



# “The State of the Bottom” address: Management of common anorectal conditions

Mr Ash Prabhudesai

Consultant General & Colorectal Surgeon

Hillingdon & Mount Vernon Hospitals

Clementine Churchill Hospital

Bishops Wood Hospital

# Introduction

- Large problem
- Often neglected
- Embarrassing to report
- May significantly affect QoL
- Association with pelvic floor dysfunction
- May represent worrying pathology

# Symptoms

- Pain/ discomfort
- Bleeding PR
- Discharge
- Pruritis
- Lump
- “Difficult to clean”
- Incontinence

# History & Gen Examination

- Complaint
- Aggravating/ relieving factors
- Painless PR bleeding
- Unexplained change in bowel habits > 6 weeks
- Perianal instrumentation
- Spinal trauma
- Obstetric history
- Family History of Colorectal cancer, IBD
- Medications: e.g. Nicorandil

## O/E

- Anaemia
- Signs of Hypothyroidism
- Axillary/ groin examination
- Abdominal exam
- Signs of liver disease

# Examination of the anus

Left lateral (Sims position)

- Inspection

Underclothes- “skid marks”/blood/ mucus

Perianal massage (external fistulous opening)

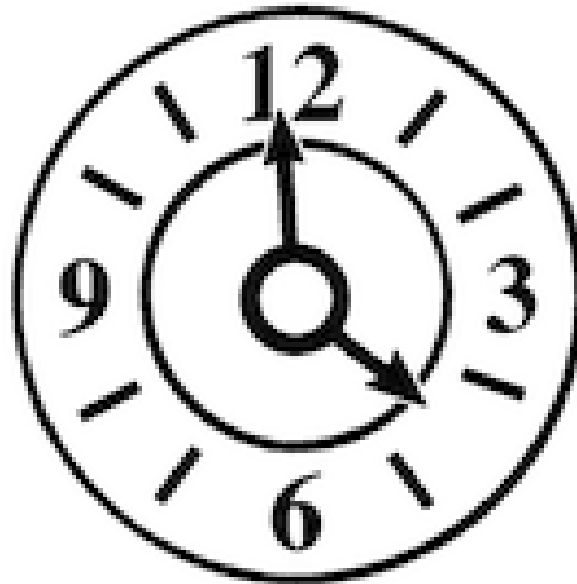
Valsalva manoeuvre

DRE inc sphincter assessment

- Rigid sigmoidoscopy

- Proctoscopy

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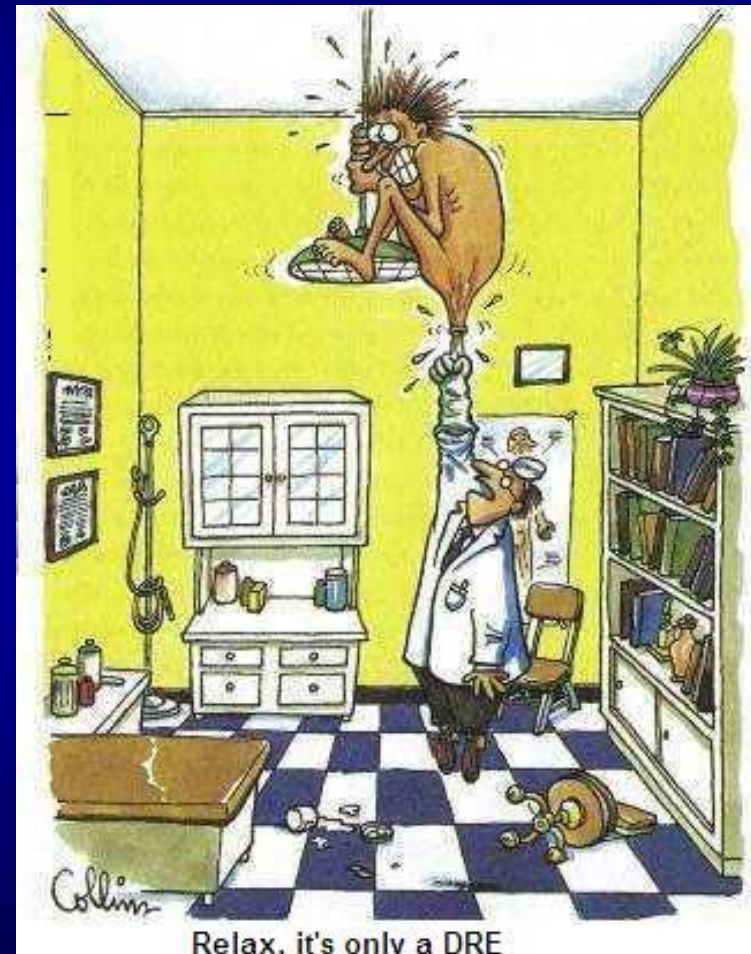


