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Common anorectal conditions

Patients present to GPs with a wide variety of anorectal symptoms and complaints, most of which are benign and easily treated. The purpose of this article, by [Sze-Lin Peng](#), is to provide a pictorial guide of a few common, benign anorectal conditions, with treatment recommendations for each one

Anorectal symptoms are very common in patients presenting to general practice and general surgery. Benign and malignant conditions may present with similar symptoms, and can also coexist, making diagnosis and treatment difficult at times. Fortunately, the majority of patients will have benign conditions, but they can still experience significant impacts on quality of life.

This article includes a discussion of five common anorectal conditions. These are not necessarily seen in isolation because different conditions are often interrelated (eg, haemorrhoids can give rise to fistulae).

After careful history and accurate examination, simple dietary and lifestyle modifications will suffice in the majority of patients. Many patients stand to benefit from dietary changes, including increased soluble fibre and fluid intake and reduced processed food intake. General lifestyle changes include increasing moderate daily exercise and avoiding excessive straining and/or time on the toilet.

However, an accurate examination can be difficult and uncomfortable in some patients. Furthermore, patients may delay seeking medical advice because of embarrassment, meaning their condition may require more extensive treatment than if it had been adequately diagnosed and managed earlier.

Serious conditions such as malignancy and inflammatory bowel disease (IBD) should be considered in patients regardless of age, especially if the following red flags are encountered:

- persistent symptoms despite four to six weeks of reasonable treatment measures
- unexplained and/or persistent iron deficiency anaemia

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- change in bowel habit, specifically increasing frequency of stools or urgency – isolated constipation is uncommon in patients with bowel cancer; often patients describe erratic bowel function alternating between diarrhoea and constipation
- altered rectal bleeding or mixed blood in stools – patients with bowel cancer or IBD often describe streaks or clots of blood with mucous
- abdominal pain requiring significant analgesia and/or affecting activities of daily living
- unexplained, significant weight loss.

In patients with rectal bleeding, no individual symptom, sign or blood test is likely to shift the probability of colorectal cancer to the extent of “ruling in” or “ruling out” the diagnosis with any degree of certainty.¹ The incidence of bowel cancer increases with age but there have been recent reports of increased incidence in patients under the age of 50 in various countries, including New Zealand.²

Importantly, bowel cancer in patients under the age of 50 is predominantly left sided, so digital rectal examination at initial review is crucial. Our own audit of bowel cancer in younger patients showed that nearly 40 per cent of cases were located in the rectum, highlighting again the importance of a simple digital rectal examination.

In our practice, we generally exonerate the colon with either a colonoscopy or CT colonography in all patients presenting with symptoms over the age of 45. However, any re-presenting patient with increasing symptoms, regardless of age, should be carefully considered for formal colorectal exoneration, and referral to a specialist may assist with that.

Do you need to read this article?

Try this quiz

1. Bowel cancer in patients under the age of 50 occurs predominantly on the right side. **True/False**
2. Perianal haematoma can be incised and drained under local anaesthetic within the first 48 hours of presentation with severe acute pain. **True/False**
3. Topical diltiazem 2 per cent is equivalent to topical nitrate when treating anal fissure, but has less risk of headache. **True/False**
4. Botox is more effective than topical treatments for anal fissure. **True/False**
5. A permanent seton drain is a potential option for patients with complex recurrent perianal fistula(e). **True/False**

Answers on page 30



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Benign anorectal conditions include skin tags and perianal haematomas

Once cancer is ruled out, most anorectal conditions can be managed with dietary and lifestyle modifications or treated in the GP's office using simple techniques. This article starts by looking at skin tags and perianal haematomas (external haemorrhoids), which often require little intervention.

Skin tags

Skin tags are extremely common in patients presenting with anorectal symptoms (Figure 1). They are often the consequence of resolved prolapsing haemorrhoids, perianal haematoma or anal fissures (see later sections of this article). Patients may complain of pruritis ani, difficulty maintaining anal hygiene and pain.

