COMMON ANORECTAL CONDITIONS

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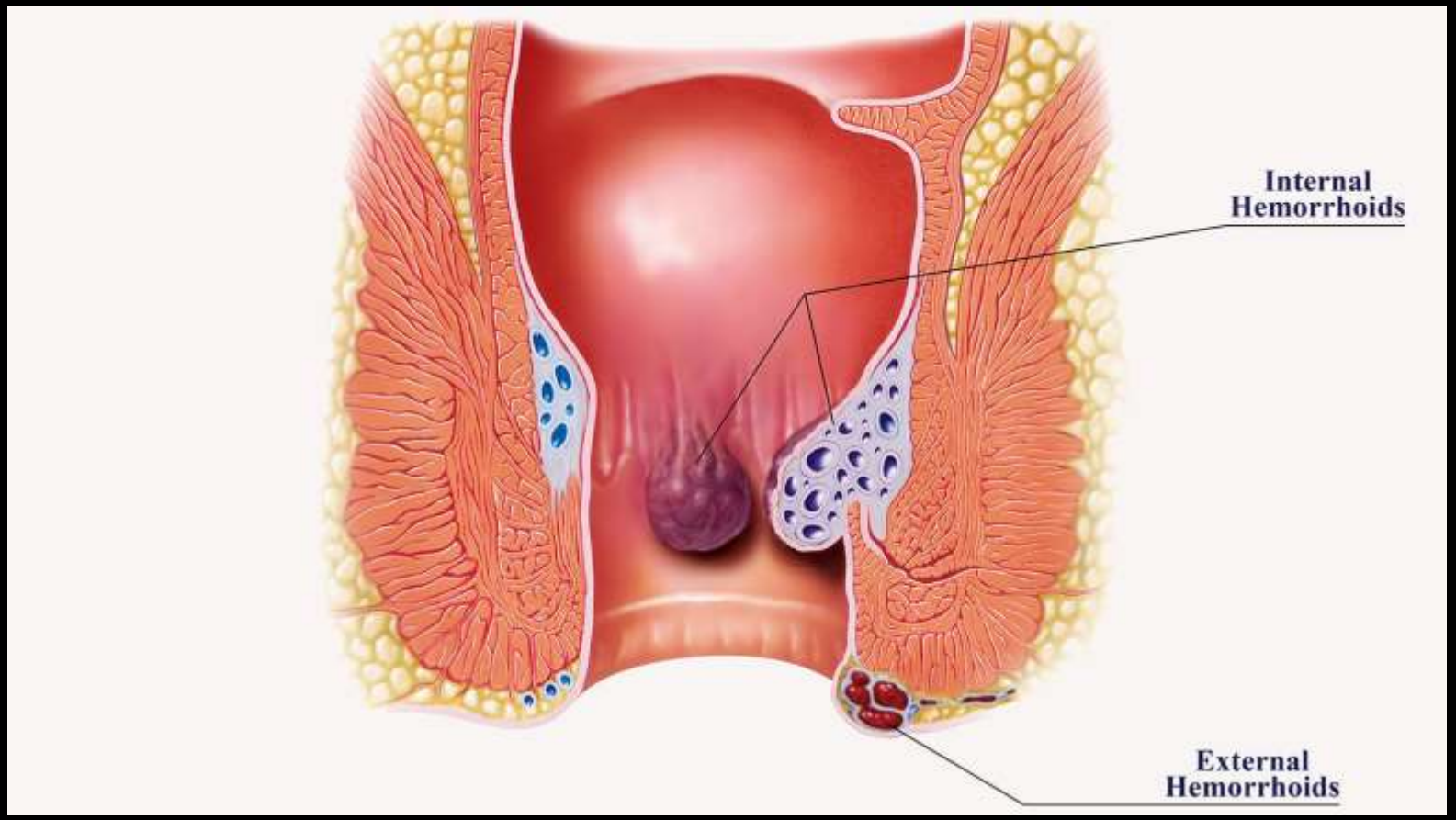
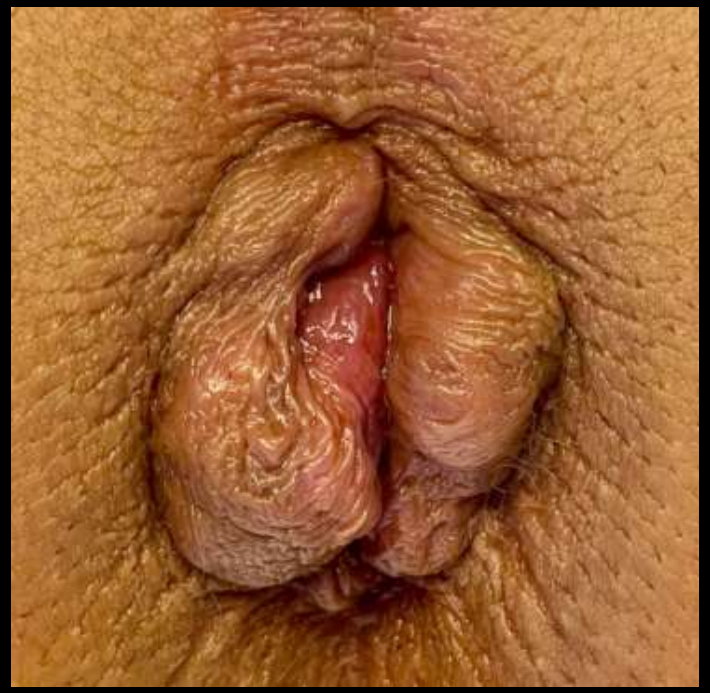
AUCKLAND COLORECTAL CENTRE

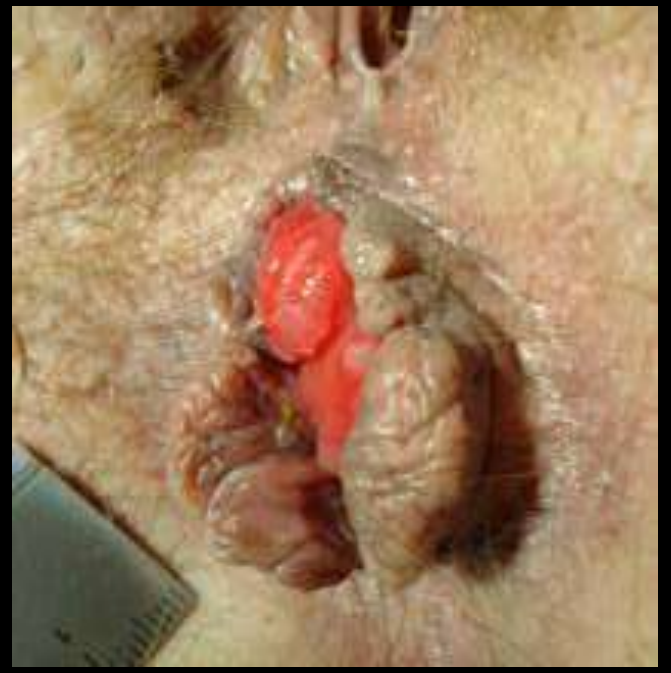
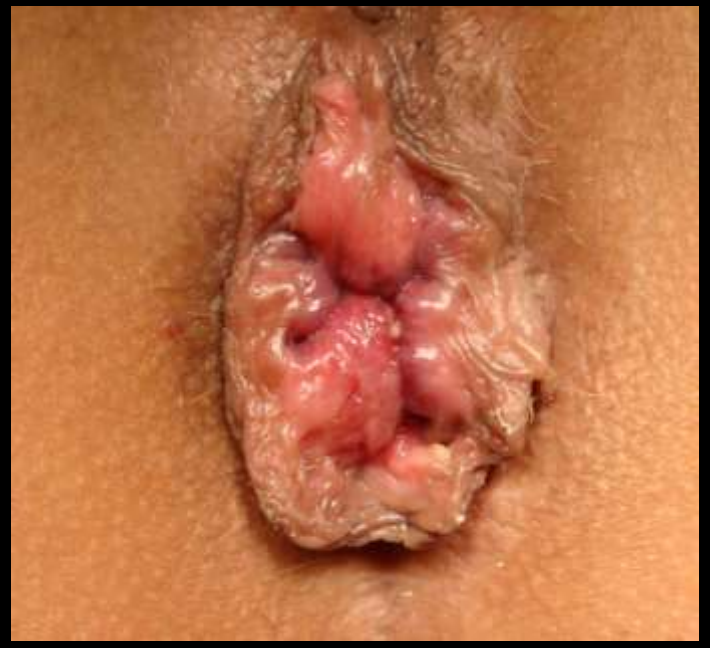
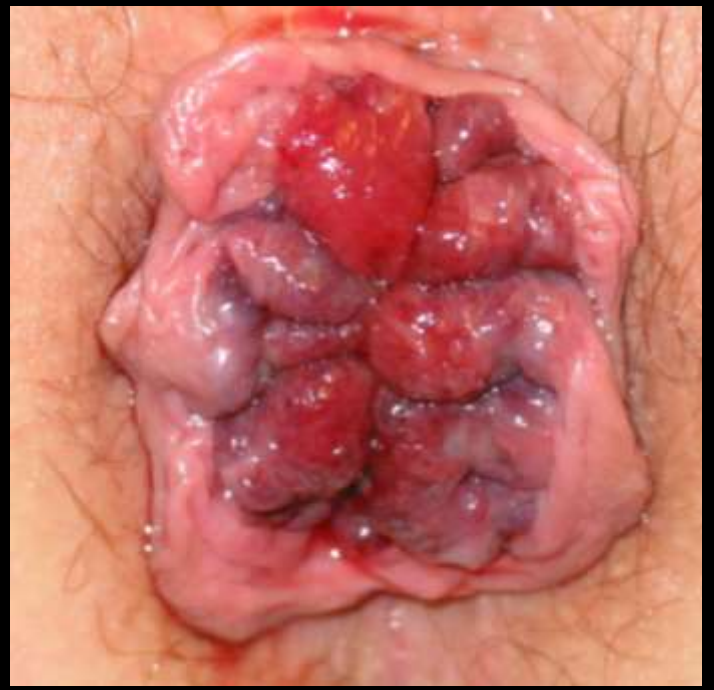
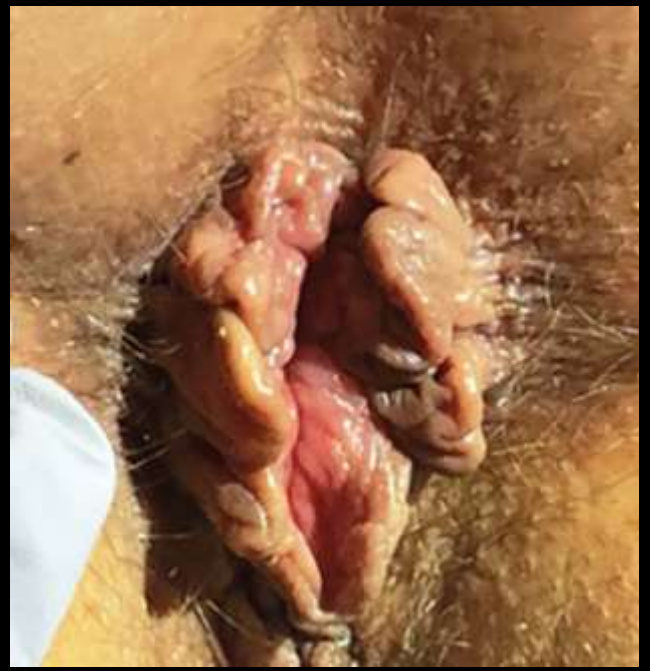
Greenlane Medical Specialists

