

Demystifying Benign Anorectal Disease: A Cheeky Surgeon's Anal-Retentive Perspective

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2023 ACP COLORADO CHAPTER MEETING

Disclosures

▶ None

Disclosures

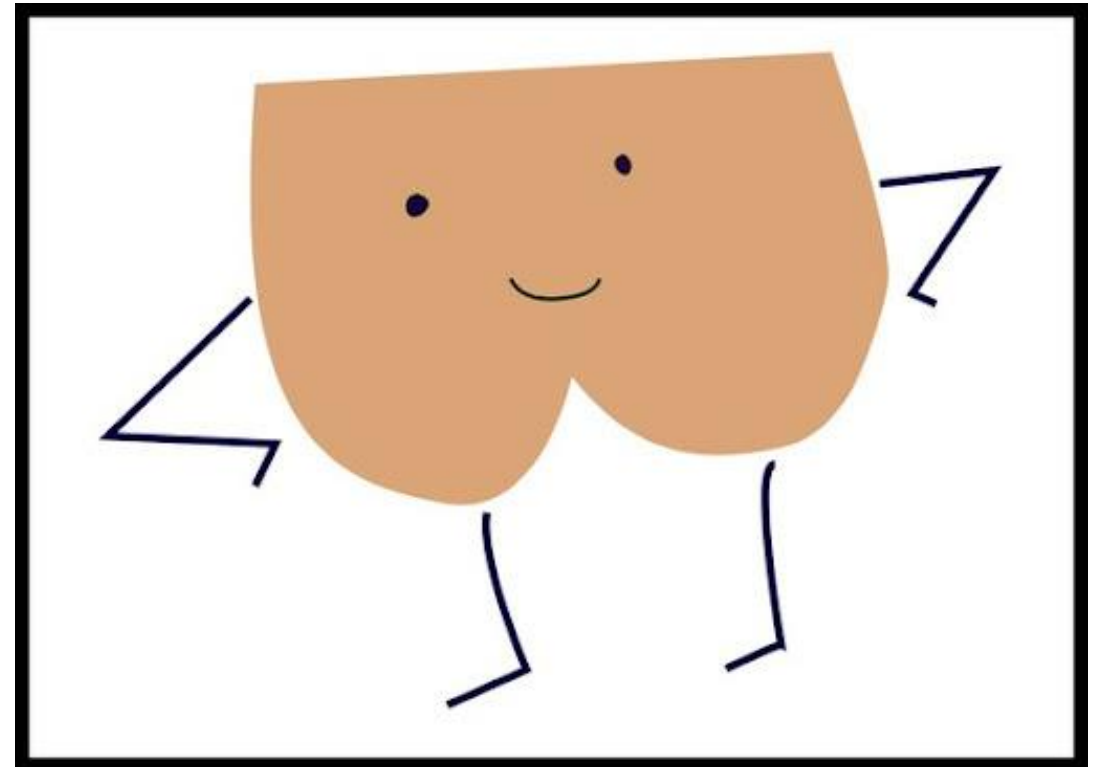
- ▶ None
- ▶ There will be photos of the subject of this talk. Apologies in advance.

Learning Objectives – at the end of this talk participants should be able to:

- Understand the anatomy of the anal canal and how it applies to the presentation of various benign anorectal conditions.
- Use best practices for the perianal exam including digital exam and anoscopy.
- Diagnose and treat the most common benign anorectal diseases.
- Know when to refer these conditions to a surgeon and how to counsel the patient about what to expect.

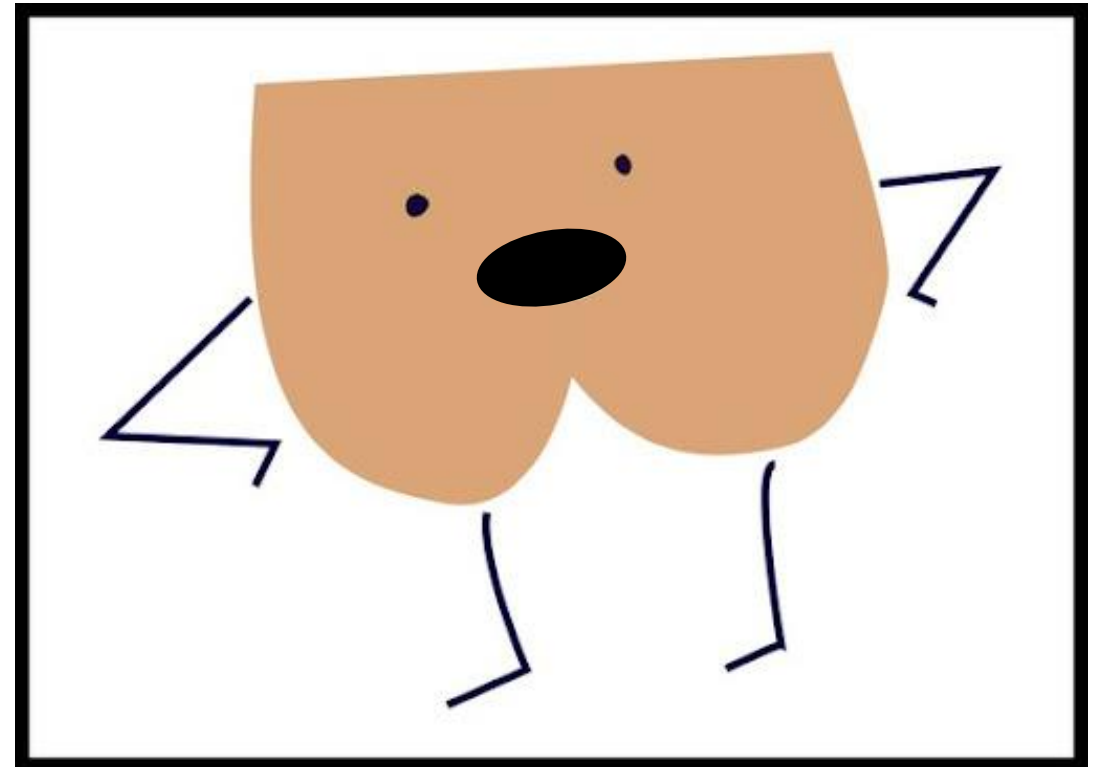
Common Anorectal Problems

- ▶ Hemorrhoids
- ▶ Peri-anal abscesses
- ▶ Fistula en ano
- ▶ Fissure
- ▶ Pruritis Ani
- ▶ Fecal incontinence
- ▶ Rectal Prolapse
- ▶ Rectal and Anal Cancer



Common Anorectal Problems

- ▶ Hemorrhoids
- ▶ Peri-anal abscesses
- ▶ Fistula en ano
- ▶ Fissure
- ▶ Pruritis Ani
- ▶ Fecal incontinence
- ▶ Rectal Prolapse
- ▶ Rectal and Anal Cancer



Patient Presentation

35 year old woman complaining of “I have hemorrhoids.”



ARS Question #1: Poll – Approximately how frequently do you personally see anal/rectal complaints in your own practice?

1. Daily
2. Weekly
3. Monthly
4. Less frequently than monthly

When poll is active, respond at pollev.com/christinewes031

Text **CHRISTINEWES031** to **22333** once to join

Approximately how frequently do you personally see anal/rectal complaints in your own practice?

Daily

Weekly

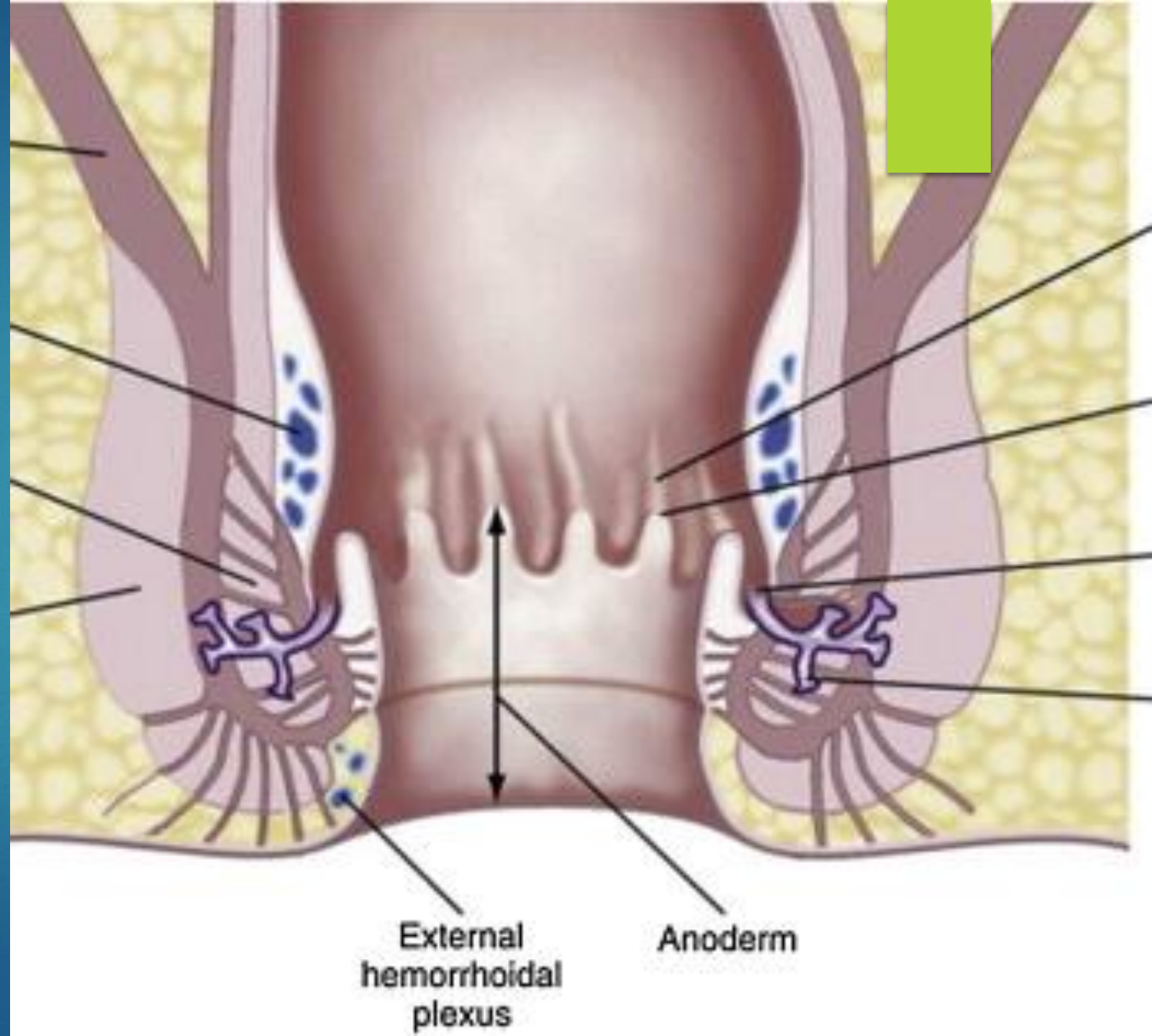
Monthly

Less frequently than monthly

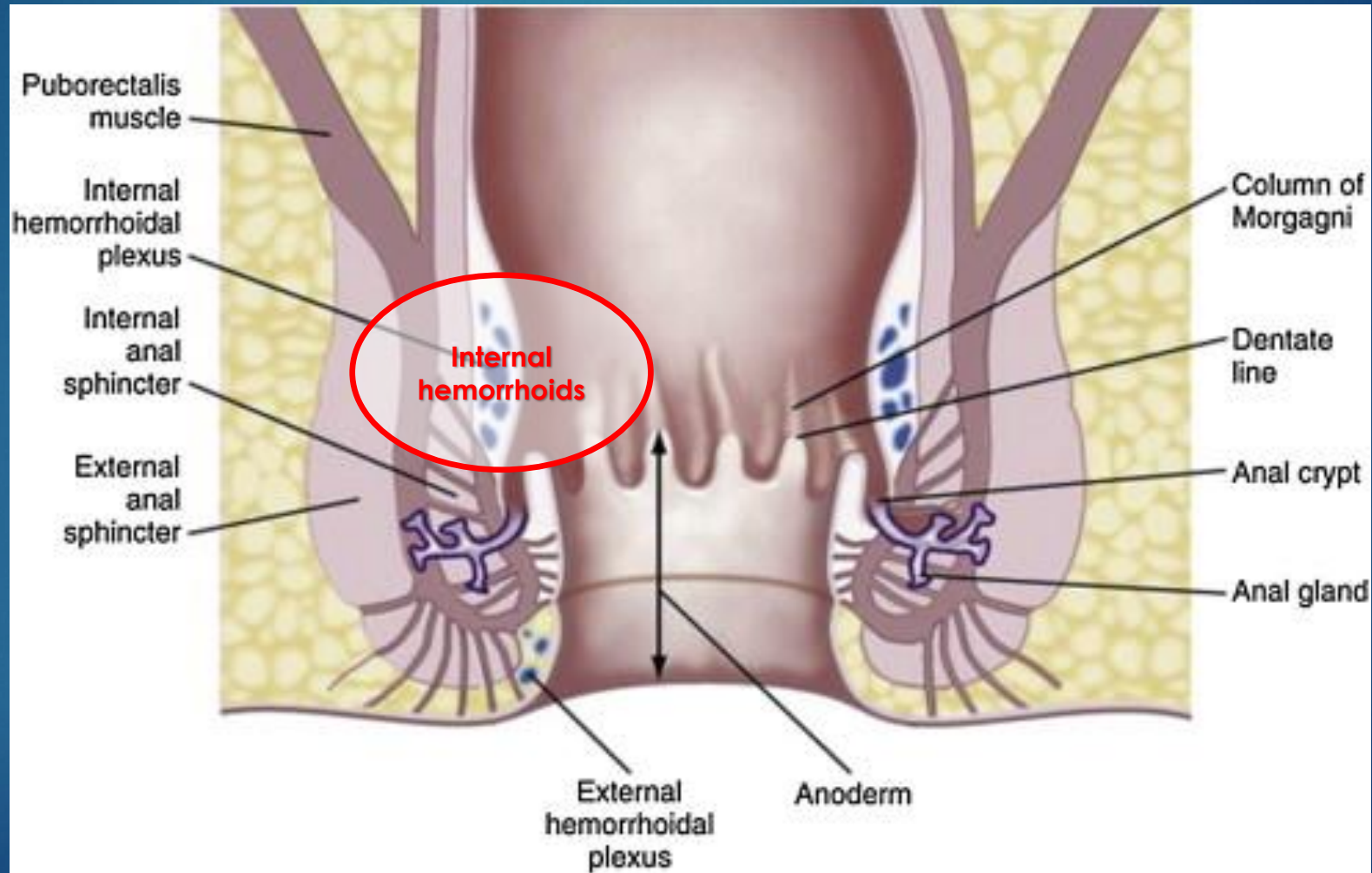
Outline

- ▶ Pertinent Anatomy
- ▶ History – how to begin differentiating
- ▶ Exam – confirming the diagnosis in three parts
- ▶ Treatment algorithms including when surgery is indicated
 - ▶ Hemorrhoidal disease
 - ▶ Fissures
 - ▶ Fistulas

