Anorectal Complaints:
Office Diagnosis and Treatment, Part 2

ABSTRACT: Symptoms associated with anorectal abscesses include throbbing or aching pain, swelling, drainage or bleeding, constipation, urinary difficulty, and fever. Treatment is surgical drainage. About 50% of anorectal abscesses fail to heal after drainage due to formation of an anal fistula. Characteristic findings in pilonidal disease include a painful, fluctuant mass near the posterior midline at the superior aspect of the buttocks and a sinus opening within the intergluteal fold. Treatment consists of drainage of the abscess followed by light daily packing. Patients with rectal prolapse may present with a protruding mass, a history of constipation and incontinence, bleeding, discharge, or a sensation of incomplete emptying. Pruritus ani can be caused by a number of anorectal disorders; however, in about 50% of cases, it is idiopathic. Anal neoplasms appear as unusual masses that arise from the anal or rectal mucosa; biopsy is often needed for diagnosis.

Key words: anorectal fistula, pilonidal disease, rectal prolapse, pruritus ani

Anorectal abscesses and fistulae

Anorectal infections may present acutely as abscesses or chronically as fistulae. Anorectal abscesses result from inflammation of the crypts and glands around the dentate line inside the anal canal and spread to various locations (perianal, intersphincteric, ischiorectal, supralevator). Although a cryptoglandular origin is most common, other causes to consider include Crohn’s disease and a history of previous anorectal surgery.

Abscesses. Patients often present with throbbing or aching pain, swelling, drainage or bleeding, constipation, urinary difficulty, and/or
fever. Physical examination usually reveals an erythematous, fluctuant, and occasionally indurated mass that is tender to palpation (Figure 1).

Treatment consists of infiltrating local anesthesia into the overlying skin, followed by abscess drainage via a cruciate incision (Figure 2). Antibiotics are unnecessary in the treatment of anorectal abscesses except in the setting of sepsis, cellulitis, immunocompromise, or recent prosthesis. Keep in mind that only about 50% of abscesses heal primarily after drainage; the remainder result in anorectal fistulae.

Fistulae. Fistulae are the natural sequelae of drained anorectal abscesses that have not healed completely. Anoscopic evaluation typically reveals an internal opening within a crypt near the dentate line, and perineal inspection reveals an external opening in the skin. In the operating room, the fistula tract can often be demonstrated by introduction of a fistula probe (Figure 3). Fistulae can be classified based on their anatomic course in relation to the internal and external anal sphincters. The 4 types of fistulae are: • Intersphincteric. • Transsphincteric. • Suprasphincteric. • Extrasphincteric.

Surgical treatment is the mainstay of fistula management and includes fistulotomy, seton placement, mucosal advancement flaps, fistula plugs, ligation of intersphincteric fis-
tula tract (LIFT) procedure, and fibrin glue injection.¹

PILONIDAL DISEASE

Pilonidal disease refers to an abscess or draining sinus that results from a subcutaneous infection in the sacrococcygeal region.

Symptoms and physical findings. Patients typically present with a painful, fluctuant mass near the posterior midline at the superior aspect of the buttocks. Examination of this area tends to reveal both a mass and a sinus opening within the intergluteal fold, which confirms the diagnosis.

Management. Treatment involves drainage of the abscess followed by light daily packing. Improved hygiene and meticulous hair removal (accomplished by shaving around the area) are important for optimal healing.² Antibiotics are unnecessary except in high-risk populations (patients with sepsis, immunocompromise, or recent prosthesis).

RECTAL PROLAPSE

Rectal prolapse, or procidentia, represents an intussusception of the rectum. Its cause is unclear, but a redundant sigmoid colon and loss of rectal support and fixation are contributing factors. Prolapse may involve only the rectal mucosa (partial) or the full thickness of the rectum (complete). Rectal prolapse is classified as follows:

- **Grade 1**: occult prolapse.
- **Grade 2**: prolapse to the anus but not through it.
- **Grade 3**: protrusion through the anus for a variable distance.

Symptoms and physical findings. Patients may present with a protruding mass, a history of constipation and incontinence, bleeding, discharge, or a sensation of incomplete emptying. In patients with a grade 3 prolapse, physical examination reveals visible rectal tissue, which can be identified by its circumferential appearance (Figure 4). Visualization of radial folds or the dentate line may indicate the presence of prolapsed internal hemorrhoids. When the diagnosis is suggested by the history but not confirmed by the physical examination, further studies may be necessary (ie, defecating proctography).