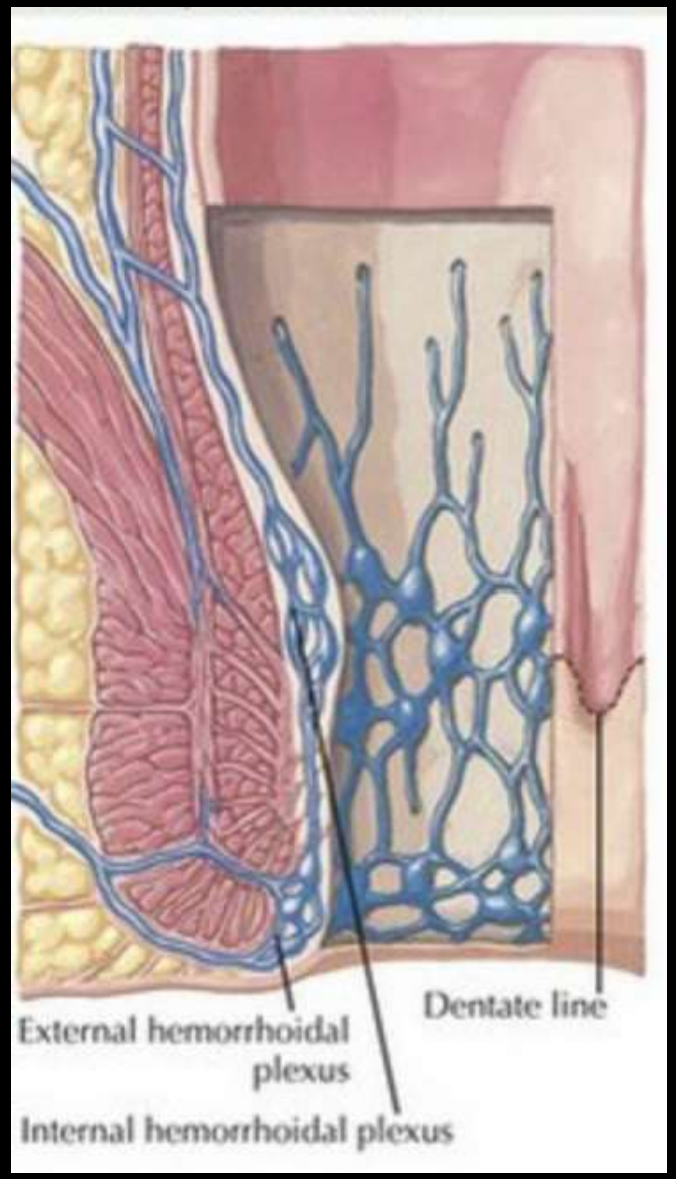
- Haemorrhoids
- Perianal haematoma
- Anal fissures
- Perianal abscess
- Anal fistulas
- Pruritis