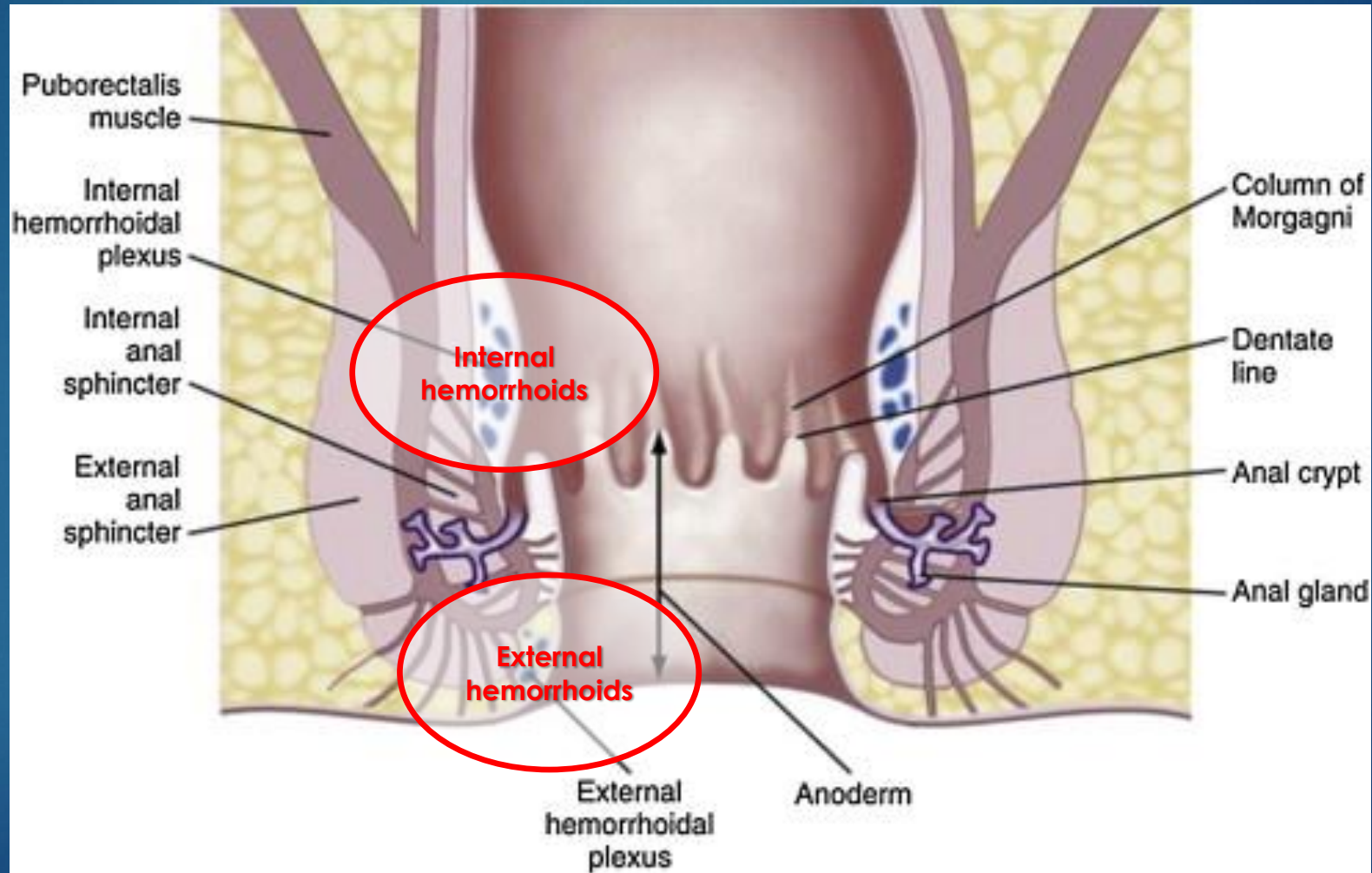
Pertinent Anatomy



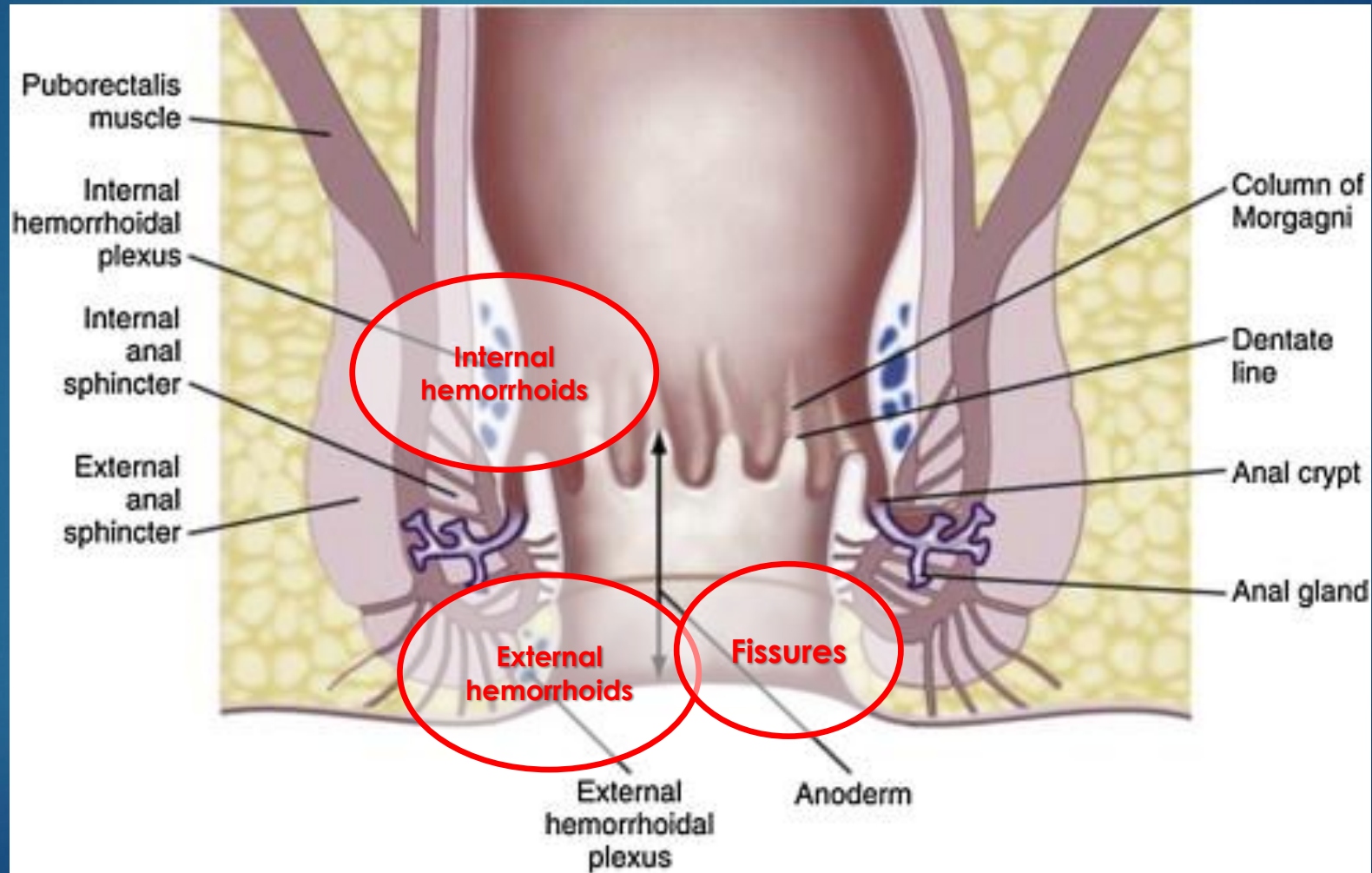
Pertinent Anatomy



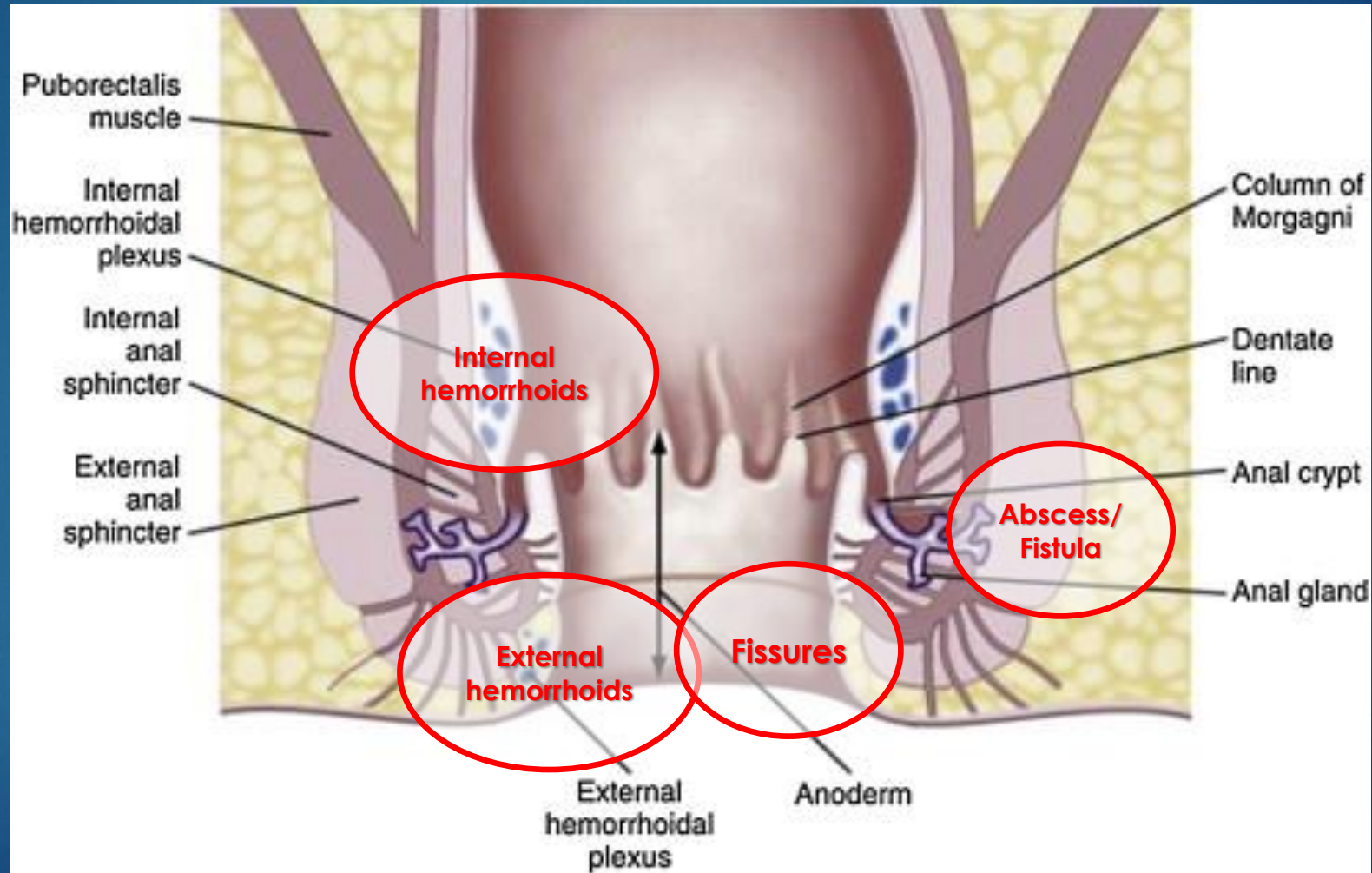
Pertinent Anatomy



Pertinent Anatomy



Pertinent Anatomy



ARS Question #2: True/False – Pain is the primary presenting symptom of all anorectal conditions.

1. True
2. False

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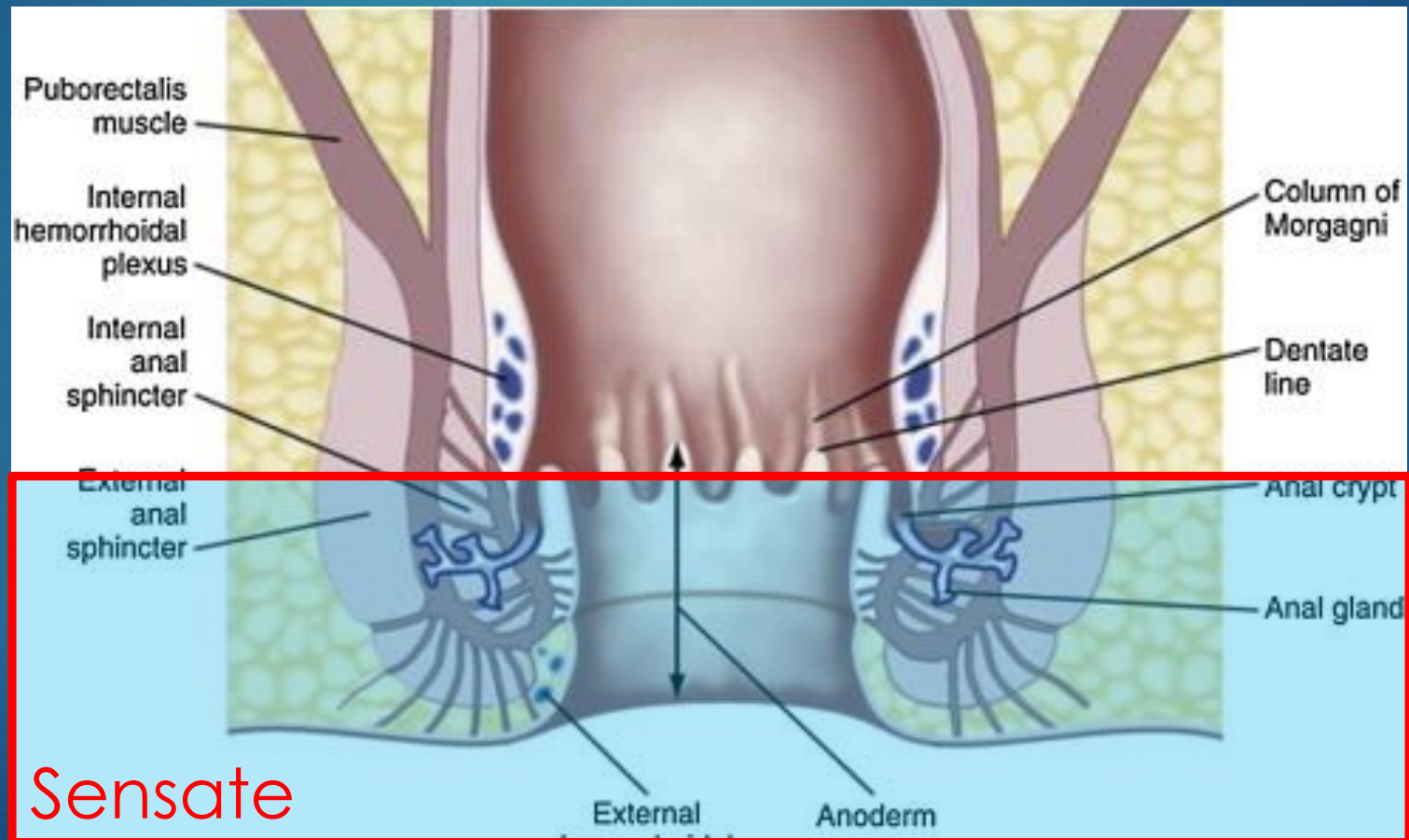
Text **CHRISTINEWES031** to **22333** once to join

True/False – Pain is the primary presenting symptom of all anorectal conditions.

