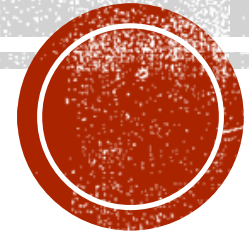
PROCTOLOGY

Dr Sze-Lin Peng, FRACS, FCSSANZ



COUNTIES MANUKAU HEALTH

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

AUCKLAND COLORECTAL CENTRE

OBJECTIVES

- Pictorial review
- Haemorrhoids
- Perianal hematoma
- Anal fissure

CONCERNED ABOUT CANCER?

- Anorectal symptoms
  - Aged 45 yrs and over → CT colonography or colonoscopy
  - High suspicion of neoplasia → COLONOSCOPY
  - In this age group colonic exoneration should occur regardless of benign anorectal pathology
- Note:
  - COLONOSCOPY within 2 years is generally acceptable
  - But there is a missed pathology rate of 2-5%
  - So the patient continues to have unexplained or worsening symptoms repeat colonic evaluation is warranted

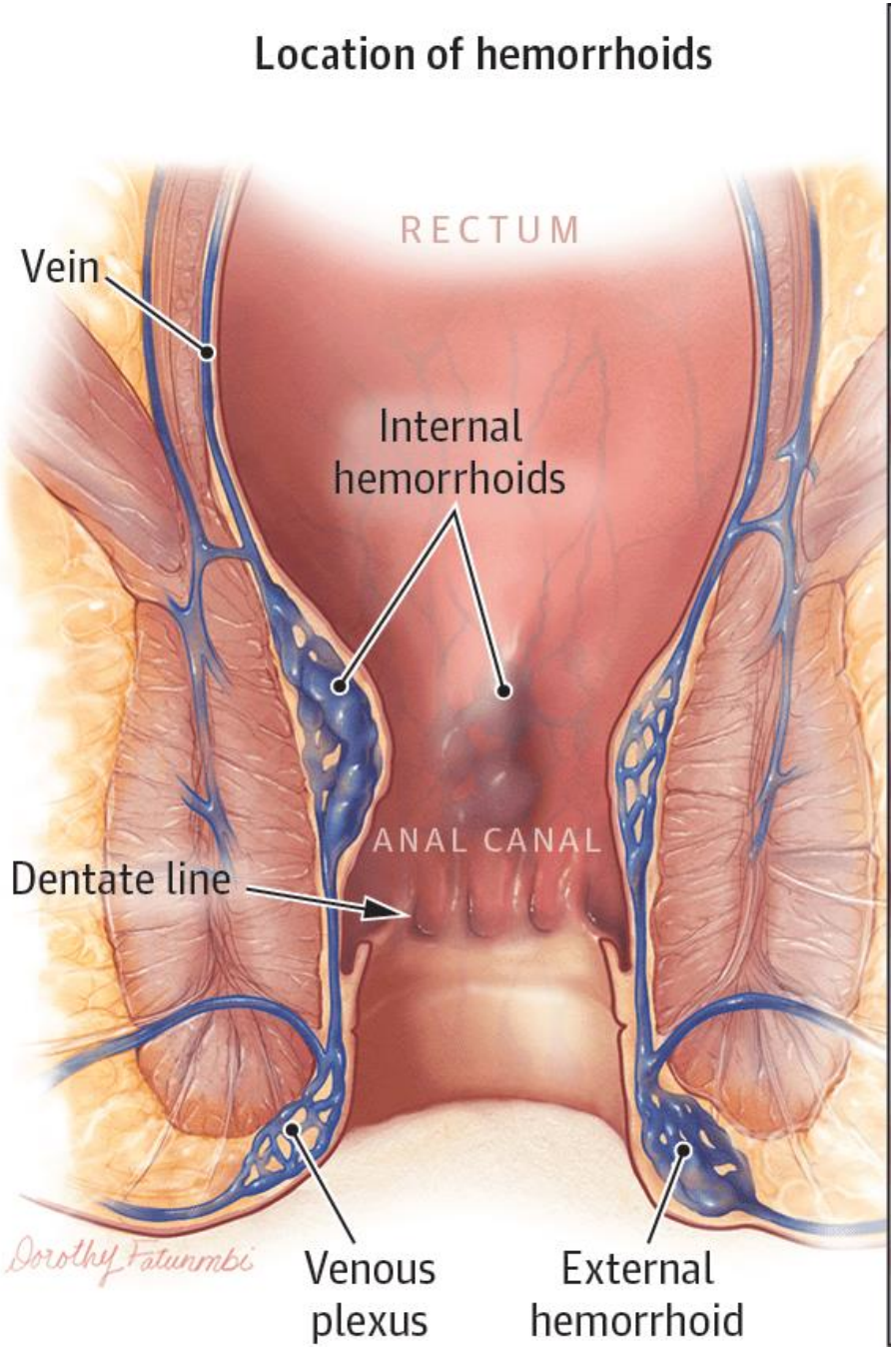
YOUNG PATIENTS (<50YRS) WITH COLORECTAL CANCER LESSONS LEARNT AT CMDHB

- 99 patients (2013-9)
- Majority symptomatic for > 6mths
- 2/3 have left sided tumours, 40% of these had rectal lesions
- All were repeat presentations with escalating symptoms
- Atypical features in history
  - Increasing bowel frequency ie tenesmus
  - Altered blood on PR bleeding

HAEMORRHOIDS

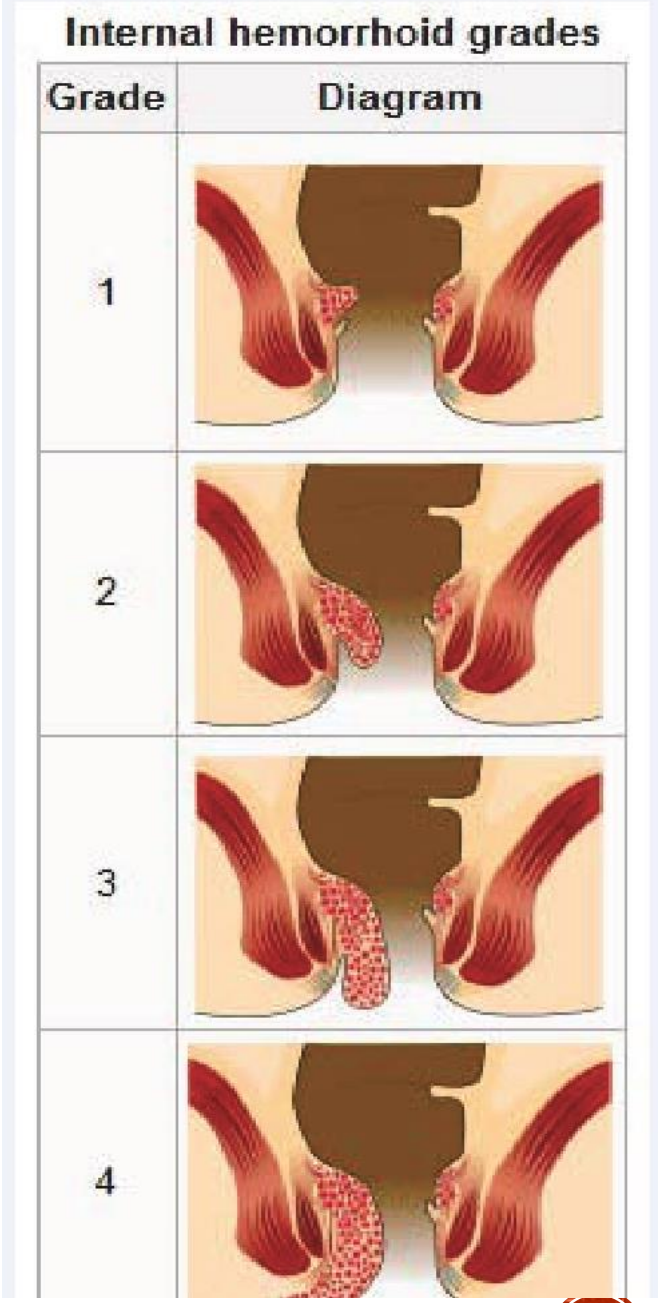
ANATOMY

- Normal vascular cushions in the anal canal
- When enlarged → can bleed/ prolapse
- Typically not painful unless prolapsed with associated swollen skin
- Usually normal examination
  - PR
  - Proctoscopy



