

## SYMPOSIUM: ANORECTAL DISORDERS : CURRENT MANAGEMENT

### Our Guest Editor



**Dr. Sarabjit Singh** is currently working as a surgical specialist at Government Multispeciality Hospital (GMSH), sector 16, Chandigarh. He has a special interest in minimal access surgery. He has done fellowship in minimal access surgery (FMAS), university recognised and endorsed by Society of American Gastro Endo Surgeons (SAGES). Dr. Sarabjit Singh, has developed expertise in the surgical management of anorectal disorders. A speciality clinic is being run at GMSH-16 for anorectal diseases.

He is the **pioneer circle member** for ASIA-PACIFIC for minimally invasive procedure for haemorrhoids (MIPH). He is recipient of several awards, notable amongst them are **Vashisht Chakitsa Medal** by Society of Advanced Studies in Medical Sciences and **Rashtriya Gaurav Award** by IIFS, New Delhi. He is a member of various surgical societies and actively participates in academic activities. Considering his academic achievements, he has been awarded fellowship by International College of Surgeons of America (FICS). He has also been awarded fellowship by Association of Surgeons of India (FAIS), Indian Association of Gastro Endo Surgeons

(FIAGES), Society of Minimal Access Surgeons of India, International Medical Science Academy (FIMSA). He has also been awarded membership by National Academy of Medical Sciences (MNAMS), New Delhi. He holds an important position in prestigious scientific body of surgeons at Chandigarh.

Dr. Sarabjit Singh is an excellent clinician and has keen interest in the research and contributes regularly to various surgical and medical journals. He is also a **medicolegal consultant**. He has done post graduation in medicolegal systems and provides help to medical fraternity as a noble gesture. He has recently completed post graduate course in hospital administration. He is actively involved in public awareness programmes for anorectal diseases and recently was invited on a talk show on piles on Chandigarh radio. He is dedicated to providing *low cost surgery* to poor masses in India; he has developed *day care surgery* for common anorectal diseases like haemorrhoids and anal fissure and has been able to provide minimally traumatic, low cost and day care surgery to patients admitted to the hospital.

### Editorial

Anorectal disorders include conditions that effects the junction of the anal canal and the rectum. These disorders are commonly encountered in general surgical practice. Patients with diseases of the anus and rectum are some of the most miserable people in the world. These patients are usually in pain, often anxious and frequently embarrassed by the examination. Doctors need to be reassuring and explain clearly what exactly is to be done.

Anal canal also called as anus, is the opening at the distal end of digestive tract and it has lining of external skin and tissue lining of the digestive tract both. Anal canal is innervated by sensory nerves and is sensitive to pain. Rectum is the last part of the digestive tract which is lined by columnar epithelium and has an autonomic innervations and hence relatively insensitive to pain. Anal canal is surrounded by anal sphincter which is a ring of musculature and it keeps the anus closed.

Anorectal pathology is common, the incidence is increasing over the last few decades. Diseases of the anorectum are easy to diagnose in most cases. The patient's case history in itself provide a great deal of information. Clinical examination with digital examination supplemented with anoscopy or proctoscopy will help in diagnosis.

Patient's with diseases of ano- rectum present with symptoms of pain, discharge and bleeding per rectum. Haemorrhoides

are the most prevalent anorectal disorder and are the most common cause of hematochezia. Anal fissures are one of the most common causes of anorectal pain. Anal carcinomas are rare and majority of these are squamous cell or epidermoid carcinomas. A doctor examining a patient with bleeding per rectum must keep a high degree of suspicion and must obtain or refer the patient to a surgeon for biopsy from suspicious lesion in order not to miss the diagnosis of carcinoma. The most common presenting complaint of anal tumours is rectal bleeding. Anoreceptive intercourse can be cause of bacterial, viral and protozoal infections, such infections should be considered when a patient presents with rectal pain or discharge, tenesmus, or rectal or perianal ulcers. Anorectal abscess are another cause of rectal pain and can be of various types depending upon site of location, most of these are idiopathic and contain mixed aerobic-anaerobic pathogens. Fistula formation varies from 25%-50% and is much more common with gut derived organisms.

Haemorrhoids are swollen or varicose veins in the rectum and anal canal. They can be external, internal or combined depending upon where located. Internal haemorrhoids are of various degrees depending upon extent of protrusion in and out of anal canal and are located at 3, 7 and 11 o' clock position. External haemorrhoids are covered by skin and are present

from dentate line to anal orifice. Patient with haemorrhoids present with bleeding per rectum, prolapsed of pile, mucus discharge and pruritis ani. Haemorrhoids are generally painless but pain can be present if complications set in. Diagnosis is by examination and skin tags or prolapsed haemorrhoids are found. Proctoscopy is a must and helps in finding degree of haemorrhoids. Treatment is based on degree of haemorrhoids. Conservative management and non operative methods like sclerotherapy, banding, infrared coagulation are useful in early disease. Surgical management with haemorrhoidectomy or newer management techniques like stapler haemorrhoidopexy and HAL are useful in advanced stages.

