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WELCOME

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Even a pain in the ass needs someone to care about them.

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Anorectal Diseases
Latest Updates

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INTRODUCTION

- Anorectal diseases (hemorrhoids, fissure and fistula) are seen very commonly by the general practitioner.
- Most of the times due to shyness, patients do not seek medical help or seek treatment from quacks leading to complications.
EPIDEMIOLOGY

- Changing lifestyle to sedentary work, lack of exercises and food habits lacking fibre is causing increase in incidence of anorectal diseases.

QUADROPODS DON’T HAVE ANO-RECTAL PROBLEMS
COMMON ANO RECTAL DISEASES

● 1-Piles or Hemorrhoids
● 2-Fissure in ano
● 3-Fistula in ano
● 4-ANO rectal Abcess
● 5-Pilonidal Sinus
● 6-Anal pruritis
● 7-Rectal polyp-mainly in paediatric patients
● 8-Rectal Prolapse-mainly in paediatric patients
● 9-ANO rectal malignancy-mainly in elderly
● 10-Congenital Anomalies
● 11-Foreign Bodies & Sexual Abuse
NORMAL ANATOMY
CONSTIPATION-LAXATIVE ABUSE
EARLY SYMPTOMATIC DIAGNOSIS

A proper detailed history usually gives a fair enough correct diagnosis of common anorectal condition.
History in Typical Conditions

- **PILE S**-
  Prolonged sitting, Less dietary fibre, Post defecation fresh red P/R bleeding, Post Delivery, P/R swelling.

- **FISSURE IN ANO**-
  Hard Stools, Faulty dietary habits, Severe post defecation pain, may be associated with minimal P/R bleeding.
History in Typical Conditions

- **FISTULA IN ANO**-
  Chronic discharging perianal sinus which heals with treatment & again reccurs.

- **ANO RECTAL ABSCESS**-
  Short history, Severe throbbing pain, Fever.
History in Typical Conditions

- **ANAL PRURITIS** - Non specific symptom may be associated with passage of worms or psychological disturbances.

- **RECTAL POLYP** - Fresh painless P/R bleeding in children
History in Typical Conditions

RECTAL PROLAPSE-
P/R rectal swelling, esp post defecation mainly in children

ANO RECTAL MALIGNANCY-
Elderly, Altered bowel habits, P/R bleeding, persistent pain. Constitutional symptoms.
Are Your Sick Of The Itching, Burning, Pain, Swelling Or Bleeding Of Your Hemorrhoids?
Clinical Features of Anorectal Disease

1. Bleeding.
2. Pain.
3. Altered bowel habit.
4. Discharge.
5. Tenesmus.
6. Prolapse.
7. Pruritis.
8. Loss of weight.
Bleeding

- The color of blood
  - Bright red → anal or rectum
  - Dark → proximal lesion in the large bowel or higher.
Clinical Features

- **Pain**
  - Painful or not?
    - Painless → Hemorrhoids and rectal Ca.
    - Painful → anal fissure, abscess

- **Altered Bowel Habits**
  - Spurious diarrhea
Clinical Features

Discharge
- Mucus or pus
- Tenesmus
  - “I feel I want to go but nothing happens”
- Prolapse
- Pruritis
  - Secondary to a rectal discharge
Anorectal Examination

- Position of the patient-Left lateral
- Equipment-Gloves,Lubricant

**Inspection**
- Skin rashes
- Fecal soiling, blood or mucus.
- Scars or fistula.
- Lumps.
- Ulcers especially fissures, skin tags, sentinel pile.

**IF YOU DON’T PUT YOUR FINGER IN, YOU WILL PUT YOUR FOOT IN YOUR MOUTH**
Anorectal Examination

Palpation

- Anal Canal.
- Rectum.
- Rectovesico/rectouterine pouch
  - Prostate and seminal vesicles
  - Cervix and uterus
- Bimanual examination.
Investigations

- Most of common ano rectal problems can be diagnosed with a proper detailed history and proper P/R examination.