NOT ALL NEED 'TREATMENT'

- Exclude cancer or polyps if > 45 y
- IBD
- Any recurrent/ atypical features (anemia, systemic symptoms)
- Non –invasive treatment
  - Occasional bleeding only
  - < 40 yrs – PR/ proctoscopy/ rigid sigmoidoscopy
  - Reassure – fluids, soluble fibre, weight loss, exercise, less toilet time
  - Grade 1-2
- Exclude serious pathology, avoid intervention
  - Level 1 – reassurance, advice
  - Level 2 – banding
  - Level 3 - surgery



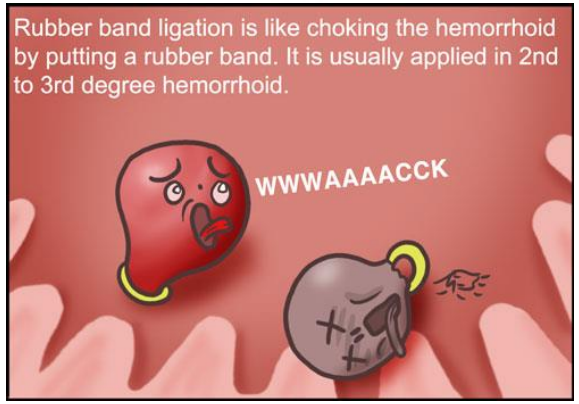
RUBBER BAND LIGATION

- Silicone bands
- Usually no sedation required
- Not all can tolerate proctoscopy
- If frequent bleeding – can be very effective
- Immediate risk → discomfort, tenesmus → urinary retention
- Delayed risk → bleeding in 7-14 days –rarely need admission

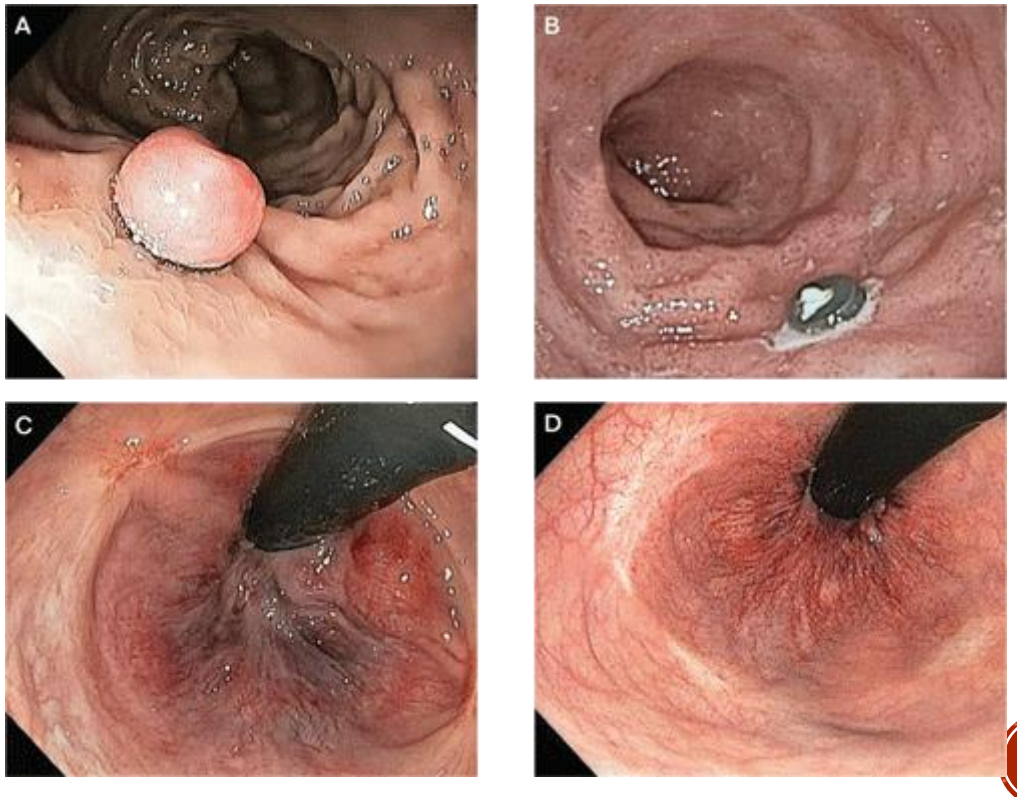
- Anticoagulation
  - If important indication (stent, cva, etc) → if not anemic, may be better to accept some bleeding
  - If not – careful discussion re risk of delayed bleeding with ANY haemorrhoid intervention, consider stopping anticoagulation for the RISK PERIOD ie 1-2 wks after banding

