

FAMILY PRACTICE IN ANO-RECTAL DISEASES

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ABSTRACT:

The institution of general practitioners is the backbone of healthcare system. Their competence at the core level had often averted small ailments developing into major problems. Ano-rectal disorders include a diverse group of pathologic processes that are frequently encountered in general medical practice but are seldom taken seriously.

An attempt has been made in this write up to supplement family practitioners' expertise with information on advances in techniques and practices in effectively managing various ano-rectal lesions commonly encountered by them in their practice.

KEYWORDS: Proctology Family practice Office treatment Ano-rectal disorders.

Pak J Med Sci January-March 2006 Vol. 22 No. 1 82-87

INTRODUCTION

Disorders of the rectum and anus are frequently encountered in primary care setup, but these often receive casual attention, providing only a temporary and unsatisfactory relief. Family physicians or doctors offering primary care are supposed to offer optimum treatment for ailments related to anus and rectum. The diagnosis of majority of ano-rectal disorders usually is easy and conclusive by a thorough physical examination of the ano-rectum. It however, is inadequately performed in the general clinical practice.

It is estimated that hemorrhoids, anal fissures, and pruritus ani roughly accounts for more than 80% of the pathologies centering around this part of human anatomy.

The anal canal: The rectum is the lower 10 to 15 cm of the colon and the anal canal starts at the ano-rectal junction to end at the anal verge.

The length of the anal canal is about 3-4 cms. A 'dentate' or pectinate line divides the anal canal into upper two third and lower one third. Above the dentate line, the rectum is supplied by stretch nerve fibers instead of pain nerve fibers. This allows many surgical procedures to be performed without anesthesia above the dentate line. On the other hand, the anal canal below the dentate line is extremely sensitive, with the perianal area being one of the most sensitive areas of the body.

The evacuation of bowel contents depends on action by the muscles of both the involuntary internal sphincter and the voluntary external sphincter.

The symptoms of ano-rectal diseases: Though, in most of the cases, the presentations of symptoms in patients with ano-rectal disorder are

Symptomatology of ano-rectal pathologies

1. Pain
2. Bleeding per rectum [hematochezia]
3. Pus discharge from or around anus
4. Prolapse
5. Anal itching
6. Presence of swelling or lump in or around anus
7. Mucus discharge
8. Disordered bowel movements
9. Difficulty in passing stool
10. Incontinence to flatus or feces.

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* Received for Publication: June 16, 2005

Accepted: August 6, 2005

typical, they at times may be misleading because of the patient's understatement or underplaying of symptoms.

A systematic approach to the patient with anorectal complaints allows for an accurate and early diagnosis of the underlying problem. The process can be divided into the interview, the examination, and conveyance of information. Throughout this process, the patient is needed to be reassured and made as comfortable as possible.

Approach towards diagnosing an ano-rectal pathology: While it is not to overemphasize that patient's history, inspection, and palpation of the anorectum remain the basic and essential

The ano-rectal lesions can be listed with the order of their frequency.

Ano-rectal lesions

Commonest

- o Hemorrhoids [Internal or external]
- o Anal fissures [Acute or chronic]
- o Anal fistula [Low or high]
- o Abscesses [Perianal, Ischio-rectal, Submucosa]
- o Polyps [Adenomatous, fibrous anal, juvenile]
- o Rectal Prolapse [Mucosal or complete]
- o Anal skin tags or sentinel pile/tags
- o Ano-rectal sepsis [Hydradenitis suppurativa, AIDS, Syphilis]

Less Common

- o Sacro-coccygeal pilonidal sinus disease
- o Neoplasm [Benign or Malignant]
- o Condylomas /warts
- o Connective tissue masses like papilloma, fibroma, and lipoma.
- o Antiboma [Organized abscess]
- o Inflammatory conditions [Proctitis, Anal cryptitis and papillitis]
- o Inflammatory bowel disorders [Ulcerative colitis and Crohn's disease]
- o Hypertrophied anal papillae.

Uncommon

- o Strictures of anal canal or rectum
- o Solitary rectal ulcer
- o Incontinence [Flatus or feces]

features of diagnosis, carefully eliciting the exact nature of patients' complaints helps in clinching the diagnosis.