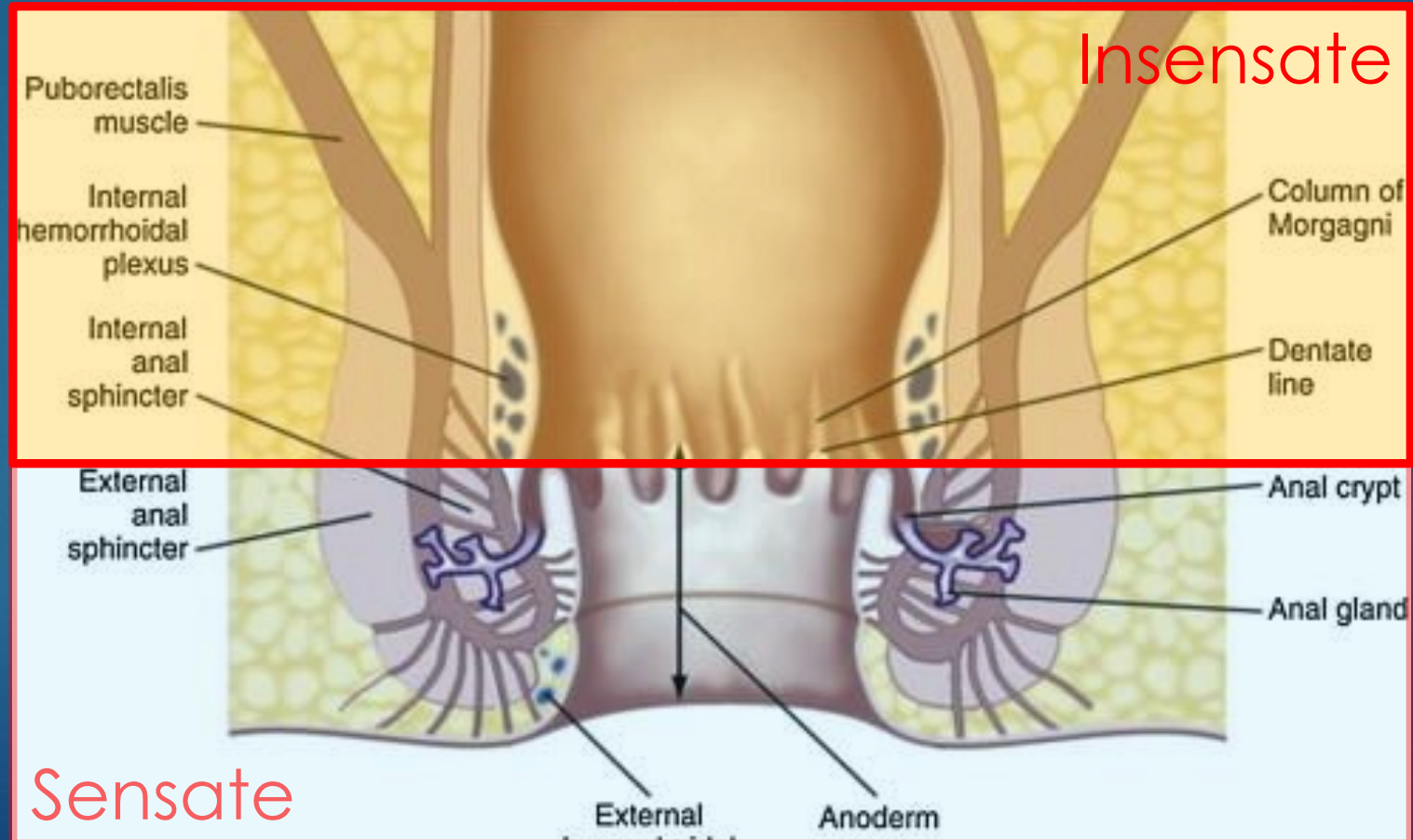
True

False

Pertinent Anatomy



Pertinent Anatomy



5

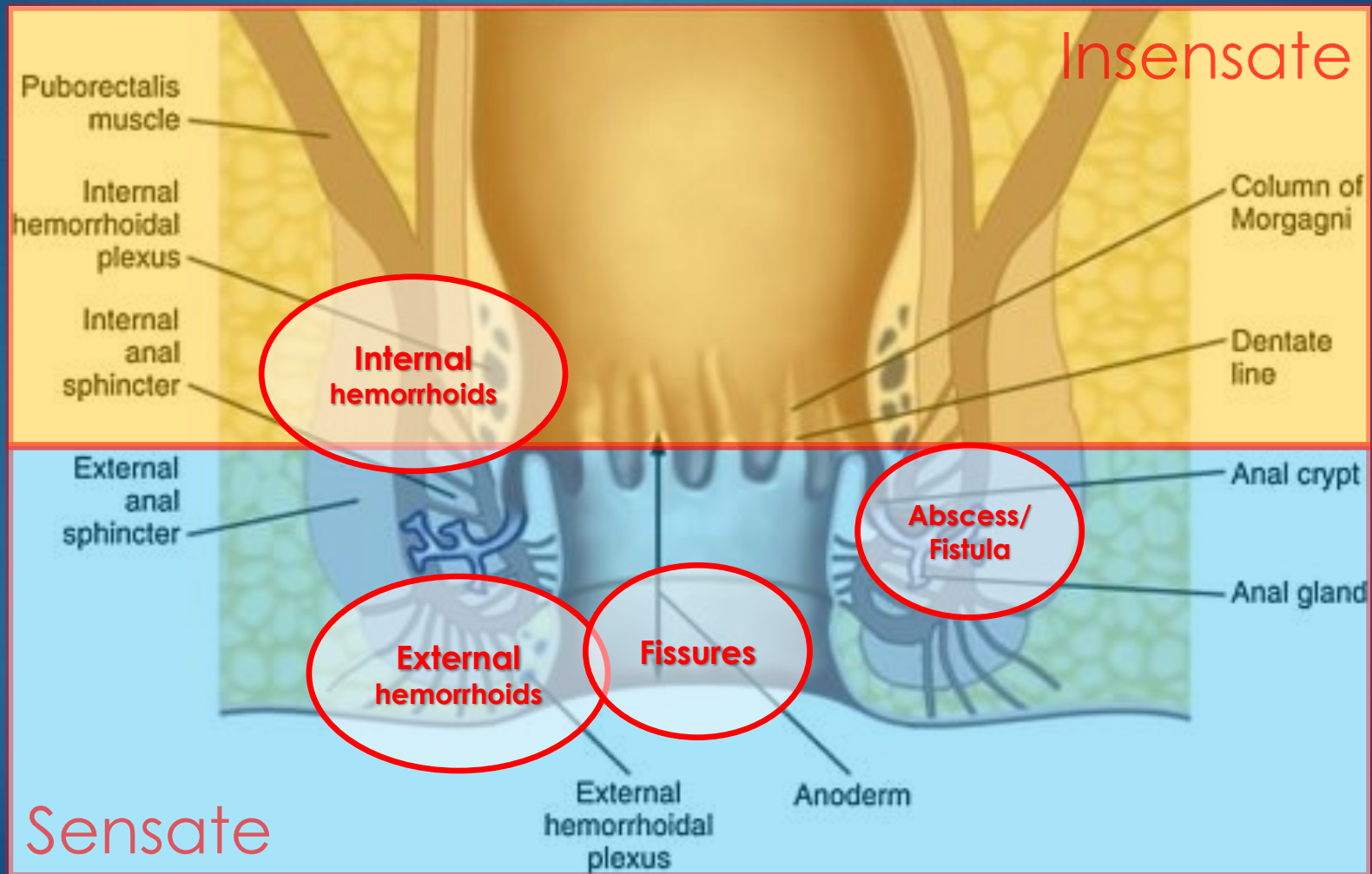


- 

- 

Sensate

Pertinent Anatomy



Patient Presentation

35 year old woman complaining of “I have hemorrhoids.”



Patient Presentation



History

>90% of the diagnosis comes from the history

- ▶ Symptoms
- ▶ Chronicity
- ▶ Bowel habits (not just constipation)
 - ▶ Frequency
 - ▶ Consistency
 - ▶ Amount and time of straining
 - ▶ Total time spent on the toilet
 - ▶ Regimen (think #1 fiber #2 fiber #3 fiber....etc.)

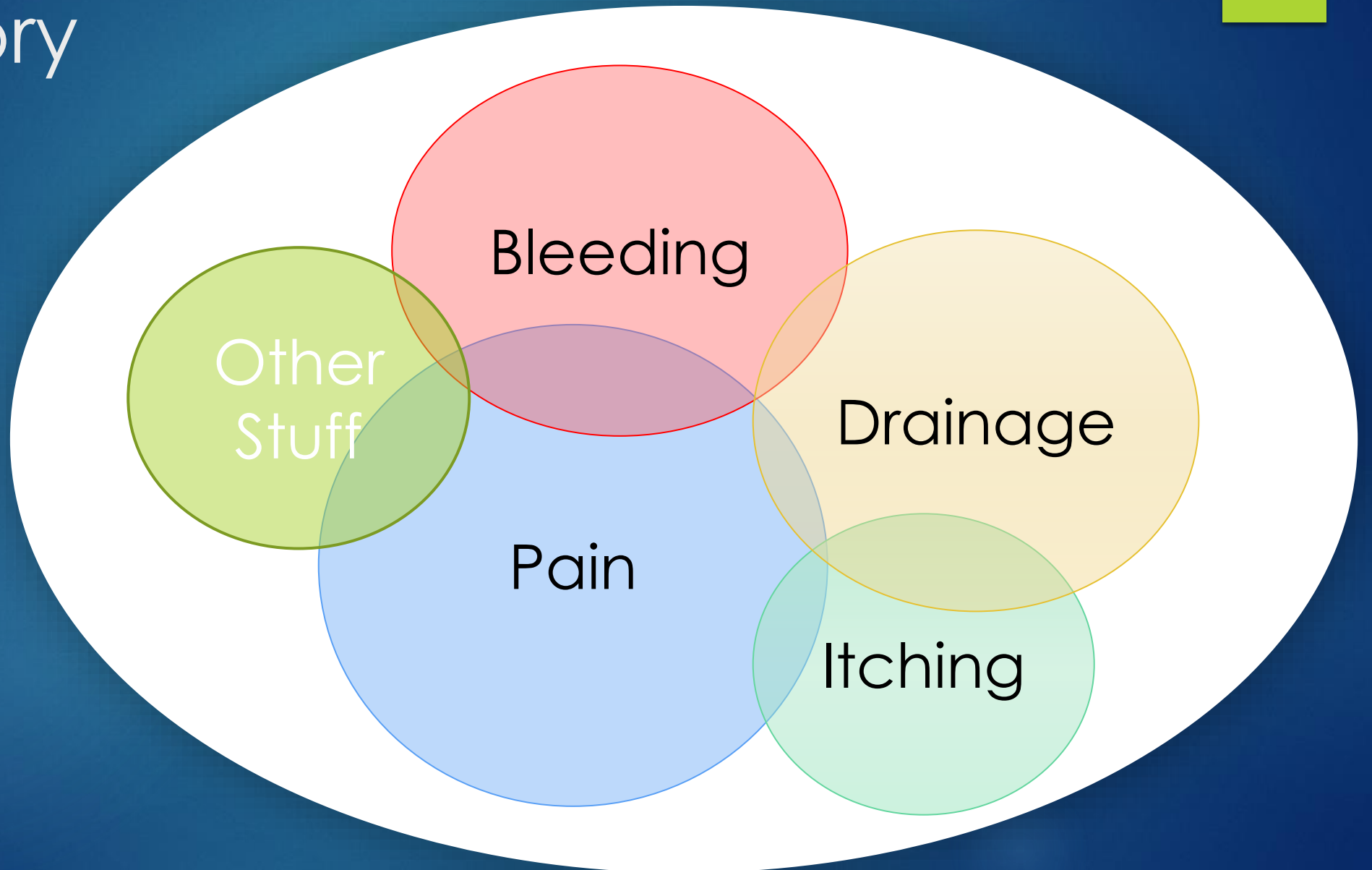


History

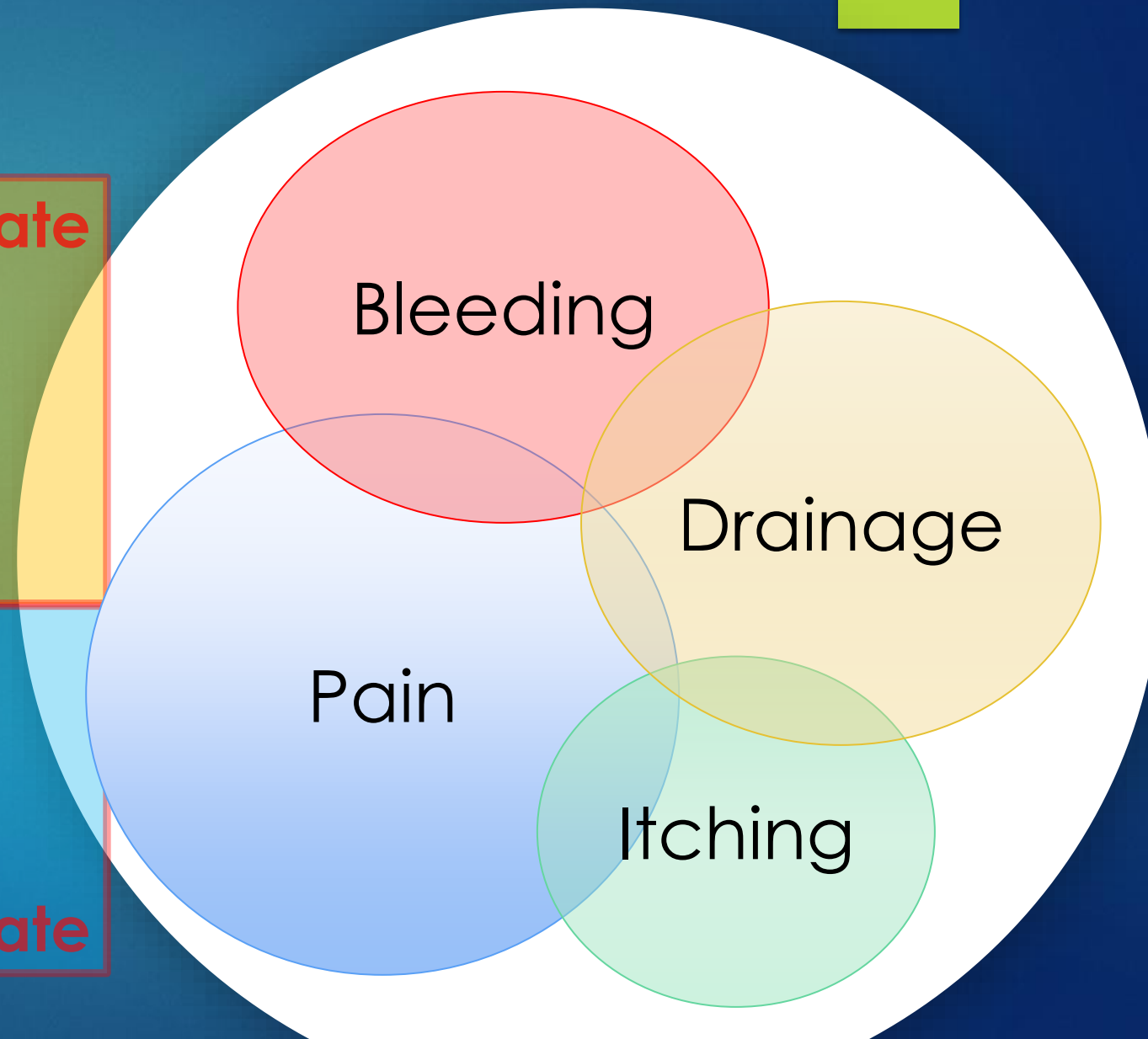
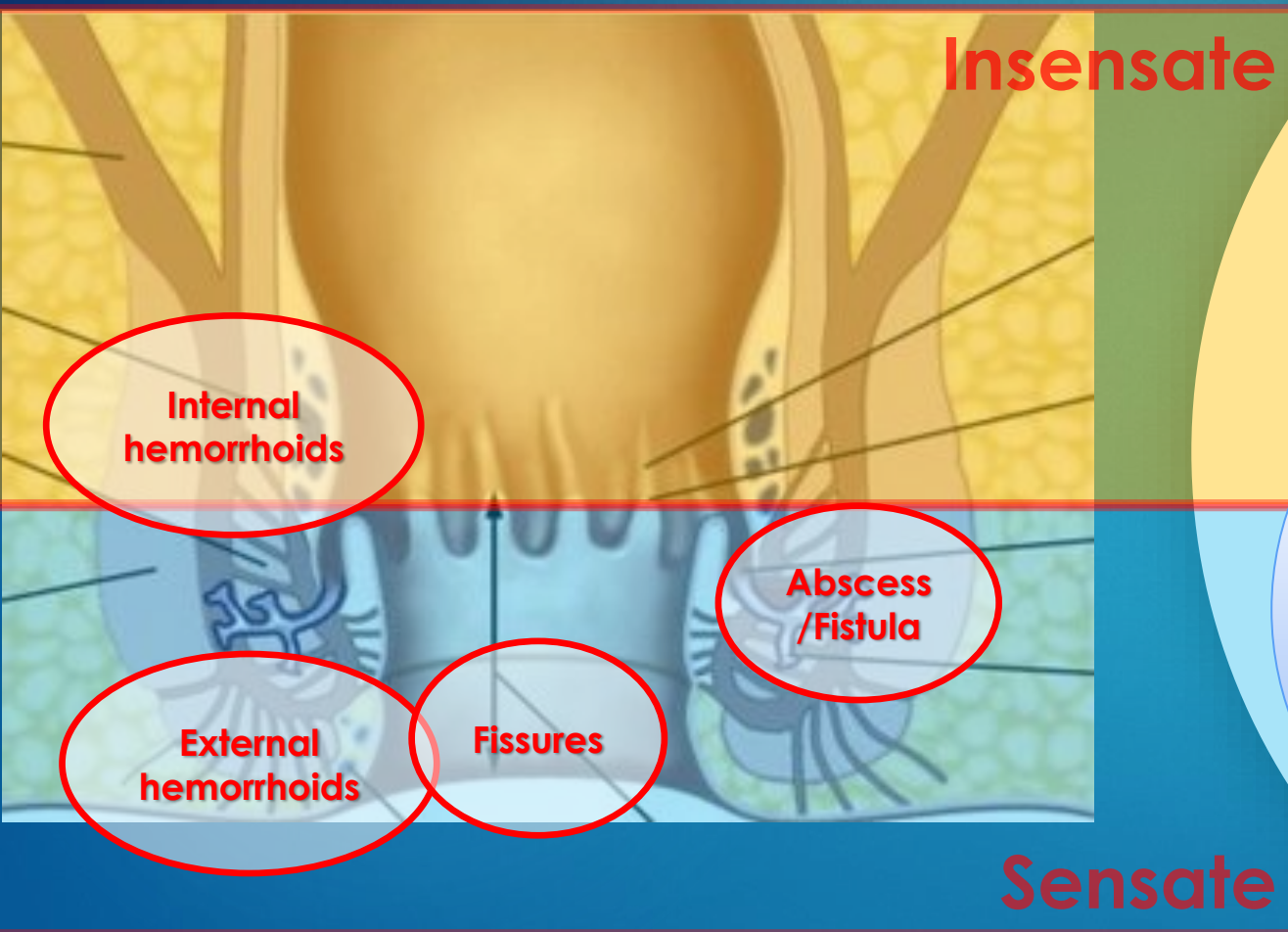
- ▶ Open ended questions to describe the symptoms that bother them
 - ▶ Pain
 - ▶ Bleeding
 - ▶ Tissue moving in and out
 - ▶ Constipation