BANDS ARE PLACED ABOVE THE HAEMORRHOID, DELAYED BLEEDING IS FROM THE ULCER FORMED

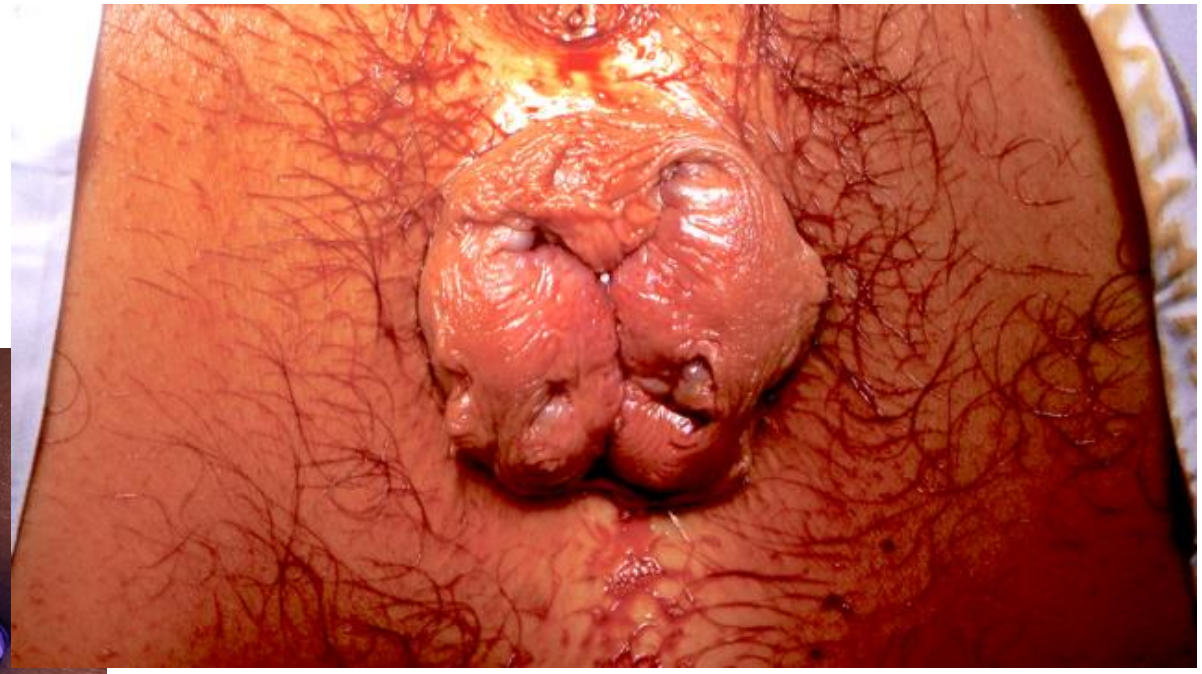
WRONG ✕

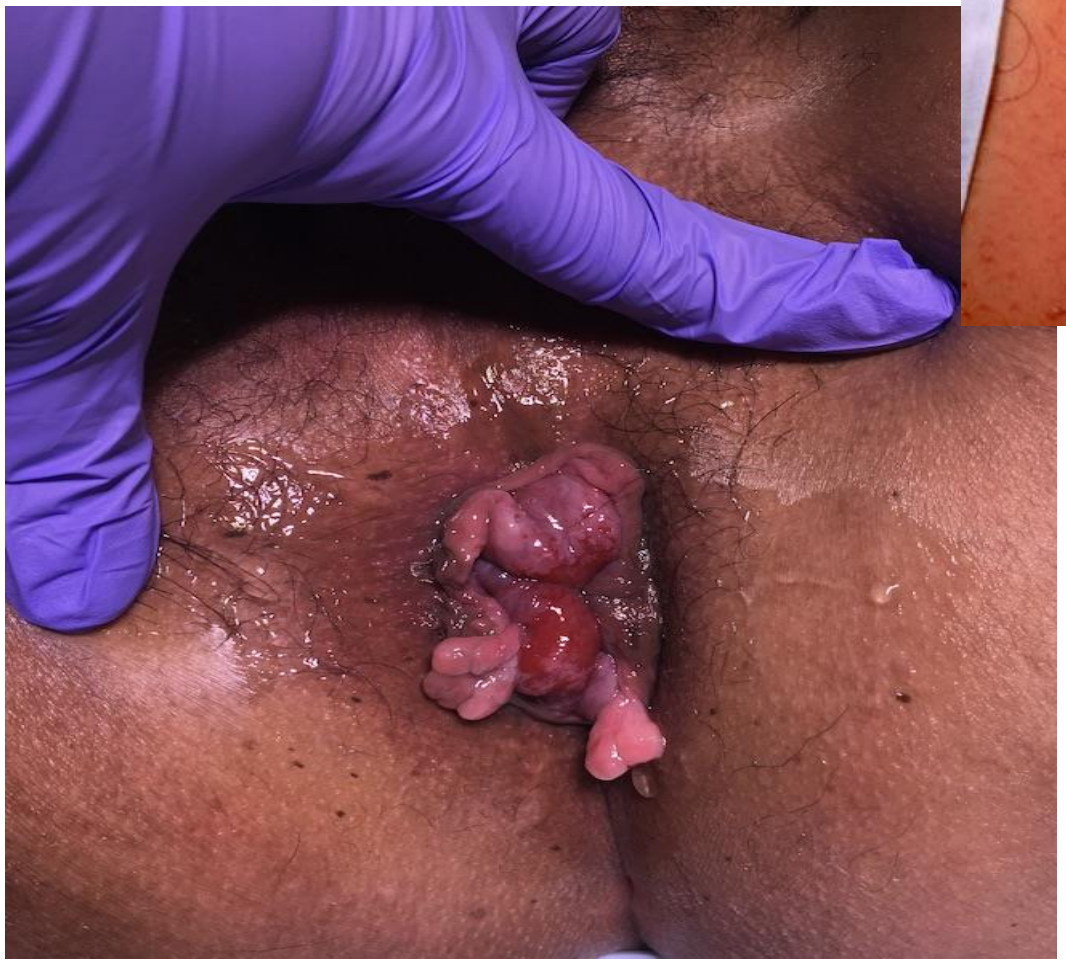


CORRECT ✓



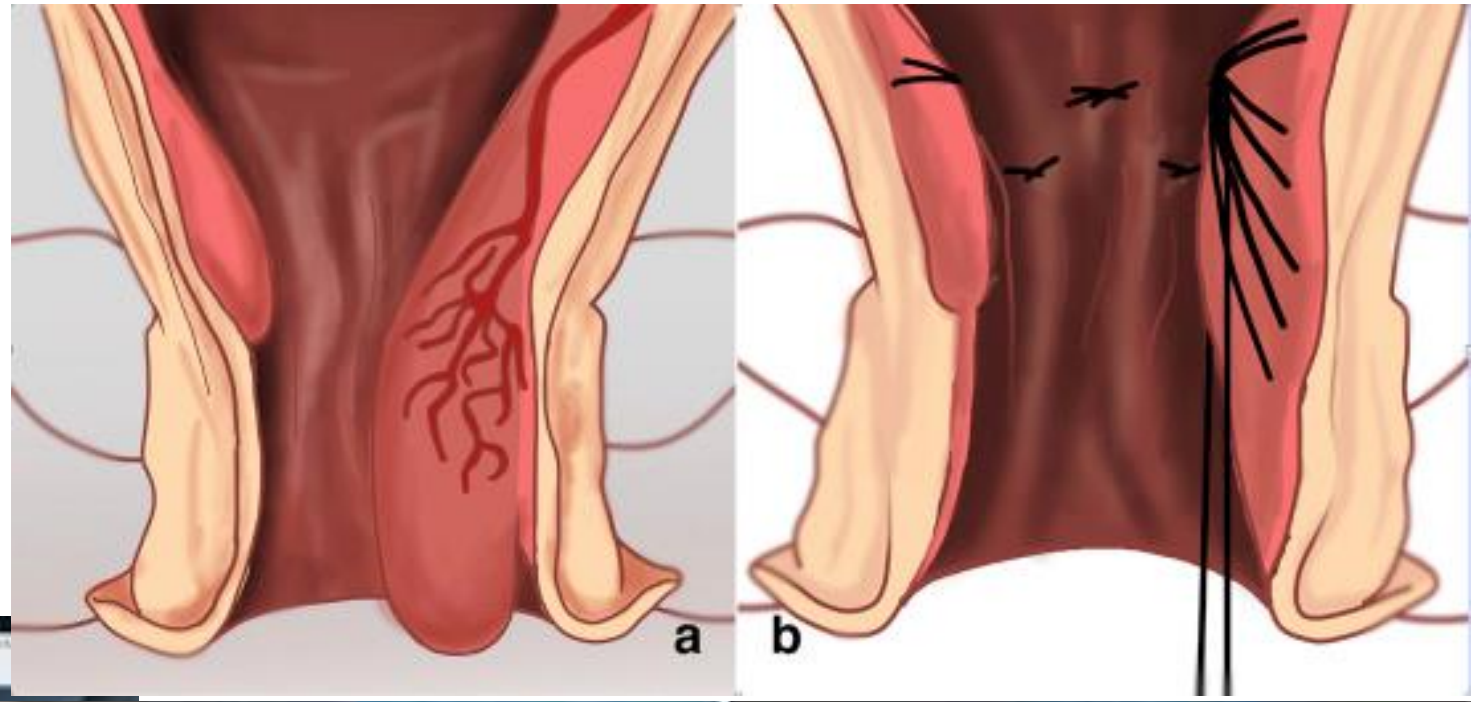
DIFFERENT?