Pruritis ani can be a frustrating symptom to manage, but initial advice includes avoiding irritants, such as soap, and using non-alcoholic wipes or toilet paper moistened with water for hygiene. Short-term use of local preparations containing low-dose steroid and local anaesthetic may help relieve symptoms. Skin tags that remain symptomatic can be considered for excision.

Skin tags are usually painless. If they are painful, the patient may have an inflamed skin tag secondary to another process, such as an active anal fissure.

While considering excision of anal skin tags, the following caveats should be noted:

- Patient expectations should be carefully managed.
- Larger (at least 1cm) skin tags on a narrow stalk tend to have better end results.
- Broad-based skin tags often heal with a resulting recurrent skin tag that may not be smaller than the initial tag.
- A careful anorectal examination is essential prior to excision.

Complications of excision include:

- Potential for significant pain and swelling after excision, especially in the first one to two weeks – patient reassurance is needed.
- Anal fissure can be the result of over-excision and a non-healing wound.

Treatment summary

- If the skin tag is asymptomatic, reassure the patient and avoid excision for cosmetic reasons alone.
- Excision can be considered for symptomatic skin tags, especially those greater than 1cm and/or with a narrow stalk.

Perianal haematoma

Perianal haematomas are external haemorrhoids (Figure 2), although that term is often incorrectly used for skin tags. External haemorrhoids are perianal subcutaneous venous plexuses distal to the dentate line, somatically innervated and covered by squamous epithelium. Hence, these are typically very painful lumps with the following characteristics:

- small – typically pea sized but can be up to 1–2cm
- blood clot visible under the skin surface
- associated with an episode of straining, Valsalva (eg, heavy coughing), diarrhoea or constipation
- intense pain for about 72 hours – the pain spontaneously improves, often with anal bleeding caused by the haematoma self-discharging.

When examined, the lump has a surface covered by skin (not mucosa) with a dark matte purple appearance indicating the underlying clot. There can be a small ulcerated surface when the haematoma has spontaneously discharged.

Treatment summary

- Most perianal haematoma resolve spontaneously in two to three weeks (Figure 3). Topical preparations containing anaesthetic and steroid may provide some relief.
- Treatment should focus on the underlying cause. For example, if there is a significant change in bowel habit, appropriate investigations should be ordered.
- Patients who present within 24 to 48 hours of an acute, painful perianal haematoma can be considered for incision and drainage – usually under local anaesthesia. A small radial incision is made over the visible clot, and normally one or two clots can be extruded. The small wound is left open, and pain relief can be immediate.
- A small group of patients experience recurrent perianal haematoma. Only those with recurrent haematoma in the same location, which is typically obvious on examination, can be considered for surgical excision. Normally, a surgical review is warranted and formal excision under anaesthesia is performed if appropriate.

CASE STUDY 1

Rectal cancer in pregnancy

Talia is a 28-year-old, morbidly obese (BMI 45kg/m²) Samoan woman who reported a prolapsing anal lump with fresh outlet per rectal bleeding during her first pregnancy. This was presumed to be “haemorrhoids”, so she was prescribed stool softeners and reassured. She delivered her first child uneventfully and did not seek follow-up regarding the prolapsing anal lump. She had persistent iron deficiency anaemia that was thought to be pregnancy then post-partum-related.

Talia became pregnant again within a year. On her initial obstetric blood tests, she was found to have iron deficiency anaemia again. She had a haemoglobin level of 88g/L, microcytosis and a ferritin level of 4µg/L. She reported intermittent per rectal bleeding with a prolapsing anal lump. Again, she was reassured regarding likely haemorrhoids, but a referral was made to the general surgical clinic.