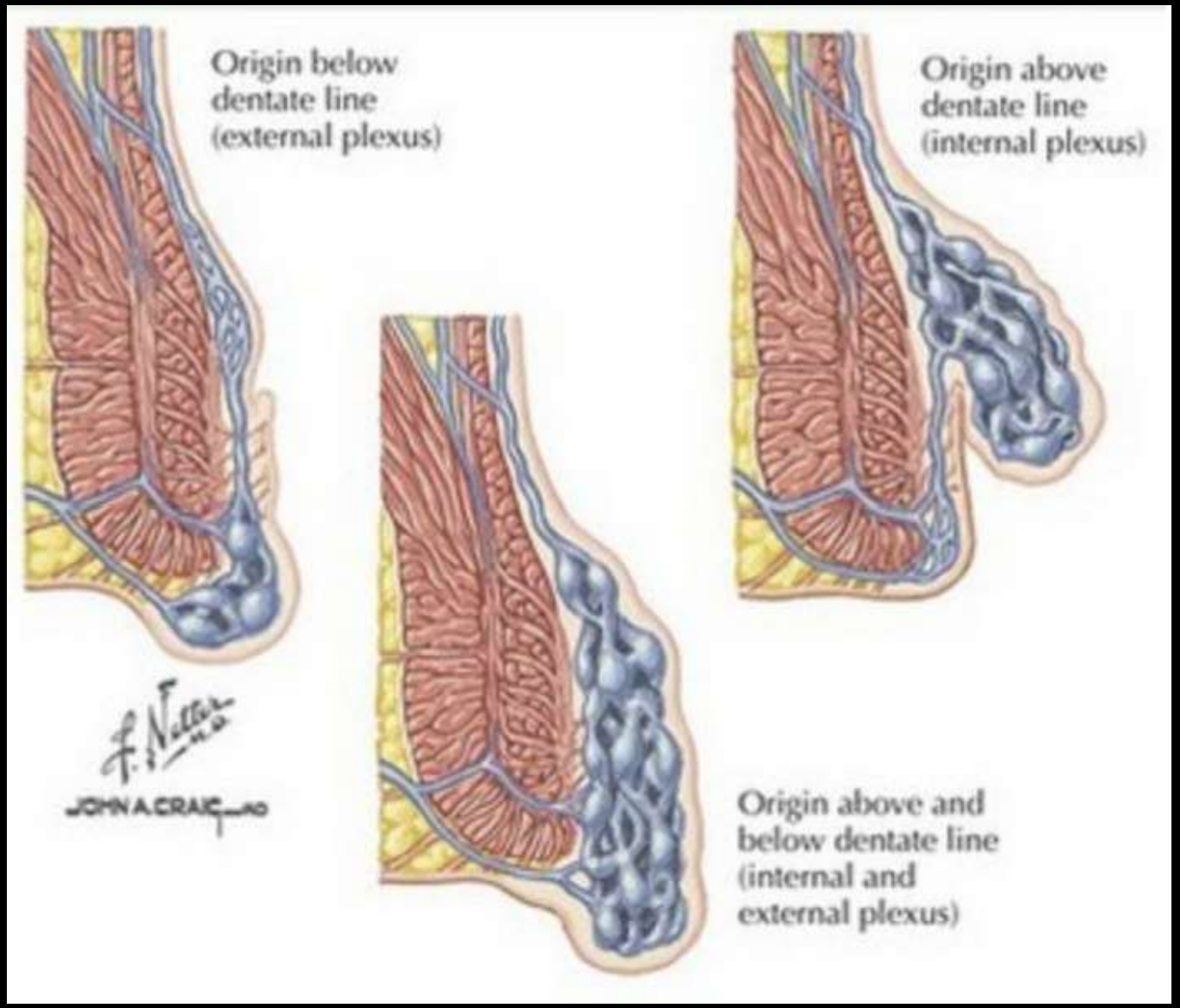
Haemorrhoids

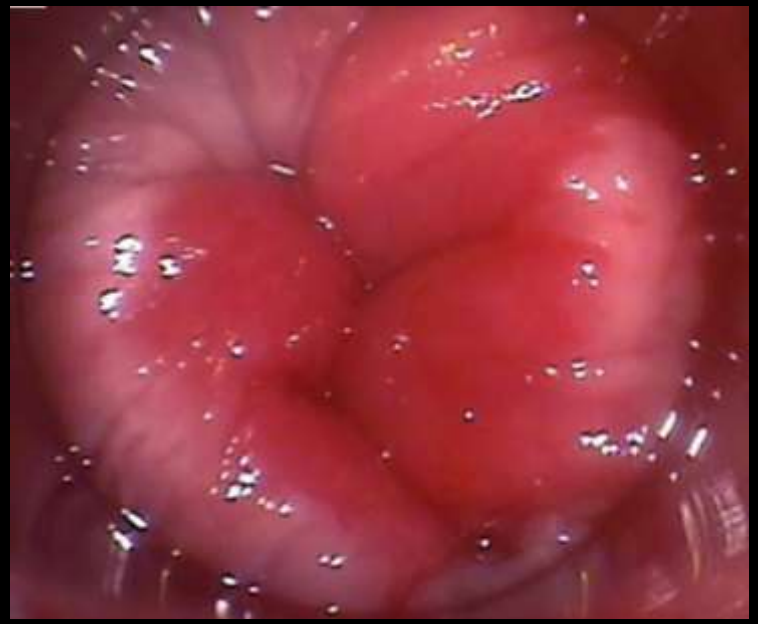


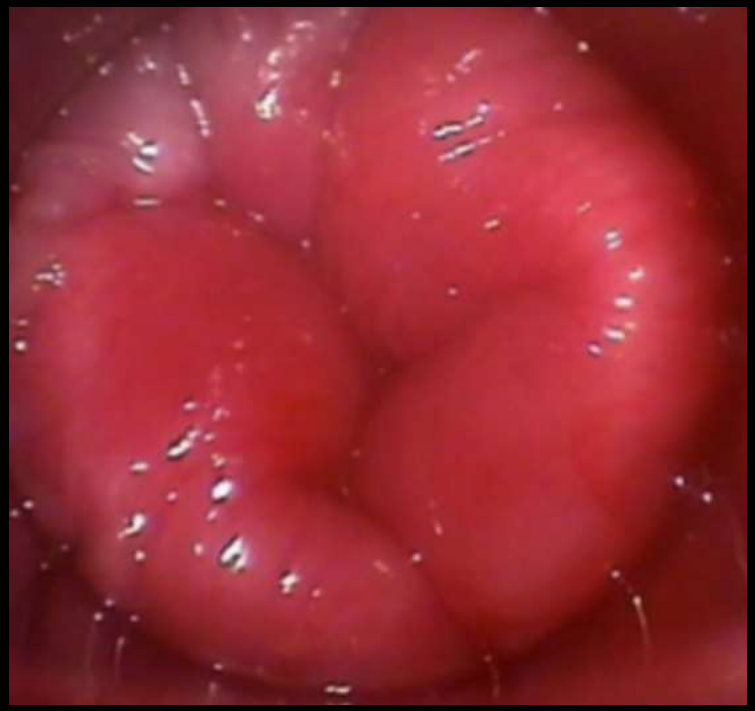


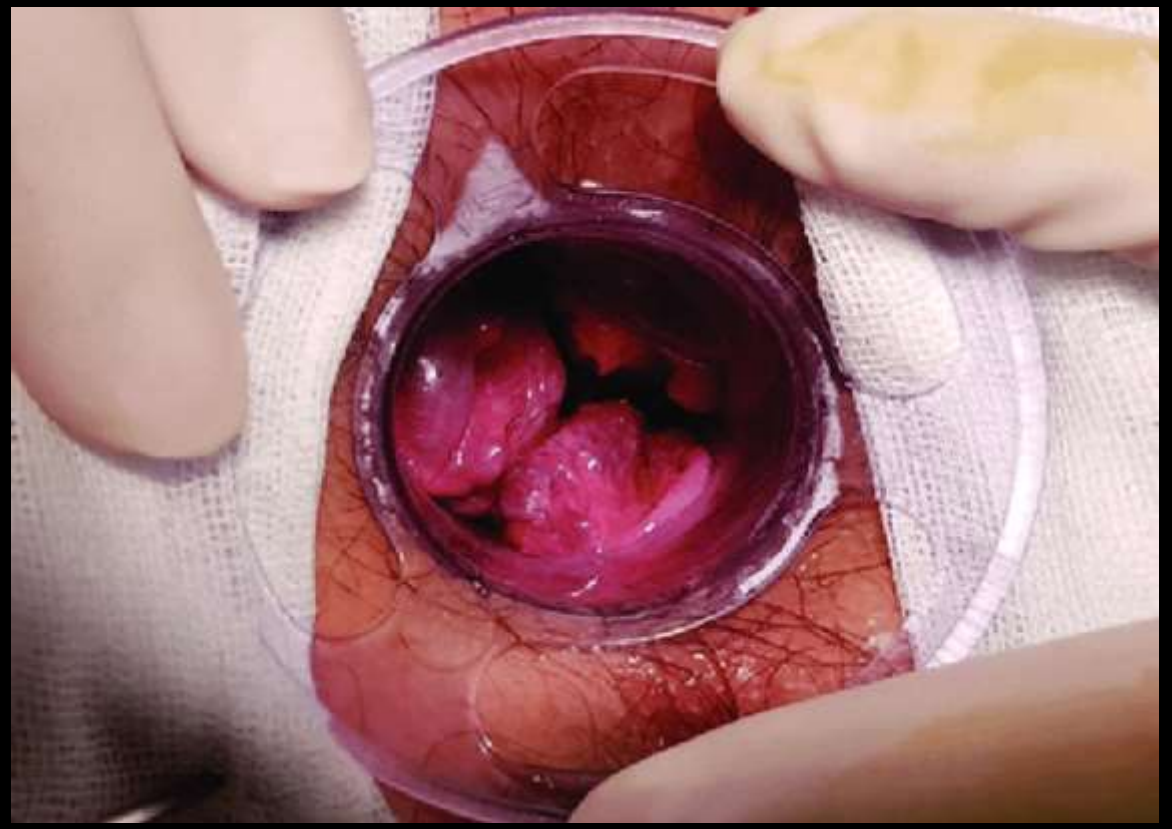





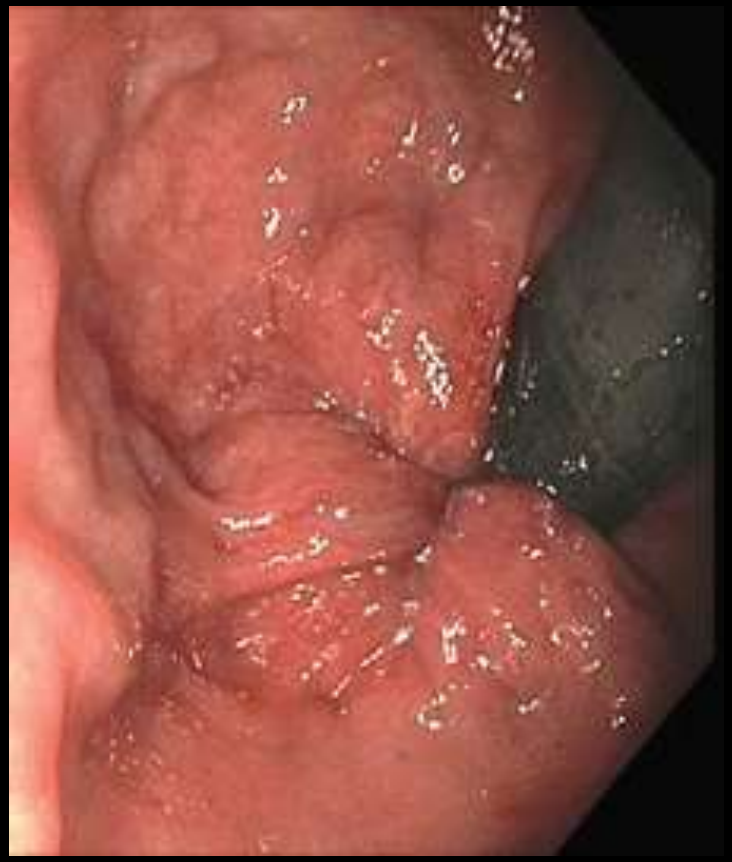

External hemorrhoidal plexus
Dentate line
Internal hemorrhoidal plexus

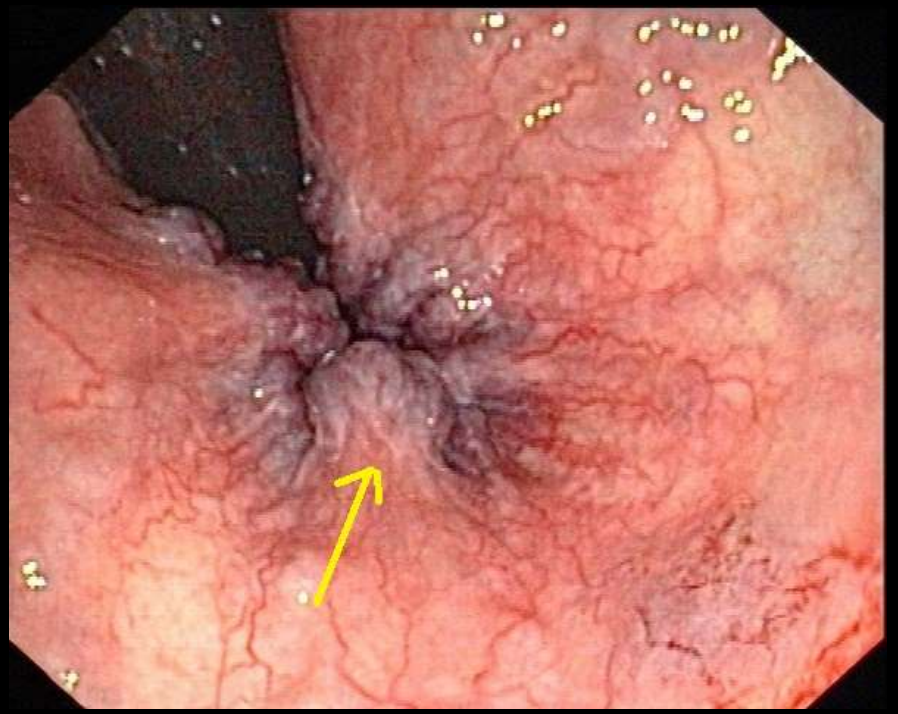

Origin below dentate line (external plexus)
Origin above dentate line (internal plexus)
Origin above and below dentate line (internal and external plexus)
JOHN A. CRAIG

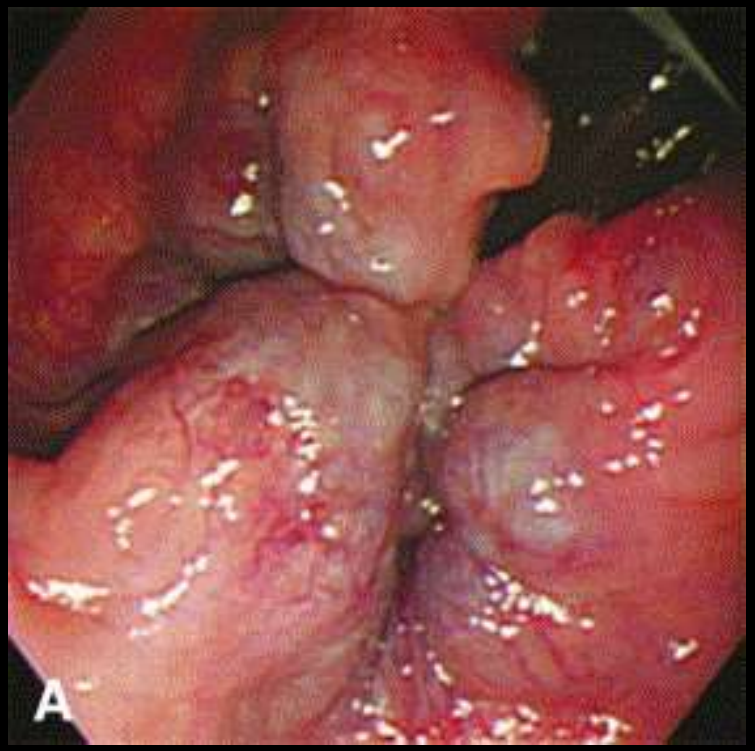











A

Haemorhoids

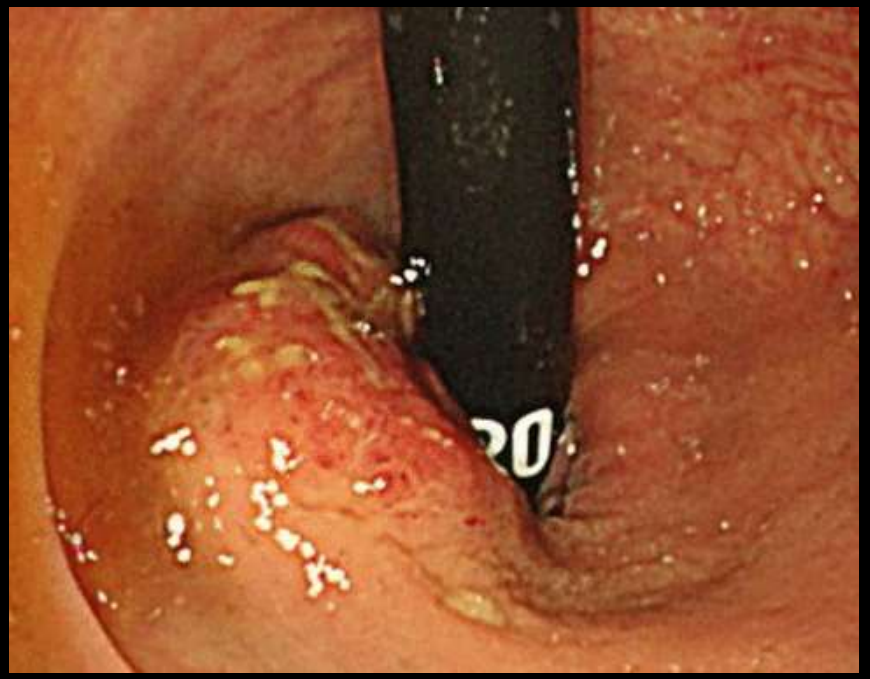
- History
  - Bright-red rectal bleeding (“outlet type”)
  - Painless*
  - Prolapse / Lump
  - Mucous discharge
  - Pruritis
- Examination
  - Good inspection –rest, straining
  - Digital rectal examination

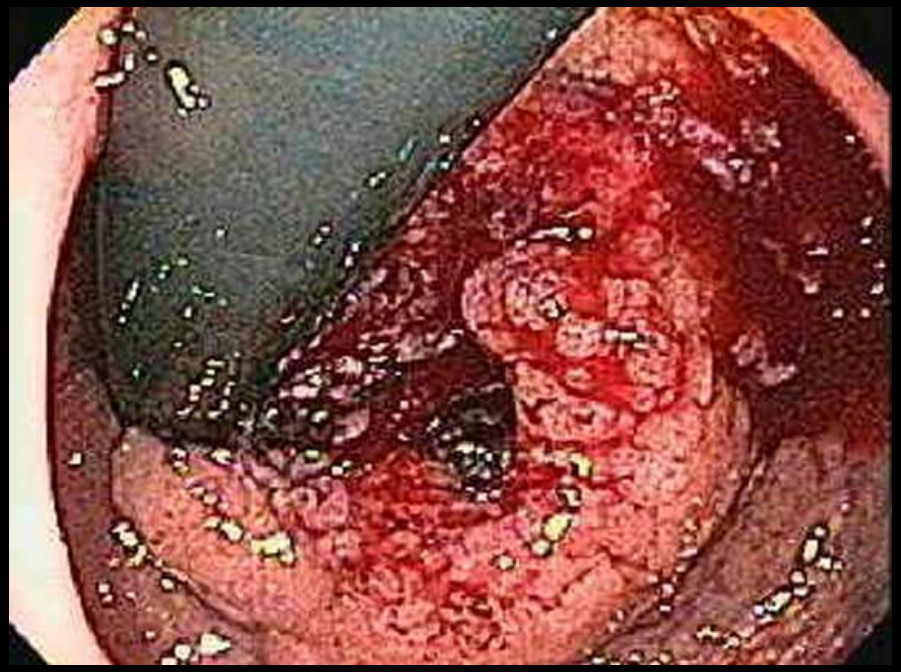
Concerning features

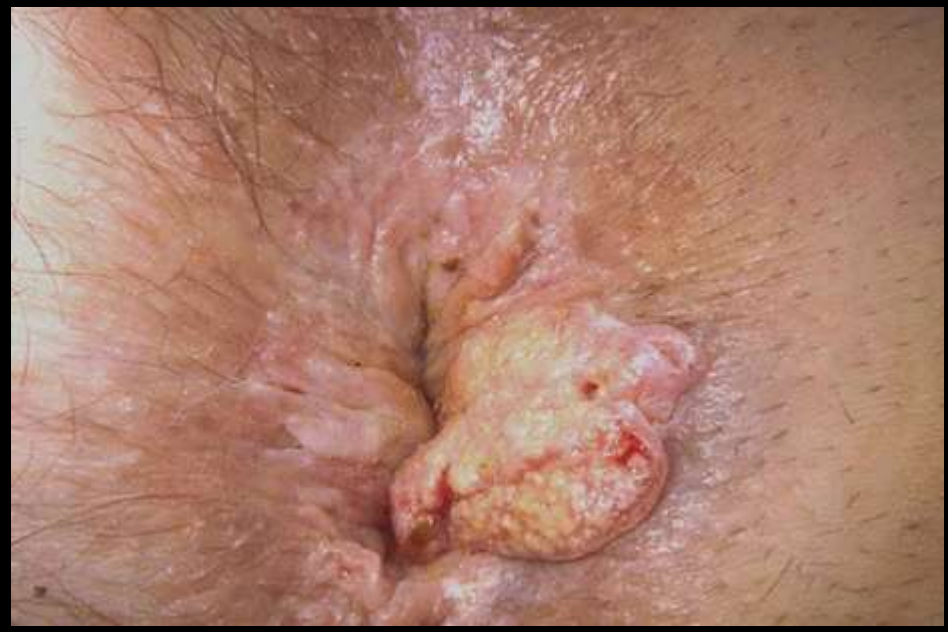
- History
  - Blood mixed with stool
  - Change in bowel habit
  - Abdominal pain or mass
  - Weight loss
  - Family history of colorectal malignancy, polyps
  - Age >45

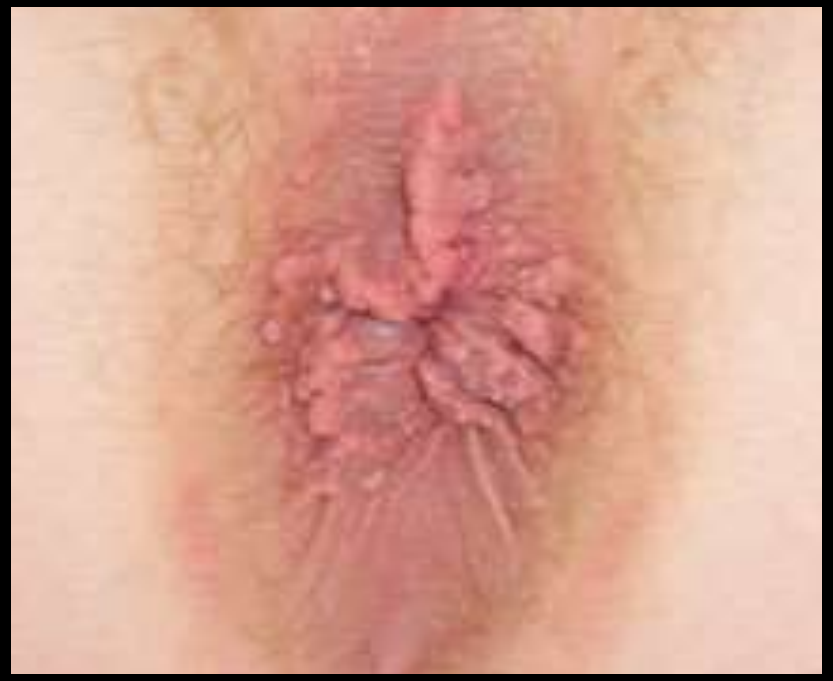
- Examination
  - Palpable mass
  - Irregular / exophytic growth