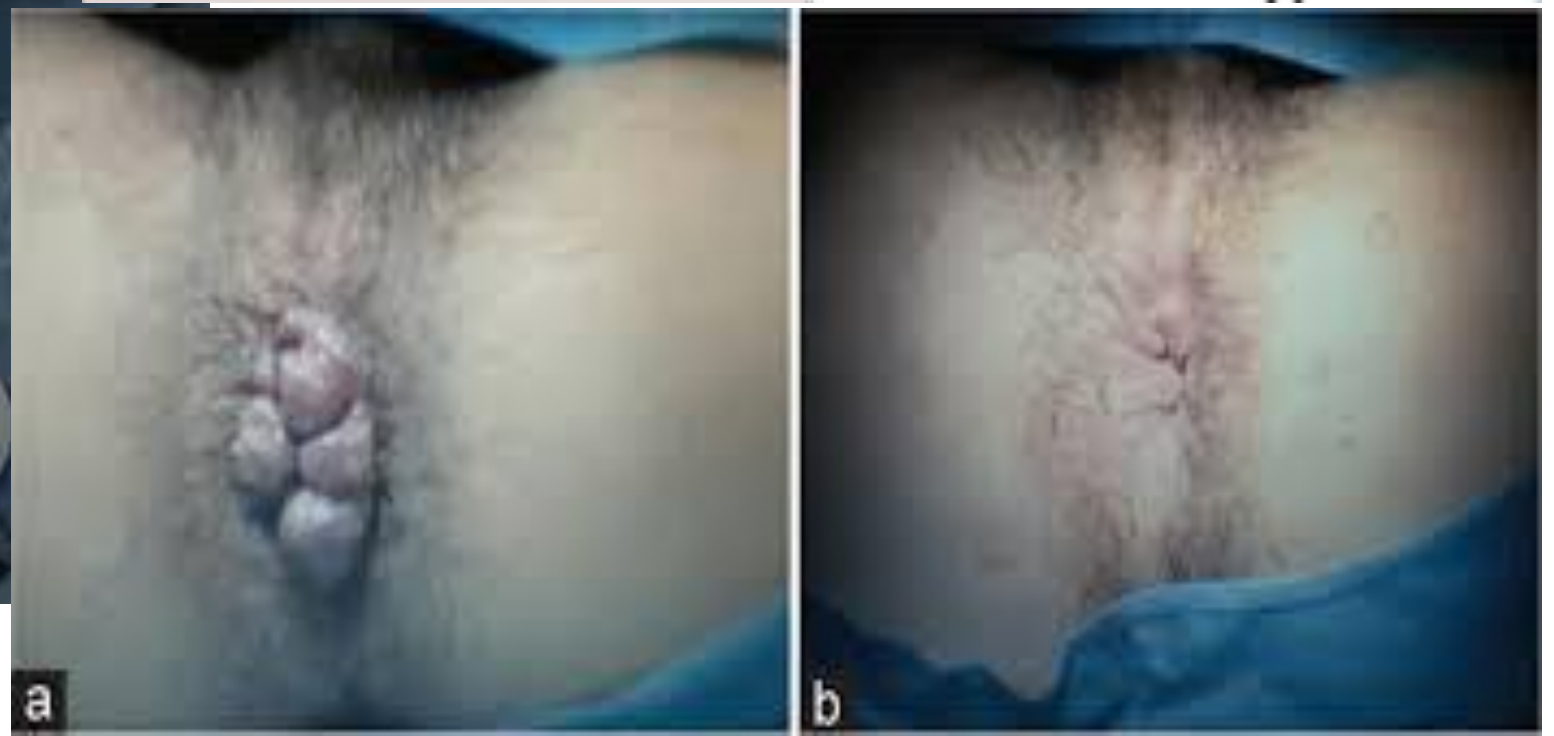




HAL-RAR

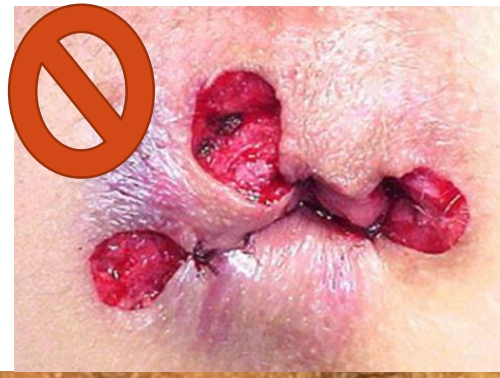
- **H**aemorrhoidal **A**rtery **L**igation – **R**ecto**A**nal **R**epair