During the vaginal birth of her second child, the obstetric team noted an “unusual looking rectal prolapse”. The colorectal surgeons confirmed a 4cm low rectal polypoid mass located at the dentate line. Talia proceeded to have a full colonoscopy, and biopsies showed adenomatous tissue with low-grade dysplasia. A staging CT scan revealed no evidence of distant metastasis. An MRI scan confirmed a posteriorly based rectal mass without definite invasion.

She went on to have a full-thickness transanal excision under general anaesthesia. Final histology confirmed a large tubulovillous adenoma with a small focus of invasive adenocarcinoma (Haggitt level 2) and deep peripheral margins greater than 2mm. Based on the early Haggitt level, which confers a low risk of lymph node metastasis, and her comorbidities, the colorectal cancer multidisciplinary meeting recommended close surveillance only. If Talia develops local disease recurrence, her options would include radiotherapy and/or an abdominoperineal resection.

Learning points

- Always examine every patient who presents with per rectal bleeding. If patients are too sore, a careful visual inspection is still crucial and can be helpful.
- While infrequent, pregnant women can present with unrelated illnesses, and alternate diagnoses should be considered when symptoms persist.

CASE STUDY 2

Persistent bleeding haemorrhoids on anticoagulation

Brian is a 71-year-old man with per rectal bleeding and known haemorrhoids. His only comorbidity is atrial fibrillation on dabigatran. He has iron deficiency anaemia and proceeds to have normal colonoscopy and gastroscopy.

Brian describes painless fresh outlet bleeding that often drips into the toilet bowl, and there is an associated perianal bulge on defaecation or prolonged standing. Brian is already on soluble fibre supplements and has no issues with constipation or diarrhoea.

Clinical examination reveals predominantly grade 3 haemorrhoidal disease (prolapsed but spontaneously reduced). He had an excisional haemorrhoidectomy many years ago and has no perianal skin redundancy.

Rubber band ligation is performed initially (dabigatran is withheld for one week after the procedure due to the risk of rebleeding), but his symptoms persist. He eventually undergoes surgery – a combination of haemorrhoidal artery ligation with recto-anal repair and mucosal excision of prolapsing areas – with good effect.

Learning points

- For all patients with iron deficiency over the age of 45–50, always ensure there is good quality colonoscopy and gastroscopy within the last two years. A good quality colonoscopy has excellent or good bowel preparation, reaches the caecum or terminal ileum, and has a withdrawal time of at least six minutes.
- Persistent bleeding haemorrhoids can be difficult to treat, and there are a variety of surgical techniques that can be tailored to a patient's symptoms and anatomy. Small-volume persistent bleeding without anaemia in patients on anticoagulation does not mandate surgical intervention.

