Anorectal complaints are frequently encountered in a primary care practice, and many of them can be managed during an office visit. In this article, we present a general approach to the patient who has an anorectal complaint or disorder. We also outline the typical symptoms and physical findings associated with 2 of the most common disorders, hemorrhoids and anal fissures, followed by a discussion of management strategies. In a coming issue, we will discuss anorectal abscesses and fistulae, pilonidal disease, rectal prolapse, pruritus ani, and anal masses.

EVALUATION OF THE PATIENT

Patients often have unvoiced concerns about anorectal problems that frequently lead to delay in seeking medical attention. They may be anxious about the examination of such a sensitive region, or they may fear that they have cancer.

Relaxation is an important pre-requisite for obtaining a complete and accurate history and performing a thorough physical examination in these patients. You can allay their fears by informing them step-by-step of what you plan to do during the physical examination.

History. A detailed history of the anorectal complaint—along with relevant medical and surgical, family, and social histories—often leads to a working and focused differential diagnosis. Ask about bleeding, protrusion of tissue or presence of a mass, and pain. Because pain is associated with many anorectal disorders, be sure to ask about the quality and timing of the pain and whether it is associated with bowel movements.

Physical examination. Although the history usually suggests a likely cause of the patient’s symptoms, physical examination is essential to confirm the diagnosis. A directed light source facilitates adequate visualization of the anal region. Position the patient in the prone jackknife or left lateral knee-chest (Simm) position.

Begin the examination with inspection of the perineum. Separate the buttocks so that the anal opening and its surrounding skin are easily visible. Note the presence of any perianal erythema, bleeding, discharge, mass, protrusion, or other visible lesions. Next, perform a digital examination with a lubricated, gloved finger. Evaluate the tone of the anal sphincter, and perform a circumferential sweep to feel for any masses. Keep in mind that the prostate in men and the cervix in women can be palpated anteriorly during the digital examination, while the distal sacrum and coccyx can be felt posteriorly in all patients; these anatomic landmarks are helpful reference points. An anoscope or rigid procto-
scope or sigmoidoscope can be used to evaluate anal masses or internal hemorrhoids.

HEMORRHOIDS

Hemorrhoids are vascular cushions that arise from the venous plexuses within the upper anal canal. They are consistent in anatomic position: left lateral, right posterior, and right anterior and are a normal part of every patient's anatomy.

Symptomatic hemorrhoids are what we care about, and are thought to result from elevated intra-abdominal pressure, which leads to the separation of connective tissue support and the subsequent sliding of these vascular cushions and the overlying mucosa distally along and even outside the anal canal. Conditions that predispose patients to increased intra-abdominal pressure include pregnancy, constipation, chronic straining, and heavy weight lifting. Decreased intake of fiber and increased consumption of processed foods, which are characteristic of a typical American diet, have also contributed to the increased incidence of symptomatic hemorrhoids.

Although hemorrhoids are very common, they may not necessarily be responsible for a particular patient's symptoms; be alert for coexisting anorectal disorders.

External hemorrhoids. These are found below the dentate line (the division between squamous epithelium distally and transitional columnar epithelium proximally); consequently, they are covered by skin (Figure 1). Patients experience significant pain when external hemorrhoids are dilated and thrombosed. They often describe the pain as severe, throbbing, and sudden in onset (often after straining or a traumatic bowel movement). The pain is caused by stretching and resultant ischemia of the overlying skin. Examination of the area usually reveals a bluish perianal mass that is tender to palpation.

Thrombosed external hemorrhoids normally resolve on their own within 3 weeks. If the patient's pain is diminishing at the time of evaluation, you can prescribe warm baths, topical anesthetic ointments, and psyllium or other bulking agents; instruct him or her not to strain or lift weights; and offer reassurance.

However, if the pain is severe or an ulceration has developed (as a result of ischemia of the overlying skin [see Figure 1]), surgical excision can relieve symptoms. Locally anesthetize the hemorrhoid, make an elliptical incision, and evacuate the clot, or, preferably, excise the hemorrhoid (Figure 2). The remaining wound can be left open or closed loosely with 4-0 chromic gut suture.