Management. Treatment is surgical, via various abdominal or perineal procedures; the object is to prevent the sequelae of pudendal neuropathy, sphincter weakness, and fecal incontinence.³

PRURITUS ANI

Pruritus ani can result from a variety of causes, including fecal incontinence, systemic diseases such as diabetes, dermatologic conditions, drugs, dietary habits, and environmental factors. In addition, itching can result from any of the anorectal disorders discussed here and in part 1 of our article in the August issue. The physical examination may point you toward one or more of these diagnoses. If the physical findings do not suggest a specific cause, idiopathic pruritus ani is the likely diagnosis. In 50% of cases, perianal itching is defined as idiopathic, although occult fecal incontinence is likely the cause of many of these cases.

Treatment of idiopathic pruritus ani is multimodal. Instruct patients to use baby wipes instead of toilet tissue; use a cotton “plug” at the anus while sleeping to decrease anal drainage; take frequent warm baths; use psyllium or other bulking agents; apply topical hydrocortisone, anesthetic, and analgesic ointments; and use cornstarch to keep the perianal skin dry. Perform a skin biopsy if the pruritus is refractory to treatment.

ANAL MASSES

Anal masses can represent a variety of entities. The history of the mass, (including the time of its initial appearance, any variation in its size, and any recent change), the patient’s sexual preferences, and any history of a prior mass are important details.

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1. Tula tract (LIFT) procedure, and fibrin glue injection.
2. Pilonidal disease refers to an abscess or draining sinus that results from a subcutaneous infection in the sacrococcygeal region.
3. Rectal prolapse, or procidentia, represents an intussusception of the rectum. Its cause is unclear, but a redundant sigmoid colon and loss of rectal support and fixation are contributing factors. Prolapse may involve only the rectal mucosa (partial) or the full thickness of the rectum (complete). Rectal prolapse is classified as follows:
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Figure 4 – Pictured here is a grade 3 rectal prolapse. The distinctive concentric rings, which represent rectal tissue, clinch the diagnosis.

Figure 5 – These condylomata acuminata are caused by human papillomavirus.
Anorectal abscesses usually result from inflammation of the crypts and glands around the dentate line; however, Crohn’s disease and previous anorectal surgery can also give rise to abscesses.

Anorectal fistulae typically have an internal opening within a crypt near the dentate line and an external opening in the perineal skin.

Improved hygiene and meticulous hair removal (accomplished by shaving around the area) are important for optimal healing of pilonidal disease.

Prolapsed rectal tissue can be distinguished from other protruding masses on the basis of its circumferential appearance. Visualization of radial folds or the dentate line may indicate the presence of prolapsed internal hemorrhoids.

Advise patients with idiopathic pruritus ani to use baby wipes instead of toilet tissue; place a cotton “plug” at the anus while sleeping to decrease anal drainage; take frequent warm baths; use psyllium or other bulking agents; apply topical hydrocortisone, anesthetic, and analgesic ointments; and use cornstarch to keep the perianal skin dry.

The presence of warts in a patient with a history of anal intercourse, or of HIV infection or another immunocompromised state, strongly suggests condylomata acuminata. Treatment options for these warts include caustic agents, immunotherapy, chemotherapy, and surgery.

**REFERENCES:**


**FOR MORE INFORMATION:**


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**CONCLUSION:**

- The presence of warts in a patient with a history of anal intercourse, or of HIV infection or another immunocompromised state, strongly suggests condylomata acuminata. Treatment options for these warts include caustic agents, immunotherapy, chemotherapy, and surgery.

- Prolapsed rectal tissue can be distinguished from other protruding masses on the basis of its circumferential appearance. Visualization of radial folds or the dentate line may indicate the presence of prolapsed internal hemorrhoids.

- Advise patients with idiopathic pruritus ani to use baby wipes instead of toilet tissue; place a cotton “plug” at the anus while sleeping to decrease anal drainage; take frequent warm baths; use psyllium or other bulking agents; apply topical hydrocortisone, anesthetic, and analgesic ointments; and use cornstarch to keep the perianal skin dry.

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