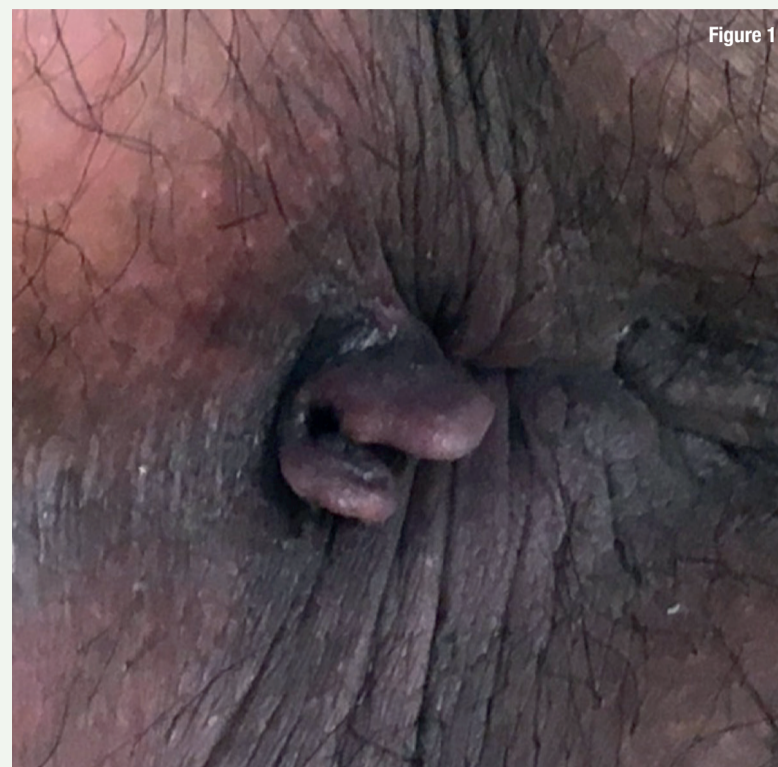


Figure 1



Figure 2

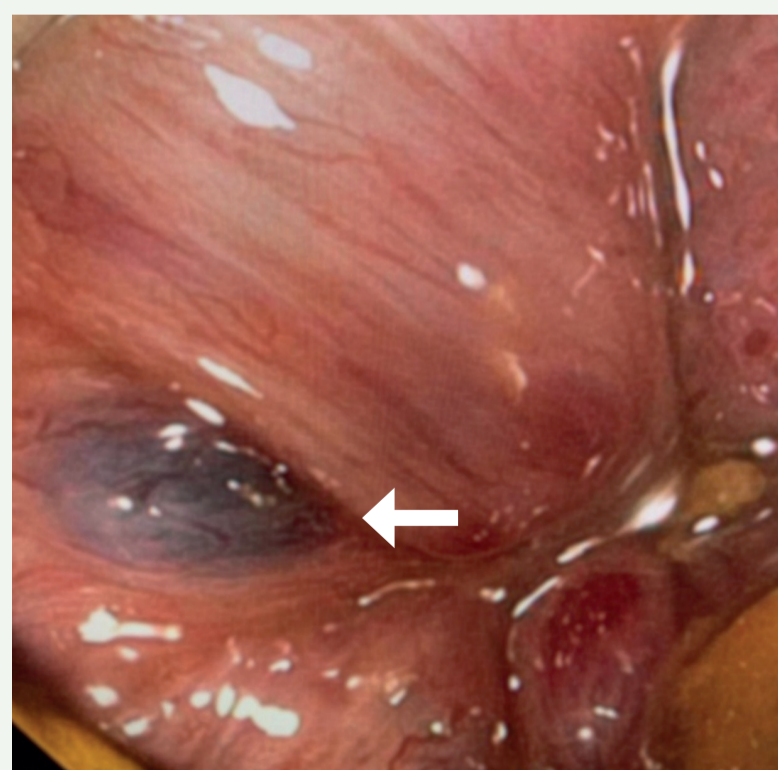


Figure 1. Broad-based anal skin tag (there may be a fissure in the middle of this bilobed tag)

Figure 2. Typical appearance of a perianal haematoma with the clot (usually pea sized) visible under skin

Figure 3. A resolving perianal haematoma (rice-sized clot)

Haemorrhoids: Choice of treatment is highly dependent on symptoms



Figure 4

This section pertains to *internal* haemorrhoids, which are proximal to the dentate line and have visceral innervation. They are extremely common in the general population. At Counties Manukau DHB in 2015–2016, presumed haemorrhoids accounted for over 90 per cent of referrals to the outpatient colorectal service (own data).

What are haemorrhoids?

Hemorrhoidal columns, also known as “anal cushions”, are normal anatomic clusters of vascular and connective tissue, smooth muscle and overlying mucosa that exist in the left lateral, right anterior and right posterior anal canal (the classic four, seven and 11-o’clock positions). They serve in providing continence but become pathological when engorged, and subsequently symptomatic.

In 2012, Austrian screening colonoscopy data reported that up to 40 per cent of patients had haemorrhoids but only 45 per cent of those were symptomatic.³ Haemorrhoids are clinically classified when they become symptomatic:

Grade 1 – haemorrhoids do not prolapse

Grade 2 – prolapse with straining

Grade 3 – require manual reduction to reduce prolapse

Grade 4 – are irreducible.