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# Digital rectal exam

*“ A few quiet words from the doctor can prevent many loud ones from the patient...”*

(Bailey & Love’s Short Practice of Surgery 1988)



# Digital rectal exam

- **Intraluminal**  
polyp; foreign body
- **Intramural**  
polyp, cancer
- **Extramural** – (Beware the cervix/ tampons)  
ovarian cancer  
cervical cancer  
sigmoid cancer  
pelvic abscess

# Rigid sigmoidoscopy

- Visualise mucosa upto 22 cms
- Useful for mucosal abnormalities
- Biopsies may be taken
- Small polyps may be excised



# Proctoscopy

- Visualises anal canal
- Can grade haemorrhoids
- Useful for therapeutic measures like injection sclerotherapy, suction banding



# Pathology

- **Mechanical**
  - Haemorrhoids
  - Fissures
  - Prolapse
- **Inflammatory**
  - Abscess
  - Fistula
- **Neoplastic**
  - Benign
  - Malignant

# Haemorrhoids



Greek: *haem* (Blood) + *rhoos* (flow)

Latin: *pila* (ball or swelling)

# Anatomy

- Anal cushions consist of mucosa, fibroelastic tissue and smooth muscle on arteriovenous channels
- Contribute to fine control over continence
- H'oids develop when the supporting submucosal fibres of the anal cushions fragment
- Cushions engorge excessively with blood causing bleeding and prolapse
- External piles – dilated vascular plexuses located below the dentate line

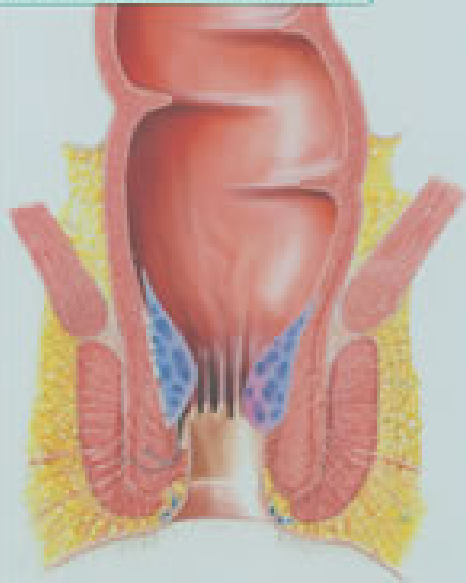
# Clinical Picture

- Bleeding PR
- Prolapse
- Mucus discharge
- Perianal itching
- Discomfort (Pain usually when thrombosed)
- Associated with constipation & straining

# Grading of Haemorrhoids/Piles

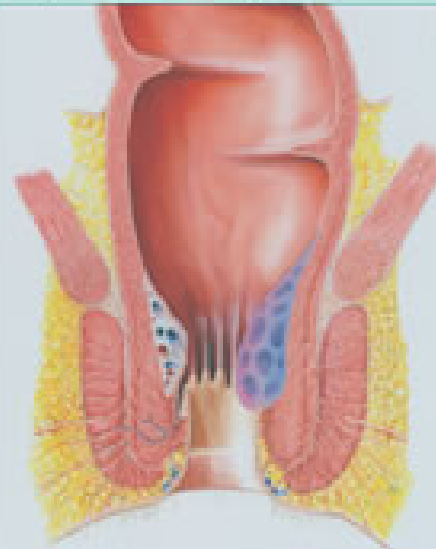
## Stage I

No protrusion of haemorrhoids, yet.



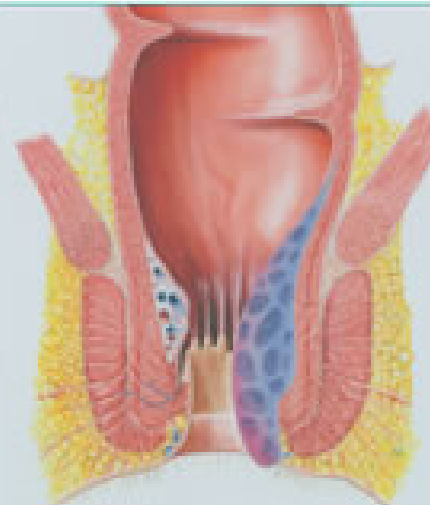
## Stage II

Protruding haemorrhoids that spontaneously reduce!