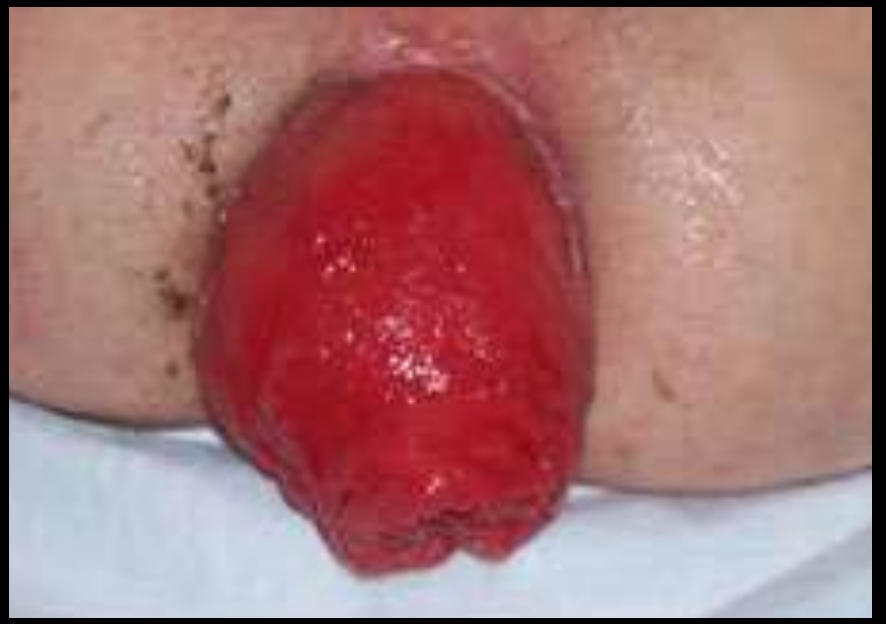
- Investigations
  - Anaemia (esp. IDA)

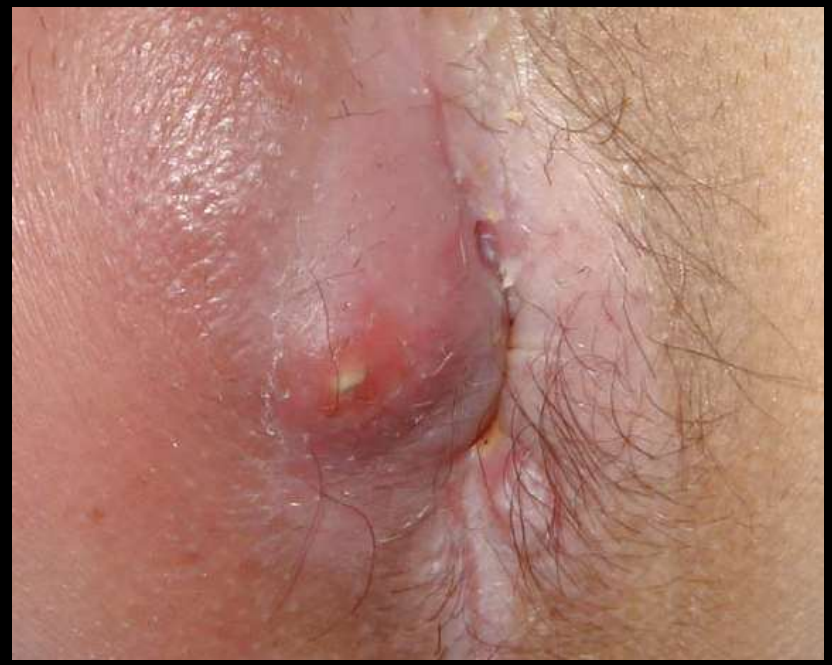


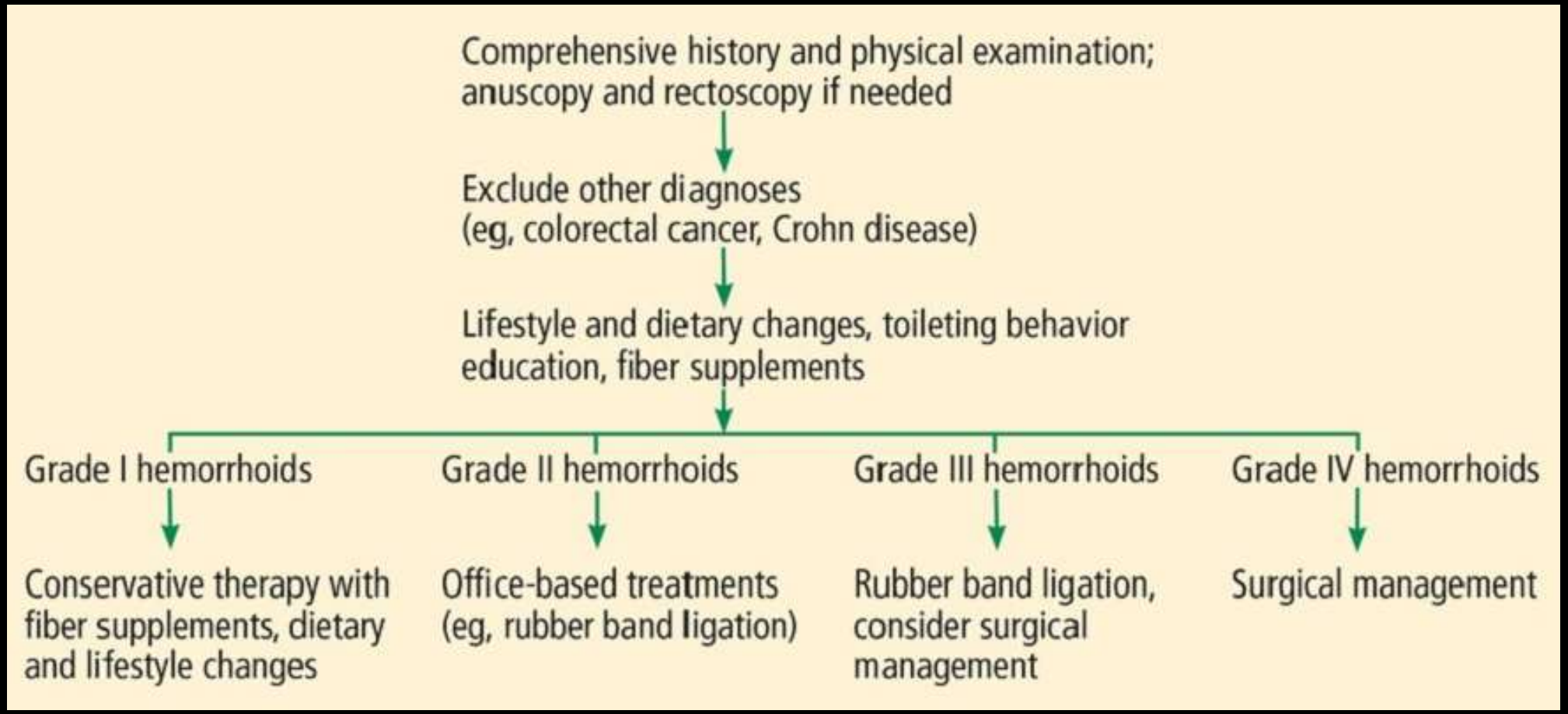











Comprehensive history and physical examination; anuscopy and rectoscopy if needed
Exclude other diagnoses (eg, colorectal cancer, Crohn disease)
Lifestyle and dietary changes, toileting behavior education, fiber supplements
Grade I hemorrhoids
Grade II hemorrhoids
Grade III hemorrhoids
Grade IV hemorrhoids
Conservative therapy with fiber supplements, dietary and lifestyle changes
Office-based treatments (eg, rubber band ligation)
Rubber band ligation, consider surgical management
Surgical management

First Line Management

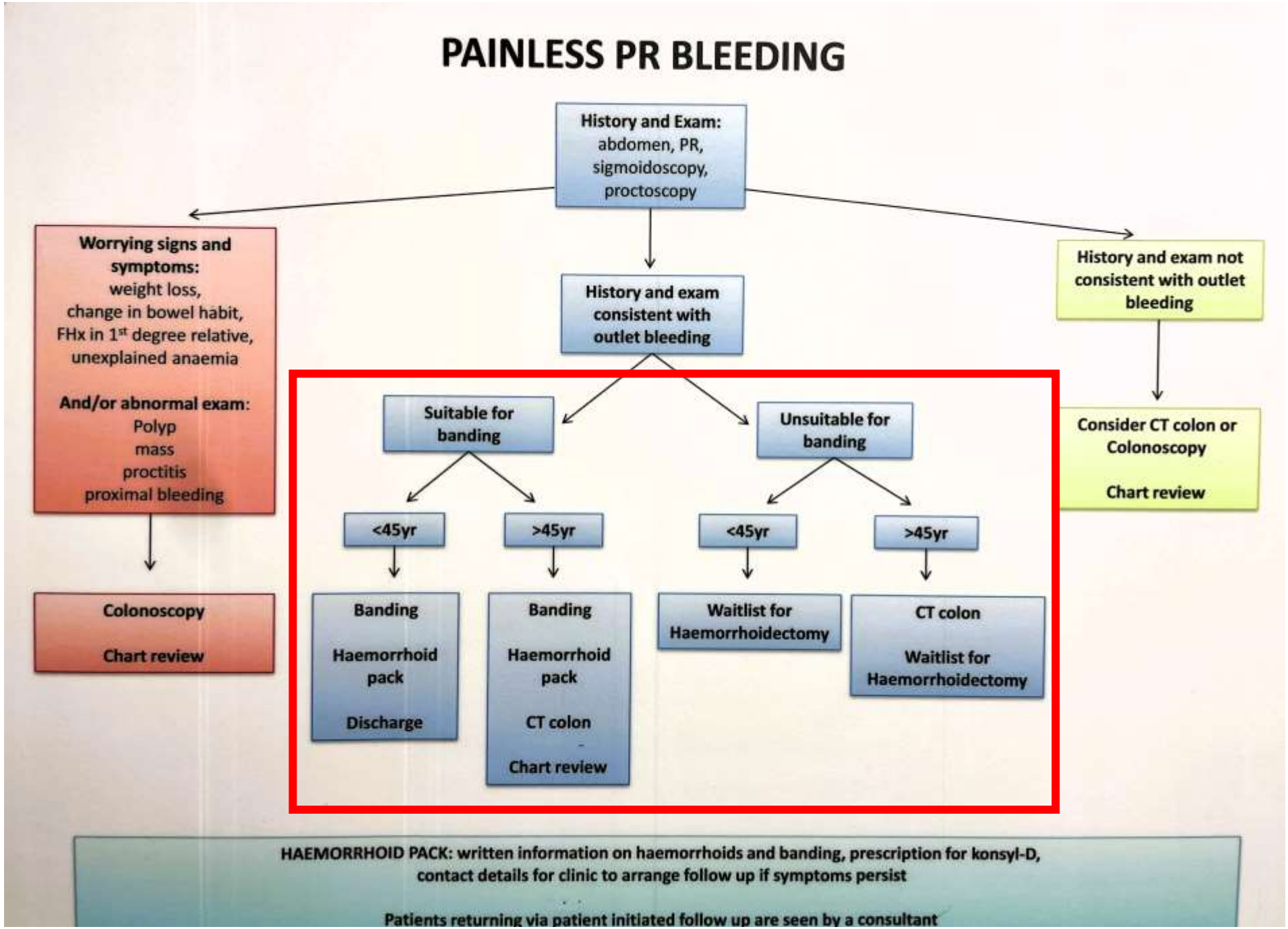
- Address constipation – diet, fluids, laxatives
- Fibre supplementation
- Toileting behaviour
  Avoid straining
  Avoid prolonged sitting
  Avoid excessive wiping – use wipes, pat dry, barrier cream
  Foot stool
  Sitz baths
  Bidet toilet seat
- Topical agents (e.g. Ultraproct, Proctosedyl) for symptomatic relief if pain/discomfort

When to refer?