The common symptom of haemorrhoids is *painless* outlet rectal bleeding. Patients typically describe bright red blood (often causing them concern) and often hear the blood dripping into the toilet bowl. If they have any prolapsing disease, they may complain of perianal discomfort or an ache/heaviness, pruritis ani (from mucous soiling) and/or faecal incontinence.

Treatment of haemorrhoids is highly dependent on symptoms and needs to be carefully balanced with the patient’s comorbidities. All patients with per rectal bleeding over the age of 45–50 should have formal colonic exoneration by either colonoscopy or CT colonography. The risk of malignancy in this age group is around 1–3 per cent, with an incidence of polyps of around 15 per cent.^{4,5}

There are two groups of patients with symptomatic haemorrhoids that should be discussed.

Patients with painless outlet bleeding

Symptomatic haemorrhoids, especially those in grades 1–2, are usually self-limiting and often respond well to non-invasive treatment: increasing fluid and fibre intake, regular exercise, avoiding straining (can be constipation or diarrhoea) and spending less time on the toilet.

A meta-analysis of seven randomised trials showed that fibre supplementation (7–20g/day; one teaspoon of psyllium husk only contains about 6g of fibre) decreased bleeding symptoms by 50 per cent, but had little effect on prolapse, pain and itching from haemorrhoids.⁶ There is no evidence to support the use of popular over-the-counter topical corticosteroids, such as Ultraproct and Proctosedyl, although many patients report subjective improvement.⁷

Surgical treatments should be reserved for patients who report regular bleeding, especially with anaemia.

Rubber band ligation – is the most common office-based procedure used to treat grade 1–2 haemorrhoids. It can be an option for some patients with grade 3 haemorrhoids who may want to avoid formal surgery. A small silicone band is placed through a proctoscope well above (about 1cm) the dentate line along the superior aspect of the symptomatic haemorrhoidal columns.

The bands are *not* placed around the haemorrhoids themselves as normally that would include tissue of the anal transition zone, which is sensate and causes significant pain. Topical anaesthetic, such as 10 per cent lignocaine spray, applied before the banding can be useful. Some patients cannot tolerate banding in the clinic and require either sedation or a general anaesthetic.

Potential complications include discomfort (often a deep lower abdominal ache) for up to a week, tenesmus, delayed bleeding at one to two weeks, urinary retention and, very rarely, perianal sepsis. Results are generally very good with up to 90 per cent resolution of symptoms. Even if repeated treatments are required, banding is very cost effective with low impact on quality of life.⁸

Patients on anticoagulation – can pose a clinical challenge in terms of treatment decision. The indication for anticoagulation, the risk of significant bleeding from haemorrhoids, and treatment complications should be carefully balanced. It may be acceptable for these patients to experience minor bleeding without anaemia.

The risk of rebleeding after any haemorrhoid treatment is at one to two weeks after the procedure, and often anticoagulation is only stopped in the days prior to treatment.

A recent paper found that most patients can safely receive banding while on anticoagulation and that anticoagulation should only be stopped afterwards to reduce the risk of significant rebleeding.⁹

Patients with outlet bleeding with prolapse

Surgical options are usually reserved for grade 3–4 haemorrhoids. The procedures described are commonly performed under general or spinal anaesthesia.

Excisional haemorrhoidectomy (EH) – is still the “gold standard” technique. Various methods have been described, ranging from sutured versus not (ie, closed Ferguson versus open Milligan–Morgan) and standard diathermy versus energy devices (eg, LigaSure and Harmonic). The common principle is excision of the prolapsing haemorrhoid with or without associated skin tags. EH is the most definitive option for haemorrhoids as shown in Figures 4 and 5.