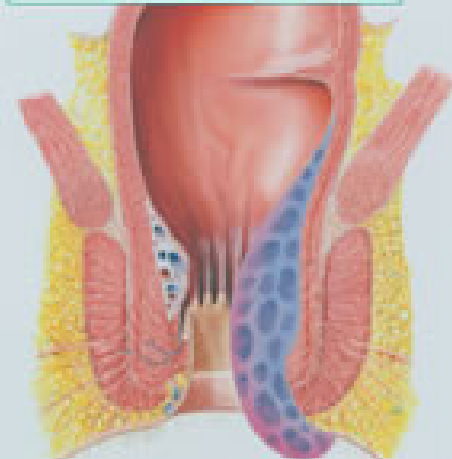
## Stage III

Protruding haemorrhoids, possible to push back in manually!



## Stage IV

Protruding haemorrhoids that can't be pushed back in manually anymore!



# Management

- Investigations to rule out proximal cause of bleeding ( colorectal cancer/ polyps/ IBD)
- Symptoms govern treatment
- Less than 10% of patients referred for symptomatic haemorrhoids will come to surgery

# Treatment

## 1<sup>st</sup> degree

HFD + fluids

Stool softeners

## 2<sup>nd</sup>/3<sup>rd</sup>/4<sup>th</sup> degree

Haemorrhoidectomy

PPH

HALO

## 2<sup>nd</sup>/3<sup>rd</sup> degree

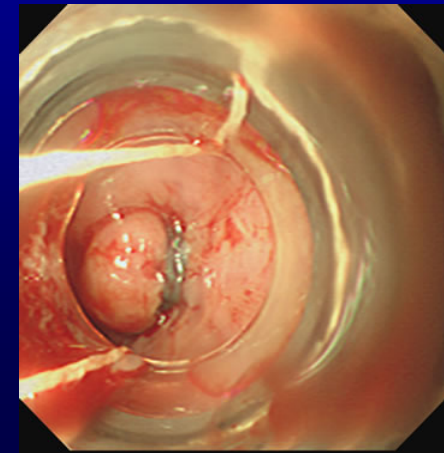
Rubber band ligation

Injection Sclerotherapy

*Symptoms govern treatment*

# Rubber band ligation

- Outpatient procedure
- Applied to base of haemorrhoid(s)
- Three haemorrhoids can be banded at one time
- Relatively painless, but may get tenesmus
- 60-80% effective
- According to some, most effective outpatient treatment (BMJ 2003)
- 2-5% risk of secondary haemorrhage



# Injection Sclerotherapy

- Outpatient procedure
- Submucosal injection around pedicle causes fibrosis, reducing blood flow
- Common agent: 5% Phenol in Almond Oil
- About 70% effective
- Deep injections can cause infection, urethral irritation, prostatitis
- May require > 1 session

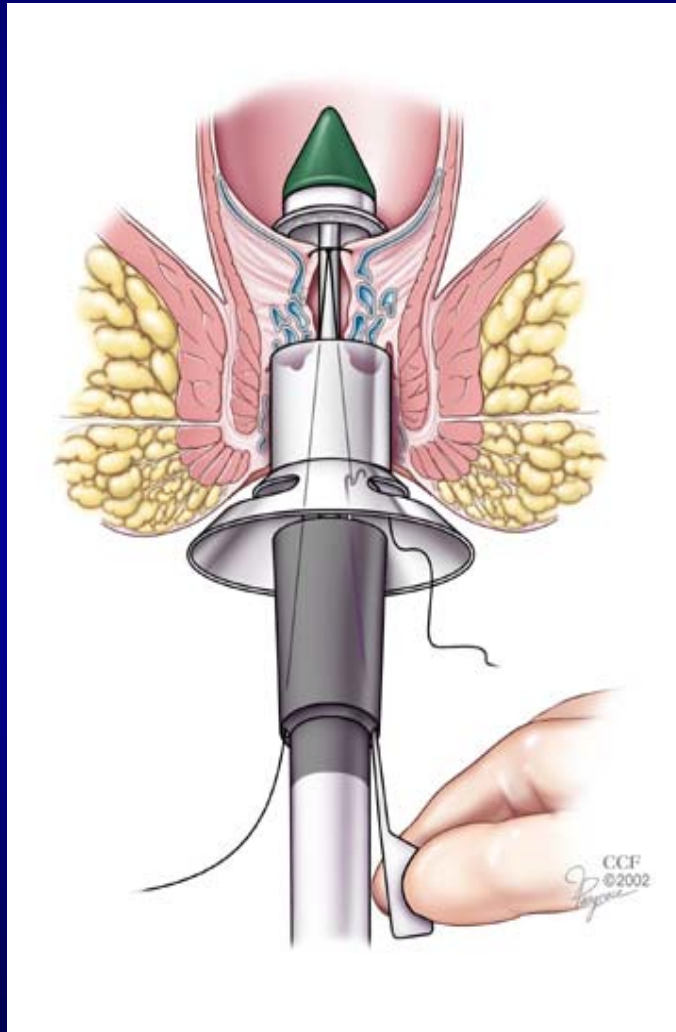
# HALO

## (Haemorrhoidal Artery Ligation Operation)



- Doppler based ligation of feeding vessel
- Combined with posterior anopexy
- Day case
- Virtually pain free
- Not useful if large prolapse
- 8-10% PRB/ prolapse at 1yr
- Long terms results awaited