No ano-rectal examination could be completed without performing an anoscopy, which, however, may be avoided in painful anal conditions. When a more proximal lesion is suspected, the patient should be subjected to sigmoidoscopy or colonoscopy. Anal manometry, defecography, and endoanal ultrasonography are more advanced investigative tools for the ano-rectal workup.

Treating an ano-rectal pathology: While majority of the ano-rectal lesions could be treated with a conservative approach, the primary care physician should be able to distinguish complex pathologies that need an expert care. Common pathologies encountered in the general practice setup include-

Fissure-in-Ano: Acute anal fissures present themselves with severe anal pain and bleeding of a recent origin. They should be treated with stool softeners, a warm sitz bath, topical creams containing anesthetic agents, oral analgesics, and dietary modifications. Avoiding spicy food and maintaining a good anal hygiene are essential to prevent persistence or recurrence.

The treatment modalities for chronic anal fissure are summarized below.¹

Non-surgical	Surgical
Injection of botulinum toxin around the fissure.	Endoscopic or pneumatic balloon dilation.
Oral Nifedipine, Lacidipine, Bethnecol, and Salbutamol	Anal stretch/ Anal dilatation
Topical application of nitroglycerine/nifedipine/diltiazem/ L-arginine	Fissurotomy/ Fissurectomy
Alpha-1 adrenoceptor blockers like Indoramine	Internal sphincterotomy
Chemical cauterization	Anal advancement flaps

Chronic anal fissures do not respond well to the above line of treatment. They may have concomitant pathologies including sentinel tags, anal papillae, fibrous polyps, or infective lesions in association. Therapies useful for acute fissures could only provide a short-term relief

in such situation. A more aggressive approach aiming at relief of internal sphincter spasm and reducing resting anal canal pressure is essential to achieve long term relief of symptoms. Such sphincter manipulation could be either surgical or non-surgical.

Treatment of Hemorrhoids: Hemorrhoids are one of the commonest conditions of the ano-rectum. They share their symptoms with a whole series of other diseases and it is this lack of specificity that calls for a thorough examination to reach a precise diagnosis.

Medical therapy of hemorrhoids: The first line therapy of non prolapsing hemorrhoids should be a conservative one, which help relieving the symptoms and may avoid the need of an instrumental or surgical procedure.

Medical treatment of hemorrhoids

- o Control of constipation using bran, mucilage, lactulose or bulk forming laxatives
- o Increasing daily intake of fibers
- o Avoidance of colonic stimulants like coffee, tea and spices
- o Use of flavonoid derivatives [Diosmin] and Calcium Dobisilate
- o Use of hemorrhoidal creams, ointments and suppositories
- o Use of anti-pruritics
- o Adequate local hygiene

Instrumental treatment of hemorrhoids

- o Sclerotherapy
- o Rubber band ligation
- o Ultroid [Direct current probe]
- o Infra red photocoagulation
- o Bicap
- o Doppler guided hemorrhoidal artery ligation [DGHAL]
- o Radiofrequency ablation

Surgical treatment

- o Hemorrhoidectomy [Conventional, diathermy, harmonic scalpel, laser]
- o Stapler hemorrhoidopaxy [PPH]

Instrumental [minimally invasive] approach is needed in situations where the medical treat-

ment fails or there is recurrence after initial response to medical therapy. Similarly, prolapsing or painful hemorrhoids do need an instrumental or surgical treatment.²

Treatment of infective pathologies around ano-rectum: Ano-rectal sepsis is a medical emergency requiring immediate hospitalization and treatment, including surgical debridement and high dosages of broad-spectrum antibiotics. Abscesses usually originate through anal cryptoglandular infection. They should be drained under adequate anesthesia.³

Bacterial, viral, and protozoal infections could be transmitted to the anorectum via anoreceptive intercourse. Rarely, perineal sepsis can occur as a complication of rubber band ligation or sclerotherapy of internal hemorrhoids.

Treatment of anal fistula: Subcutaneous or low anal fistulae can be laid opened in the office under local anesthesia. Patients with complicated or high anal fistula should be referred to a specialist for treatment.

Treatment of rectal prolapse: Rectal prolapse needs a surgical correction. Various abdominal and perineal procedures have been proposed. Mucosal prolapse in children is known to achieve spontaneous recovery with the time and the initial approach should aim at relieving constipation, correction of faulty dietary habits, toilet training, and reassuring the parents. In case of failure, injection of sclerosing agents in the prolapsing mucosa gives satisfactory results.