- Still certain investigations other than routine, are needed to confirm diagnosis or decide on further plan of management.
Investigations

Proctoscopy and Proctosigmoidoscopy
Video anorectoscopy - Very useful OPD procedure to diagnose most of the conditions and to create a record of disease.

Sigmoidoscopy & Colonoscopy - esp useful in suspicion of malignancy

Endo luminal USG
Fistulogram-in cases of fistula in ano to determine type of fistula.

Barium Enema studies

MRI & CT scan-in cases of Ca rectum/Complicated fistulas.

Defecography-Newer investigation for cases of chronic constipation

Anal & Rectal Pressure Studies.
The duty of Family physician is to properly diagnose the condition and give basic treatment to relieve the patient of his immediate complaints.
QUACKS RULE THE ROOST
RED FLAGS

• 1-Tendency of patients to seek late treatment due to shyness, ignorance or misconcepts.
• 2-Flourishing of Quacks claiming to cure anorectal conditions leading to variety of complications.
• 3-Misconcepts about surgical treatment that it leads to recurrence and incontinence.
• 4-Host of unqualified & doctors of alternative system are treating anorectal conditions primarily.
Primary Conservative Treatment

- 1-Tab Metronidazole/Ornidazole/tinizadole
- 2-Tab Antibiotic, esp covering gram negative spectrum eg, Quinolones/Amox+Clauvanic acid.
- 3-Analgesics
- 4-Deworming Tabs
- 5-Laxatives/Stool softners
- 6-Sitz bath-Warm water fomentation in tub with antiseptic solution
- 7-High fibre, non spicy food.
- 8- Local ointments

**GUN SHOT THERAPY**
**Diet in Anal Fistula, Fissure and Piles**

<table>
<thead>
<tr>
<th>Avoid these in your diet</th>
<th>Recommended diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spicy food</td>
<td>1. Fruits &amp; Vegetables</td>
</tr>
<tr>
<td>2. Fried food</td>
<td>2. Salad</td>
</tr>
<tr>
<td>3. Alcohol</td>
<td>3. Whole Grain Breads</td>
</tr>
<tr>
<td>4. Pickles</td>
<td>4. Dry fruits</td>
</tr>
<tr>
<td>5. Meat</td>
<td>5. Plenty of Water</td>
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Referral To Specialist

- Following the conservative treatment for 3-5 days, usually complaints are relived. Thereafter it is advisable to refer the patient to a Proctologist/Surgeon for further evaluation and management.

- If presented with complication - Urgent referral
Haemorrhoids ( Piles )

Haemorrhoids (the dilatated rectal venous plexus) consist of an internal and external component (haemorhoideal disease).

- very frequent disease

Ethiology

- hereditary (weakness of the vein walls)
- higher pelvic pressure (pregnancy),
- constipation, straining at stool
Hemorrhoids-Piles

- Internal
- External

Sites
1. Left lateral (3 o’clock).
2. Right posteriolateral (7 o’clock).
3. Right anterolateral (11 o’clock).
Haemorrhoids (Piles)

Symptoms: bleeding, prolapse of nodes, pruritus, pain, discharge

Diagnosis: inspection - at 3, 7 and 11 o’clock in lithotomy position
rectoscopy, anoscopy

Complications: bleeding, thrombosis, inflammation
Haemorrhoids (Piles)

Classification: 4 degrees

I. degree: Internal occasional bleeding
II. degree: Internoexternal prolapse after defecation with spontaneous reposition
III. degree: External prolapse need to be replaced manually
IV. degree: permanent prolapse with inflammation, thrombosis etc.
## Grading of Haemorrhoids/Piles