# Stapled haemorrhoidopexy or PPH



- Reduces prolapse by excising circumferential band of prolapsed anal mucosa above dentate line, using circular stapling device.
- Interrupts blood supply to piles
- “Pexy” because it hoists the haemorrhoids back
- Selective patients
- Recurrent prolapse (X MMH)

# Milligan-Morgan Haemorrhoidectomy



- Traditional (first described in 1937)
- *“If it looks like a clover, the trouble is over; if it looks like a dahlia, it’s surely a failure.”*
- Postoperative pain
- Low recurrence rates
- Day case surgery possible in over 80% patients

A patient with painful haemorrhoids usually has a fissure in ano



# Fissure- in- ano (1)

- Common
- Linear ulcer in anal canal epithelium just distal to the dentate line
- 10-15% of new referrals to colorectal clinics
- Painful defaecation + bleeding PR
- Most common cause of anal pain
- Concomitant haemorrhoids may be present
- Associated with straining, commonly constipation; at times with diarrhoea due to tenesmus
- At times, post haemorrhoidectomy- excess skin removed

# Fissure- in- ano (2)

- Acute fissures
- Chronic fissures:
  - persistent after 6 weeks of medical treatment
  - assoc with sentinel skin tag
  - caused by sphincter hypertonia/ anal canal ischaemia
- O/E: sentinel skin tag/ hypertrophied anal papilla  
may be seen on parting anal margins  
limited exam due to tenderness  
sphincter spasm  
fissure usually palpable 6o/c  
“vertical button hole”

## Fissure- in- ano (2)

- Treatment (at times presumptive)  
EUA to rule out anorectal sepsis/ malignancy  
Avoid constipation: High fibre & fluid intake  
Medical treatment:
  - Topical 0.4% GTN/ 2% Diltiazem
  - BotoxSurgical treatment

# Medical Treatment

Relaxation of IAS tone is achieved by the reduction of intracellular  $\text{Ca}^{++}$  in the smooth muscle cells, reducing muscle tone. This can be achieved by:

- nitric oxide donation using GTN or
- by direct intracellular  $\text{Ca}^{++}$  depletion using  $\text{Ca}^{++}$  channel blockers (diltiazem)
- Irreversible acetylcholine neuromuscular blockade using Botulinum toxin also reduces resting tone

# Medical Treatment

## GTN cream

- Vasodilator causing smooth muscle relaxation
- Healing in 60% in short-term, with recurrence of 30% over 18 months
- Dose (0.2% or 0.4%) does not influence efficacy, but increases side effects
- Pt compliance issues: 25-30% suffer from headaches

## Diltiazem cream

- Similar efficacy to GTN (RCT)
- Good patient compliance- rarely headaches, occasionally pruritis ani
- Unlicensed

# Botox

- Transient relaxation of IAS for 3 months
- Similar healing to GTN
- Used in pts not responding to GTN/DZM
- Intra/ intersphincteric
- May be performed as OP procedure
- GA: EUA performed
- Useful in ladies due to occult obstetric trauma
- Promotes healing in 70-96%
- Costs £ 200/ 100 units



# The surgical option

- Lateral sphincterotomy
- Fissurectomy
- Anal advancement flaps
- Lord's dilatation - historic!

# Lateral sphincterotomy

- For patients who fail medical treatment
- More effective than medical management
- > 90% cure rate
- 30% flatus incontinence/ soiling/ mild mucus discharge
- Open vs closed- no difference
- Tailored sphincterotomy: decreased incontinence

# Surgical treatment- others

- **Fissurectomy**

Excision of fibrotic edge of fissure, curettage of base & excision of sentinel pile

- **Anal advancement flap**

Recommended in patients with a low resting anal pressure

# Beware...

- Recurrent/ resistant fissures
- Multiple fissures
- Low pressure fissures

Suspect:

Cancer

Crohn's

Perianal sepsis

# ANAL FISSURE SUPPORT FORUM



# Rectal prolapse

# Rectal prolapse



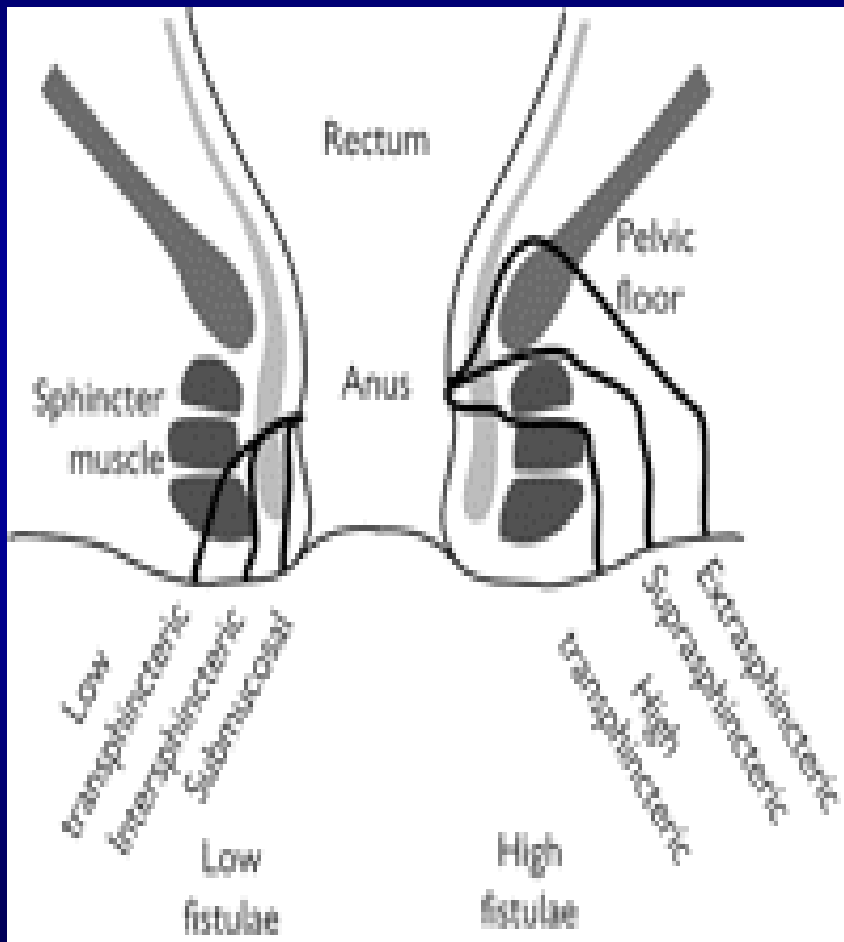
- Complete eversion of rectum thro' anal canal
- Frequently associated with incontinence
- Elderly women (M:F= 1:7)
- Parity/ lax pelvic floor/ redundant sigmoid
- Examine on commode to elicit prolapse
- Assess pelvic floor & left colon
- Abdominal/ perineal procedures

# Fistula in ano

# Fistula in ano

- A track, lined by granulation tissue between anal canal/rectum and perianal skin
- Cryptoglandular sepsis
- Usually results from anorectal abscess, inadequately drained or ruptured spontaneously
- Results in recurrent perianal sepsis

