

Approach to the Diagnosis of Anorectal Disorders.

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Abstract: Anorectal pathology is common and its incidence is increasing over the last few decades. Diseases of the ano-rectum are usually easy to diagnose. The patient's history provides a great deal of information; clinical examination with digital examination supplemented with anoscopy or proctoscopy help in diagnosis. Specialized investigations are required in selected group of patients only.

INTRODUCTION

Anorectal disorders are common, and their prevalence in the general population is probably much higher than that seen in clinical practice as most patients do not seek medical attention¹. These affect men and women of all ages. The spectrum of Anorectal disorders ranges from benign and irritating (pruritis ani) to potentially life-threatening (anorectal cancer). The evaluation of patients is sometimes made difficult by nonspecific symptoms². Evaluation of anorectal disorders comprises of a careful history and physical examination before the patient can be subjected to various investigations.

Anorectal disorders are a group of medical disorders that occur at 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 is to be done exactly.

HISTORY

Pain, bleeding, discharge (mucoid, purulent, fecal) and change in bowel habits are the common presenting symptoms. It is also important to know about the associated illness, medications, family history, bleeding tendency, and exposure through travel or sexual contacts³.

Anal fissure is one of the most common causes of severe anorectal pain⁴. Patients may complain of a sensation of intensely painful anal spasms lasting for several hours after a bowel movement. Thrombosed external hemorrhoids may cause significant pain because the anoderm is richly innervated⁴. Throbbing pain is a symptom in anorectal abscess. Pain unrelated to defecation is likely to be associated with proctalgia fugax or levator ani syndrome³. (table 1)

Table 1 : Differential Diagnosis of Rectal Pain

- * Anal Fissure
- * Perianal Abscess With Or Without Fistula
- * Thrombosed Haemorrhoid
- * Levator Ani Syndrome
- * Proctalgia Fugas
- * Coccydynia

- * Fecal Impaction
- * Neoplasm (Rectal, Pelvic Or Cauda Equina)
- * Idiopathic
- * Inflammatory Bowel Diseases (Ulcerative Colitis, Crohn's Disease)
- * Solitary Rectal Ulcer
- * Pruritis Ani
- * Trauma
- * Anal Sex
- * Constipation
- * Diarrhoea
- * Familial Rectal Pain
- * Endometriosis
- * Pelvic Inflammatory Disease
- * Prostatitis
- * Foreign Body

In both benign and malignant conditions, bleeding is a common presenting symptom; haemorrhoids is the most common cause ; (table 2). The patient should be asked whether the bleed is dark, bright red, or associated with clots, is it mixed with stool or separate, and does it drip into the toilet bowl or only on paper. Clots may suggest a colonic or a more proximal source of bleeding³.

Table 2 : Differential Diagnosis (Haemorrhoids)

- * External Haemorrhoids
Located Below Pectinate Line And Typically Painful.
 - * Internal Haemorrhoids
Located Above Pectinate Line, Typically Not Painful Unless Thrombosis Occurs.
 - * Condylomata Acuminata or Genital Warts.
 - * Prolapse Rectum (Complete/ Partial/Mucosal Prolapsed Only)
 - * Rectal Polyp
 - * Rectal Or Anal Carcinoma
 - * Hypertrophied Anal Papilla Or External Skin Tag
 - * Perirectal Abscess
 - * Anal Fissure And Fistula
 - * Rectal Varices As In Portal Hypertension
 - * Rectal Cavemous Hemangioma
- Discharge is generally a presenting symptom of fistula- in- ano. Change in bowel habits may indicate a malignant process but it is

necessary to establish previous pattern of bowel habit³.

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 tumors 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 and 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.

PHYSICAL EXAMINATION

It is done in left lateral position with buttocks projecting slightly beyond the edge of the table. Perianal area should be inspected for any skin tags, excoriations, scars, or any change in colour or appearance. Index finger is lubricated with Xylocaine jelly for digital examination which helps in appreciating any mass, induration, stricture, apart from assessing the resting tone and strength of squeeze pressure. In males, prostate can be assessed whereas in females rectocele can be detected after pushing forward the vaginal wall³.

Anoscopy enables a satisfactory examination of anal canal and distal rectum. For complete examination of anorectum, proctosigmoidoscopy is the preferred method. Any suspicious area can be biopsied³.

DIGITAL RECTAL EXAMINATION (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.

ANOSCOPY/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.

LABORATORY INVESTIGATIONS

These include stool examination if infectious diarrhea or sexually transmitted disease is suspected.

Histopathological Examination is done to know the histological

diagnosis of the mass or the suspicious area seen in proctosigmoidoscopy or colonoscopy.

IMAGING STUDIES

Anoscopy and proctosigmoidoscopy can detect haemorrhoids and any growth in the anal canal.

Fistulography is a good diagnostic method for detecting the internal opening in fistula in ano. MRI (magnetic resonance imaging) and anorectal endosonography (EUS) are accurate means of delineating anatomy in relation to a fistula⁵.

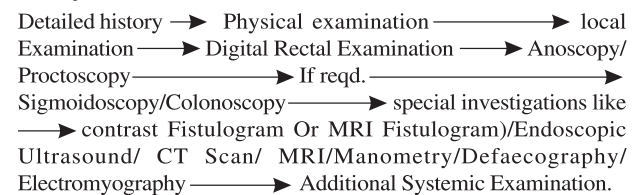
EUS is easily performed and less expensive than **Magnetic Resonance Imaging (MRI)**, but it is not appropriate for the patient with severe anal pain or an anatomical stricture. Adopting endoanal coils and phased array imaging has contributed to the evolution of using MRI to evaluate anorectal disease⁵⁻⁸. The exact choice of which modality to use depends on local expertise, cost, and the available equipment. The overall sensitivity of Computed Tomography (CT) in identifying abscess was 77 per cent and it lacks sensitivity in detecting perirectal abscess, particularly in the immunocompromised patient⁹.

SPECIAL INVESTIGATIONS

Manometry, defecography, and electromyography may help in the assessment of anorectal incontinence, constipation or any other pelvic floor disorder³.

Steps to be followed in evaluation of a case of ano-rectal disease.

The following flow Diagram shows steps in the evaluation of a case of Anorectal Disease



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