Anal fissure is an elongated ulcer in the long axis of the lower anal canal situated in the posterior midline (men 90%; women 60%) or anterior midline (men 10%; women 40%). It is caused by tearing of anal valve due to passage of hard faecal masses which are unsupported by muscle especially at the posterior anal-rectal angle. In women childbirths may also contribute. Anal fissure extends from the dentate line above to stratified sensitive lower half of the anal canal below. Ulcer shows inflamed indurated margin and a base of either scar tissue or lower border of internal sphincter. An edematous tag of skin is attached to the lower end of the ulcer which is known as sentinel pile. There is marked spasm of the involuntary musculature of internal sphincter. Patient presents with acute agonising pain during defecation and lingering thereafter for sometime, blood streaks on stool. On examination sentinel pile, tightly closed anus due to spasm are found. Digital rectal examination should only be done after proper lubrication. Treatment is conservative therapy for acute, superficial fissure in form of laxatives and stool softeners and local anaesthetics and lubricating jelly. Surgery like LLIS is best for chronic fissures.

Anorectal abscesses are characterised by pus forming infections in the ano-rectal region. These are formed by extension of an infection from an anal gland or by blood spread of infection. Different types are – perianal, ischio-rectal, submucous and pelvirectal. Perianal are the commonest and constitute about 60% cases. Pain and swelling in perianal region are presenting symptoms.

Fistula-in-ano is a tract lined by granulation tissue and establishes communication between anal canal or rectum and perianal skin superficially. It is caused as a result of perianal or submucous abscess bursting both outside and inside. Some conditions like-tuberculosis, regional ileitis, ulcerative colitis, actinomycosis are associated with multiple fistulae. Fistula may be high or low depending upon whether above or below anorectal ring. Presentation is with persistent seropurulent discharge, causing pruritis ani or pain and discomfort when external opening is closed. Solitary external opening within 1.5" of anal opening is on a small elevation with granulation tissue pouting from it. On DRE fistulous tract is felt as an indurated tract and on proctoscopy internal opening may be seen. Fistulogram helps in demonstration of the tract.

Carcinoma rectum may arise de novo as a nodule of atypical columnar epithelium or malignant transformation of diffuse polyposis, papillomas or chronic ulcers. Carcinoma rectum macroscopically can be of four types – annular, proliferative,

ulcerative and mucoid. Microscopically commonest is adenocarcinoma. Colloid carcinoma and anaplastic carcinoma are other types found. Spread of carcinoma occurs, locally – circumferentially about one-quarter of circumference in six months and whole circumference in about two years. Fascia propria limits further infiltration initially but in advanced stages neighbouring structures are involved like bladder, uterus, sacrum. Lymphatic and vascular spread and peritoneal dissemination can also occur. Presentation is with bleeding per rectum, sense of incomplete evacuation, altered bowel habits, loss of weight, obstruction or pain.

Levator ani syndrome and proctalgia fugax are causes of chronic or recurrent pain with episodes of pain lasting 20 minutes or longer. Levator ani syndrome is caused by chronic tension of the levator muscle. Proctalgia fugax is caused by rectal muscle spasm.

Diagnosis is made by visual inspection of the skin around the anus, digital rectal examination and proctoscopy. Inspection; the buttocks are held apart to reveal the anus and perineum. The perianal skin should be examined for dermatitis, excoriation, ulceration, warts, scars, carcinoma and fissure. Fissure is in the midline and inspection of these areas is possible by deliberate parting of the anal verge. DRE: this is very important examination in anorectal diseases and should not be missed. Gloved lubricated finger is placed at the anal verge and gently inserted through the anal canal into the rectum. Rectal mucosa is systemically examined for benign or malignant lesions. It is possible to feel at least 10 cm from anal verge. Assessment of anal sphincter is also made with assessment of resting tone and voluntary contraction. PROCTOSCOPY means a visual examination of the lower part of rectum and anal canal through a proctoscope. The proctoscope with obturator in situ is well lubricated and introduced into the anal canal, while introducing one must remember the direction of anal canal that is directed towards upwards and forwards towards the umbilicus of the patient. After it has been fully introduced, the obturator is taken out and the inside of the proctoscope is well illuminated. Haemorrhoids, internal opening of the fistulous tract, anal polyps, fissures and ulceration can be identified.

Proper history taking with meticulous examination by direct rectal examination (DRE) and proctoscopy will help in making a proper diagnosis and accordingly condition can be managed with conservative or surgical management. Newer surgical techniques for management of benign conditions have been introduced and are quite successful.

I would like to thank the editorial board of JIMSA for giving me opportunity to contribute dedicated issue on anorectal disorders.

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