- Any concerning features / red flag symptoms
- Persistent symptoms despite dietary and lifestyle changes
- Prolapse or large external component

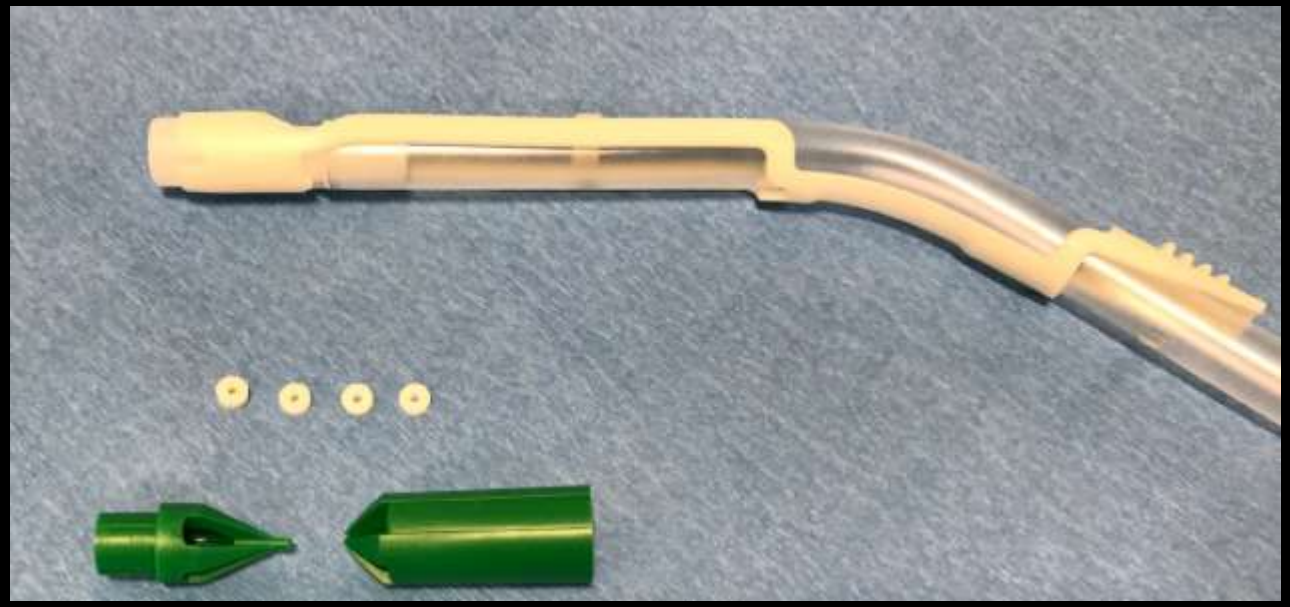
- History
  - Blood mixed with stool
  - Change in bowel habit
  - Abdominal pain or mass
  - Weight loss
  - Family history of colorectal malignancy, polyps
  - Age >45
- Examination
  - Palpable mass
  - Irregular / exophytic growth
- Investigations
  - Anaemia (esp. IDA)

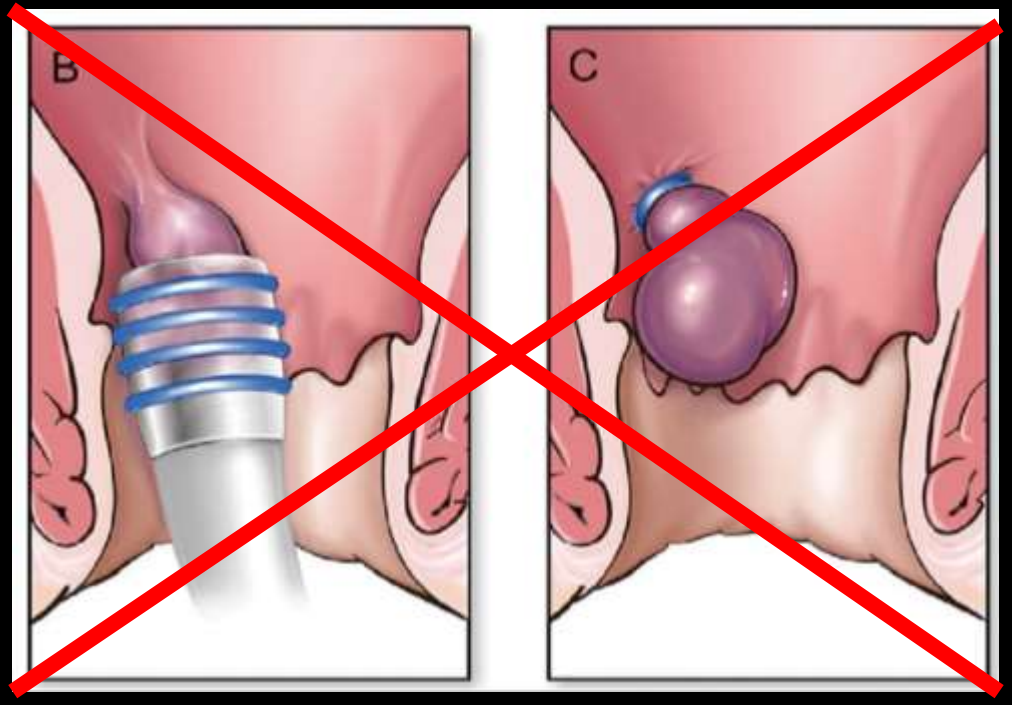
PAINLESS PR BLEEDING

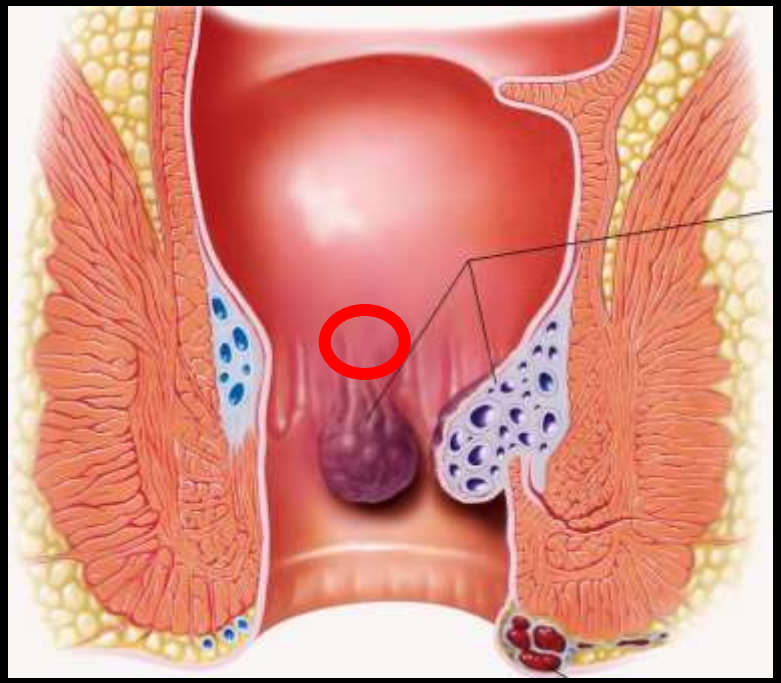


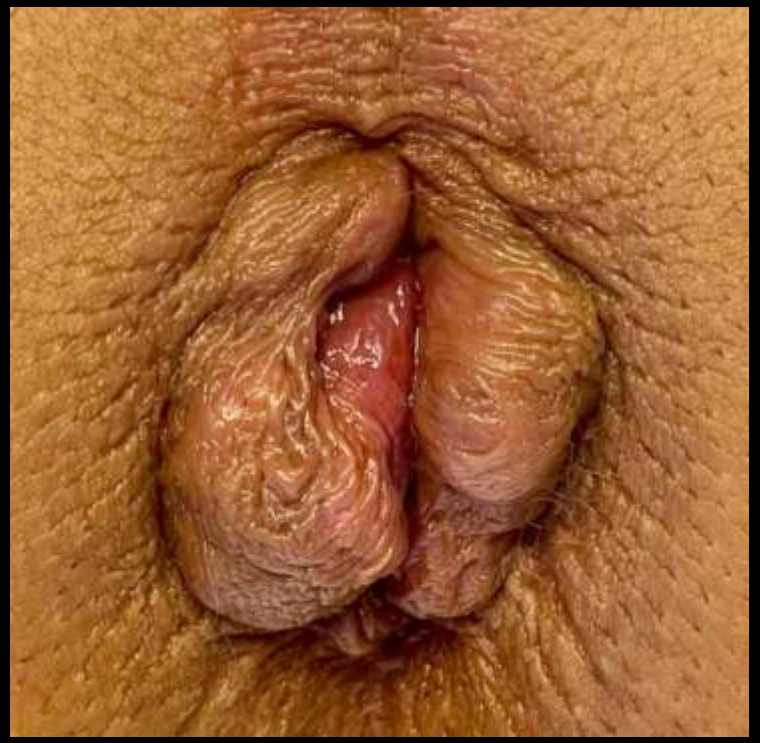
Surgical management

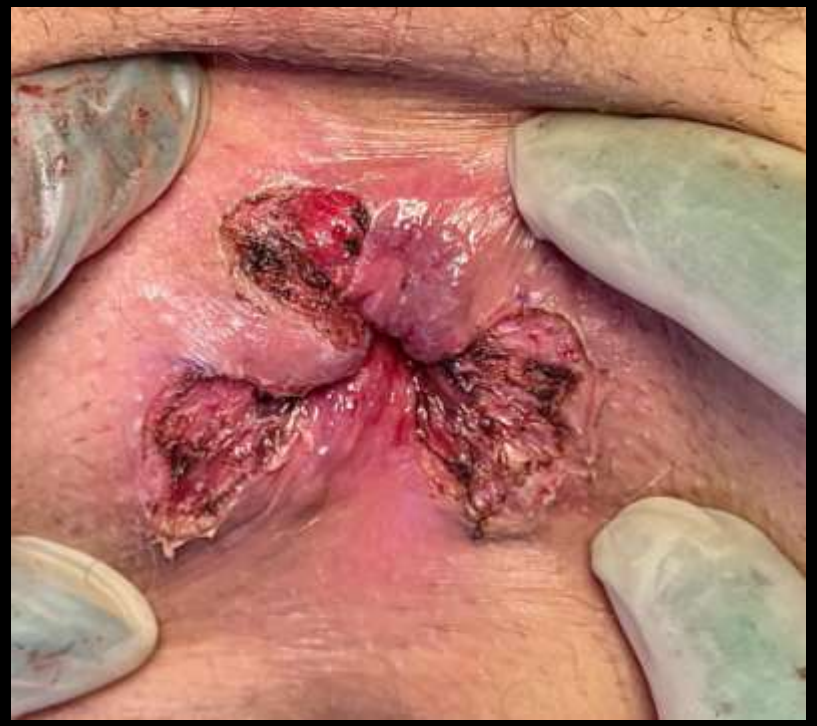
- Rubber band ligation
- Haemorrhoidectomy
- Haemorrhoid artery ligation + recto-anal repair (HAL-RAR)
- (Sclerotherapy, Stapled Haemorrhoidopexy)

