posterior components—has led to a greater effort to treat these conditions simultaneously. At the Cleveland Clinic Florida, about 65% of women with rectal prolapse also have urinary incontinence, and about 34% have genital prolapse, said Dr. Weiss, a colorectal surgeon and director of surgical endoscopy at the clinic.

At Cleveland Clinic Florida, about 65% of women with rectal prolapse also have urinary incontinence, and about 34% have genital prolapse.

The evaluation of women presenting with rectal prolapse, then, should include a complete vaginal pelvic examination by a urogynecologist, he said.

The evaluation should also differentiate between hemorrhoids and rectal prolapse, which are often confused.

Many women are referred for hemorrhoids when they actually have true rectal prolapse—or full thickness prolapse of the rectum through the anal sphincters. The reverse is also true, with some women with hemorrhoids being misdiagnosed with prolapse.

Rectal prolapse will often have a target-like appearance with circular folds of tissue circumferentially protruding from the anus—often up to 10-15 cm. Hemorrhoids, which can include mucosal prolapse, have radial folds that rarely protrude more than 5 cm.

The anorectal evaluation of patients with suspected rectal prolapse should be performed in the prone jack-knife position, in which the prolapse may be immediately evident.

But in some patients it may also be necessary to perform the examination with the patient in a squatting position, with the patient pushing down to demonstrate the prolapse.

Anal sphincter tone at rest and squeezing should be evaluated to assess damage from chronic prolapse, and a digital examination is necessary to check for palpable masses.

Conditions such as fecal incontinence and constipation—the presence of which should be elicited during a thorough history—are secondary to the prolapse. These will resolve following correction of the prolapse unless they are due to another condition, such as pudendal neuropathy.

To rule out colonic pathology, perform a complete endoscopic evaluation, and colonoscopy should be considered in older patients.

When the prolapse is not demonstrable during the evaluation, defecography is useful for identifying rectoceles and other pathology that might be affecting evacuation.

If surgery is being considered, a cardiovascular assessment is important to determine if the patient is a good candidate.

The type of surgery selected depends largely on patient age and health, Dr. Weiss said.

Abdominal approaches typically are more effective, but are associated with greater morbidity. Therefore, they are typically reserved for younger patients with a good surgical risk profile. Perineal procedures are associated with more recurrences, but usually are a safer option for the elderly and other higher risk patients.

The abdominal approaches use posterior mobilization of the rectum with fixation to the sacrum. Rectopexy is most common, and other approaches include anterior resection, and combined sigmoid resection and rectopexy. Complication rates range from 15% to 29%, and mortality ranges from 0% to 2%. Recurrence rates are low, ranging from 2% to 12%.

A common complication with rectopexy is constipation, but some data suggest this may be overcome by using the combined rectopexy/sigmoid resection procedure, Dr. Weiss noted.

The perineal approach usually involves rectosigmoidectomy. Studies suggest that perineal rectosigmoidectomy outcomes are improved when levatorplasty is also performed.

In one Cleveland Clinic Florida series of 84 patients with severe fecal incontinence and rectal prolapse treated over a 7-year period, those who were treated with both had significantly lower recurrence rates and decreased incontinence scores, compared with those who underwent only perineal rectosigmoidectomy, Dr. Weiss noted.

The recurrence rate there for all perineal procedures is about 13%, compared with 5% for perineal rectosigmoidectomy with levatorplasty, and the recurrence-free interval was longer in this group of patients, he added.

Another perineal option is the Delorme procedure, which involves circumferential incision of the mucosa of the prolapsed rectal wall just above the dentate line, and circumferential dissection in the submucosal layer of the prolapsed bowel as far up as possible. This is followed by plication of the muscular layer of the prolapsed muscle and coloanal anastomosis. ■

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