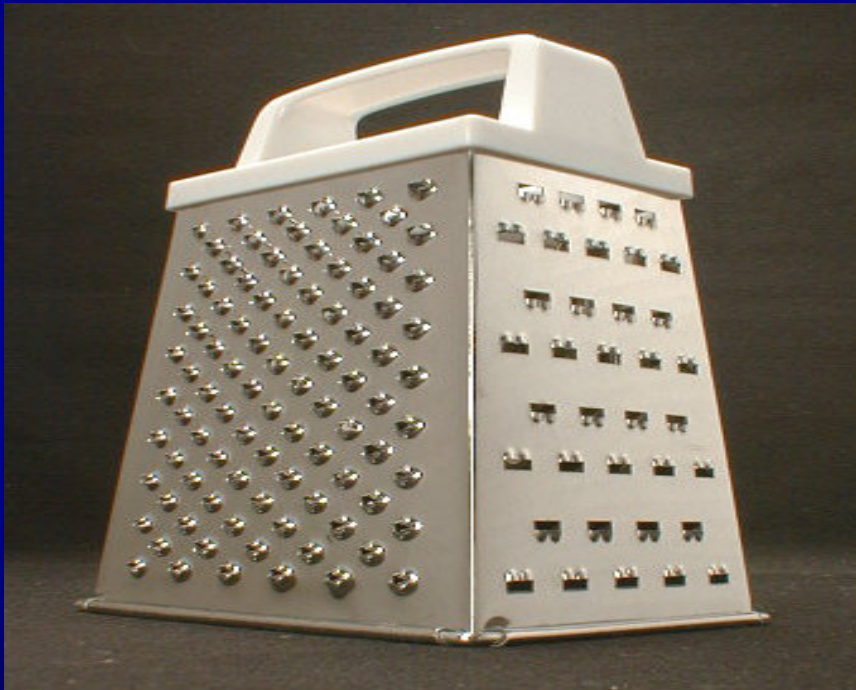
# Classification of Fistula in ano



- Intersphincteric sepsis
- Commonest intersphincteric (45%)
- In high fistulae, rule out intra abdominal pathology e.g. Crohn's
- Clinical examination vital to assess int/ ext opening, primary & secondary tracts

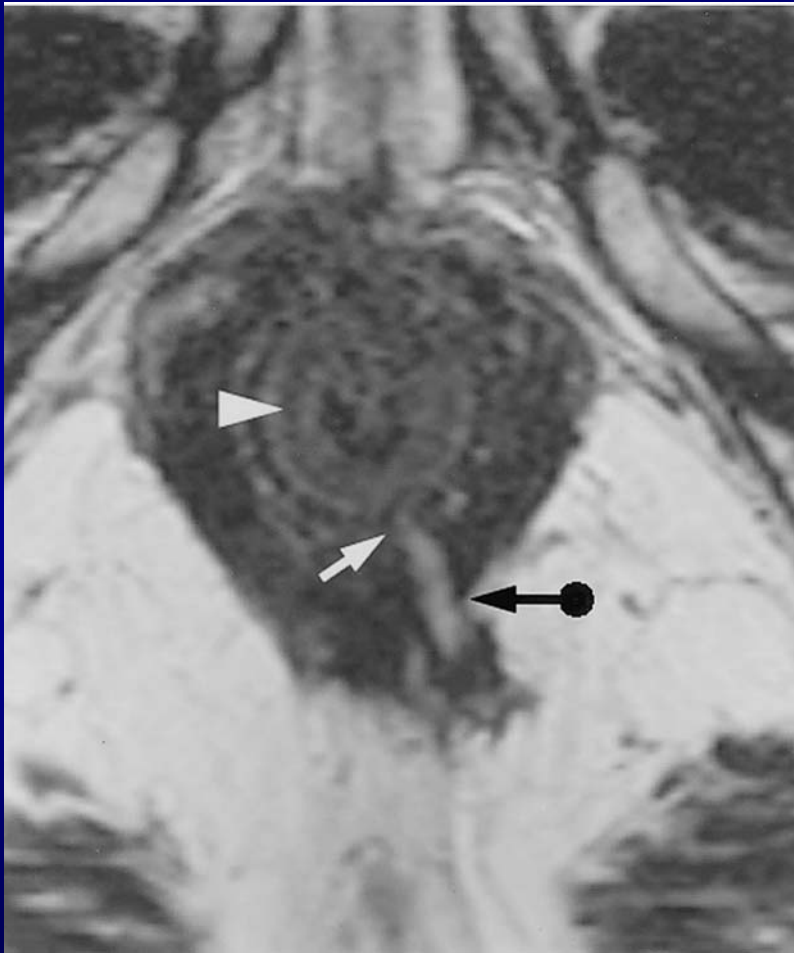
# Fistula in ano

O/E:



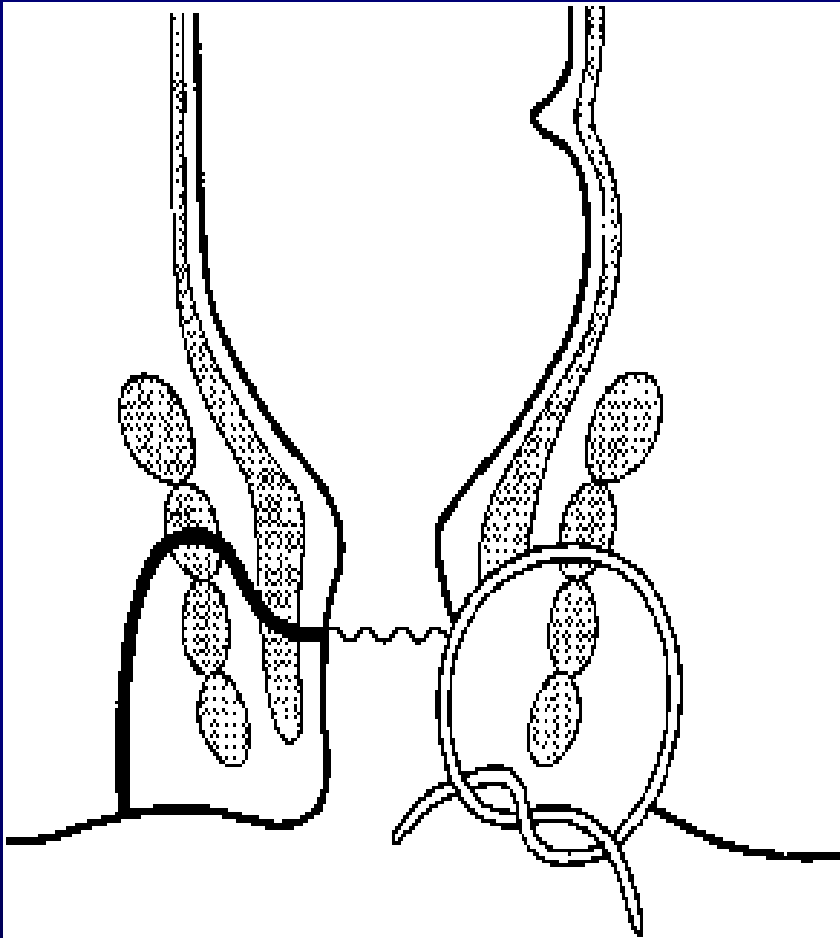
The “cheese grater” analogy

# Investigations



- Careful EUA
- Flexible sigmoidoscopy
- MRI pelvis – complex or recurrent fistula for road map
- CT/ MR abdomen- if supralelevator pathology suspected

# Treatment



- Laying open
- Seton
- Combination
- Staged repair

- Fibrin glue
- Fistula plug

} Variable results:  
Better for short  
tracks

Is this a fistula?

# Hidradenitis suppurativa



- Chronic relapsing inflammation of apocrine glands
- Multiple fistulae
- Recurrent perianal sepsis
- Affects groins, perineum and axillae
- Association with Crohn's disease
- Stop smoking/ reduce weight
- Antibiotics/ Retinoids/ ?  
Steroids
- Conservative surgical approach d/t recurrence

# Pilonidal disease



- (Latin *pilo*: hair; *nidal*: nest)
- Affects natal cleft
- “Jeep bottom”
- Ingrowing hair
- Recurrent sepsis
- Conservative management
- Surgical management

# Pruritis ani

# Pruritis ani (Perianal itch)

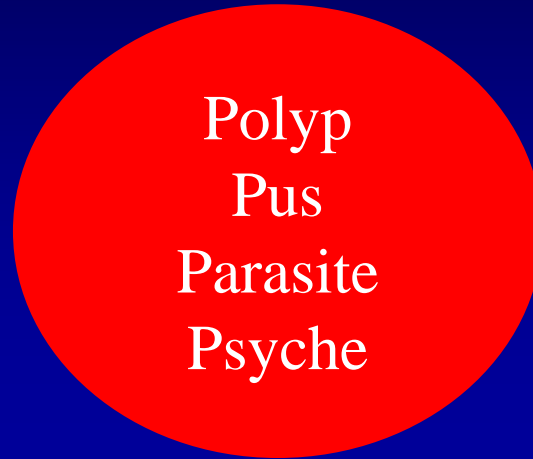
- Difficult problem
- Causes ranging from anorectal to dermatological conditions
- Idiopathic pruritis ani
- May be associated with minor faecal incontinence
- Good history & exam to find likely cause of leakage



# Pruritis ani- Causes

- Neoplasia

Polyps  
Rectal/ anal cancer  
Paget's disease



- Infections

Condyloma acuminatum  
Herpes simplex  
Candida albicans  
E vermicularis (Threadworm)

- Benign anorectal conditions

Haemorrhoids  
Fistula in ano  
Fissure in ano  
Rectal prolapse  
Anal sphincter dysfunction

- Dermatological

Contact dermatitis  
Psoriasis  
Lichen simplex

- Idiopathic

# Pruritis ani- Treatment

- Difficult to manage
- According to cause
- Aims should be to-  
reduce leakage  
good personal hygiene  
prevention of further insult to perianal skin
- May require dermatological input

# Anal cancer

# Anal cancer

- Rare- about 4% of colorectal malignancies
- ? Incidence rising
- 80% squamous cell carcinomas; 10% adenocarcinomas
- M < F
- H/o genital warts increased RR of anal cancer (27-fold in men, 22-fold in women)

# Anal cancer- Clinical picture

- Premalignant lesions (AIN I-III):  
hyperkeratosis/ irregular pigmentation in flat/  
raised lesions
- Pain & bleeding
- Lump
- Anovaginal fistula
- Inguinal lymphadenopathy