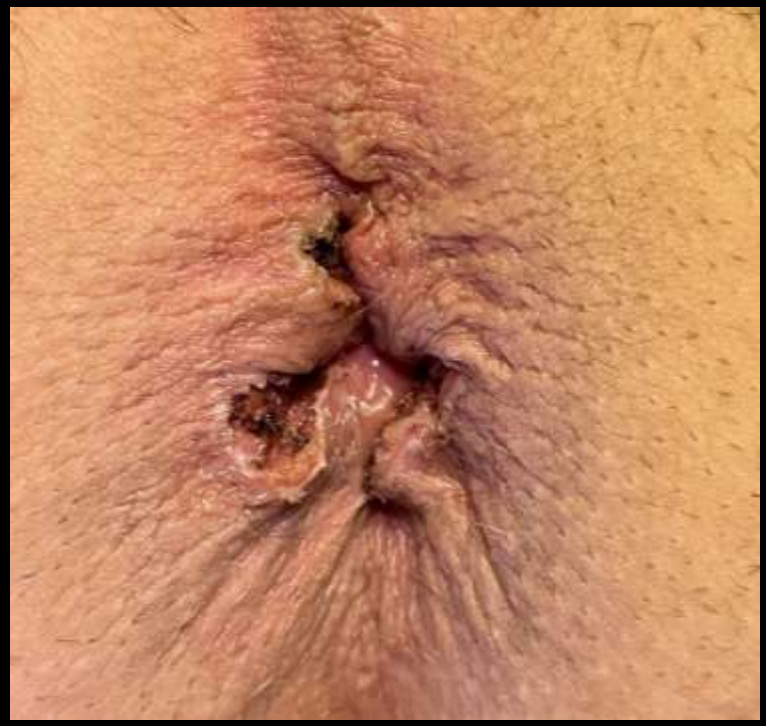



B
C

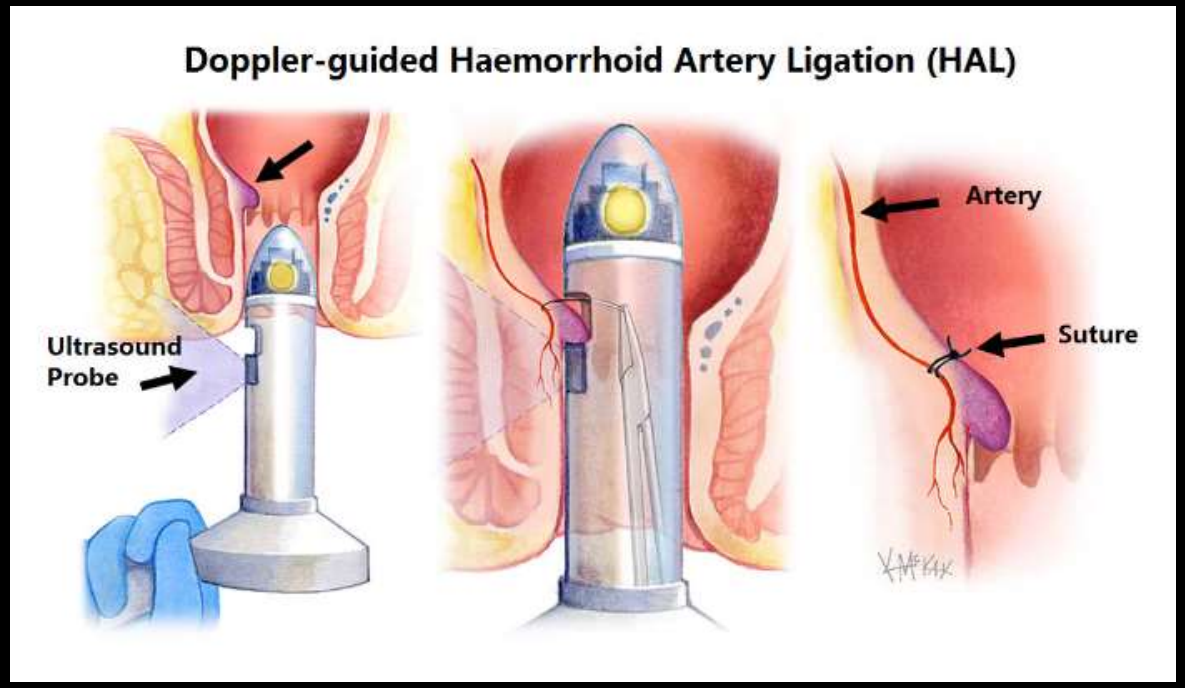


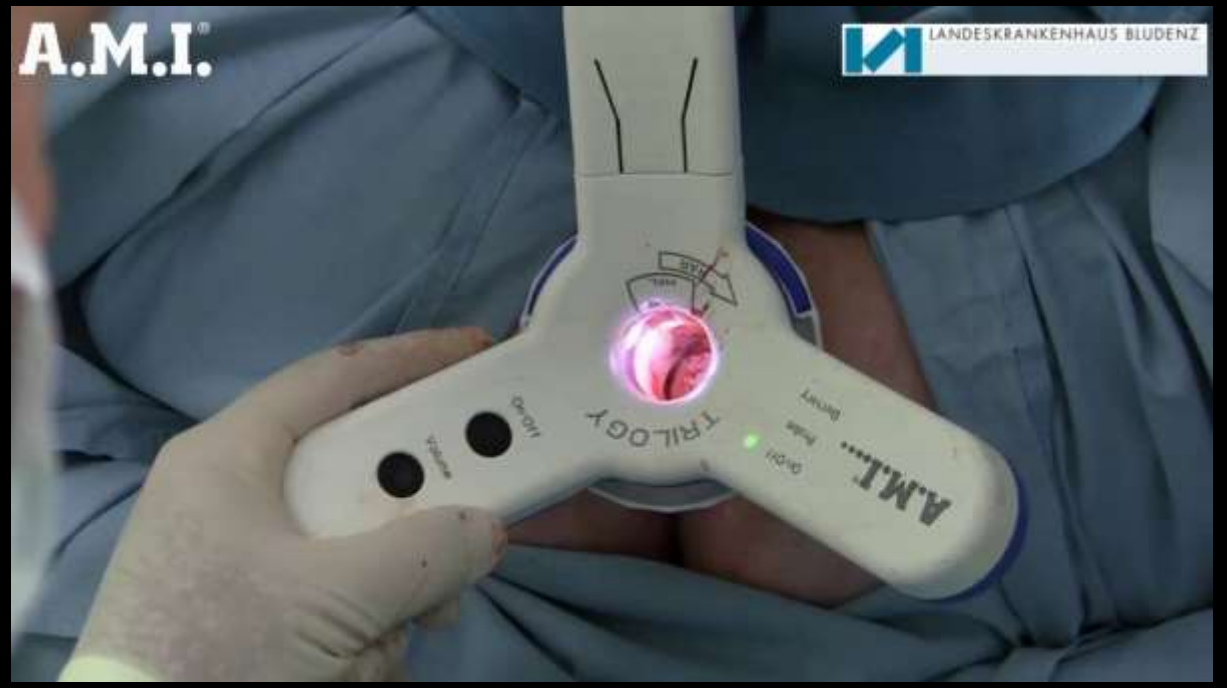


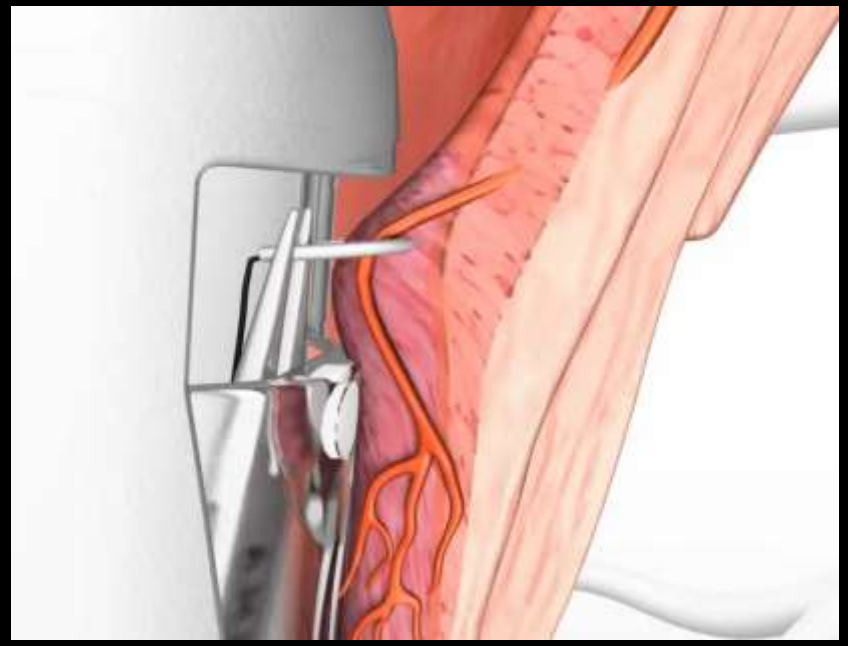


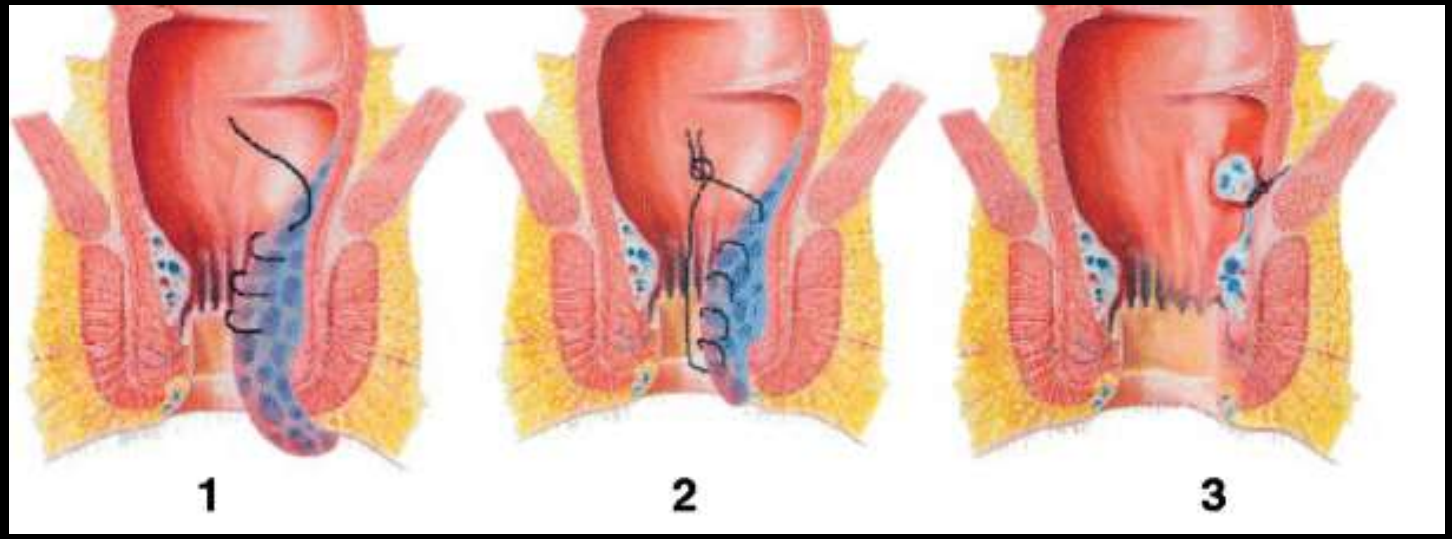



COVIDIEN


Doppler-guided Haemorrhoid Artery Ligation (HAL)
Ultrasound Probe
Artery
Suture


A.M.I.
LANDESKRANKENHAUS BLUDENZ
TRILOGY
A.M.I.

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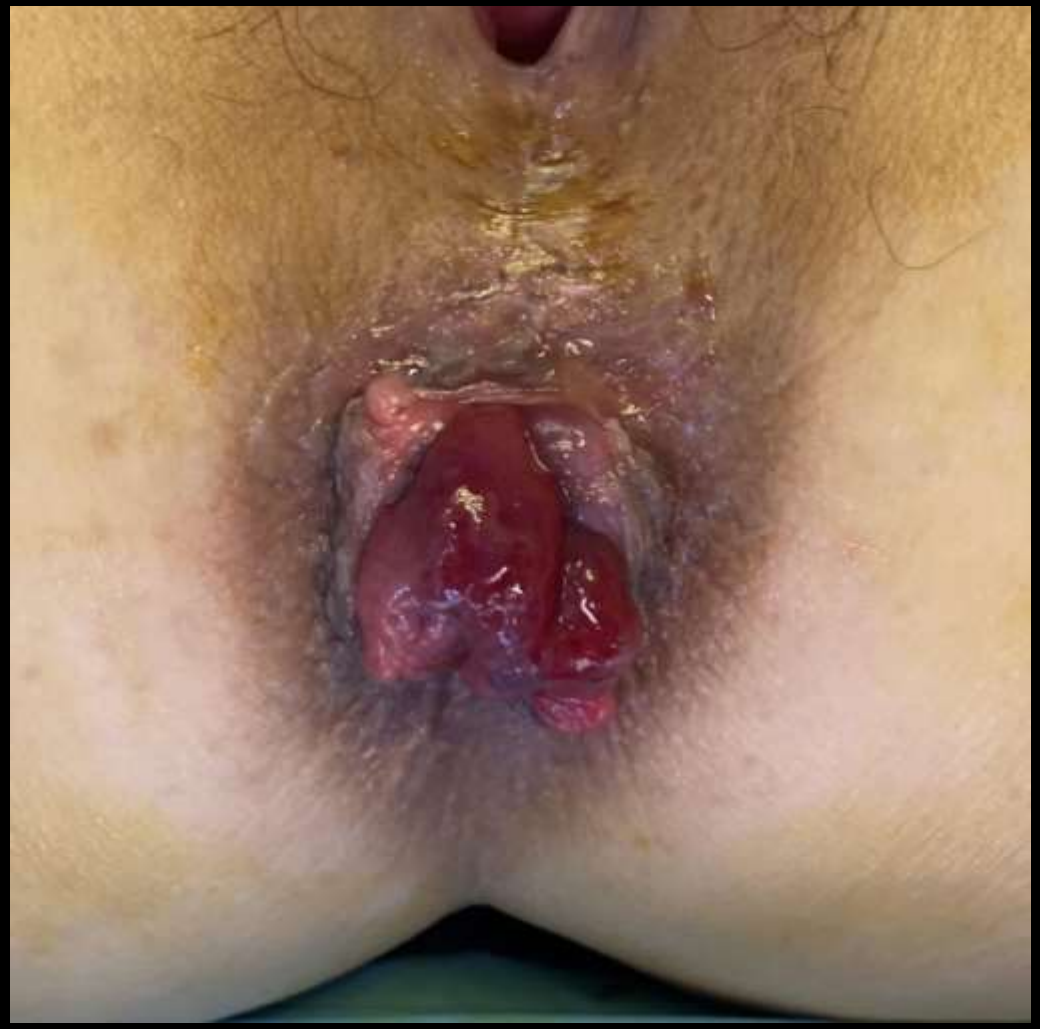