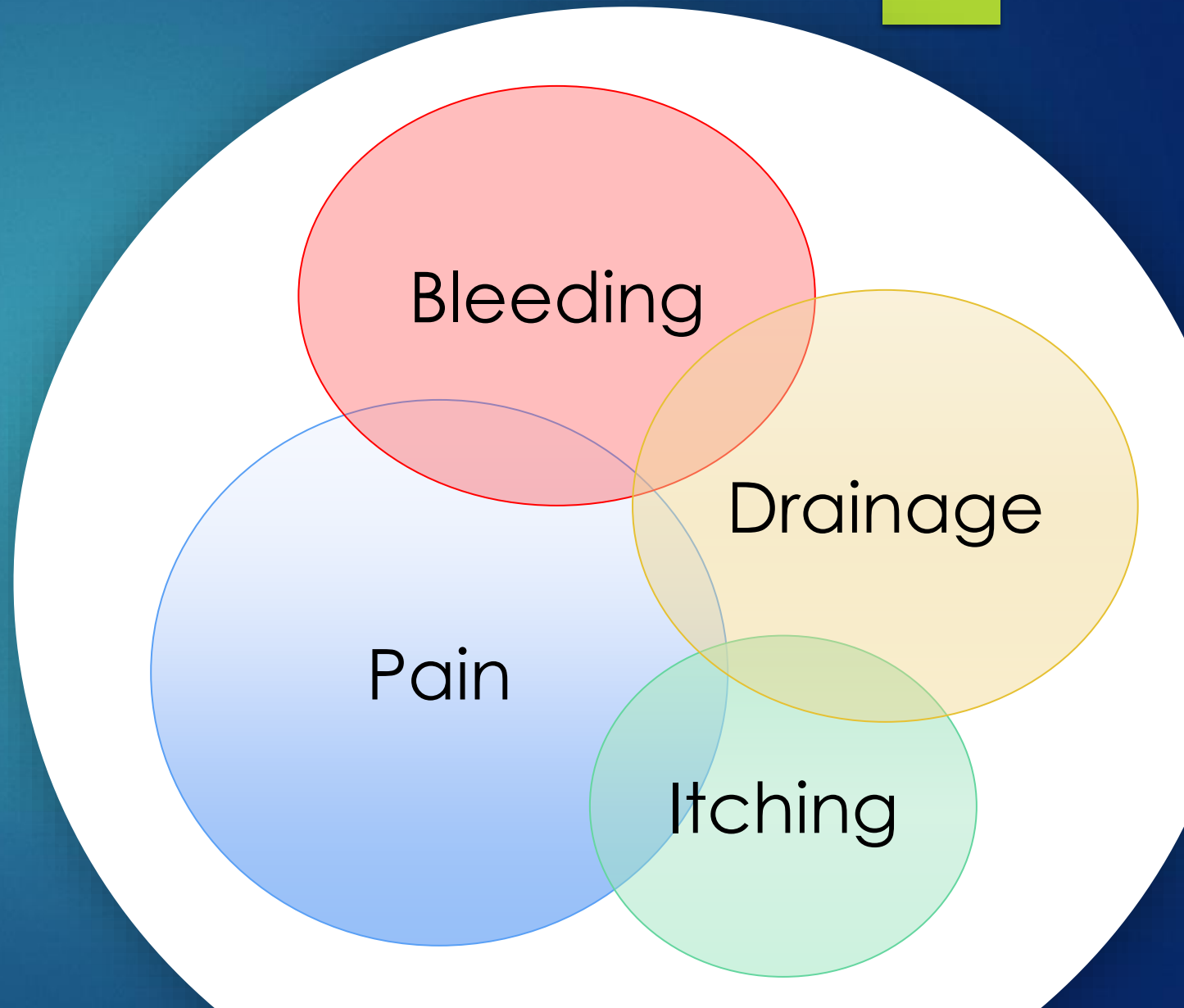
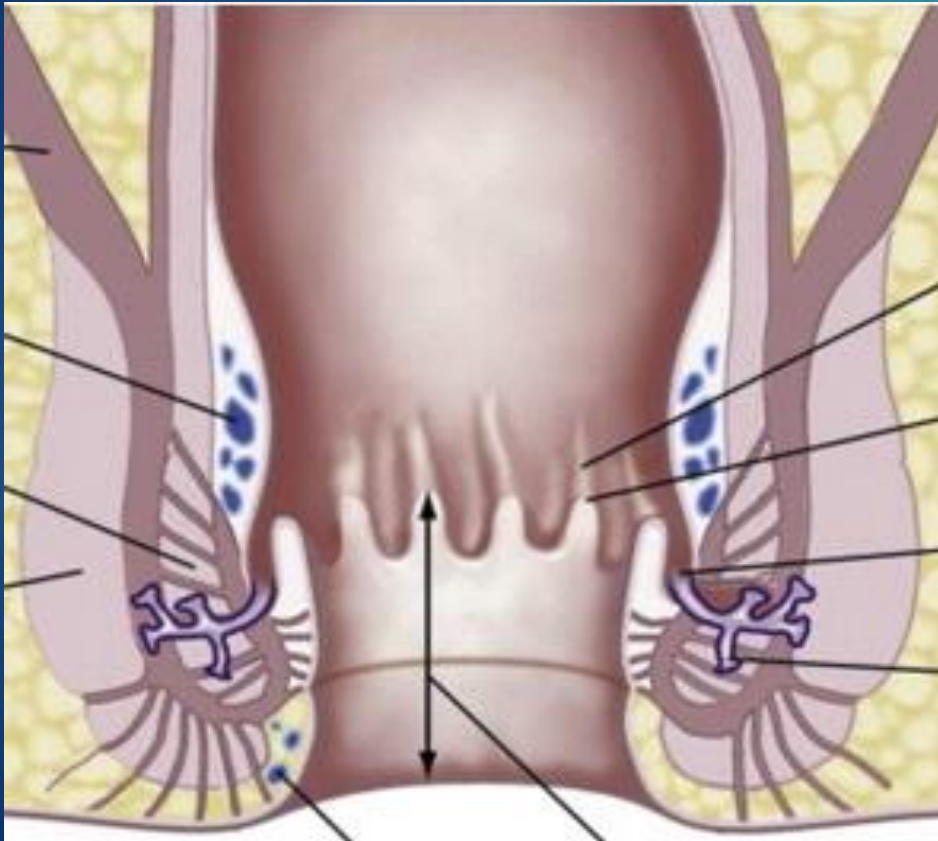
History



History

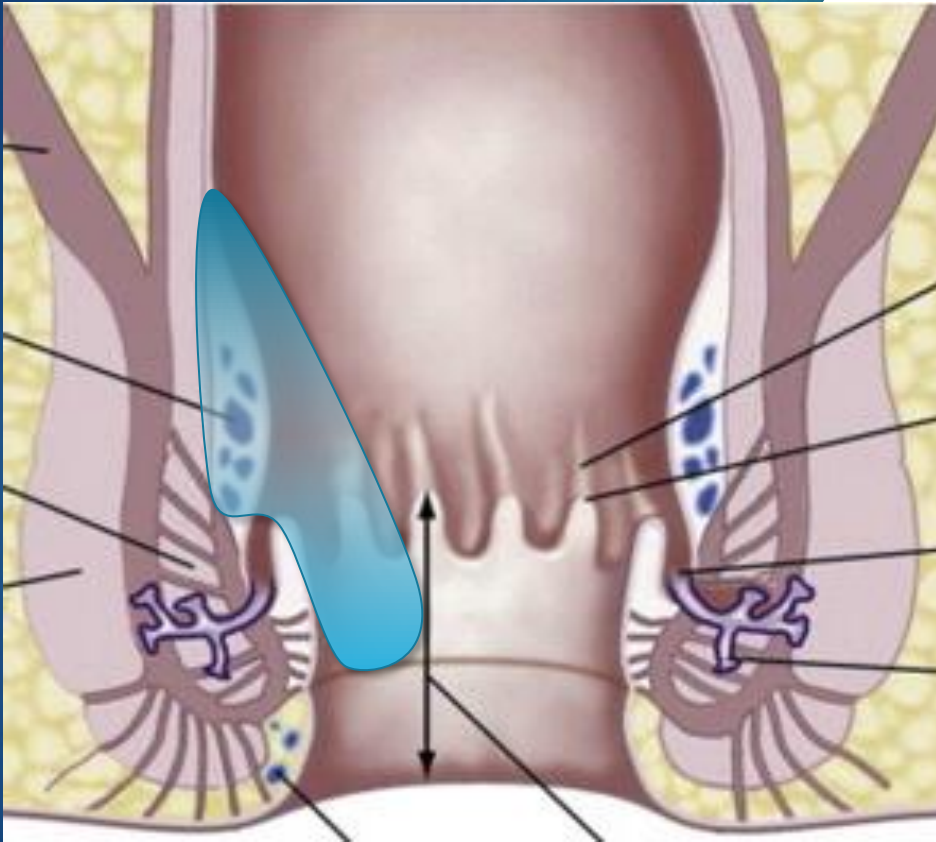


History



History

Internal hemorrhoids



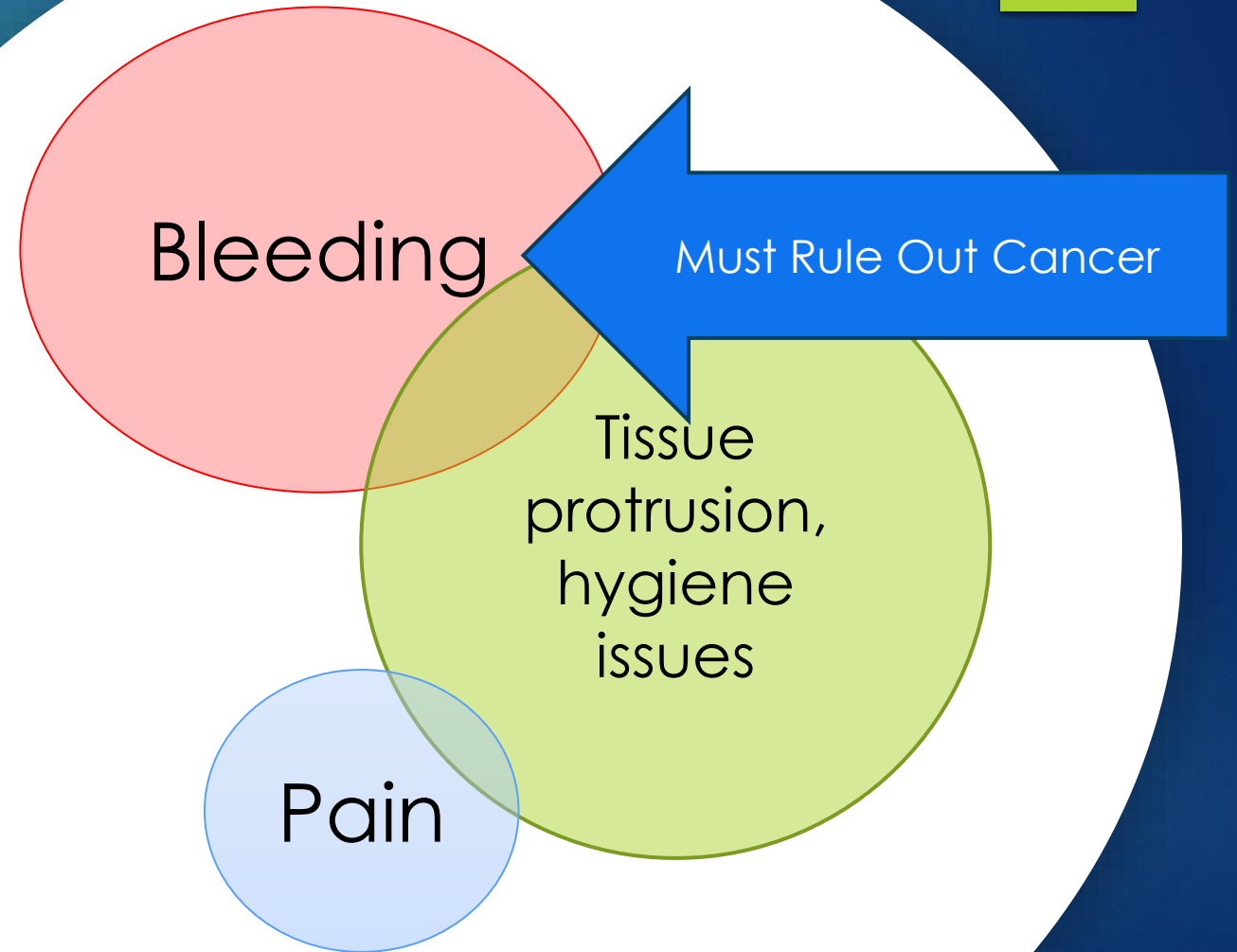
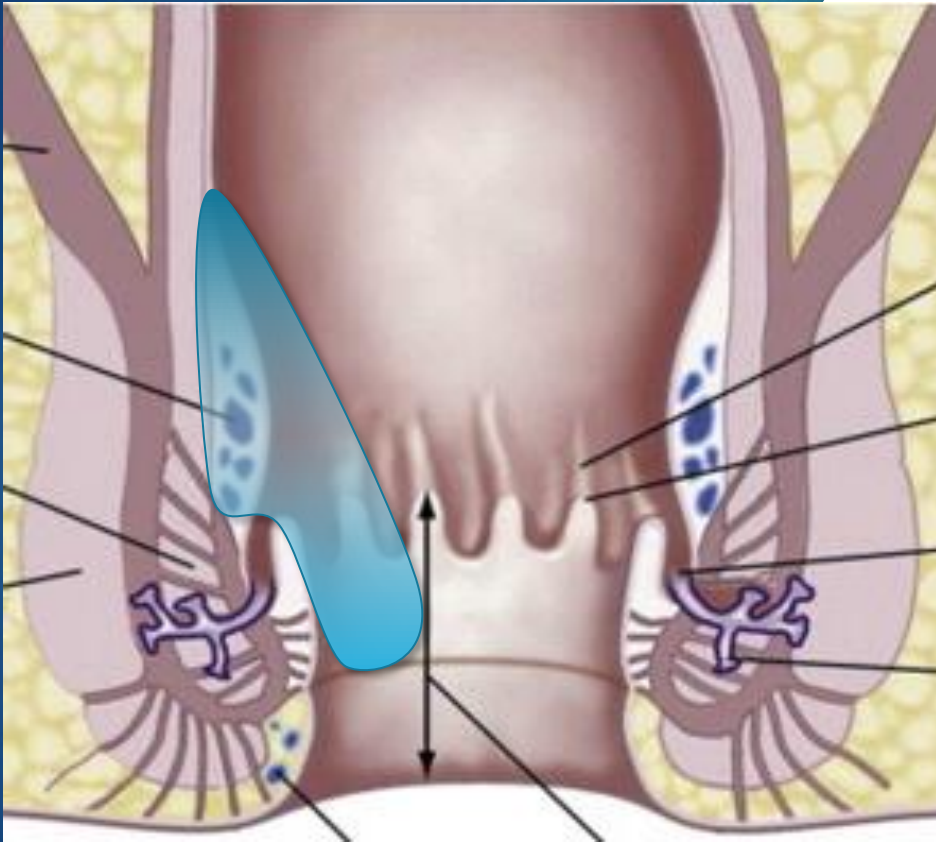
Bleeding