<table>
<thead>
<tr>
<th>Stage I</th>
<th>Stage II</th>
<th>Stage III</th>
<th>Stage IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>No protrusion of haemorrhoids, yet.</td>
<td>Protruding haemorrhoids that spontaneously reduce!</td>
<td>Protruding haemorrhoids, possible to push back in manually!</td>
<td>Protruding haemorrhoids that can't be pushed back in manually anymore!</td>
</tr>
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**Piles**
Treatment of Hemorrhoid

1\textsuperscript{st} degree
Conservative

- Dietary advise
- Bulk laxatives
- Sitz bath

Treatment will be effective at 6 month
Haemorrhoids (Piles)

OPERATIVE MANAGEMENT

1 - Open haemorrhoidectomy (Traditional method)
2 - Closed sub mucosal haemorrhoidectomy
3 - Banding - for grade 1
4 - ERC - for grade 1
5 - Sclerotherapy - for grade 1
6 - Radio Frequency Ablation
7 - CO2 ablation
8 - Stapler haemorrhoidectomy
9 - Doppler guided Haemorrhoidal artery ligation.
Anal Abscess and Fistula

Anal abscess and fistula are two phases of the same disease.

Abscess - acute phase
Fistula – chronic phase

Ethiology:
- majority of abscesses originate in the intersphincteric space from infection of anal gland.
Anorectal Abscess

- **Definition**: Infection in one or more of anal spaces, usually is bacterial infection of blocked anal gland at dentate line.

- **Organisms**
  - Ecoli
  - Staph aureus.
Anorectal Abscess

- **Sites**
  1. Perianal.
  2. Ischiorectal.
  3. Pelvirectal.
  4. Intersphincteric.

*Fig. 23.9 Abscesses in the anorectal region*
Anal Abscess

Symptoms:
- acute abscess – pain, fever

Management:
- Antibiotics

Acute abscess – surgical incision and drainage
cavity is packed with gauze
( changing every 24 hours )
wound is left open for secondary healing
Anal Fistula

Fistula-in-ano-consists of:
- internal opening
- primary tract
- external opening

Primary tract connects the internal and external openings.
Anal Fistula

- Definition-Low/High/Complicated
- Post peri anal abscess.
- secondary to crohn’s, TB, CA of rectum or lymphogranuloma.
- S/S
  - Watery or purulent discharge from the external opening of fistula
  - Recurrent episode of pain.
  - Pruritis.
Anal Fistula

Management:

Anal fistula – treatment according to the type of fistula
1. Fistulectomy (lay open the primary track)
2. drainage cum seton
3. advancement flap
4. VAFT-Endoscopic
Fissure-in-ano (anal fissure)

Definition:

- Acute & chronic
- Longitudinal split in the skin of the anal canal.

Common sites:

- Midline 6 and 12 o’clock.

associated with crohns, HIV.
Fissure-in-ano

longitudinal ulcer in the distal part of anal canal

**location:**
- mid-line posteriorly - 80%
- mid-line anteriorly - 10%
- lateral – 10 % (Crohn’s disease)

**Ethiology** – unknown (passage of a hard stool)
- resting anal pressure is raised,
  but this may be due to secondary sphincter spasm induced by pain

**Two types:**
1. acute
2. chronic (hypertrophic anal papila and sentinel tag)
FISSURE IN ANO


http://www.proctologiacr.com/fisura.htm
Symptoms: pain, bleeding, pruritus, constipation, discharge

Management:
1. conservative (acute) - sitz baths, laxatives, anal dilatation, local creams
2. operative - excision of fissure, Lords dilatation, lateral internal sphincterotomy to reduce the high resting anal pressure
Proctitis

- **Cause**
  - Nonspecific
  - Ulcerative proctocolitis
  - Crohn’s disease
  - Infection
    - *Clostridium difficile*
    - Bacillary dysentery
    - TB proctitis
    - Syphilis
    - Gonococcal
Proctitis

Nonspecific proctitis

- is an inflammatory condition affecting the mucosa and, to a lesser extent, the submucosa, confined to the terminal rectum and anal canal.