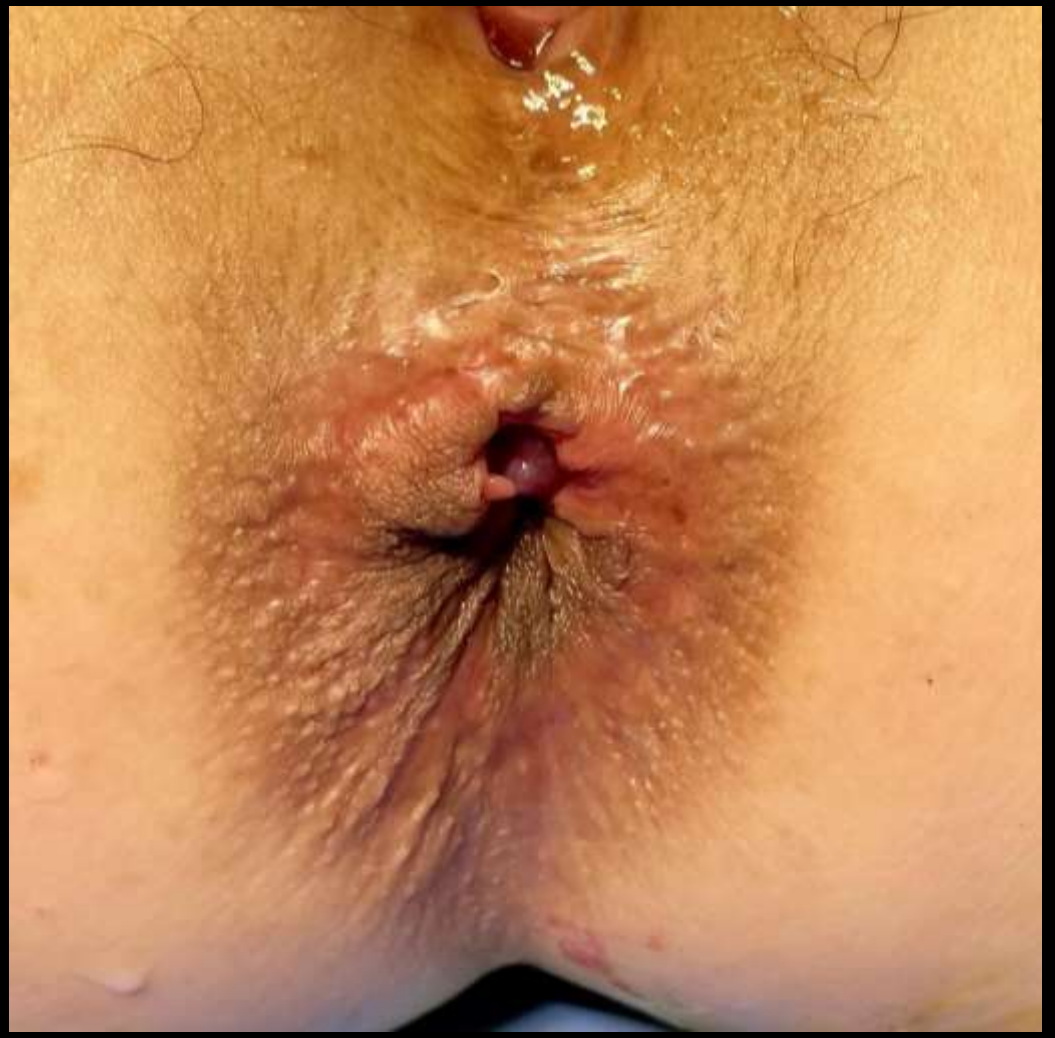

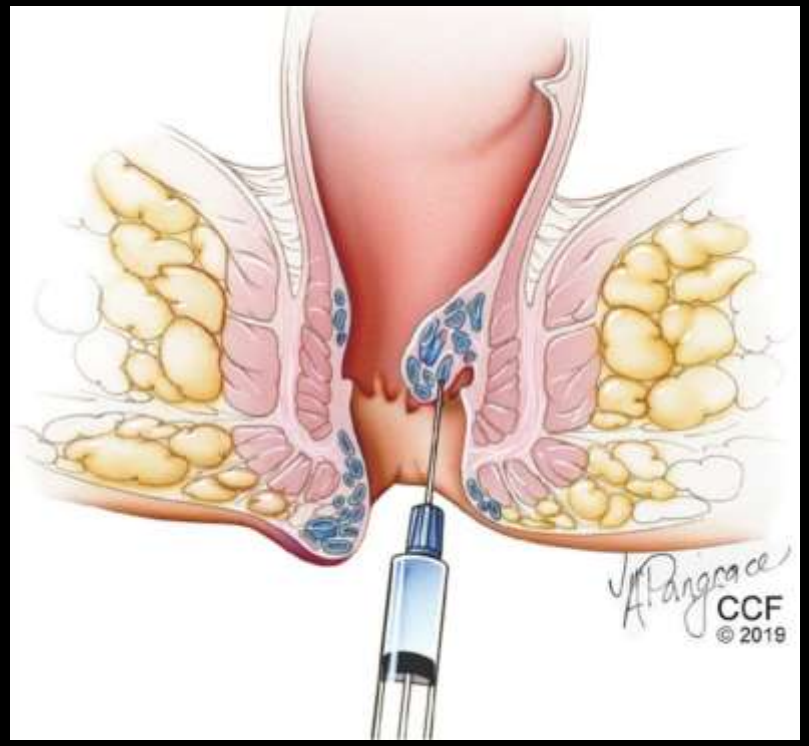
CCF
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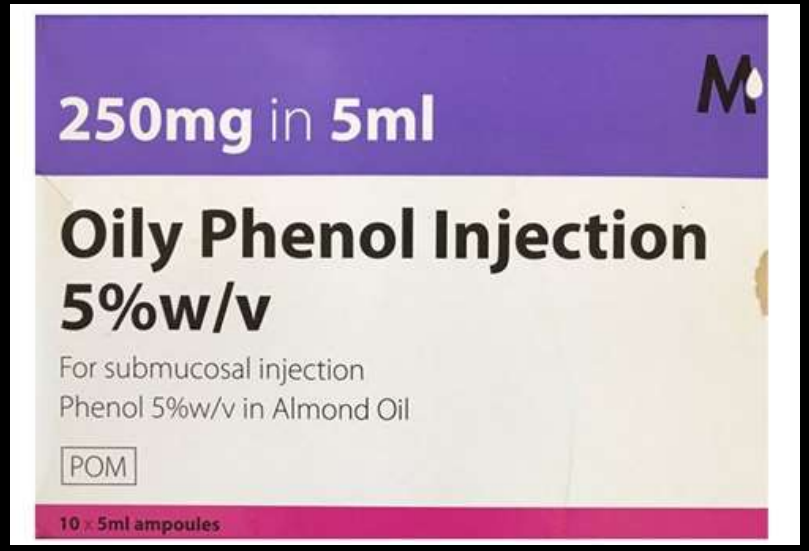
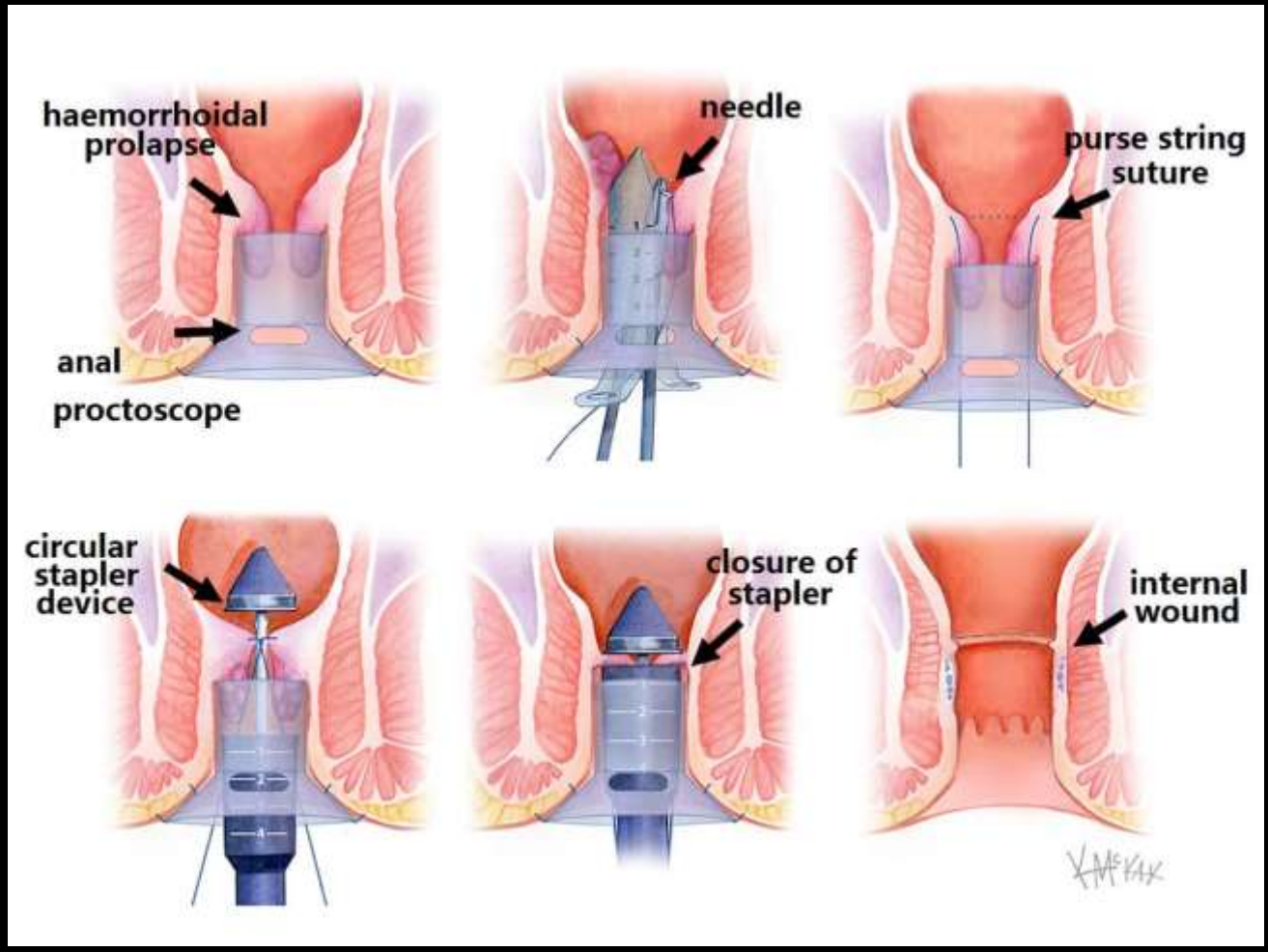
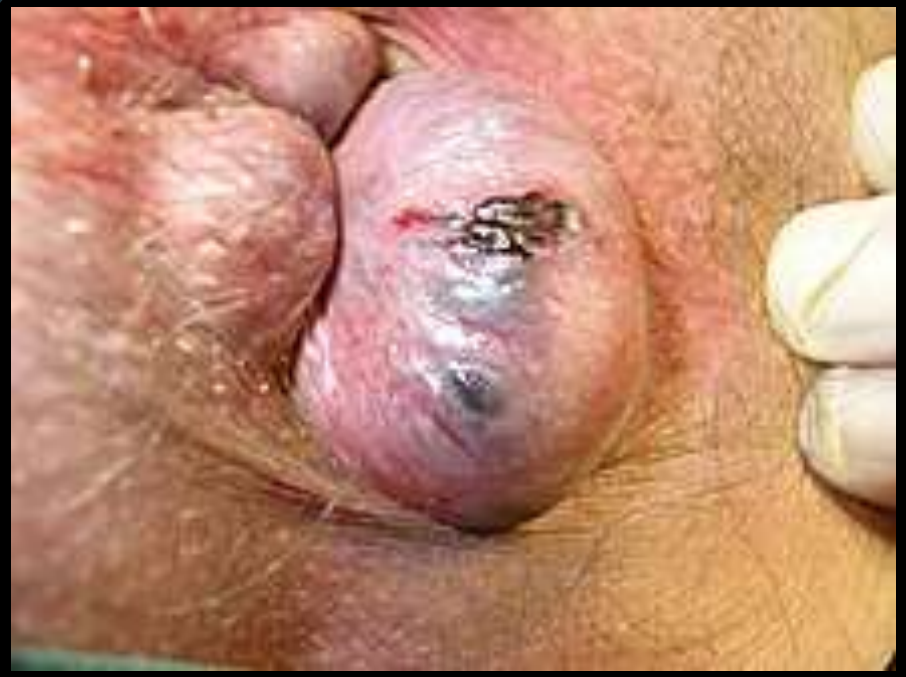
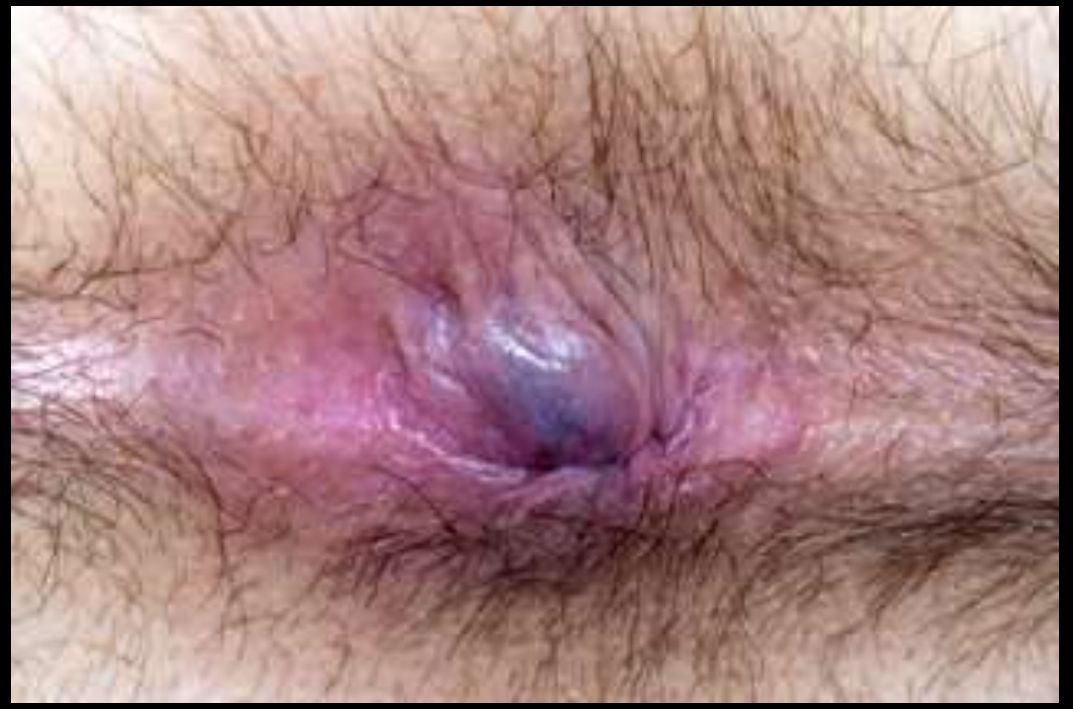

