

## COLON AND RECTAL SURGICAL ASSOCIATES

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## Anal Pain – Beware: It’s not always just hemorrhoids...

Anal Pain is common, and commonly misdiagnosed. Most patients and many clinicians assume that a complaint of anal pain is synonymous with a diagnosis of hemorrhoids, especially when the pain is associated with the presence of bright red blood. A familiarity with the causes of anal pain will help the physician arrive at a correct diagnosis and begin the correct treatment.

### HOW TO BEGIN THE EVALUATION.

Internal hemorrhoids are associated with itching, a discharge or blood on the tissue. Hemorrhoids rarely cause pain unless they are markedly inflamed or thrombosed. When evaluating a patient with anal pain, a thorough history must be obtained, noting the time, and manner of onset (figure 1). The physician should also note any associated symptoms such as fever or the sudden relief of the pain, which might indicate a spontaneously drained abscess. A visual inspection may reveal anal erythema, which could be secondary to an abscess, a fistula, a thrombosed external hemorrhoid, or irritation due to the use of soap on the perianal area. Palpation might reveal a fluctuant area, or point tenderness. A digital exam may uncover a fluctuant abscess hidden in the anal canal. At this point, most clinicians will refer the patient to a specialist for anoscopy or sigmoidoscopy if the cause of the pain cannot be found.

### COMMON CAUSES OF ANAL PAIN:

#### Anal Fissure

Anal fissures are linear tears in the anal canal, commonly the result of constipation, a difficult bowel movement or uncontrolled diarrhea. Fissures typically occur in the

anterior or posterior midline and are associated with acute pain and occasionally with rectal bleeding. The pain may occur immediately after a bowel movement or may be delayed for several hours. The pain is often severe, and described as feeling like the passing of razor blades during the bowel movement. An associated external sentinel anal tag or an internal hypertrophic anal papilla are often seen. The anal sphincter is hypertonic, interfering with the local flow of blood and resulting in non-healing of the fissure.



Figure 1: A person with anal pain

Treatment is aimed at improving blood flow by decreasing anal sphincter tone. This can be achieved with a topical vasodilator such as Nitroglycerine, or with a calcium channel blocker such as Diltiazim or Nifedipine. Botox injections temporarily paralyze the

internal anal sphincter, allowing for increased local blood flow, with healing of the fissure in up to 50% of patients. A surgical lateral internal sphincterotomy may be necessary if other measures fail.

#### Anorectal Abscess

A perianal or perirectal abscess forms as a result of an obstructed and infected anal gland. The pain associated with an abscess is often gradual in onset and constant. The patient may report a history of fever or general malaise. As the abscess enlarges, the increased pressure within the abscess cavity may result in excruciating pain. The skin overlying the abscess may be erythematous or indurated. A palpable abscess may be firm or fluctuant. Incision and drainage of the abscess, often per-

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formed as an office procedure, may be all that is necessary to resolve the problem. However, antibiotics may be used in addition to drainage if there is associated cellulitis. A delay in recognition may result in systemic sepsis and rarely Fournier's gangrene. Up to half of the patients treated for an abscess may develop a fistula, which is a tubular communication between the anorectum and the perianal skin. A fistula may require additional surgical treatment.

## Thrombosed External Hemorrhoids

An external hemorrhoidal vein may develop a blood clot within its lumen. This is known as a thrombotic hemorrhoid. The thrombotic may occur as a result of straining with a bowel movement or during other physical exertion. The thrombosed hemorrhoid appears as a firm, purple, grape-like nodule adjacent to the anal canal. Occasionally, there may be multiple, simultaneous thrombotics in multiple locations. Painless thrombotics may be followed and allowed to regress spontaneously without any intervention. If the thrombotic causes acute stretching of the overlying skin, severe, localized pain may result. Sitz baths and topical preparations may provide a modicum of pain relief. If the clot is under extreme pressure, superficial skin breakdown with venous rupture and persistent oozing may occur. In many cases, the clot and swelling will resolve over several weeks. When identified early, painful thrombosed hemorrhoids may be opened or excised in the office setting using local anesthesia. Hemorrhoidal sclerotherapy and banding do not have a role in the management of acute thrombosed external hemorrhoids.