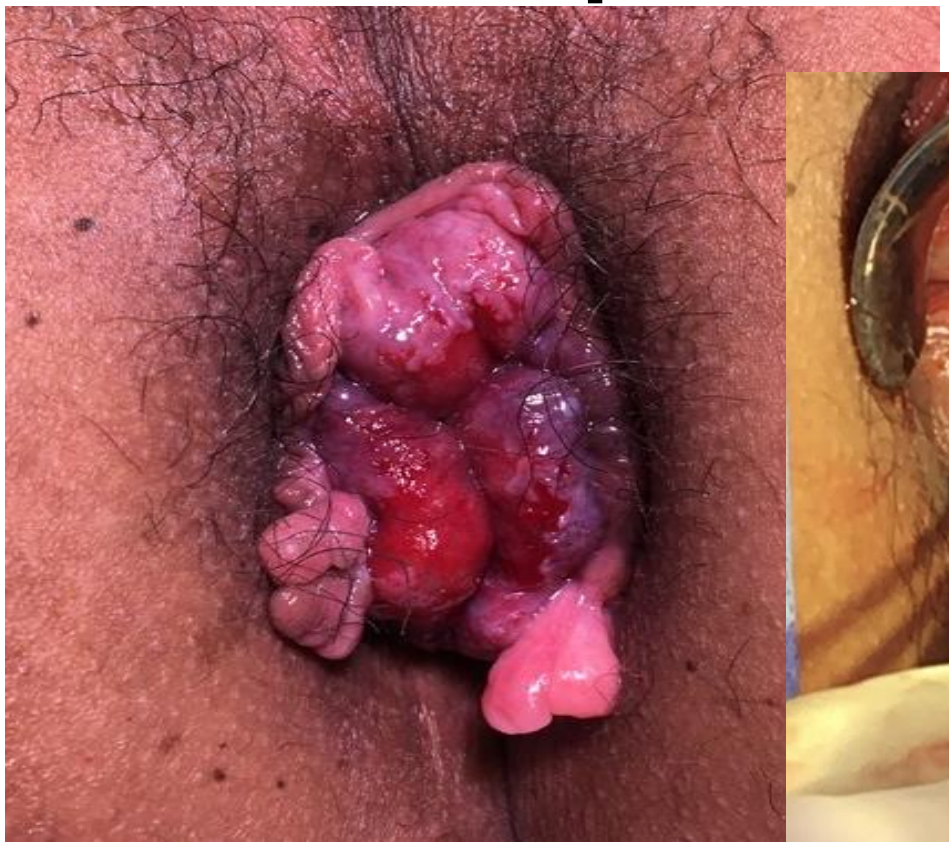


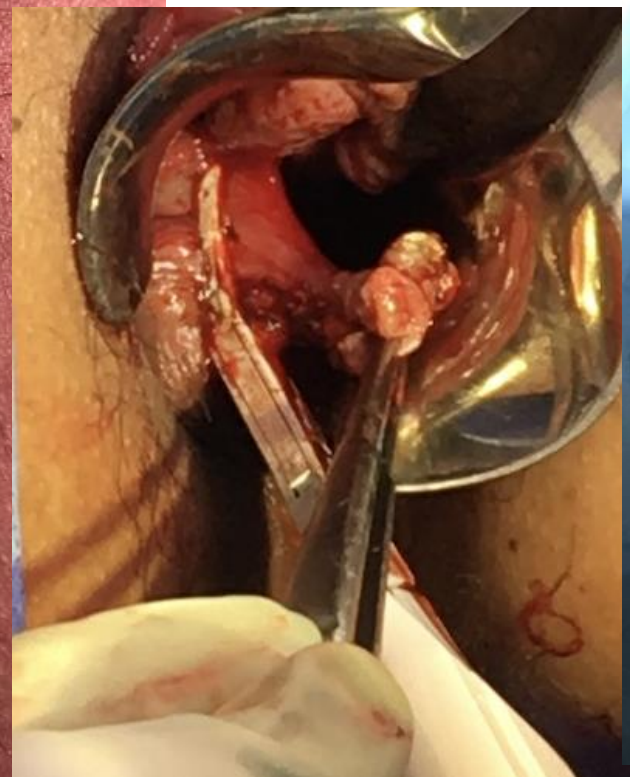


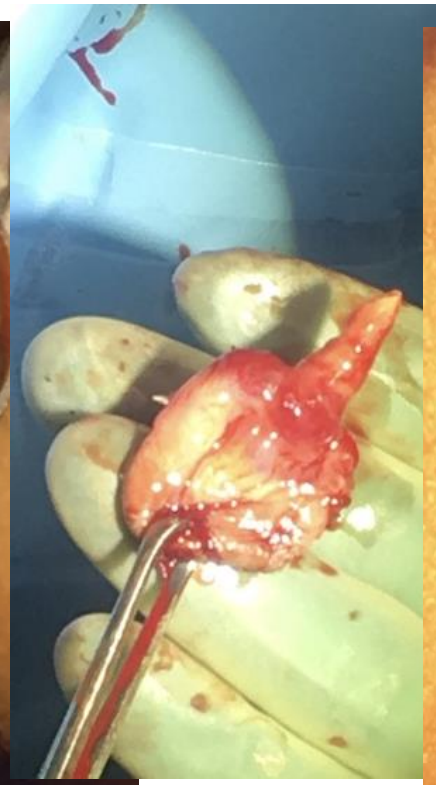
EXCISIONAL HAEMORRHOIDECTOMY

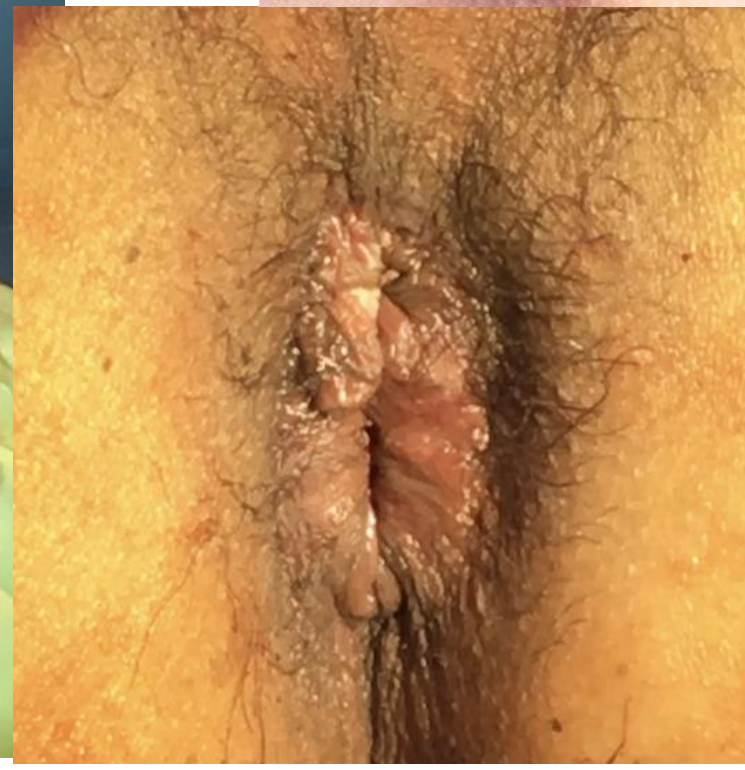
- GOLD standard, tried and tested
- ‘modern modifications’ involve more sophisticated energy-devices
- Less is more, preserve as much skin as possible



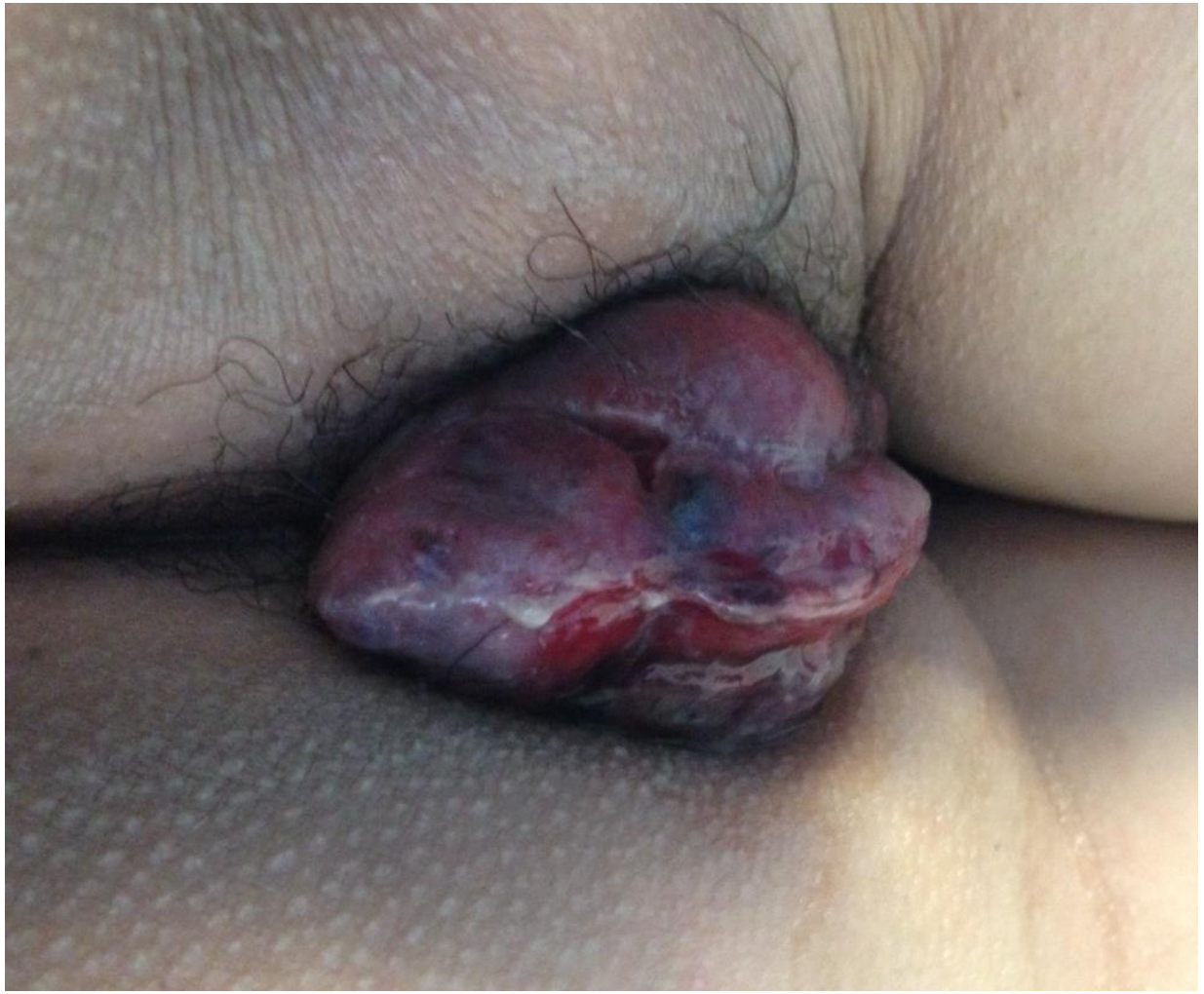








THE ACUTE HAEMORRHOID 'CRISIS'

