Information about medication, bleeding, and even sexual practices can help in nailing down a diagnosis.

and information about sexual practices—history of similar pain, medication use, radiating pain, and the duration of pain, as well as the location, the presence of fever or proctalgia. In most cases, the diagnosis can be made by visual inspection of the anal canal with the patient in the prone jackknife position. The digital examination usually can’t be tolerated and can be reserved for after the patient has been treated and the pain is improved or resolved.

Tumors. Pain associated with anal cancer is insidious in onset. Patients do not complain of fever or prolapasse, but may describe a recent change in bowel movement that may have been noted on the anal margin, or digital examination may reveal a palpable mass. Low-lying rectal cancers can also cause anal pain, and may be associated with febrile urgency, bloated stool, swelling, weight loss, and a change in the caliber of the stool. The tumor may be palpable on digital examination; pay careful attention to the posterior midline, which is the location where rectal cancer is most often missed. If “find this is reproducible on palpation of thelevator muscles,” said Dr. Sands, noting that patients may also have associated anal hypertonia.

A good endoscopic evaluation is important in these patients, and once organ-specific pathology of proctalgia is appropriate, she said.

Rectal Prolapse Requires Individualized Approach to Therapy

BY SHARON WORCESTER Tallahassee Bureau

The key to successful treatment of true rectal prolapse is an individualized approach, and in many cases that means a multidisciplinary approach, Eric G. Weiss, M.D., said at a symposium on pelvic floor disorders sponsored by the Cleveland Clinic Florida.

That’s because the majority of women with rectal prolapse have concomitant genitourinary incontinence. In addition, expanding knowledge of pelvic floor function—and the evolution of the concept of the pelvic floor as a single functioning unit with anterior and posterior components—has led to a greater effort to treat these conditions simultaneously. At the Cleveland Clinic Florida, about 65% of women with rectal prolapse also have urinary incontinence, and about 34% have genital prolapse.

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Physicians should pay careful attention to the posterior midline, which is the location where rectal cancer very often is missed.

Patients with fissures can be in agony—and are “terribly afraid and extremely anxious” about undergoing an anal examination, Dr. Sands said. In most cases, the diagnosis can be made by visual inspection of the anal canal with the patient in the prone jackknife position. The digital examination usually cannot be tolerated and can be reserved for after the patient has been treated and the pain is improved or resolved.

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Dr. Sands noted at the meeting.

Patients with unexplained anal pain and no obvious benign condition who cannot tolerate an office examination should be examined under anesthesia, she said.

Stenosis. This painful condition has a slow onset and can result from overly aggressive anal surgery, such as hemorrhoidectomy. Hemorrhoids, anal canal and Crohn’s disease also can cause stenosis. The patient complains of painful bowel movements and a change in the caliber of the stool, but not of fever or prolapse.

Infection. Sexually transmitted diseases are a common cause of anal pain. Urethra around the anal canal may signal an STD. Ask about potential exposures during the history, examine external genitalia for additional clues to the diagnosis, and follow up with appropriate cultures and biopsies, Dr. Sands advised.

Proctalgia. This is a diagnosis of exclusion in patients presenting with rectal pain and pressure. They describe increased pain after bowel movement, but not of bleeding or fever. They may describe long-term pain.

“I find this is reproducible on palpation of thelevator muscles,” said Dr. Sands, noting that patients may also have associated anal hypertonia.

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The evaluation of women presenting with rectal prolapse poses a diagnostic challenge, but a careful, detailed history will lead to the correct diagnosis in 90% of cases, Dana R. Sands, M.D., said at a symposium on pelvic floor disorders sponsored by the Cleveland Clinic Florida.

Ask patients about the quality of their pain, as well as the location, the presence of radiating pain, and the duration of pain, advised Dr. Sands, associate staff surgeon at the Cleveland Clinic Florida, Weston.

Also, associated symptoms—such as changes in bowel habits and bleeding, a history of similar pain, medication use, and information about sexual practices—can help in nailing down a diagnosis.

Among the differential diagnoses are:

Hemorrhoids. Most patients presenting with anal pain have been referred for, or believe they have, hemorrhoids. In some cases hemorrhoids are the cause of the pain, but it is important to keep in mind that only external thrombosing hemorrhoids or prolapsed internal hemorrhoids will cause pain. The pain may be described as acute in onset, short-term, and associated with occasional bright red bleeding and the sensation of a lump around the anal canal, Dr. Sands said.

If the pain is severe, excision can usually be accomplished in the office setting, but prolapsed, irreducible internal hemorrhoids can become gangrenous and pose a surgical emergency.

Anal abscesses. Pain associated with anal abscesses is insidious in onset and is usually associated with fever, swelling, and drainage. Patients may have a history of a previous abscess. Evaluation and treatment is entirely dependent on the location of the abscess, as various spaces around the anal canal can harbor abscesses.

The most common type is a perianal abscess, which can usually be drained easily. Unexplained anal pain is often attributed to internal hemorrhoids or fissures, but may be due to an internal abscess. Such pain warrants examination of the patient under anesthesia, Dr. Sands stressed.

Fissures. Patients with anal fissures describe severe pain, bright red blood from the rectum, and pain for 3-4 hours following a bowel movement. There is no associated fever and usually no drainage.

Proctalgia.

Complication rates range from 15% to 29%, and mortality ranges from 0% to 2%. Recurrence rates are low, ranging from 2% to 12%.

A common complication with rectectomy is constipation, but some data suggest that it may be overcome by using the combined rectectomy/sigmoid resection procedure, Dr. Weiss noted.

The perineal approach usually involves rectosigmoidectomy. Studies suggest that perineal rectosigmoidectomy outcomes are improved when levatorplasty is also performed.

In one Cleveland Clinic Florida series of 84 patients with severe fecal incontinence and rectal prolapse treated over a 7-year period, those who were treated with both had significantly lower recurrence rates and decreased incontinence scores, compared with those who underwent only perineal rectosigmoidectomy, Dr. Weiss noted.

The recurrence rate there for all perineal procedures is about 13%, compared with 5% for perineal rectosigmoidectomy with levatorplasty, and the recurrence-free interval was longer in this group of patients, he added.

Another perineal option is the Delorme procedure, which involves circumferential incision of the mucosa of the prolapsed rectal wall just above the dentate line, and circumferential dissection in the submucosal layer of the prolapsed bowel as far up as possible. This is followed by placement of the muscular layer of the prolapsed muscle and coloanal anastomosis.