Treatment of Pilonidal abscess and sinuses: Pilonidal abscess could be drained under local anesthesia in the office. Sinuses could be laid opened in the similar manner. Multiple or recurrent sinuses should be left to the care of specialty centers.

Treatment of rectal polyps: A child presenting with bleeding per rectum and protrusion of 'something' from the anus may have a juvenile rectal polyp, which can be removed after ruling out presence of similar polyps in the colon. A fibrous anal polyp associated with anal fissures requires removal during treatment of the basic pathology.

Treatment of malignancies of the rectum and anal canal: Cancer of the ano-rectum could manifest in many different symptoms or may be incidentally found during rectal examination. Unknowingly, the patients may be treated as a case of 'piles' as the malignancy also presents with painless bleeding per rectum.

Anal cancer usually shows up as an ulcer or a polyp, or as a verrucous growth. Rectal cancers need a surgical treatment. Most anal cancers respond well to treatment with combined local excision, chemotherapy, and pelvic radiation.

Treating anal itch: Pruritus ani is a common presenting problem in general practice, one that is particularly distressing to patients. Perianal itch probably arises from localised inflammation. This may be the result of anorectal disease, skin disorders, excessive cleaning, application of local irritants or allergic manifestation. In children, perianal itch may be caused by intestinal hermetic infection such as pinworm. Whatever may be the initial cause, the problem at times become chronic, with scratching of the inflamed area results in further itching. Avoiding trauma caused by excessive washing, extensive use of toilet paper and topical agents is important. Treatments likely to be effective are use of emollients such as sorbolene, a short course of topical hydrocortisone cream and capsaicin cream. Intradermal methylene blue injections have recently been reported to help resolving over 90% of cases.

Treatment of anal warts [Condylomas]: Anal warts produce pruritus, soiling and bleeding to become a constant source of irritation. Warts can be managed in the office with various options like application of 85% trichloroacetic acid [TCA], oral Interferon, oral and topical Flurouracil, electrocauterization and surgical removal.

Treatment of inflammatory bowel diseases: Ulcerative colitis and Crohn's disease may involve the rectal area presenting themselves with features of proctitis or fistulae. A full-length colonoscopy and biopsy is needed to establish the diagnosis. Medical treatment is quite effective in most of the cases. Drugs like

Sulphasalazine, 5-Aminosalicylic acid and corticosteroids have been found effective in containing the problem. These medicines can also be used in the form of suppositories and enemas.

Treatment of external anal tags: They represent old thrombosed external hemorrhoids or are post surgical. Mostly they are innocuous, but may cause symptoms like itching, anxiety, or hygienic problems and require removal under local anesthesia.

Treatment of anal stenosis or stricture: Stool softeners, osmotic agents, and lubricants to ensure smooth passage of stool help in relieving the trauma experienced during defecation. Regular anal dilatation using an anal dilator is quite effective in strictures of a recent origin.

Rectal injuries: Rectal injuries may result from penetrating or blunt trauma, iatrogenic injuries, or by a foreign body. Rectal injury should be suspected when a patient presents with low abdominal, pelvic, or perineal pain or bleeding per rectum after sustaining trauma or following an endoscopic or surgical procedure. They should better be treated by an experienced colo-rectal surgeon.

Treatment of Constipation: Patients complaining of constipation are fairly common in the family practice. As constipation has a different meaning with different group of people, it is important to find out whether the patient is complaining of infrequent defecation, excessive straining at defecation, abdominal pain and bloating, soiling, or a combination of more than one of these symptoms. It is imperative to rule out any definable abnormality as a cause of these symptoms.

The practice parameters for the treatment of constipation are rather complex. A holistic approach, which includes patient counseling, reassurance, and using medications with maximum benefits and minimum adverse side effects cannot be overemphasized. Patient should be made aware of the need to recognize the call for stool, to attend to it forthwith, and to not to postpone it for any reason. He should be encouraged to adopt a regular defecation time schedule.

Increasing daily dietary fiber intake and use of bulking agents like Ispaghula [Fybogel], methylcellulose, bran, and karaya gum helps facilitate a smooth and swift defecation. Lactulose [Duphalac], sorbitol, and lactilol have minimum known side effects and these can be safely prescribed during pregnancy and in children and elderly patients.