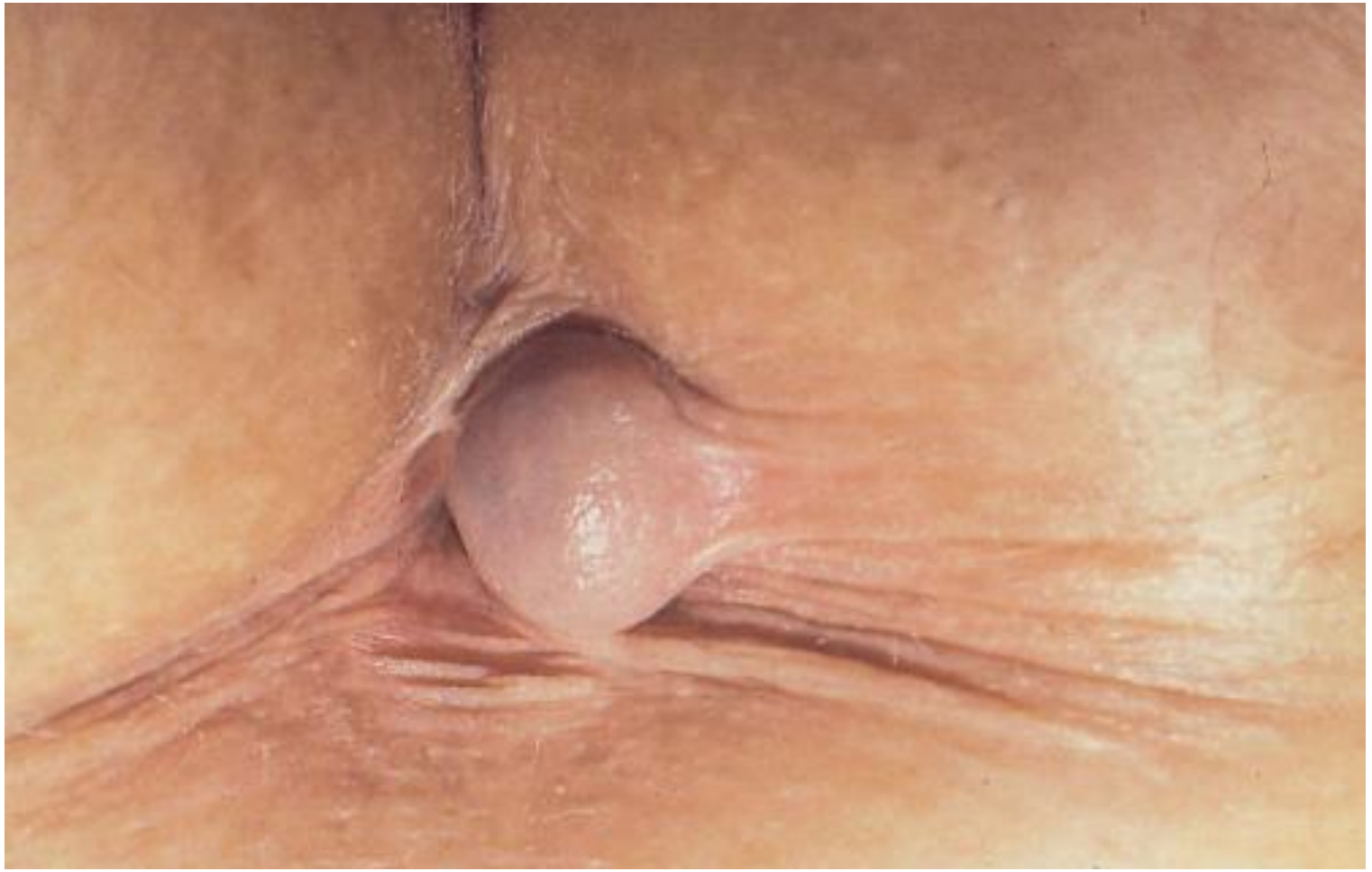


- Admit for analgesia
- Ice
- If sepsis/ necrosis → acute haemorrhoidectomy but pain is not necessarily improved as still 6-8 wks post-op pain

PERIANAL HEMATOMA

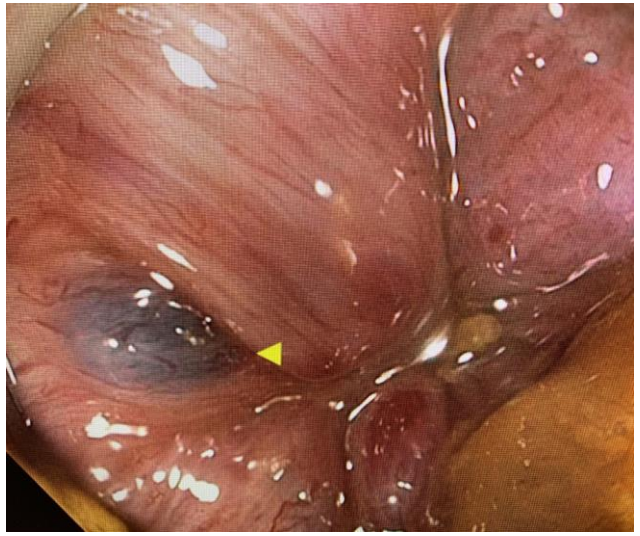
Aka external haemorrhoid

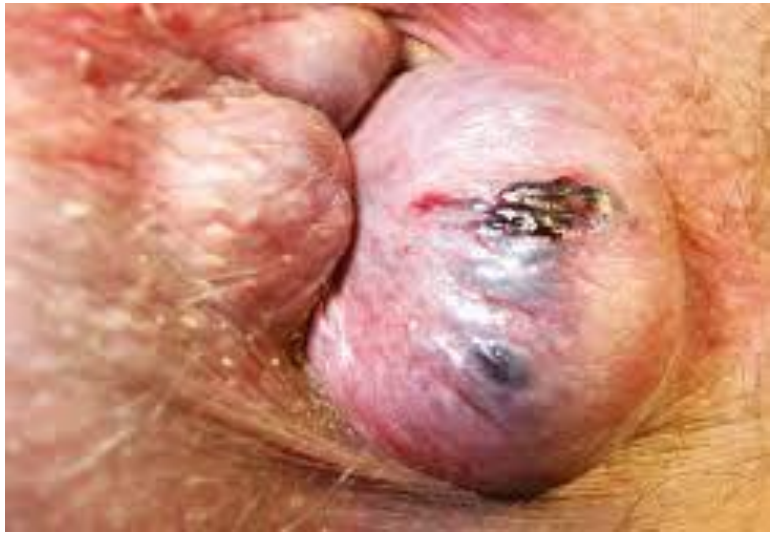
PAINFUL



MANAGEMENT IN PHASES

- Acute – tense presenting within 2-3 days consider incision and drainage under local, radial incision, evacuate the clot
- Resolving – ulcerated surface, bleeding has occurred, skin not tense, still painful but no need to evacuate. Oral and topical analgesia. Settles to a rice like lump – can see a small blood clot – reassure, likely no further issues.
- Chronic/ recurring – consider surgery





