A Man With Throbbing, Severe Anal Pain

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A 50-year-old man with no significant medical history and no prior colonoscopy presented to our clinic with severe, constant, throbbing anal pain that had been worsening over the past 5 days. The pain was associated with bright red blood per rectum, described as red streaks on toilet paper. The patient denied weight loss, nausea, fever, or a family history of colon cancer.

Physical examination findings revealed a tender, grape-sized, purple mass emerging from the anal verge **(Figure)**. A rectal examination was not performed because of excruciating pain associated with palpation.

What is the most likely diagnosis?

A. Rectal prolapse with skin tag
B. Prolapsed distal colon polyps
C. Thrombosed, prolapsed internal hemorrhoid
D. Anal cancer

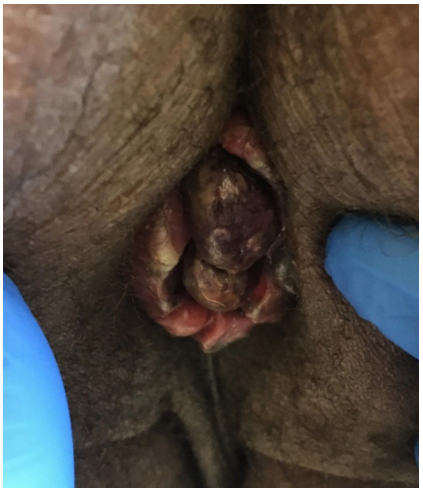

Figure. A painful, protruding, purple, partitioned mass with surrounding inflamed skin tags.

Correct answer: C. Thrombosed, prolapsed internal hemorrhoid

Discussion

Hemorrhoids are reported to affect 10 million US adults per year, with a worldwide prevalence of 4.4%.[1] Patients often present with rectal bleeding with or without defecation, pruritus, swelling, and throbbing pain depending on the location and severity of the hemorrhoids.[2] Risk factors include any cause of increased intra-abdominal pressure such as pregnancy, constipation, and prolonged straining. Another significant contributor is weakened supporting tissue because of older age or genetics. The increased pressure and lack of support cause the veins to dilate and distend to form vascular sinusoids.[3] Hemorrhoids are usually chronic.

There are 2 categories of hemorrhoids, internal and external, distinguished by their location regarding the dentate line located approximately 3 to 4 cm from the anal verge.[2] Internal hemorrhoids are located above the dentate line, whereas external hemorrhoids are located below the dentate line. While reports of pain can aid the diagnosis by distinguishing the type of hemorrhoid, the report of bright red blood per rectum, on the other hand, is nonspecific and requires further investigation. In addition, hemorrhoids' appearance may vary significantly and can deceptively look like anal fissure, polyps, rectal prolapse, inflammatory bowel disease, condyloma, or cancer.

The correct answer is C. The figure depicts a prolapsed, thrombosed internal hemorrhoid (the purple center) with surrounding tags. This is a hemorrhoidal crisis and a relatively rare presentation of chronic hemorrhoidal disease that have acutely prolapsed. Our patients' skin was necrosed, and part of

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the thrombosis was already drained.

Answer A is incorrect, as rectal prolapse is seen with concentric mucosal rings. Answer B is false because prolapsed polyps take on a more spherical, cauliflower-like appearance. Answer D is trickier because anal cancer can appear as flat or raised lesions and can often present with similar symptoms as hemorrhoids, such as rectal bleeding and pruritus. The skin is affected in anal cancer, and there are ulcerations and/or raised, hard, irregular textures to the skin. Anal cancer is mostly painless. Our patient did not have a history that would raise our suspicion for malignancy, had no skin involvement, and reported pain.

Treatment modalities for hemorrhoids include nonsurgical management, in-office procedures, and surgical management. Therapies range from increased fiber and water intake to emergent colonoscopy, immediate antibiotic infusion, and surgical excision.[4]

Lifestyle changes with increased insoluble fiber (typically 25-35 g/day) and water intake to prevent constipation and straining is the first line. Fiber supplementation has been shown to reduce symptoms and risk of rectal bleeding significantly.[4] In addition to lifestyle changes, conservative medical management with sitz baths, stool softeners, and topical therapies containing steroids and analgesics may provide significant but temporary relief. If treatment remains unsuccessful, office-based procedures such as rubber-band ligation, injection sclerotherapy, and radiofrequency ablation can be offered. Rubber-band ligation, which can be performed in the office with inexpensive equipment, has been shown to be superior to other forms of treatment. It also has a lower failure rate compared with photocoagulation.[4,5]

Surgical indications for elective hemorrhoidectomy include patients who have failed medical and nonoperative therapy, patients with symptomatic high-grade internal or mixed internal and external hemorrhoids, patients with symptomatic hemorrhoids in the presence of a concomitant anorectal condition that requires surgery, and patient preference.[5] Recurrent hemorrhoids are also treated with excisional hemorrhoidectomy, which is highly effective when performed within the first 2 to 3 days of onset of symptoms. Presence of hemorrhoids does not exclude the presence of a neoplasia, and should the symptoms fail to resolve after 2 to 3 months of adequate therapy, referral for a colonoscopy is indicated.

Conclusions

Although hemorrhoids are common, their presentation is still difficult to discern on the physical examination from other potentially life-threatening conditions. However, only a relatively small number of images are available to assist clinicians in this diagnosis. As physicians, it is crucial not to overlook other potential causes of nonspecific rectal bleeding. Therefore, the addition of images such as ours will help provide more clarity toward the correct diagnosis and therapy for patients.

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