Tissue
protrusion,
hygiene
issues

Pain

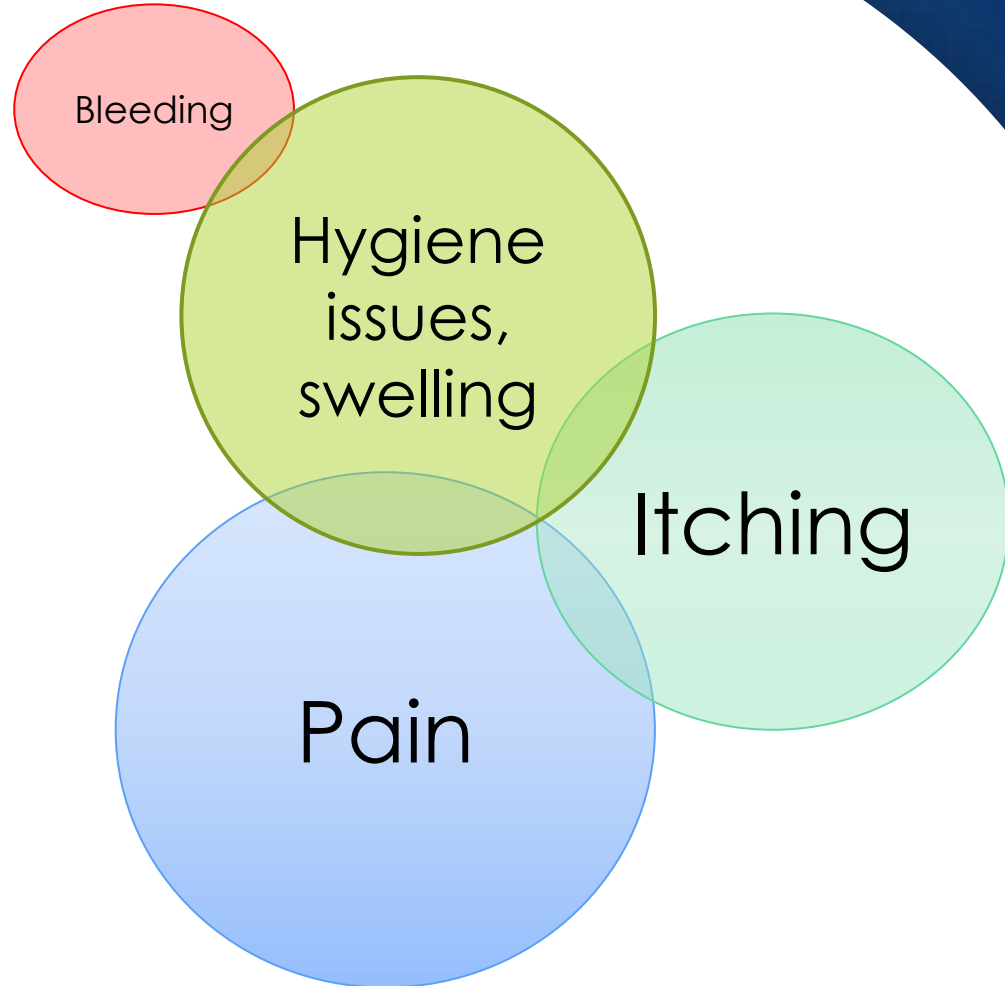
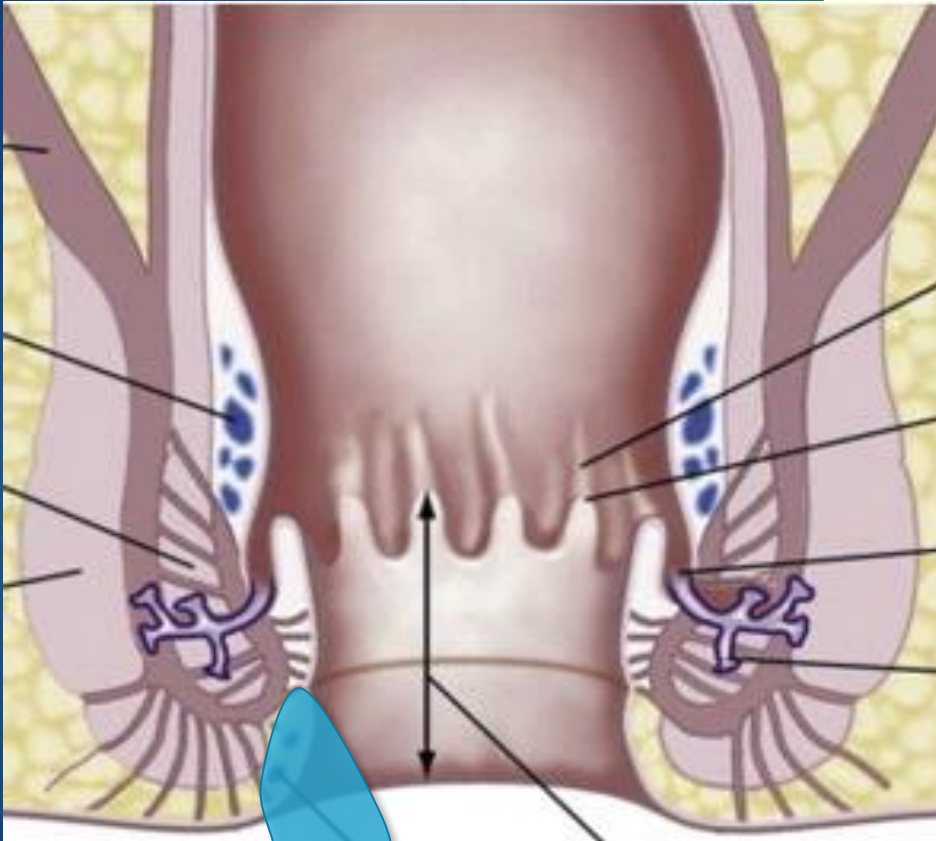
History

Internal hemorrhoids



History

External hemorrhoids



History

Anal Fissure

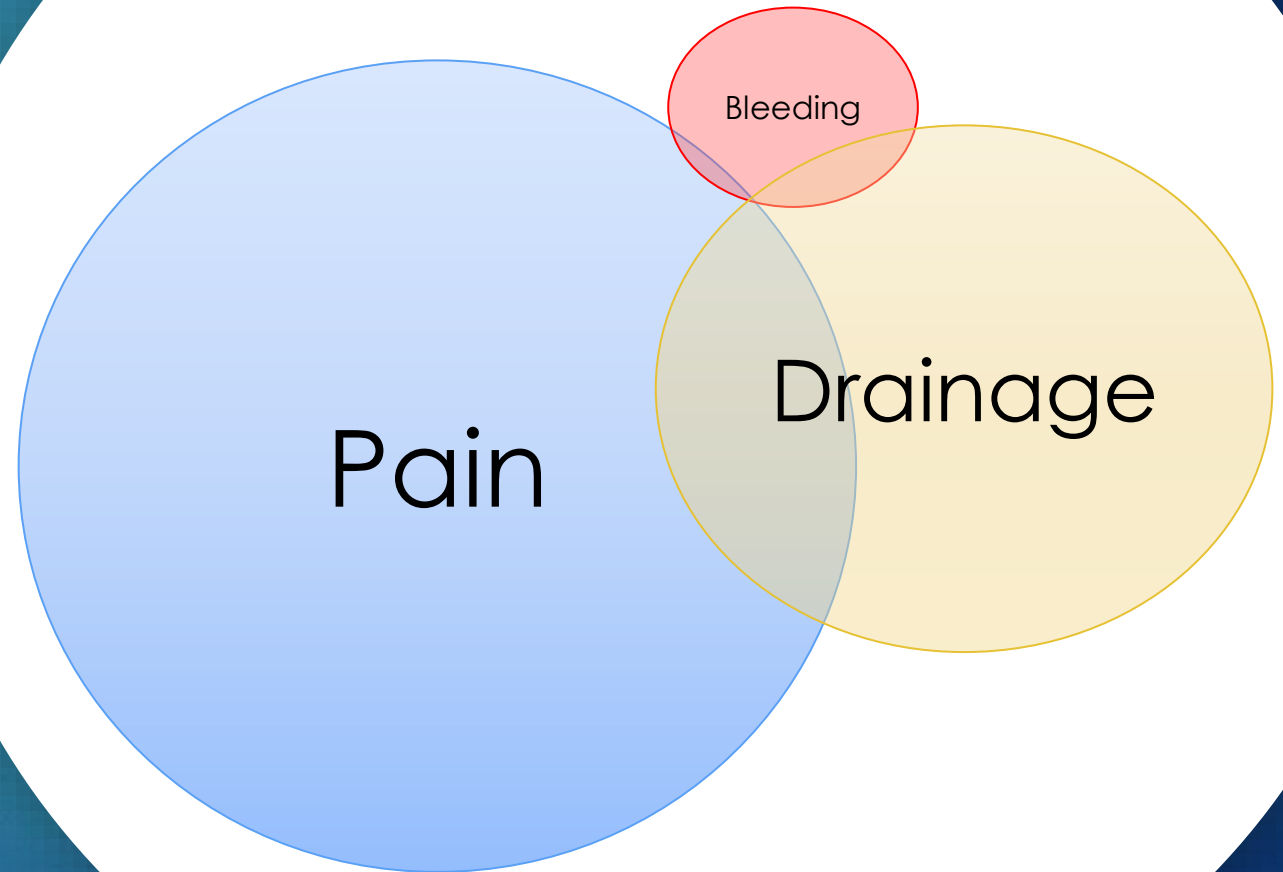
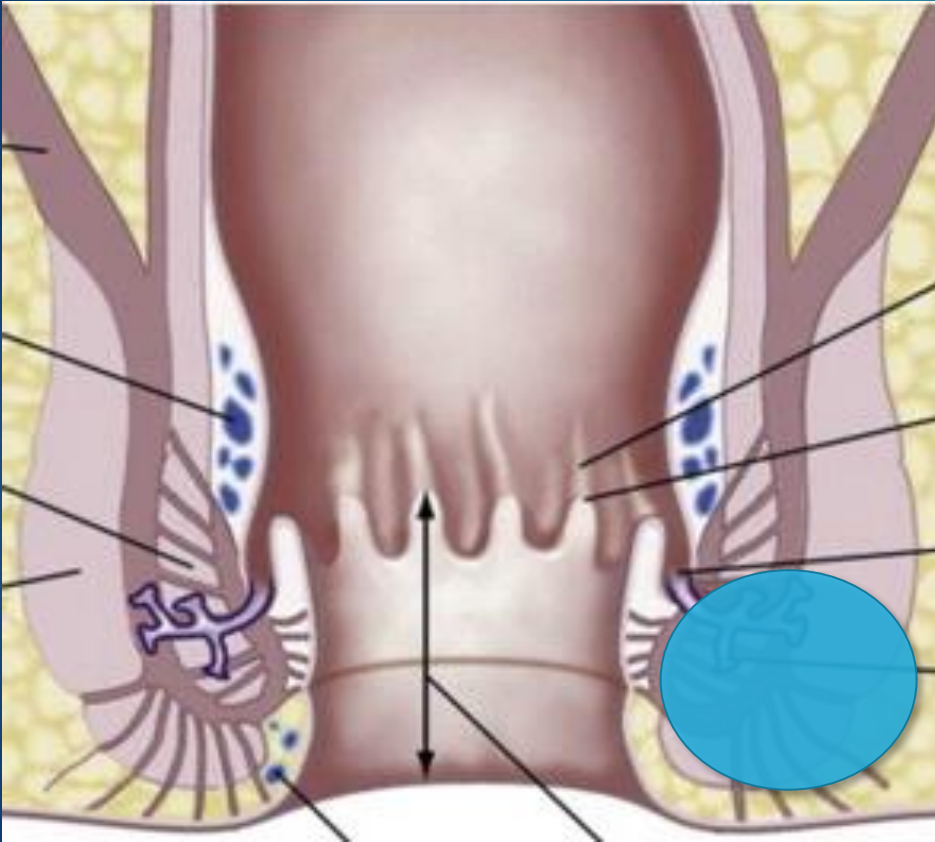