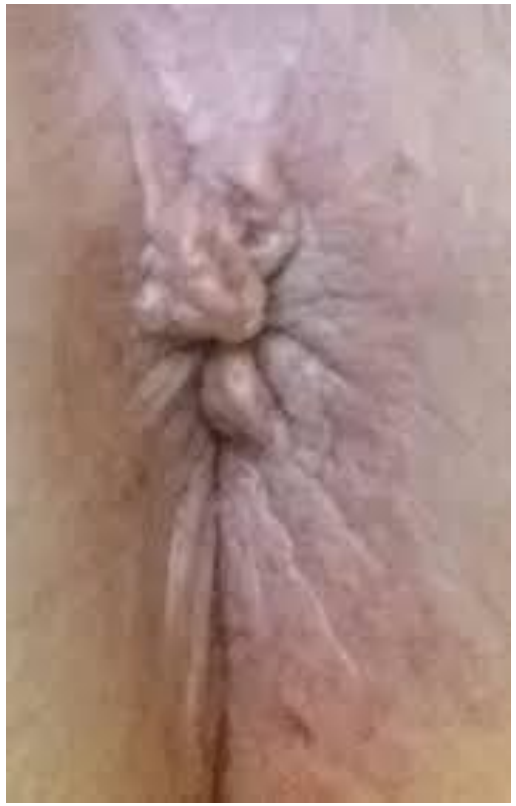
SKIN TAGS

EXCISION CRITERIA

- Symptoms
  - Itch
  - Recurrent well localized swelling of the tag
  - No underlying conditions
    - FISSURE
    - Fistula
    - CROHNS
- => 1cm
- Long narrow stalk
- Beware **anterior midline** ones especially in women
- Consent expectations
  - **Recurrence** – especially early
  - Pain
- Quicker under GA also may be vascular but local possible if narrow stalk

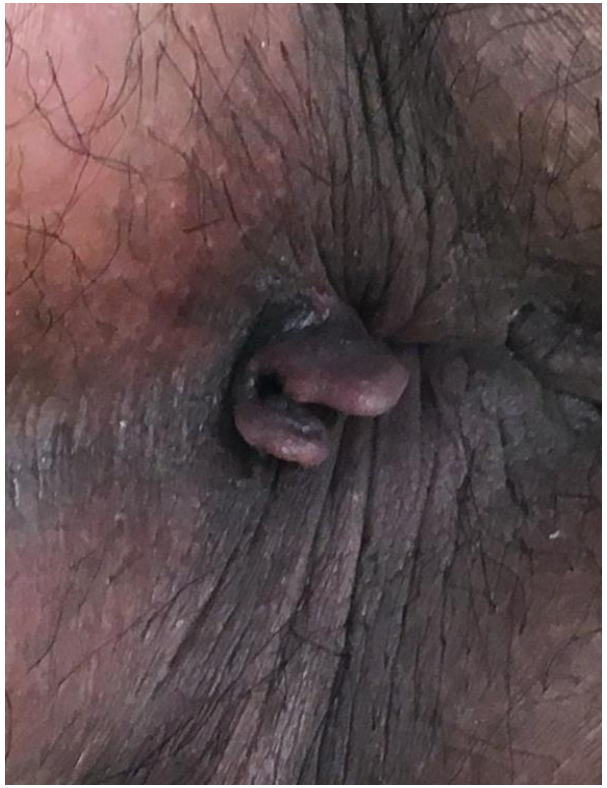
PRURITIS

HAEMORRHOIDS? – CONSIDER RBL



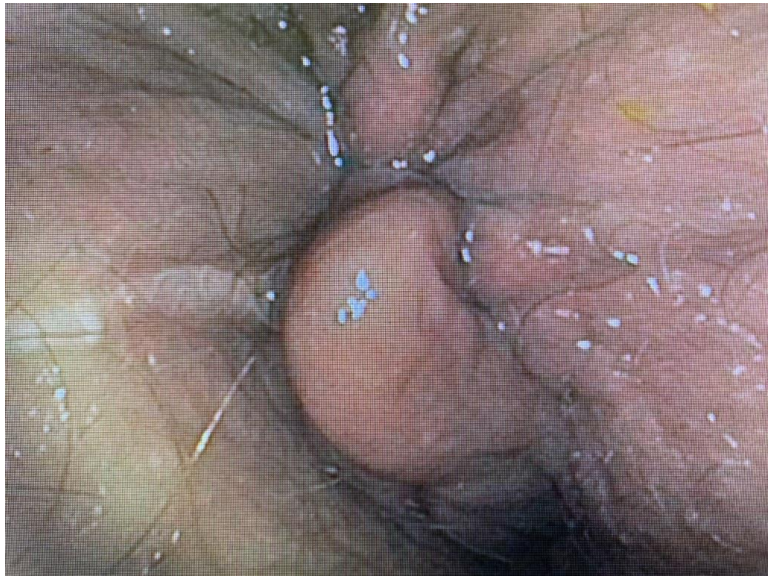
POSSIBLY EXCISE

COULD BE FISSURE IN THE MIDDLE



BROAD BASED

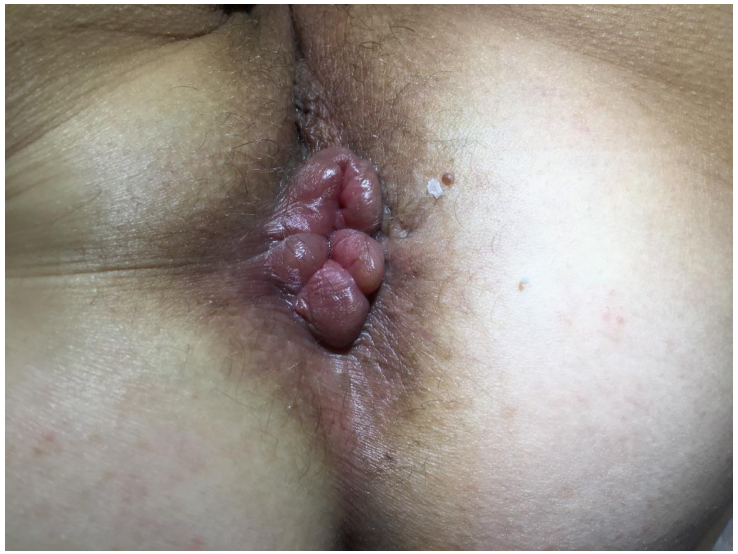
LIKELY SENTINEL TAG



EDEMATOUS CIRCUMFERENTIAL EXTERNAL HAEMORRHOIDS

UNDERLYING DIARRHEA/ STRAINING/CONSTIPATION?