# Anal cancer- Management

## Investigations:

- EUA + Biopsies
- MRI Pelvis
- Staging CT chest/ abdomen/ pelvis

## Treatment:

Chemoradiotherapy; Salvage surgery

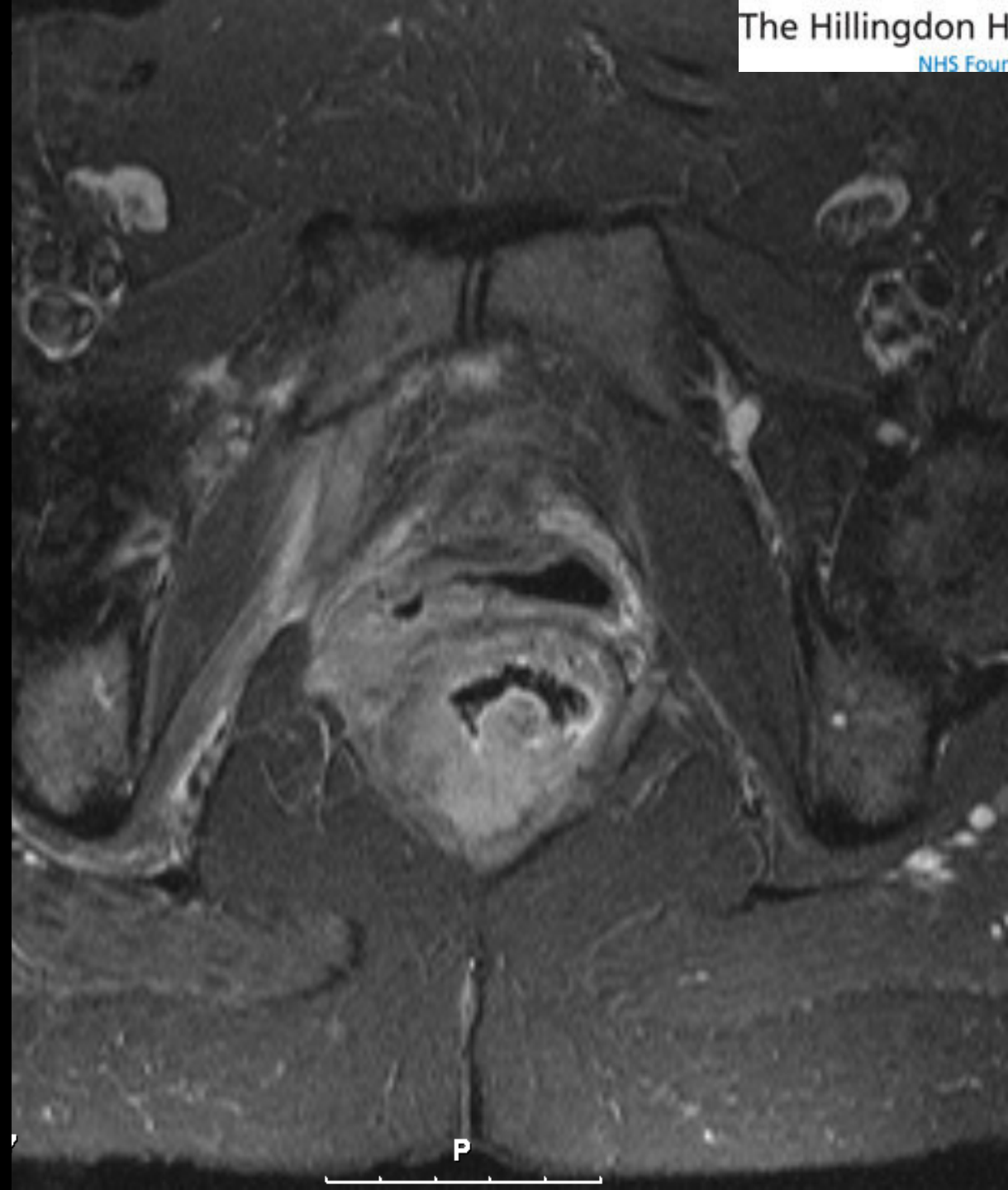
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AIN I & II: observe 6 monthly

AIN III: Local excision (10% develop into invasive cancer in 20 years); extensive lesions: 3 monthly FU

# Case study

- 31 yo woman with PR bleeding and pain
- Seen in General Surgical clinic
- Very tender on DRE
- Presumptive diagnosis of fissure- commenced on 2% Diltiazem
- OP review 6/52- patient DNA
- New referral to colorectal surgeon in 2/12



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'If you don't put your finger in it, you'll put your foot in it'