You may also want to consider offering the patient a topical anesthetic (lidocaine) for symptomatic relief of a thrombosed external hemorrhoid: another option is topical 0.3% nifedipine applied twice daily. This calcium channel blocker decreases the tonicity of the internal anal sphincter, a proposed contributor to the pain of thrombosed external hemorrhoids.

Internal hemorrhoids. These are located above the dentate line. Examination reveals a swelling that arises from the anal mucosa. Internal hemorrhoids are classified as follows:

- **Grade 1**: enlarged hemorrhoids that do not prolapse but may bleed.
- **Grade 2**: prolapsing hemorrhoids that spontaneously reduce.
- **Grade 3**: prolapsing hemorrhoids that require manual reduction.
- **Grade 4**: prolapsing hemorrhoids that cannot be reduced.
An anoscope may be required to visualize internal hemorrhoids that do not prolapse during examination.

Patients with internal hemorrhoids present differently than do patients with symptomatic external hemorrhoids. Symptoms may include bleeding, protrusion, fecal soiling, and itching. Because the columnar mucosa involved in internal hemorrhoids lacks nerve endings, pain is typically not present. If a patient with enlarged internal hemorrhoids complains of pain, look for another source (eg, a fissure). Internal hemorrhoids often coexist with external hemorrhoids (Figure 3).

Initial treatment consists of conservative therapy, such as psyllium or other bulking agents, avoidance of straining, and decreased time spent sitting on the toilet. Invasive therapy is indicated in patients for whom conservative management fails or who do not wish to wait for their symptoms to improve. Grade 1 hemorrhoids are rarely symptomatic but may be effectively treated with injection sclerotherapy or rubber band ligation. Grade 2 and grade 3 hemorrhoids can be treated in the office with rubber band ligation (Figures 4 and 5). Very large grade 3 and grade 4 hemorrhoids typically are treated with either surgical or stapled hemorrhoidectomy. An additional option, at least for grade 3 hemorrhoids, which has recently emerged is Doppler-guided hemorrhoidal artery ligation (HAL). This technique has not been subjected to adequately powered trials but appears to have reasonable effectiveness with minimal morbidity.

**ANAL FISSURES**

Anal fissures are linear ulcerations of the distal anal canal ano-derm (Figure 6). Fissures often result from difficult, traumatic bowel movements. Patients with chronic anal fissures frequently have elevated resting anal pressures; the increased pressure leads to decreased anodermal blood flow and local ischemia—especially at the posterior midline, where there is a paucity of vessels.

**Symptoms and physical findings.** Symptoms may include burning or aching pain that occurs during—and especially after—bowel...
The majority of fissures appear as anodermal defects located in the posterior midline, although 10% of women and 1% of men have anterior fissures. An associated “sentinel pile” or sentinel skin tag can often be seen at the distal or caudal extent of the fissure (see Figure 6); this represents fibrosis and excess granulation from the ulceration. These skin tags are frequently mistaken for hemorrhoids; however, a midline location—especially of an isolated skin tag—helps rule out asymptomatic hemorrhoids. Fissures that are unusual in appearance or location may be associated with Crohn’s disease, malignancy, tuberculosis, syphilis, Cytomegalovirus infection, or HIV infection.

**Management.** Medical therapies for anal fissures include avoidance of straining or heavy lifting, warm baths, psyllium or other bulking agents, topical anesthetics/analgesics, chemical sphincterotomy (by nitroglycerin 0.2% ointment or diltiazem 2% gel, applied with a gloved finger 2 or 3 times daily for 6 weeks), and injection with botulinum toxin. Anal fissures often resolve within 6 weeks of initiation of treatment; however, recalcitrant fissures may require surgical intervention (either lateral internal sphincterotomy or fissurectomy and sphincterotomy with anoplasty).

**REFERENCES:**

**FOR MORE INFORMATION:**