The majority of patients report significant post-operative pain for the first one to two weeks. There is usually significant swelling during this time, and patients should be reassured that this will improve in four to six weeks. It is common for the presence of some fibrin or wound exudate to be present for weeks. Any sutures used may dangle out in this time and are absorbable. Oral and topical metronidazole have been shown to reduce post-operative pain following haemorrhoidectomy, although patient intolerance to the oral route is common.¹⁰

After pain, a common post-operative course is delayed bleeding, which occurs one to two weeks after surgery. This is likely due to the granulating wound being traumatised by straining or defaecation. Fresh outlet bleeding during defaecation for a few days is normal, but any massive bleeding may require hospital admission. Return to theatre for control of post-surgical bleeding is uncommon.

Infections are rare and usually characterised by obvious cellulitis, fever and severe pain not responding to analgesia. **Stapled haemorrhoidectomy** – is performed using a specific circular stapling device that excises a ring of haemorrhoidal tissue and results in a circular staple line at the anorectal junction. This technique involves meticulous surgical technique as serious complications include severe pain, bleeding and rectovaginal fistula (vaginal tissue inadvertently incorporated into the stapling device).

In expert hands, stapled haemorrhoidectomy is associated with less pain than EH. However, a separate excision may still be required for associated skin tags. Multiple meta-analyses have shown that stapled haemorrhoidectomy has higher rates of recurrence than EH.⁷

Haemorrhoidal artery ligation with recto-anal repair (HAL-RAR) – is a newer technique that does not involve excision of haemorrhoidal tissue or skin tags. A specially designed doppler probe inserted into the anal canal locates arterial signals from haemorrhoidal vessels. The detected vessel is ligated, and a synchronous suture ligation is performed on the haemorrhoidal column.

A randomised study in 2016 showed a trend towards reduced recurrence compared with rubber band ligation at one year, but increased costs should be considered.¹¹ Three randomised trials comparing HAL-RAR to EH present varying results.⁷ The only significant advantage appears to be reduced post-operative pain, which may be an important factor for patients who wish to return to work earlier.

Acute haemorrhoid crisis – is rare and will appear as beefy red, ulcerated or necrotic haemorrhoids on examination (Figure 6). This occurs when internal haemorrhoids prolapse and become irreducible. Affected patients usually require hospital admission for analgesia, and occasionally acute surgery is performed in the presence of sepsis or severe necrosis.

Treatment summary

- Most patients with intermittent bleeding from minor, grade 1–2 haemorrhoids respond to dietary and lifestyle management.
- Patients who are older than 45 should be offered colonic exoneration, especially for persistent symptoms or anaemia.
- It may be acceptable for patients who require anticoagulation to have ongoing, intermittent, minor bleeding, provided serious pathology is excluded, as treatment risks and benefits need to be carefully balanced.
- Patients with bleeding, prolapsing haemorrhoidal disease often need definitive EH, although some may be suitable for consideration of either the stapled technique or HAL-RAR.
- Post-operative recovery following haemorrhoid surgery is often very painful, and patients need reassurance. Delayed bleeding at one to two weeks after surgery is common.



Figure 5



Figure 6

Figure 4. Grade 4 haemorrhoids with associated skin tags

Figure 5. Single pedicle, grade 4 haemorrhoid with associated skin tags

Figure 6. Acute, prolapsed, thrombosed grade 4 haemorrhoids

Other painful lesions include anal fissures and perianal fistulae

Other lesions in the anorectal area that are frequently seen in primary care include fissures and fistulae. Both surgical and nonsurgical treatments are available for anal fissure, while patients with perianal fistulae generally require referral to a specialist for treatment.

Anal fissure

An anal fissure is a linear tear of the anoderm distal to the dentate line. Patients commonly report sharp or tearing pain on defaecation, and the pain can last for a few hours afterwards. Many patients say they dread or fear having to pass a bowel motion. Many also have per rectal bleeding, typically on the toilet paper only. Some patients report cycles of pain and pruritis ani. If symptoms persist for more than six weeks, the fissure is considered chronic.