Bleeding

Pain

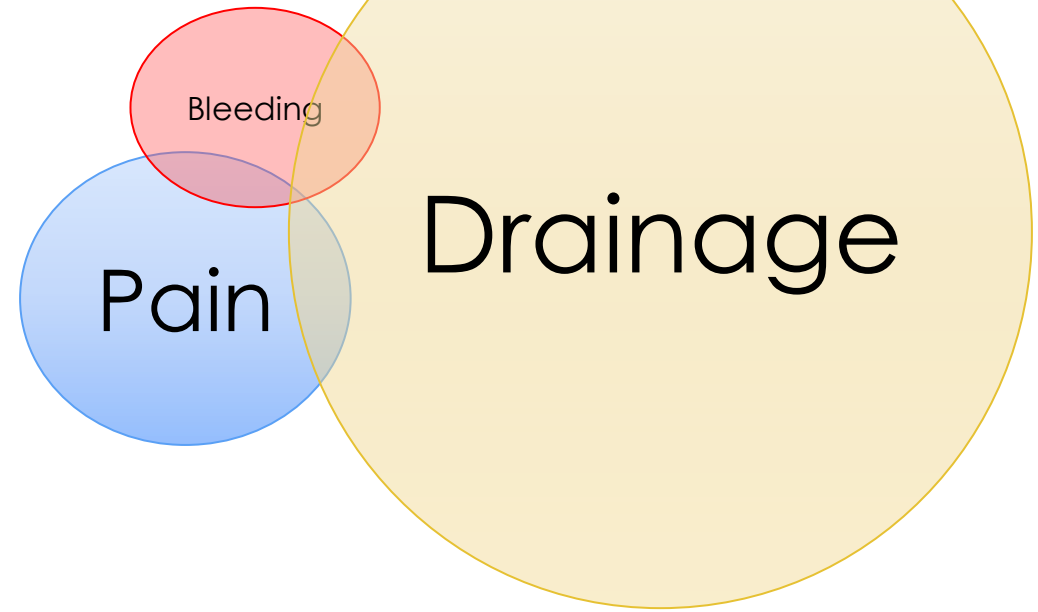
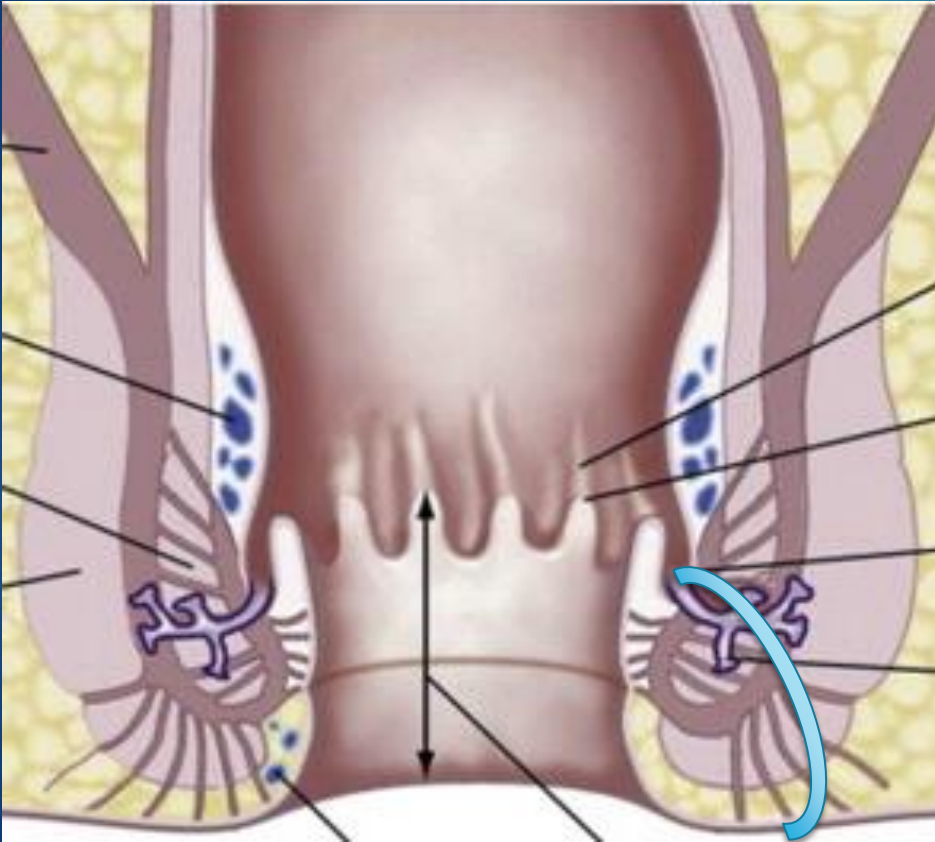
History

Perianal Abscess



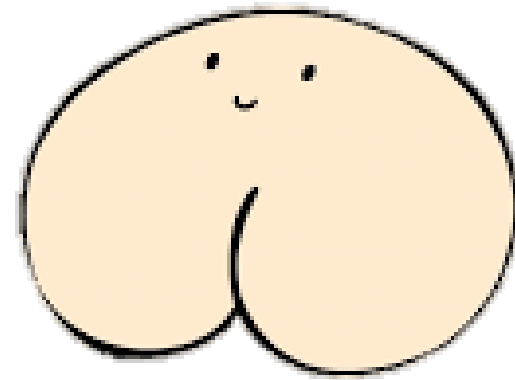
History

External hemorrhoids



History

- ▶ When I am finished with my history, I usually have about a >90% idea of what I will see on exam.



Patient Presentation

35 year old woman complaining of “I have hemorrhoids.”

Detailed history:

- spends 30 min on her phone on toilet
- moderate constipation
- hard BM several months ago followed by severe pain
Lasting 1-2 hrs after every bowel movement, feels like
“glass”



ARS Question #3: Which of the following problems is NOT necessarily readily visible on external anal exam?

1. External hemorrhoids
2. Prolapsing internal hemorrhoids
3. Anal canal cancer
4. Anal fissure
5. Peri-anal fistula

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Which of the following problems is NOT necessarily readily visible on external anal exam?

External hemorrhoids

Prolapsing internal hemorrhoids

Anal canal cancer

Anal fissure

Peri-anal fistula

Physical exam

1

External exam

external hemorrhoids,
prolapsing internal
hemorrhoids, rectal
prolapse, fissure,
abscess, fistulae



2

Digital rectal exam

goal is to rule out
large
masses/cancers,
internal abscess

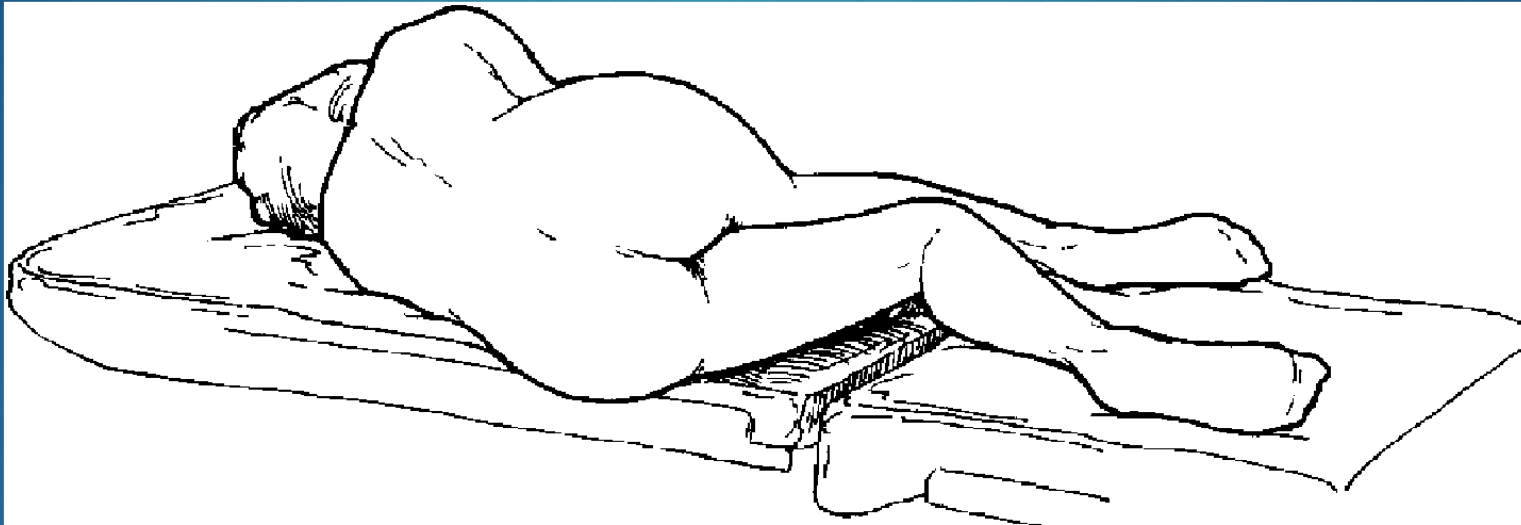


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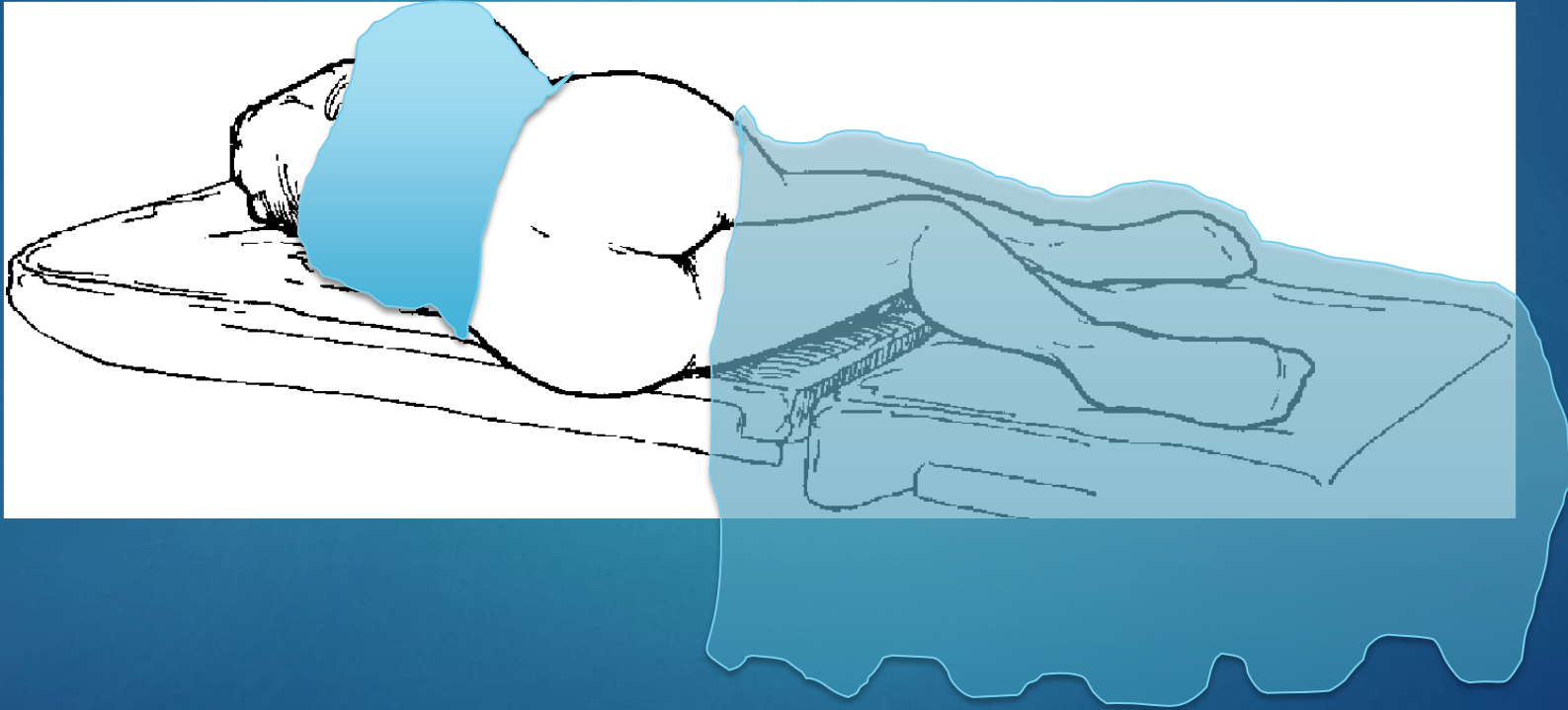
Anoscopy

internal hemorrhoids,
masses

Physical exam



Physical exam





External exam



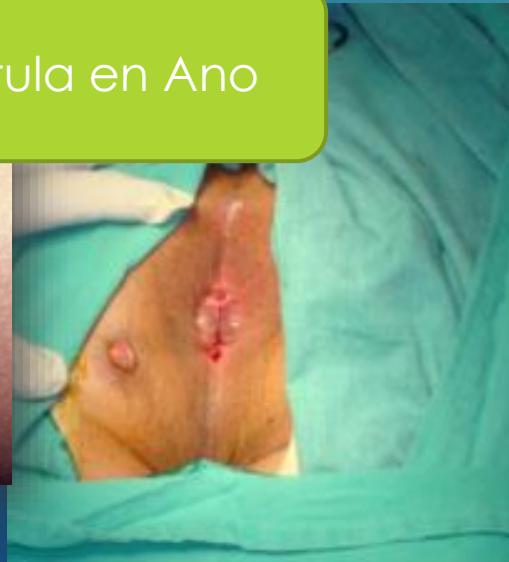
External hemorrhoids



Anal Fissure



Fistula en Ano



Perianal Abscess



External exam



External hemorrhoids



Anal Fissure



Fistula en Ano



a



Perianal Abscess

External exam



Anal Fissure

Fistula en Ano

Perianal Abscess

Patient Presentation

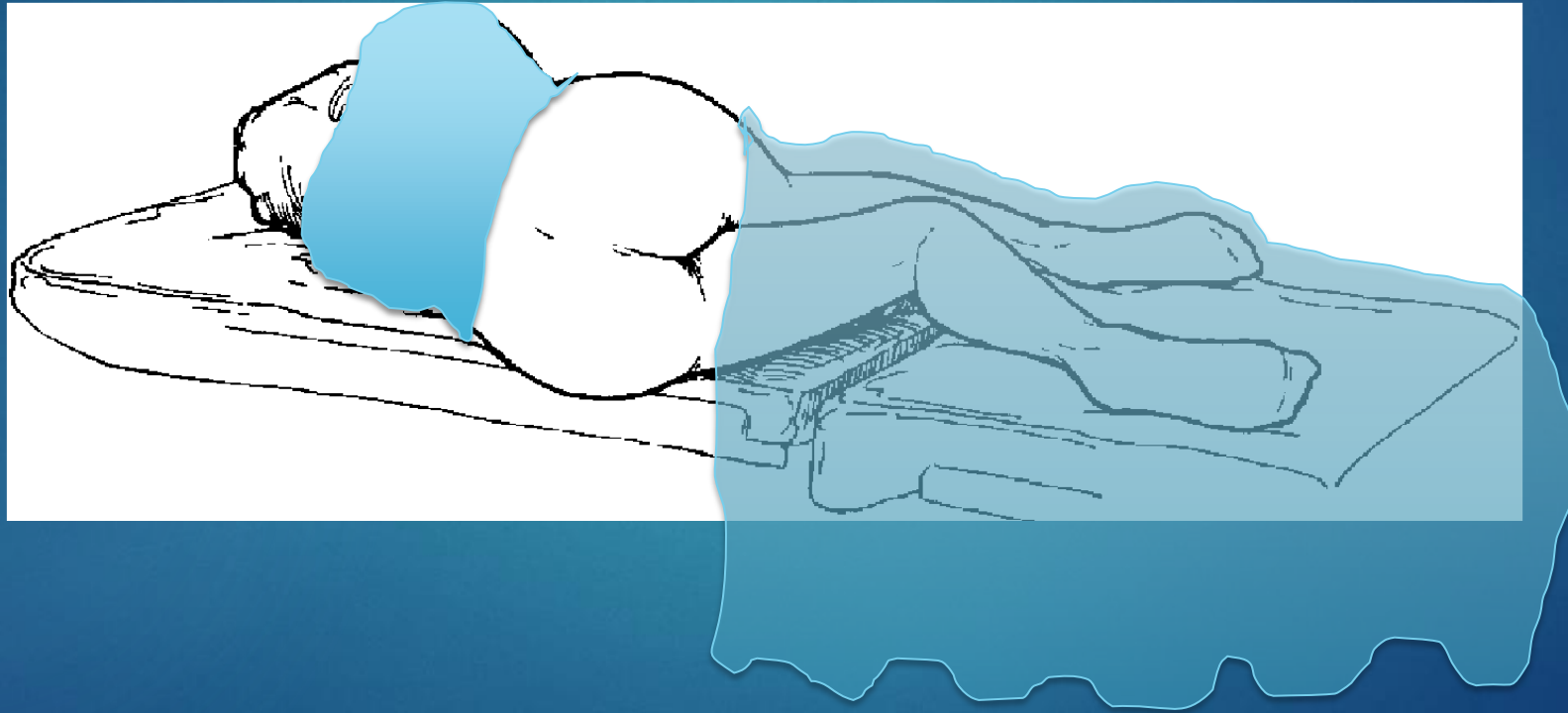
35 year old woman complaining of “I have hemorrhoids.”