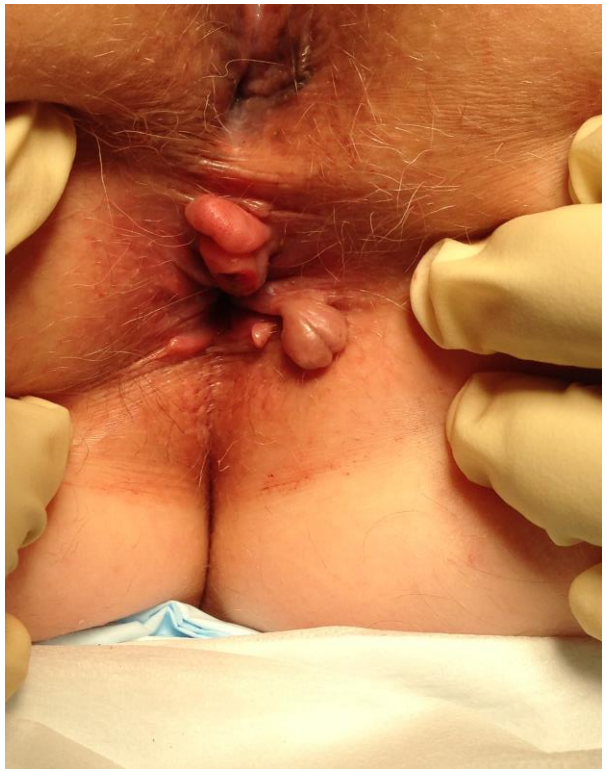
IF CHRONIC – CONSIDER EXCISION/ HAL-RAR



ANTERIOR MIDLINE FISSURE WITH SWOLLEN TAG

SEPARATE TAGS – LARGE LEFT ONE

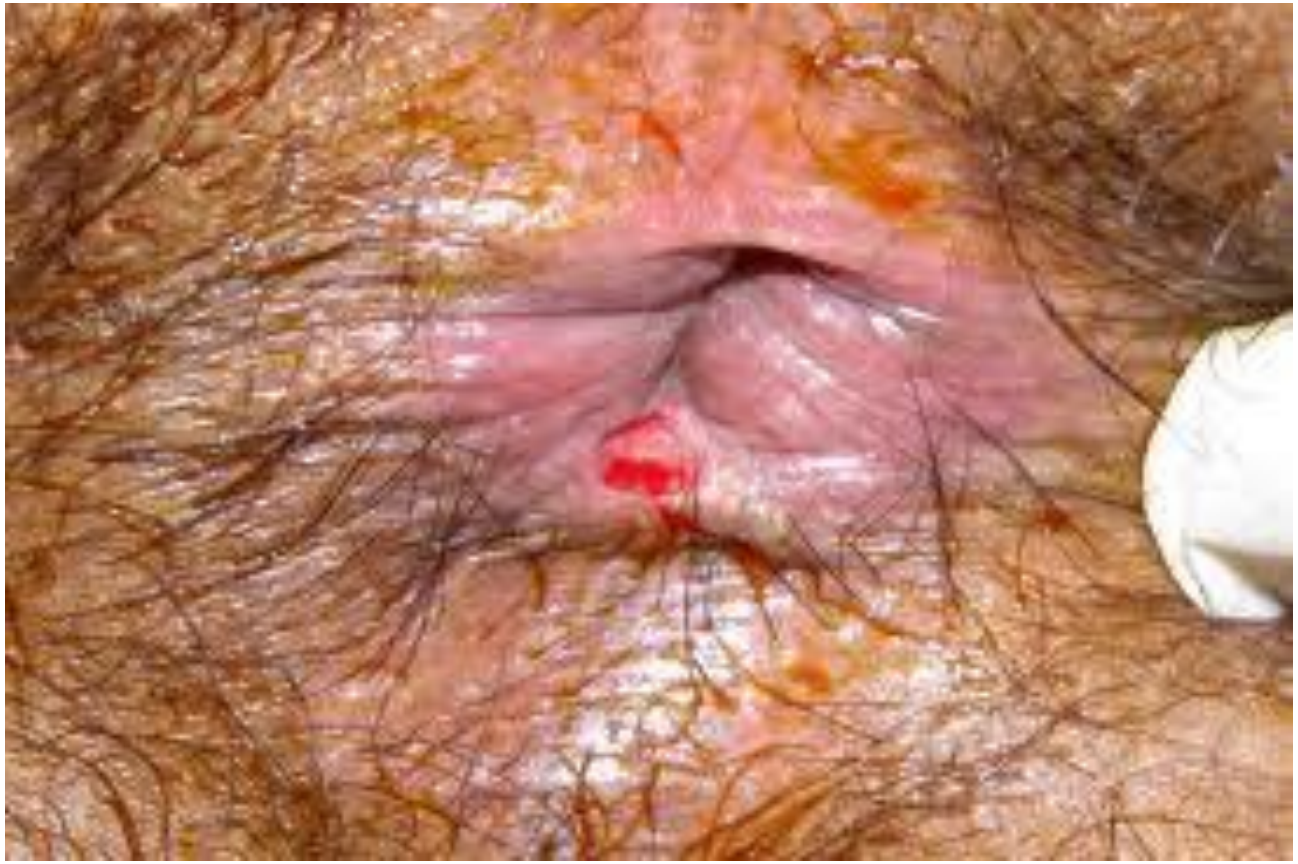
? CROHN'S



ANAL FISSURE

PAINFUL

- Painful defecation, worse 30-60mins
- Often 'normal' examination/ too sore for a proper PR
- CLUE – sentinel tags in the midline
- Don't persevere with PR/ proctoscopy
- If good history → treat as a fissure
- Review in 6-8 wks → if still symptomatic refer
- If better in 6-8 wks → young patient, no red flags no further investigation
  - If > 45 → consider iFOBT, examination



ALTERNATIVES TO RECTOGESIC

- Topical diltiazem 2 % ointment
- 4x 240mg diltiazem capsules – contents ground to fine powder
- add 47g white soft paraffin

- Topical nifedipine 0.2 %ointment (esp breastfeeding/ pregnancy)
- 10 X 20mg nifedipine tablets – ground to fine powder
- add white soft paraffin to 100g

TRICKY FISSURES

- Anterior midline in women esp postpartum
- IBS, IBD
- Fissure - fistula

BOTOX

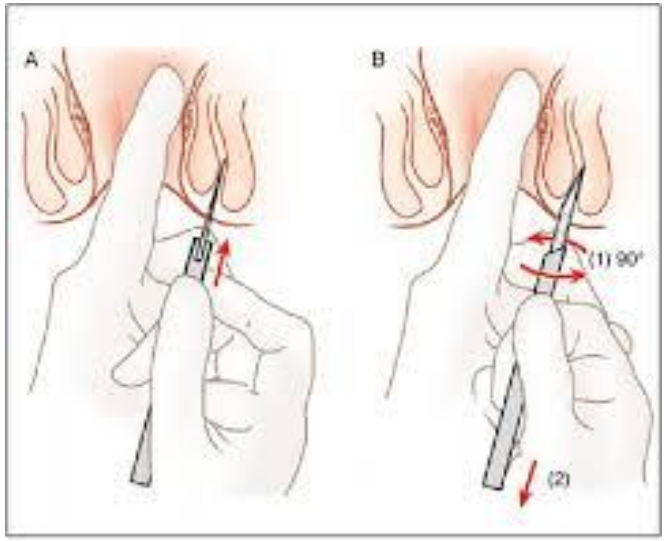
- Under anaesthesia
  - Thorough examination
  - Debride fissure/ fissurectomy
  - Directed injection into internal anal sphincter

- Not superior to topical treatment
  - Convenience
  - ? More constant IAS relaxation

- 3 months flatus incontinence for some
  - Good indication to avoid sphincterotomy

LATERAL SPHINCTEROTOMY

- Gold standard for chronic anal fissure
- Superior to topicals and Botox
- Closed vs open (tailored)
- For the low risk patient – 5% change in continence



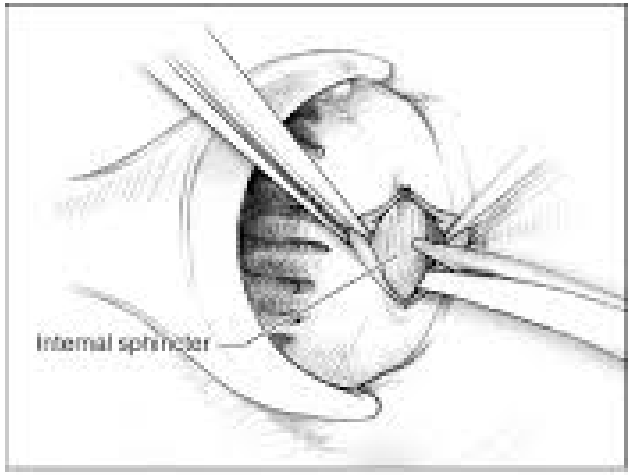


Figure 2a : Lateral internal sphincterotomy

PERIANAL FISTULA

PIN HOLE OPENINGS IN THE MIDLINE

- Related to midline fissure
- Often causes itch
- Fistulotomy