Anal pathologies

Disclaimer:
Read the disclaimer at medimaps.co.uk/disclaimer

References:
1. Surgeon lecture Alliance Federation Sept 2017
2. Conference June 2018
3. Colorectal consultant Spire, May 2020
4. Dr Helen Lobery dermatology consultant, Southampton NHS, Jan 2021
5. Colorectal webinar Feb 2025

Anal fissure

- 90% are posterior midline.
- 10% anterior midline.
- <1% off midline.
- Most idiopathic. Childbirth, constipation, straining, prolonged diarrhoea, recreandtl.
- If multiple fissures think IBD, TB, Syphilis, HIV.

Symptoms

- Intense pain during defecation.
- Can persist severeal hrs after defacation.
- Might not see it, so can simply treat if classical Hx, and see if settles.

Management

- Lasative.
- Fibre.
- Fluids.
- Topical vasodilator.

- Anoheat (diltiazem) 2%, no headache.
  OR
- Rectogesic (GTN) 0.2 - 0.4%, headaches lasts 1/52.

- Apply pea size amount BID for 6-8/52, even if feel better.
- Just on the edge of the anal verge, not insid.
- Increase blood supply to heal, and reduces spasm.
- Wear a glove to avoid systemic absorption and sde.

unhealed but asymptomatic or notable improvement

unhealed and no symptomatic improvement

- Repeat the topical vasodilator for 6-8/52 again.

if fails

- Refer to colorectal surgeons.
- Botox injected into internal anal sphincter.
- Lateral internal sphincterotomy.

Anal fistula

- The skin around is normal and calm. So unlikley abscess.
- 80-90% are due to cryptoglandular sepsis. The mucous gland gets infected then forms a track = fistula.

- Crohns.
- TB.
- Chlamidyia.
- Trauma.

- Recurrent abscess - think fistula
- Purulent discharge - think fistula.

Investigations

- MRI, or EUA

Management

- Refer to colorectal surgeon.
- Setun or more complex procedures.

Perianal abcess

- Three sites:
  a) Perianal
  b) Pilonidol.
  c) Ischorectal

- Drainage and antibiotics (metronidazole, NOT a skin Abx like flucloxacillin)

Haemorhoids

- They are actually anal cushions at 3, 7 and 11 o'clock positions.
- They are sinusoids, connective tissue and smooth muscle.
- When downward displacement of cushions, you occlude venous flow and get engorgement.
- External haemorrhoids are from perianal vessels.
- Internal haemorrhoids are from within and eventually come out.

- Due to:
- Diarrhoea can cause an increased bowel transit which puts pressure on anal canal.
- Ageing.
- Lack of exercise.

- Bleeding (can be independent of defecation).
- Pruritis.
- Painful if incarcerated (blood goes into haemorrhoid but cant leave it, so get venous engorgement).
- Mucous and faecal seeping due to the bad haemorrhoids stopping the sphincter from working well enough.
- Useful to grade as treatment differs.

Mildlearly haemorrhoids:
- Diet.
- Exercise.
- Avoid straining.
- Avoid sitting for prolonged periods on toilet,.just get off if nothing happening.
- Topical treatment e.g. anmusol, scheriproct, uniroid.

Banding treatment:
- Banding = for grade 1-3.
- 90-80% success rate.
- Pain, bleeding, fever at after 2/52 they might get brisk bleeding as the scab at the site falls away and may need hosp admission to fix.

Radiofrequency ablation:
- Local anaethetic.
- For early haemorrhoids grade 2, early grade 3.

HALO / Transanal Haemorrhoidal Dearterialisation:
- For grade 2-3.
- Use internal USS to suture the specific arterial blood vessel, which kills the haemorrhoid.
- Off work several weeks.

Haemorrhoidectomy:
- For grade 3-4.
- Very painful (agony) 2/52 post op.
- Off works several weeks.
- Risk of incontinence 10%. As the anal cushions keep flatus in and once they are removed this can be lost.

Persistent bleeding (e.g. 4 weeks):
- Stronger justification to refer to 2o care.
- Do not refer after one episode.
- Watch and wait.

Thrombosed haemorrhoids:
- Surgeons will not operate in acute phase as distorted anatomy and so could lead to anal stenosis.
- Lasative, ice pack, topical lidocaine.
- Wait 6 weeks for the thrombosis resolves.
- Then can operate if needed.

Perianal haematoma / external haemorrhoid:
- Is severe need surgical admission to incision and drainage.

RI side colectomy

- Your stools are looser as water not absorbed now from that part of gut.
- Loperamide and bulking agents (e.g. Ispaghi) can help.

Anterior recsection

- Anterior resection syndrome as cColon does not store as much hence:
- Faecal incontinence.
- Urgent.
- Frequent bowel motions.

Skin tag

- Residual excess skin associated with prior thrombosis of external haemorrhoids.

- Constantly outside tissue i.e. does not protapse.
- Makes it difficult to keep area clean.
- Sometimes occur if associated perianal Crohn's disease.

- Haemorrhoid treatments don't work.
- Can leave alone.
- Surgical removal.

Pruritis ani

- Treat cause e.g. haemorrhoids, fissure, tags.
- Avoid scratching.
- Wash rather than wipe.
- Pat dry, not rub dry, use dryer.
- Cotton wool ball to absorb moisure when placed over anus.
- Hydrocortisone to break cycle, use for 7 days.
- Refer if fails.

- Dermatology consultant giving lecture on vulval dermatosis, adviced use same regime for peri-anal lichen simplex chronicus:
- Dermovate ointment ON for 2/52, then alternate night for 2/52, then twice weekly for 2/52, then stop.

Alternatively:
- Eumovate ointment (moderate) ON, and taper dose over 3/12.
- Or
- Elocon ointment (potent) ON, and taper dose over 3/12.

Faecal incontinence and constipation

FINCH takes referrals from all around region.
Based in Sandwell hosp.
stage 1 - review diet (cut out excess fluids, caffeine and sugar), meds
stage 2 = bowel retraining - fybogel draws water in, loperamide.
pelvic floor exercises
sage 2 = bowel regtraining, sensory biofeedback
stage 3 = irrigation or wash out, PTNS (neuromodulations)
stage 4 = surgical review

Constipation
stage 1 = Diet
fluid intake, 3L per day.
medications
exercise
correct defaecatory dynamics, squatty potty.
simple laxatives
stage 2 = bowel retraining to retrain them to use right muscles with sensory biofeedback. they have forgotten hwo to open bowels !
stage 3 = irrigation or washouts
prokinetics, prucalopride, lubiprostone, linacotide
stage 4 = surgicla review