External exam:

- No crevice in the posterior/anterior midline
- Small amounts of excess skin in one of the hemorrhoidal cushions, but no other obvious findings



Digital Rectal Exam



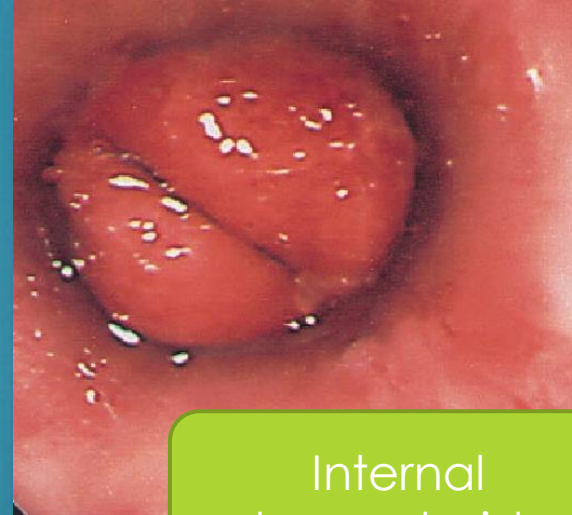
DRE



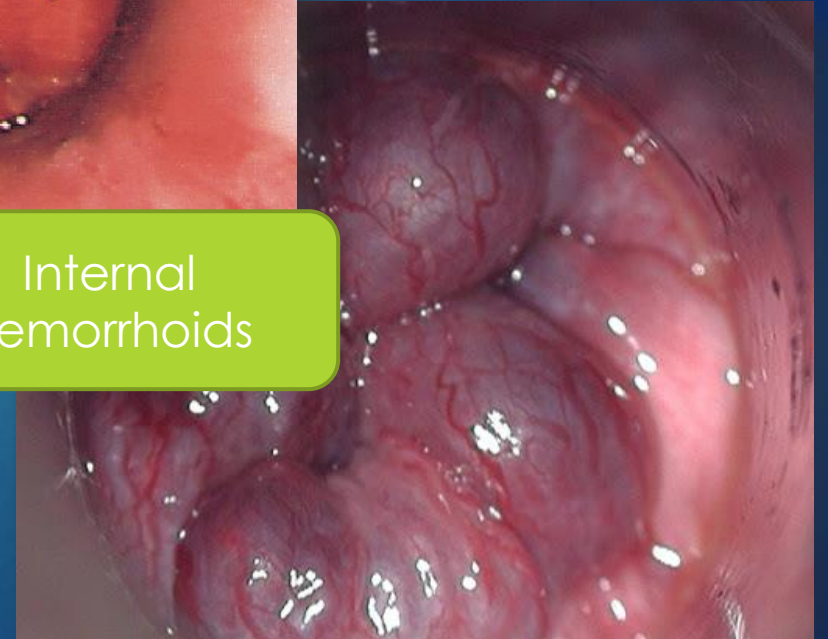
Anoscopy – The Light at the End of the Tunnel



Normal Mucosa

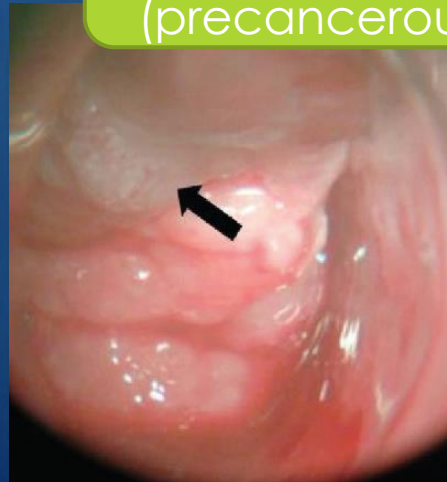


Internal hemorrhoids

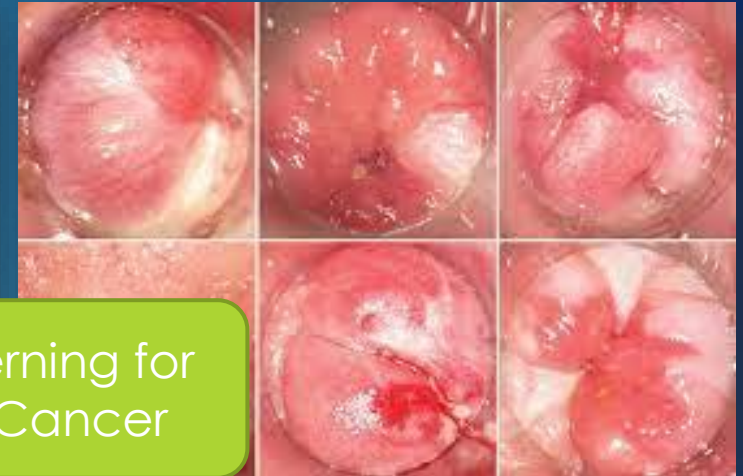


Anoscopy

Concerning for
AIN
(precancerous)



Concerning for
Anal Cancer



ARS Question #4: Hemorrhoid grading reflects finding from the...

1. History
2. Physical Exam

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Hemorrhoid grading reflects finding from the...

History

Physical
Exam

Patient Presentation

35 year old woman complaining of “I have hemorrhoids.”

DRE: firm, fixed nodule in the posterior midline just inside the anal verge

Anoscopy: limited by pain, you just see a little irregular Area of mucosa right before the verge

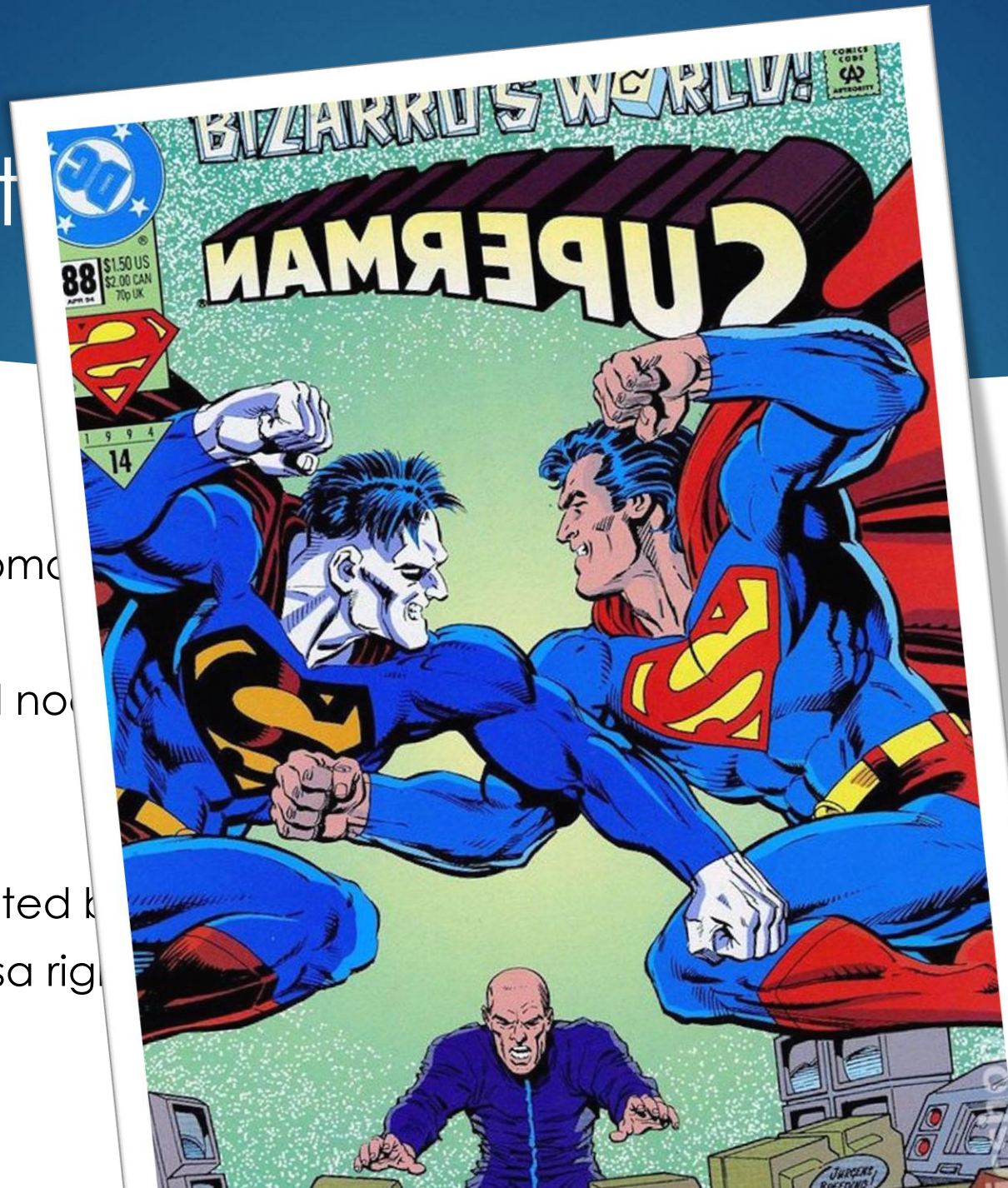


Patient

35 year old woman

DRE: firm, fixed nodules
anal verge

Anoscopy: limited by
Area of mucosa right



Patient Presentation

Alternate reality

35 year old woman complaining of “I have hemorrhoids.”



Patient Presentation

Alternate reality

35 year old woman complaining of “I have hemorrhoids.”

History: swelling, itching, prolapse of tissue during BMs
requiring reduction



Patient Presentation

Alternate reality

35 year old woman complaining of “I have hemorrhoids.”

History: swelling, itching, prolapse of tissue during BMs requiring reduction

External exam: non engorged external hemorrhoids



Patient Presentation

Alternate reality

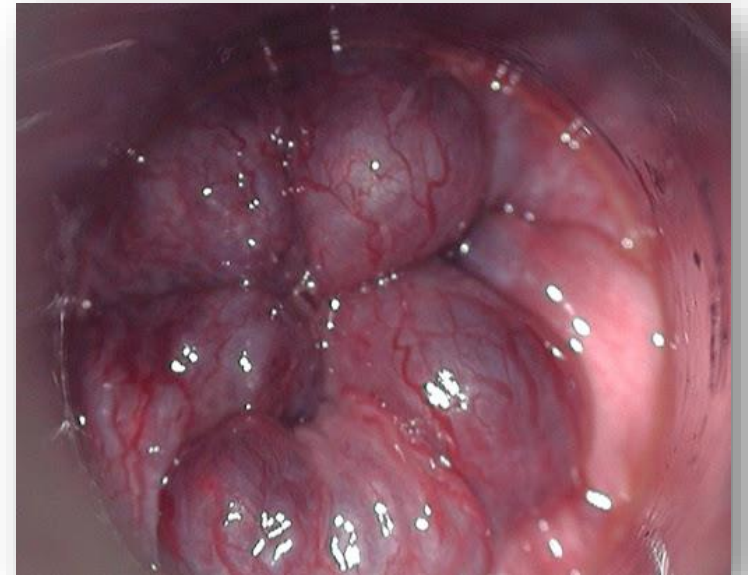
35 year old woman complaining of “I have hemorrhoids.”

History: swelling, itching, prolapse of tissue during BMs requiring reduction

External exam: non engorged external hemorrhoids

DRE: unremarkable

Anoscopy: Internal hemorrhoidal tissue, mild granulation tissue, hemorrhoid prolapses after the anoscope is removed



GRADE	DIAGRAM	PICTURE	PROLAPSE
01			▶ NO PROLAPSE, JUST PROMINENT BLOOD VESSELS
02			▶ PROLAPSE UPON BEARING DOWN, BUT SPONTANEOUS REDUCTION
03			▶ PROLAPSE UPON BEARING DOWN REQUIRING MANUAL REDUCTION
04			▶ PROLAPSE WITH INABILITY TO BE MANUALLY REDUCED

Internal hemorrhoid grading

Hemorrhoid Treatment



Important note:

Surgical repair should be reserved for very severe, high grade, or refractory hemorrhoids only.

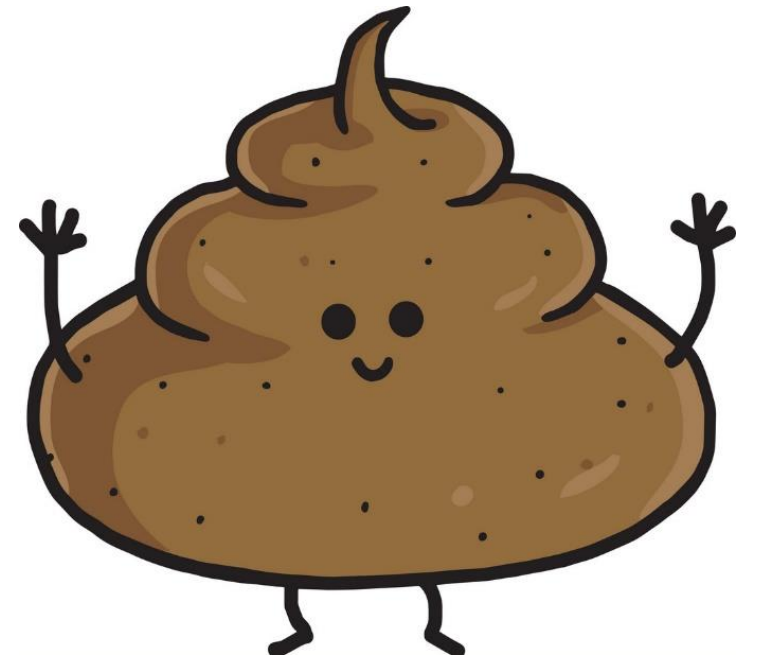
Surgical therapies are effective but incredibly painful and have rare but substantial risks (bleeding, infection, anal stenosis, incontinence).

Most patients with hemorrhoids do not require a surgical consultation.

Hemorrhoid Treatment

Medical therapies:

- 1) Dietary modification
- 2) Fiber supplementation
- 3) Hydration
- 4) Bowel hygiene correction
- 5) Medical treatment of residual constipation







Hemorrhoid Treatment

Dietary modification or
Fiber Supplementation

to a goal of
25-30g/day



Hemorrhoid Treatment

HYDRATION



Hemorrhoid Treatment

Bowel Hygiene

- ▶ No/minimal straining
- ▶ Do not sit on toilet for >5 min
- ▶ Do not bring phone/book/magazine into the bathroom
- ▶ Squatty potty or bench next to the toilet



Hemorrhoid Treatment

If patients fail months-years of conservative measures **and** their hemorrhoids significantly effect quality of life surgical consultation is reasonable.



Surgical Hemorrhoid Treatment

1) Banding

- ▶ In office (awake, somewhat uncomfortable)
- ▶ Multiple treatments, less effective
- ▶ Only treats internal hemorrhoids

2) Excisional hemorrhoidectomy

- ▶ In the OR
- ▶ Highly effective
- ▶ **INCREDIBLY PAINFUL**, difficult recovery, frequent ED visits

3) Other OR treatments

- 1) Transanal hemorrhoidal dearterialization
- 2) Stapled hemorrhoidectomy
 - ▶ in OR, work well, less painful
 - ▶ **Do not directly treat external hemorrhoids**

ARS Question #5: True/False - Anal Fissures usually require surgical management.