Anal fissures are commonly located in the posterior (majority) or anterior (more common in females) midline. It is not uncommon for patients to have both or alternating anterior and posterior fissures. A lateral fissure or multiple fissures should raise suspicion for IBD (Crohn disease), tuberculosis, syphilis or HIV infection.

Anal fissures can result from straining due to constipation or diarrhoea. A history of relevant local trauma should be obtained, specifically obstetric-related and anal intercourse. The majority of anal fissures are thought to be associated with increased internal sphincter pressures (hypertonia). Pain resulting from the fissure can also worsen the hypertonia, which causes local ischaemia leading to a chronic fissure. Women who develop anterior midline fissures after childbirth may not have hypertonia and, additionally, may have attenuated anal sphincters, so treatments based on reducing hypertonia may not be as effective.

Typically, on examination, a sentinel skin tag is seen on the midline, which may be inflamed and painful. On gently parting the anal verge, a tear will be visible at the base of the skin tag (Figure 7). In some patients, a hypertrophied anal papilla develops on the internal (superior) end of the fissure. Over time, this can present as a prolapsing fibroepithelialised anal polyp.

Another potential finding in patients with chronic fissures, where the pain has resolved but pruritis ani has become a main symptom, is a pinhole external opening in the midline. This represents a superficial (subcutaneous) fistula where the linear tear is only partially closed over the middle.

For patients in pain, a digital rectal examination can be postponed and appropriate treatment commenced. A complete anorectal examination can be considered when symptoms resolve. Any patient with persisting severe pain despite initial non-operative management should be offered a surgical review with a view towards an examination under anaesthesia.

Non-operative management

Non-operative management can lead to resolved symptoms in 60–90 per cent of patients, although up to half of anal fissures can recur.¹²

Improve stool consistency – with stool softeners (loperamide), and investigate as appropriate if the patient has diarrhoea.

Symptomatic relief – with topical lignocaine, sitz baths and oral analgesia.

Topical treatments – aimed at reducing sphincter hypertonia should be used for four to six weeks (worth trialling even in female patients with post-partum anal fissures). Topical nitrates (glyceryl trinitrate 0.2 per cent) are commonly prescribed but can be a significant cause of headache, and patients often discontinue treatment prematurely.

Two other topical options available in New Zealand with better side effect profiles are diltiazem 2 per cent and nifedipine 0.2 per cent ointments (see panel for prescription details). Topical nifedipine is more suitable in pregnant and breastfeeding patients.¹³ Diltiazem and GTN are equivalent, and a Cochrane review has demonstrated improved healing with GTN compared with placebo.¹⁴

Surgical management

Botulinum toxin (Botox) – injection into the internal anal sphincter is usually performed under general anaesthesia to facilitate an anorectal examination and to confirm the diagnosis and accurate placement of Botox. Reported healing rates vary widely (up to 60–70 per cent), and a meta-analysis found no dose-dependent efficacy.^{12,15} An important side effect is temporary flatus incontinence, which can

last up to three months. Some patients may be suitable for repeat Botox injections. Botox is not necessarily superior to topical treatments except it offers more convenience and prolonged muscle relaxation.¹⁴

Fissurectomy – involves excising or curetting the fissure to remove old granulation tissue and encourage healing by secondary intention. This is usually done in conjunction with Botox injection.

Lateral sphincterotomy – is the gold standard surgical procedure for anal fissure. Excellent healing rates of up to 90–95 per cent have been demonstrated in multiple randomised trials and meta-analyses comparing sphincterotomy with medical management, Botox and other surgical options.^{7,12} However, the procedure results in a small internal sphincter defect and, thus, change in continence is a potential complication. In patients with normal preoperative continence and no risk factors (female, obstetric history, past anal trauma or surgery), the risk of post-operative incontinence is 3–5 per cent.