Senna, bisacodyl, sodium picosulphate, and magnesium salts should be used with caution as they could cause symptoms like bloating, colicky pain, and purging. Drugs like Cisapride, Mosapride, Itiopride [Itogard], and Docusates are known to improve intestinal motility and are helpful in patients with associated reflux and flatulence.

Liquid paraffin is perhaps one of the most widely consumed oral laxatives. However, its long-term use could lead to reduced absorption of fat-soluble vitamins. Spontaneous leak of liquid paraffin from the rectum causing soiling has been reported.

Treating other ano-rectal pathologies: Proctitis is usually caused by sexually transmitted infections that could be treated with antibiotics. Pruritus ani due to fungal infections and hygiene problems are amenable to simple treatments. Perianal hematomas and thrombosed external hemorrhoids should be opened and drained.⁴

Ano-rectal lesions in children: It is not uncommon to find children in a primary care practice brought with symptoms of rectal prolapse, anal fissures, hemorrhoids, and pruritus ani. Rarely, they may have a more serious affliction like an anal abscess or fistula.

Constipation is another common complaint in children. It is estimated that between 5% and 10% of pediatric patients have constipation.⁵ Infants and young children with chronic constipation may present with symptoms of anal fissure. Shorter duration of breastfeeding and early bottle-feeding with cow's milk are reported to be responsible for development of constipation.⁶

The definitive therapy of constipation begins with emptying of stool impacted in the rectum followed by maintenance of regular soft stools

to eliminate fear of pain with defecation. The primary treatment of perianal abscess in childhood should involve a careful search for a co-existing fistula and treatment thereof by fistulotomy. Simple drainage of a perianal abscess is frequently followed by a fistula.

Anal fissures in children should be treated with laxatives like lactulose, use of anesthetic ointment and meticulous observance of local hygiene.

Treatment of ano-perianal lesions during anti and postpartum periods: It is estimated that over 30% of pregnant women develop anal fissures and thrombosed external hemorrhoids during or after delivery.⁷ Managing constipation during and after gestation helps reducing these lesions and achieves a favorable symptomatic outcome.

Anal fissure during the antepartum period should be dealt with a conservative approach. Nevertheless, patient's ability to tolerate the symptoms of her condition should dictate the need for a definitive operative therapy.

Old age and anal pathologies: Constipation, hemorrhoids with the accompanying complications, rectal prolapse, and malignancy are the most common ano-rectal disorders found in the geriatric practice.

Hemorrhoidal thrombosis, rectal mucosal prolapse, anal fissure, and constipation should be dealt with a conservative approach or minimum possible surgical intervention. Potential risks of anesthetic and surgical complications may be carefully weighed with the benefits of the surgical procedures before arriving at the treatment modality.

Topical therapy in proctology practice: The various 'hemorrhoidal' creams and suppositories available in the market aim at reducing pain, inflammation, and itching. These creams mostly contain steroids, local anesthetics, oily substances, 'vasculotropic' derivatives, and antipruritic agents.

Ointments containing opiates, xylocain, amethocain, and cinchocain to relieve pain, belladonna to alleviate sphincter spasm and silver nitrate to promote healing are commonly used either singly or in combination. These

mixtures are introduced either with the finger or with a nozzle provided with the cream.

The best practice of using these preparations is to insert them over an anal dilator, which also helps relieve the sphincter spasm. Emollient suppositories containing some of the above preparations can be inserted with ease to avoid the chanced trauma caused by the nozzle.

The possible complication with such ointments and creams is in causing local and systemic allergy. Creams containing corticoids should possibly be avoided.

CONCLUSION

A family physician is expected to focus on ano-rectal disease with a more enthusiastic and logical approach. The need to attract serious attention of the family physician towards this field of medicine has been prompted by various factors including the high incidence of ano-rectal pathologies, with an increased demand for their effective treatment, the development of safe anesthetics, availability of variety of efficacious office sur-

gical procedures, and a perceptible reduction in the treatment cost. The key to accurate diagnosis of ano-rectal disorders however, continues to remain with a primary care physician who listens a patient carefully and confirms his findings by physical examination and endoscopy.

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