1. True
2. False

Respond at pollev.com/christinewes031

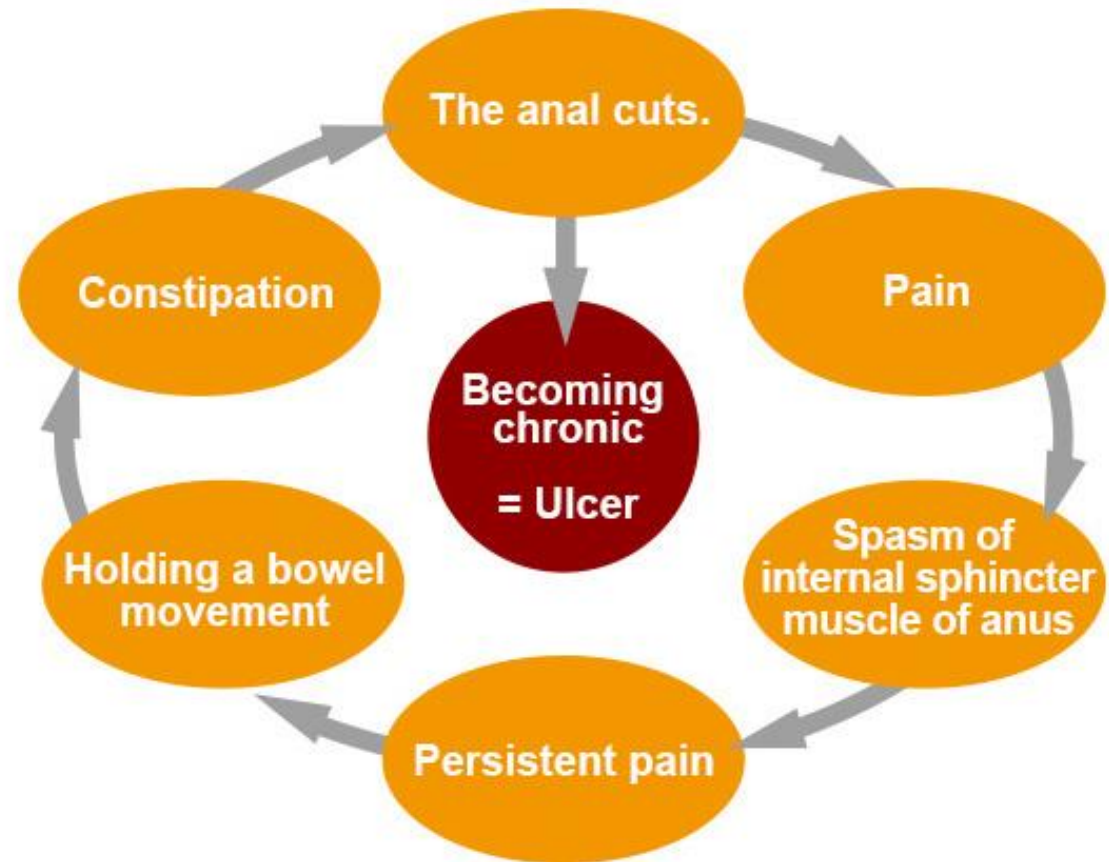
Text **CHRISTINEWES031** to **22333** once to join, then **A or B**

True/False - Anal Fissures usually require surgical management.

True **A**

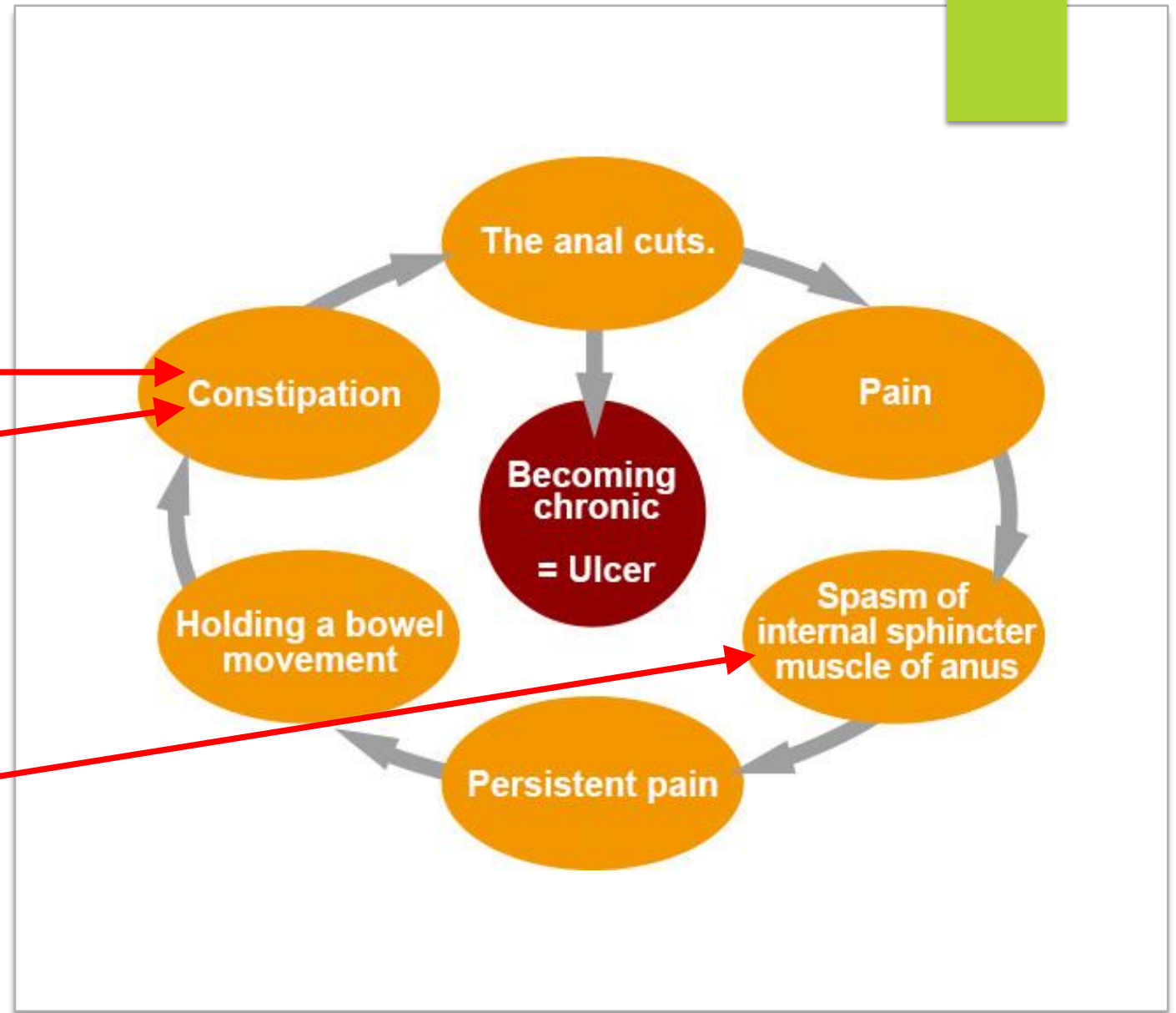
False **B**

Fissure Treatment



Fissure Treatment

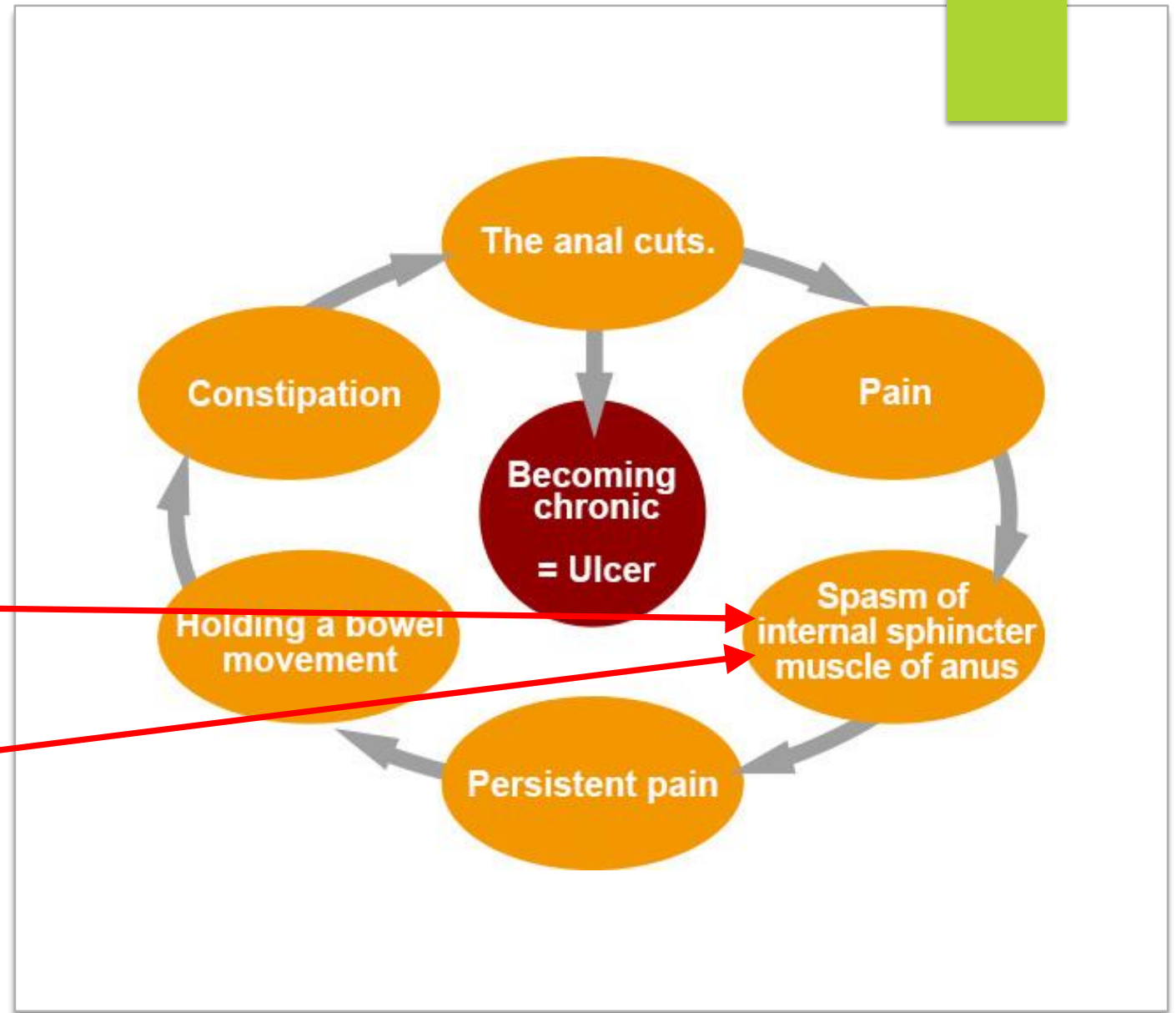
- Fiber and fluids (similar to hemorrhoids)
- Bowel regimen
- Topical muscle relaxants
 - Nitroglycerine (less expensive)
 - Topical Calcium channel blockers (better)



Surgical Fissure Treatment

If non operative management unsuccessful for 6-8 weeks, reasonable to refer for surgical treatment.

- Botox injection
(lower efficacy, no long-term SEs)
- Lateral internal
sphincterotomy
(higher efficacy, small risk of
devastating incontinence)



Abscess/Fistula en Ano



Active, acute abscess → Seek urgent/emergent care

Chronic, subacute or recurrent abscess → Surgical referral

Concern for Fistula en Ano → **Screen for IBD** → Surgical referral

Summary

- ▶ Take a thorough history
- ▶ Use physical exam to rule in/out suspicions
 - ▶ Physical exam can be made minimally traumatic, uncomfortable
- ▶ Malignancy must be ruled out in adults with pain, bleeding
- ▶ Conservative management is the mainstay in hemorrhoidal and fissure diseases
 - ▶ Surgical intervention should be **avoided** if at all possible
- ▶ Topical steroids are not a cure for any anorectal disease
- ▶ General Surgery is here to help!

Patient #1 Conclusion

35 year old woman #1 – CC “I have hemorrhoids”

Diagnosis: Anal Cancer

Had an EUA and biopsy

Underwent chemotherapy and XRT (Nigro Protocol)

Had a full response and entered surveillance

On HAART therapy for concomitant HIV – doing well



Patient #2 Conclusion

35 year old woman #2 – CC “I have hemorrhoids”

**Diagnosis: Mild external hemorrhoids, Grade III
Internal hemorrhoids**



Had a discussion about fiber supplementation, bowel hygiene

Hemorrhoids became less symptomatic over 8 wks and no further intervention required

Where to read more...

ASCRS: <https://fascrs.org/healthcare-providers/education/clinical-practice-guidelines>

The screenshot displays the ASCRS (American Society of Colon & Rectal Surgeons) website. The header includes the ASCRS logo, a navigation bar with links like 'MY ASCRS', 'HEALTHCARE PROVIDERS', 'PATIENTS', 'PARTNERS', 'MEDIA', 'ABOUT', and a search icon. A secondary navigation bar contains links for 'Login', 'Find a Colorectal Surgeon', 'Join', 'ASCRSconnect', 'Donate', and 'Dues Payment'. The main content area is titled 'Clinical Practice Guidelines' and includes a brief description of the committee's role. It lists '2021 Clinical Practice Guidelines' and '2020 Clinical Practice Guidelines' with specific topics and links to 'Guideline PDF', 'Podcast', and 'Visual Abstract'. On the left, a sidebar menu lists various resources under 'Healthcare Providers', 'Education', and 'Colorectal Cancer Awareness Month'. Three callout boxes are overlaid on the right side of the page, highlighting specific guideline PDFs: 'Management of Anal Fissures Guideline PDF', 'Management of Hemorrhoids Guideline PDF | Visual Abstract', and 'Treatment of Colon Cancer Guideline PDF | Visual Abstract'.

ASCRS
American Society of
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Home > Healthcare Providers > Education > Clinical Practice Guidelines

Clinical Practice Guidelines

The role of the Clinical Practice Guidelines Committee focuses primarily on the creation of practice guidelines for various procedures to assist physicians in caring for patients with colon and rectal disease. The following clinical practice guidelines have been published in the ASCRS scientific journal *Diseases of the Colon and Rectum*.

2021 Clinical Practice Guidelines

- Management of *Clostridioides difficile* Infection
[Guideline PDF](#) | [Podcast](#) | [Visual Abstract](#)
- Surveillance and Survivorship Care of Patients After Curative Treatment of Colon and Rectal Cancer
[Guideline PDF](#) | [Podcast](#) | [Visual Abstract](#)

2020 Clinical Practice Guidelines

- Treatment of Left-sided Colonic Diverticulitis
[Guideline PDF](#) | [Podcast](#) | [Visual Abstract](#)
- Management of Rectal Cancer
[Guideline PDF](#) | [Podcast](#) | [Visual Abstract](#)

Management of Anal Fissures [Guideline PDF](#)

Management of Hemorrhoids [Guideline PDF](#) | [Visual Abstract](#)

Treatment of Colon Cancer [Guideline PDF](#) | [Visual Abstract](#)

Healthcare Providers

- Join
- Education
 - Clinical Practice Guidelines
 - Core Subjects
 - Quality Assessment and Safety Committee Initiatives
 - Healthcare Economics/Billing Codes
 - Pelvic Floor Disorders Consortium
 - ASCRS Guide to Enhanced Recovery Programs
 - American Board of Colon and Rectal Surgery
- Colorectal Cancer Awareness Month
- For Trainees
- Leadership

Three Things to Do Starting TOMORROW

- 1) Careful attention to a safe, comfortable physical exam with open communication. Be aware of possibility of past trauma.
- 2) Stop prescribing topical therapies (except for very limited courses) and start education about fiber supplementation and bowel hygiene!
- 3) Educating patients about expectations for most peri-anal disease including life-long lifestyle changes and surgery as a last resort.