## Sexually Transmitted Diseases

Perianal herpes simplex virus infections may lead to scattered superficial ulcers on the perianal skin. Early lesions are vesicular in nature. A diagnosis is made either by obtaining a previous history of herpetic ulcers, or by observing new lesions occurring ten days after the first physical exposure to the virus. The anal lesions can be painful, with burning pain radiating down the leg. The vesicular fluid can be cultured, with the demonstration of the virus. Symptomatic treatment includes the use of anti-viral agents such as Acyclovir which may shorten the course of an outbreak. Acyclovir does not prevent further occurrences, but may lessen their frequency. Herpetic lesions will regress spontaneously with or without treatment, but will invariably recur. The frequency of outbreaks seems to decrease over time. Other infections such as anal warts, syphilis or HIV related ulcers might also be a source of anal pain.

## Don't Forget Pruritus Ani

Anal itching and scratching can lead to anal pain. The itching may be secondary to the use of any kind of soap on the perianal area, pinworm or other types of infections, or may be related to psychological stress. Discontinuing the use of perianal soaps may relieve the itch and eradicate the pain. Hemorrhoidal therapy may not relieve itching and pain unless the use of soap is discontinued and any other underlying pathology treated.

## LESS COMMON CAUSES OF ANAL PAIN:

### Anal Cancer

The incidence of squamous cell anal canal cancer is increasing. It affects heterosexual men and women and is not uncommon in HIV positive anoreceptive men. Anal cancer is thought to be related to prior exposure to HPV, the human papilloma virus. Anal warts, or condyloma, contain HPV and can be detected by a careful visual or digital rectal examina-

tion and anoscopy. Malignant lesions are firm, commonly nodular and occasionally ulcerated. Any such lesion mandates the performance of a careful anorectal exam and biopsy. If identified early, squamous anal cancers respond extremely well to potentially curative chemoradiation. Radical surgical interventions, including wide local excision or abdominoperineal resection are reserved for refractory or recurrent disease.

### Rectal Cancer

Adenocarcinoma of the rectum typically presents with rectal bleeding, and less commonly with rectal pain or pressure. If the lesion is close to the well-innervated dentate line in the anal canal, sharp anal pain may be reported. All patients with anorectal pain or bleeding of unclear etiology should undergo a proctoscopy or flexible sigmoidoscopy to rule out a distal anorectal adenocarcinoma or other rare rectal tumors. The precise location of the lesion in the anorectum must be noted, as this may be a guide to the type of operation used to remove the tumor. While chemoradiation may assist in decreasing local recurrences, operative extirpation remains the mainstay of treatment. Most of these lesions can be removed using laparoscopic techniques with sphincter preservation. More distal lesions may require an abdominoperineal resection for cure. Survival rates are excellent for rectal cancer discovered at an early stage and appropriately treated.

### Proctalgia Fugax or Levator Spasm

Proctalgia fugax is a painful spasm of the pelvic floor, often occurring at night. The etiology is unclear but may be related to psychological stress. The mainstay of treatment includes fiber supplementation, levator massage or ultrasound therapy, muscle relaxants, or anti-anxiety medications. These therapies are associated with variable degrees of success.

### Inflammatory Bowel Disease

Crohn's disease can affect the anorectum. Patients commonly report associated diarrhea. Fissures in atypical locations, large irregular anal tags, recurrent abscesses, and complex fistulas may be seen on exam. All of these may be associated with significant pain. Local and systemic therapy is often required to control symptoms. Ulcerative colitis affecting the rectum is also known as ulcerative proctitis, and may be a cause of anorectal pain. Diagnosis is made by performing a proctoscopy and biopsies. Treatment with various topical or systemic medications usually helps to resolve the pain.

### Miscellaneous Causes of Anal Pain

Diarrhea, constipation or a fecal impaction can be quite uncomfortable. Appropriate treatment will resolve the pain. Radiation proctitis may result from radiotherapy to the rectum or to areas adjacent to the rectum, as during the treatment of prostatic carcinoma, or in the treatment of various gynecologic malignancies. Other rarer causes of anal pain include a solitary rectal ulcer, anal trauma and coccydynia, also known as tailbone pain.

## A VEXING PROBLEM. SATISFYING TREATMENTS.

While anal pain is a common symptom, a focused evaluation and careful examination is essential in determining the correct diagnosis. A delayed or incorrect diagnosis can be vexing for the patient and the physician, and may have far reaching repercussions if an occult lesion is discovered at a late stage. Consultation with a specialist may allow for early diagnosis and treatment.