- It is the most common variety.

Aetiology.

- This is unknown.

- The most acceptable hypothesis: It is a limited form of ulcerative colitis (although actual ulceration is often not present).
Proctitis

Clinical features

- Middle-aged.
- Slight loss of blood in the motions.
- Diarrhoea
- On rectal examination, the mucosa feels warm and smooth. Often there is some blood on the examining finger.
- Proctoscopic and Sigmoidoscopic examination:
  - Inflamed mucous membrane of the rectum, but usually no ulceration. The mucosa above this level being quite normal.
Proctitis

Treatment

● Self-limiting.
● Sulphasalazine (Salazopyrin).
● Prednisolone retention enemas.
● Severe cases → oral steroids.
● Rarely → surgical treatment (last resort)
Rectal Prolapse

- Definition: Eversion of whole thickness of the lower part of rectum and anal canal.
- Types
  1. Partial prolapse.
  2. Complete prolapse.
- Cause
- Predisposing factors
- Differential diagnosis
Rectal Prolapse

History
● Age.
● Sex.
● Symptoms.

Examination
Skin of anus and mucosa of rectum in continuity

A

Gap between the bowel and anus, which leads to the rectum

B

The difference between a rectal prolapse (A) and an intussusception presenting through the anus (B)
Rectal Prolapse

Treatment

- Partial
  - Infant
  - Adult

- Thiersch stitch - Children
- Presacral Rectal Suspension - Adults
Pilonidal sinus

- **Definition:** Sinus which contain tuft of hairs, mainly in skin covering the sacrum and coccyx but can occur between fingers, in hairdressers, and the umbilicus.

- **Etiology**

- **Symptoms**

- **Treatment**
  - Acute abscess: Drainage
  - Chronic sinus: Flap Surgery
PILONIDAL SINUS
Pruritis ani

- Definition: Perianal itching, particularly the frequent and distressing one.

- Etiology: Infection, Bad Hygiene, Psychological

- Symptoms: Persistent Itching

- Treatment: As per cause
Anal Neoplasm

Epidermoid carcinoma

- Most common
- Type of cell
- Prone to HPV infection.
- Presented with.
- Treatment of choice.
Anal Neoplasm

Malignant melanoma of anal margin

- 3rd common site.
- Course.
- Treatment of choice.
- Survival rate.
Congenital abnormalities

**Imperforate anus** – one infant in 4500-5000 is born with imperforate anus

A. Low abnormalities: *anal stenosis* (dilatation)  
*anal membrane* - anus is covered with a thin membrane (incision)

B. High abnormalities: *ano – rectal agenesis* (80-85 %), often with recto-urethral or recto - vaginal fistula  
*rectal atresia* – anal canal is normal but ends blindly above the pelvic floor
Congenital abnormalities

Examination: inspection, X-ray-Invertogram, Barium Studies

Treatment: operation, incision, dilatation, colostomy, reconstruction of the anorectum
Rectal Polyps

- Most common cause of fresh PR bleeding in children

- Treatment - Excision of polyp
Uncommon Presentations

- Foreign Bodies
- Sexual Abuse
- HIV Infection
- Tuberculosis
HIV-FULMINANT INFECTION
FOREIGN BODY IN RECTUM
TAKE HOME MESSAGE

- Anorectal conditions are very common.
- Patients usually don’t seek proper scientific treatment.
- Proper history usually diagnose the condition.
- Combination therapy mostly relieves the acute symptoms.
TAKE HOME MESSAGE

- Always have high suspicion of malignancy in elderly patients having persistent pain and bleeding.
- PROCTOLOGY - branch of surgery dealing with anorectal diseases is fast emerging sub speciality.
- Newer modalities help in treating most of the conditions on Day Care basis.
- Quacks rule the roost.
QUACKS RULE THE ROOST
FOR YOUR KIND ATTENTION

Your queries are most welcome

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