Cutaneous advancement flaps – are an option for patients who do not respond to, or are unsuitable for, Botox or sphincterotomy. Wound breakdown and delayed healing (months) are significant issues, but sphincter preservation and reasonable healing rates have been reported.¹⁶

Treatment summary

- Trial a four to six-week course of topical ointments (nitrate, diltiazem or nifedipine) in patients with a clinical diagnosis of anal fissure, especially if no obvious pathology is seen externally in a patient with severe pain.
- Refer patients with persistent pain for consideration of an examination under anaesthetic and surgical options.

Perianal fistula

A perianal fistula is a persistent epithelialised tract from the anal canal to the perianal skin and can be intersphincteric, transsphincteric, extrasphincteric or suprasphincteric (Figure 8). This condition is most commonly secondary to perianal abscess. Most perianal abscesses heal without sequelae, but around one in four patients develop a perianal fistula. Other important but uncommon causes of perianal fistula are IBD, obstetric complications and malignancy.

Hidradenitis suppurativa can be mistaken for a perianal fistula but is usually characterised by multiple sinuses in the perianal area, often extending to the scrotal or labial area without anal communication. Thus, a thorough history and examination for underlying conditions are mandatory.

Simple perianal fistulae are short and involve minimal or no sphincter. Complex perianal fistulae are marked by significant sphincter involvement, multiple tracts and/or collections. The principles of surgery for perianal fistulae are to maintain continence (minimise risk to the anal sphincters), prevent sepsis and preserve quality of life.

Fistulotomy – involves laying open the fistula tract, resulting in a perianal incision that heals by secondary intention. Occasionally, the incision is marsupialised with sutures to prevent recurrence. When possible, a fistulotomy is the best option in terms of low recurrence rates (<5 per cent) and is a single definitive treatment for patients.

A seton – is a ring-like drain created with either a silicone loop or non-absorbable suture. This is an extremely useful option to control perianal sepsis. It can be used as a bridge towards definitive repair or as a permanent solution for some patients. The majority of patients tolerate a seton extremely well. If there is severe pain, the area should be inspected for persistent abscesses and seton-related complications, such as it being too tight or too bulky.

Advanced repair techniques – for perianal fistulae are only attempted when there is no ongoing active sepsis or inflammation. Many techniques have been described, but the most commonly performed in New Zealand are mucosal advancement flap, ligation of fistula tract and, occasionally, fistula plug. There are surgeon and patient factors that dictate which techniques are used, but overall primary healing rates are poor (ranging between 45–65 per cent).¹⁷ It is not uncommon for patients to require more than one attempt at definitive repair, and they often experience a frustrating and time-consuming cycle of recurrence, seton placement and repair.¹⁸

Therefore, if a patient with a perianal fistula has minimal symptoms and no serious underlying conditions, the risks of treatment, medical comorbidities and impact on quality of life need to be carefully balanced.



Figure 7



Figure 8

Figure 7. Acute anterior midline anal fissure with associated inflamed sentinel tag. This patient also had signs of a healed posterior midline anal fissure

Figure 8. External opening of a perianal fistula in the right posterior quadrant

Prescription details for topical treatments for anal fissure

Topical diltiazem 2 per cent ointment

- ▶ four 240mg diltiazem capsules – contents ground to fine powder
- ▶ add 47g white soft paraffin

Topical nifedipine 0.2 per cent ointment

- ▶ ten 20mg nifedipine tablets – ground to fine powder
- ▶ add white soft paraffin to 100g

Treatment summary

- Draining and controlling sepsis is the main priority in treating perianal fistulae.
- Fistulotomy, when feasible, is the most effective surgical option for simple fistulae.
- A long-term seton drain may be the best option for patients with complex recurring fistula(e), provided it controls sepsis and results in an improved quality of life. ■

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Quiz answers

1. False 2. True 3. True 4. False 5. True