250mg in 5ml
Oily Phenol Injection
5%w/v
For submucosal injection
Phenol 5%w/v in Almond Oil
POM
10 x 5ml ampoules


haemorrhoidal prolapse
anal proctoscope
needle
purse string suture
circular stapler device
closure of stapler
internal wound

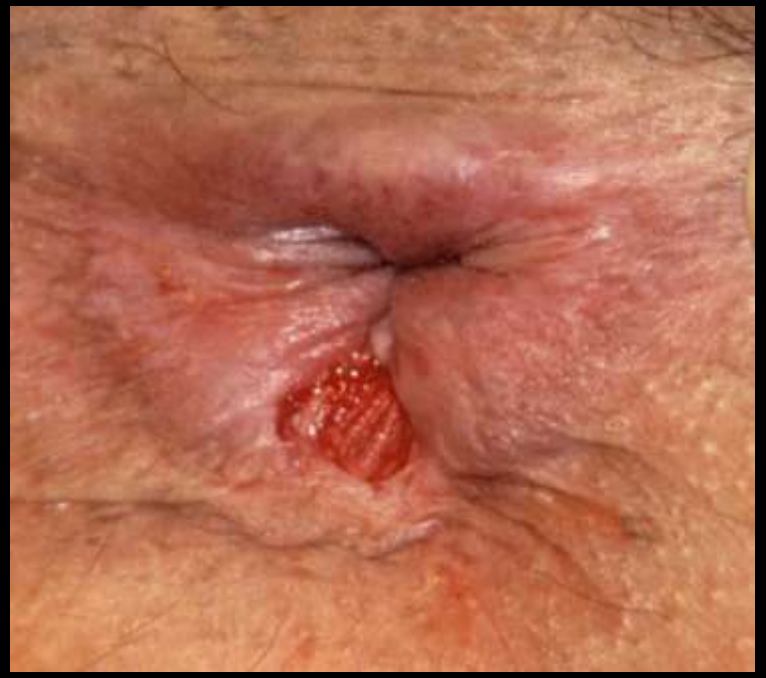
Perianal haematoma

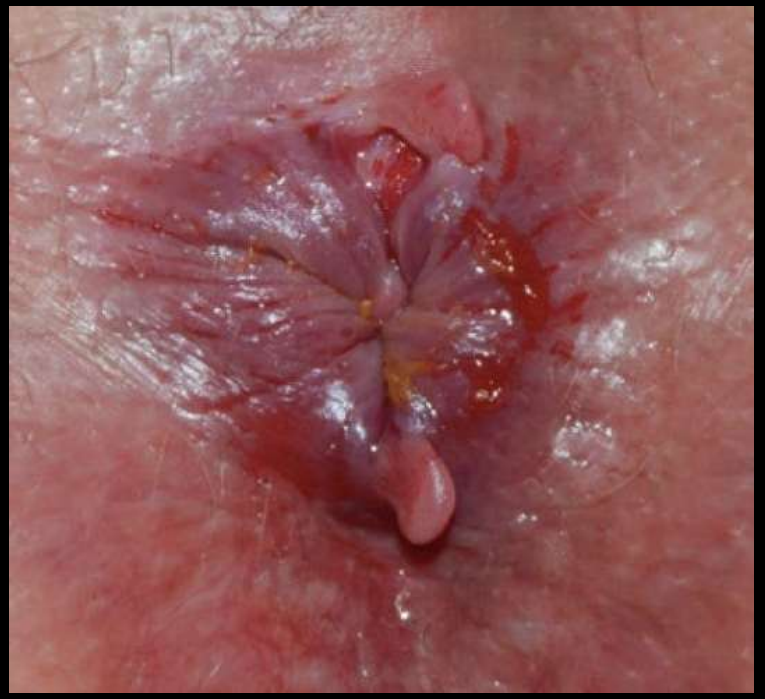


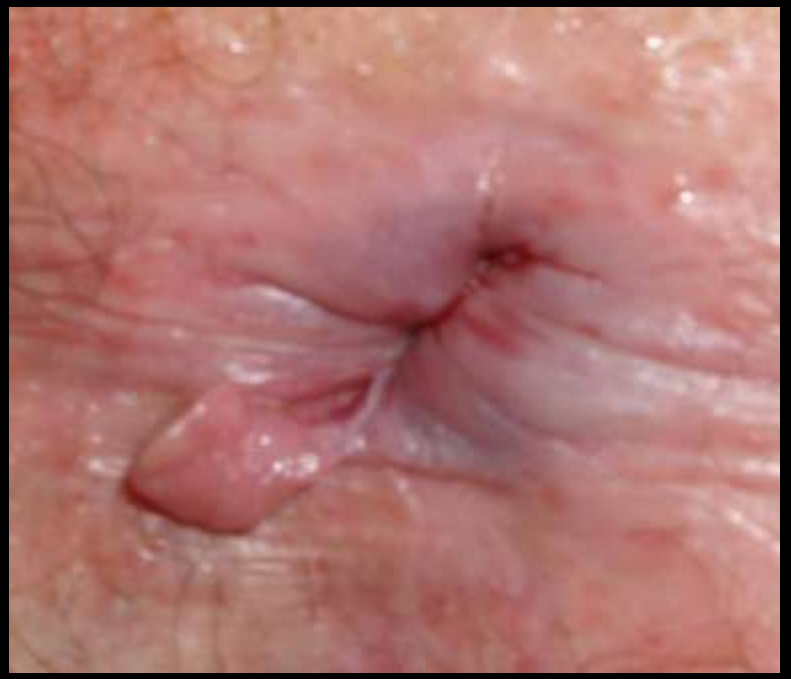


- 24-72h – consider incision and evacuation
- After 72h – conservative mx (sitz baths, lignocaine gel, ice, topical/oral analgesia)

Anal fissure







Anal fissure – management

- Lifestyle and dietary measures – as for haemorrhoids

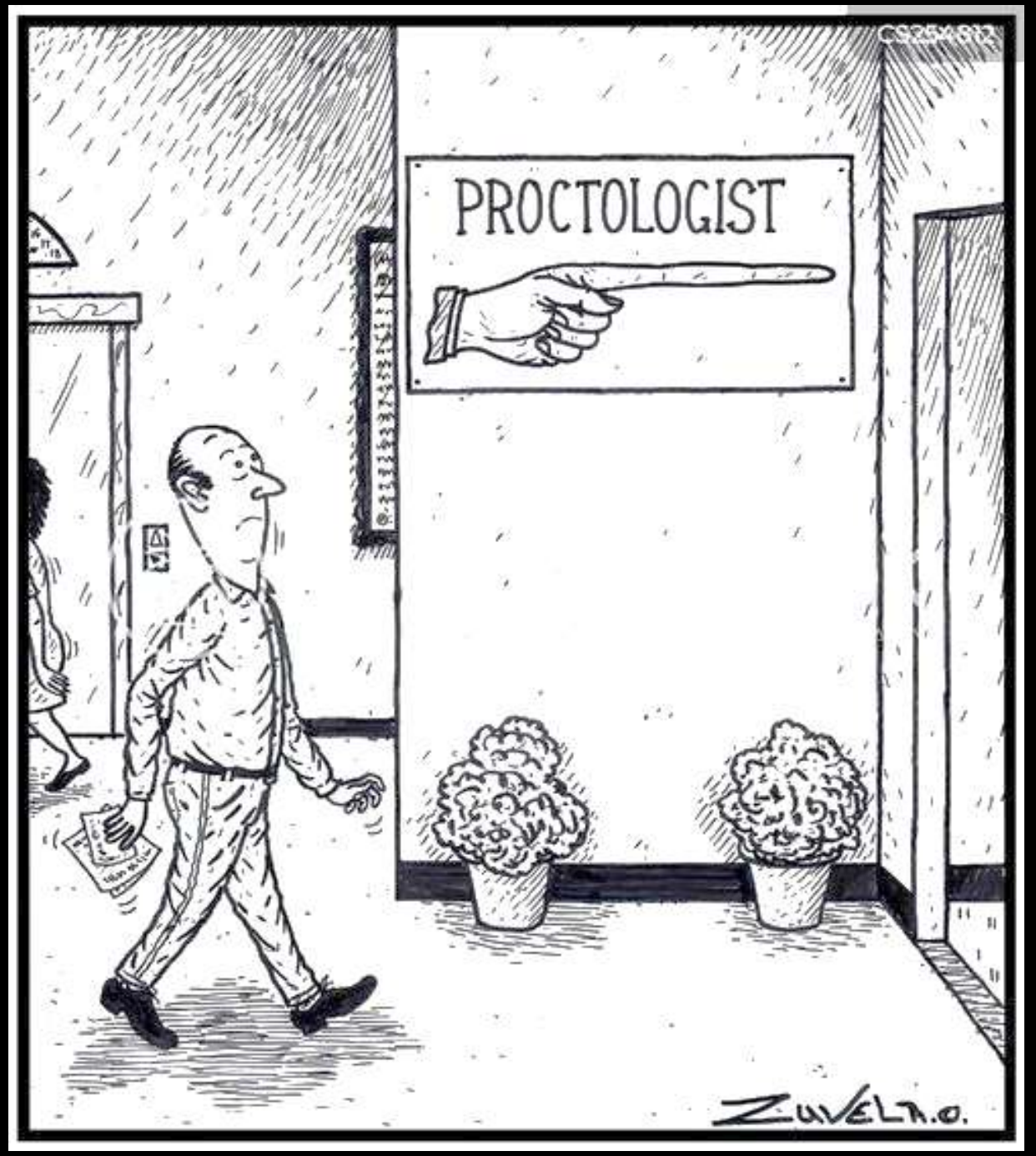
- Relieve sphincter spasm
  - Rectogesic ointment (GTN 0.2%)
  - Diltiazem paste 2%
    - *4xDiltazem CD 240mg capsules ground to a fine powder and mixed with 47g white soft paraffin*
    - *Apply TDS for 6 weeks*

- Surgical options
  - Botox injection
  - Lateral internal sphincterotomy
  - Advancement flap

**Beware anal cancer – “atypical” fissure, ulcerated or firm mass

Key points

- Look for red flags
- Painful bleeding most commonly an anal fissure
- Haemorrhoids and fissure may both be present concurrently
- First line management principles


PROCTOLOGIST
ZUVELA.O.