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Pattern of Anorectal Disorders in Surgical Practice in Rajshahi

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Abstract

Anorectal disorders include a diverse group of pathological disorders that generate significant patient discomfort and disability. Their prevalence in the general population is probably much higher than that seen in clinical practice, since most patients with symptoms referable to the anorectum do not seek medical attention .Although many anorectal conditions are benign & easily treatable, patients may delay seeking medical advice because of embarrassment or fear of cancer .Both malignant and non malignant conditions often present as advanced disease, requiring more extensive treatment and causing greater patients distress than if conditions had been adequately diagnosed and managed at an earlier stage. This article will highlight predominant symptoms of anorectal conditions and to reveal common anorectal conditions only by D/R/E & proctoscopy. This review will also evaluate current diagnostic and therapeutic methods and establish guidelines for subspecialty referral. In this prospective Study 714 patient with anorectal symptoms were examined, 71.7% were male & 28.29% were female. So male female ratio was M: F=2.5:1. 40.06% patients were within 21-30 years old. The most common symptom was per rectal bleeding (63.59%) & the second common symptom was anal pain (56.16%). The most common anorectal disorder was internal hemorrhoid 60.22% & the second one was anal fissure (50.42%). A large percentage of patients (27.17%) have both hemorrhoid and anal fissure. 98.6% disorders were benign and only 1.4% were malignant.

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Introduction

Patients with wide variety of anorectal conditions include- hemorrhoid, anal fissure, Perianal abscess, fistula in ano, ca rectum & anal canal, pilonidal sinus, pruritus ani, anal warts & fecal impaction. Though most are benign, cancer can coexists with benign lesions, Colorectal cancer can only be cured if found early .Once cancer is ruled out, more than 90% of anorectal complaints can be managed by primary care physicians. The presentations of symptoms in patients with anorectal pathologies are mostly typical, but they may be misleading due to the patient's understatement or underplaying of pathology. The common symptoms denoting anorectal pathology are -

Bleeding per rectum
Anal pain
Presence of swelling or lump in or
-around the anus
Pus discharge from or around the -anus
Passage of mucus per rectally
Anal pruritus
Frequency of stool
Difficulty in passing stool
Constipation
Incontinence of flatus and feces
Prolapse

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A systemic approach to patient's with anorectal complaints allows for an accurate and efficient diagnosis of the underlying problem .The process can be divided into the interview, the examination, and conveyance of information .Throughout this process, the patient must be reassured and made as comfortable as possible. The key to diagnosis remains the patient history, with confirmation by visual inspection and proctoscopy. A careful history focusing on the nature of the pain and its relationship to bowel movements frequently provides the diagnosis of pain in the anorectal area. As for example aching after a bowel movement can occur with internal hemorrhoid, pain during bowel movements described as "being cut with sharp glass" usually indicates anal fissure and it persist for an hour or so afterwards, the acute onset of pain with a palpable mass is almost always due to thrombosed external hemorrhoid, anal pain accompanied by fever and inability to pass urine signals perineal sepsis and is a surgical emergency. Bright red blood coating the stool or on the toilet paper generally implies an anorectal source, where as darker hemorrhage indicates a more proximal lesion. If hemorrhoid appears quiescent or if bleeding persists, neoplasm and other colorectal pathology must be considered and identified. Pruritus ani is especially common among men and is caused by a variety of local and systemic disorders, more than half of the patients had an underlying benign anorectal conditions such as hemorrhoids, fissure, idiopathic or ulcerative proctitis, condyloma, fistula and abscess. Expensive workups are usually not required. Based on the symptoms and possible differential diagnosis, further investigation may be necessary. Proctoscopy is the mainstay in the detection of anal and lower rectal pathology. When a more proximal lesion is suspected, a sigmoidoscopy or colonoscopy along with biopsy is needed. Anorectal physiology and endoanal ultrasonography are also regarded as essential investigative techniques in a colorectal laboratory. Anal manometry and defecography are more advanced investigative tools for colorectal workup. In this review, fistulogram, MRI, and tomographic scanning are other investigations to be mentioned here.

Materials and methods

This is a prospective hospital and private practice based observational study which was undertaken in Rajshahi Medical College Hospital and private chamber from June 2006 to April 2009. A total of 714 adult patients, both male and female, over the age of 18 yrs with anorectal symptoms attending the outpatients department and indoor of RMCH and private chamber were included in this study. Anorectal examination was done by inspection, palpation, and proctoscopic examination. The patients were positioned in left lateral decubitus position for this examination. Disposable plastic/latex hand gloves, proctoscope, lubricant jelly, good light source and privacy were ensured. The glutei were separated to provide adequate visualization of the anus. Unless the patient is experiencing extreme pain, a digital rectal examination was done. In males, the prostate was also palpated in addition to digital assessment of rectum and anal canal. The finger sweep 360 degree around the anal canal. The final step in the initial office examination is proctoscopy. As a lubricant 2% lignocaine jelly was applied to the entire unit and it is inserted gently .The introducer is removed, and the mucosa is visualized as the proctoscope is slowly removed. Although preparation with an enema is not usually necessary before proctoscopy, it can improve visualization and may be aesthetically more acceptable to the examiner and to the patient. In this study, all patients were examined without an enema. When palpable or visible lump was found by D/R/E or by proctoscopy with in rectum and anal canal, then the patient was advised for biopsy.

Results

A total of seven hundred and fourteen adult patients, both male and female were included in this study. The finding of the study obtained from data analysis are presented below-

Table-1: D/R/E and proctoscopy finding (n =714)

Disease	11-20 yrs	21-30 yrs	31-40 yrs	41-50 yrs	51-60 yrs	>60 yrs	Total
Internal hemorrhoid	23	97	59	16	26	15	236
Internal hemorrhoid with fissure	21	83	40	12	23	15	194
Anal fissure	20	86	29	17	09	05	166
Ext hemorrhoid	01	00	06	07	00	00	14
Fistula in ano	00	08	23	05	06	00	42
Perianal abscess	00	05	10	14	01	00	30
Pruritus ani	00	02	03	01	00	00	06
Pilonidal sinus	01	03	00	00	00	00	04
Anal wart	00	00	03	01	00	00	04
Ca rectum	00	02	03	03	01	01	10
Faecal impaction	00	00	00	00	00	08	08

Table-2: Distribution of age: this table shows anorectal pathology is more common in 21-30 yrs of age

Age ranges(in years)	Total	Percentage
11-20	66	9.24%
21-30	286	40.06%
31-40	176	24.65%
41-50	76	10.64%
51-60	66	9.24%
>60	44	6.16%

Table: Sex distribution.

Sex	Number	Percentage
Male	512	71.71%
Female	202	28.29%

Table -4: Duration of symptoms.

Sex	Minimum	Maximum
Male	2 days	1 yr
Female	3 months	3 yrs

Table-5: Incidence of various anorectal disorders.

Disease	Number of patients (male and female)	Percentage
Internal hemorrhoid	236	33.05%
Internal hemorrhoid with fissure	194	27.17%
Anal fissure	166	23.25%
Ext hemorrhoid	14	1.96%
Fistula in ano	42	5.88%
Perianal abscess	30	4.20%
Pruritus ani	06	0.84%
Pilonidal sinus	04	0.56%
Anal wart	04	0.56%
Ca rectum	10	1.4%
Faecal impaction	08	1.12%

Chart-1: This chart demonstrate the clinical presentation of the patients. Distribution of patients by clinical presentation (n =714)

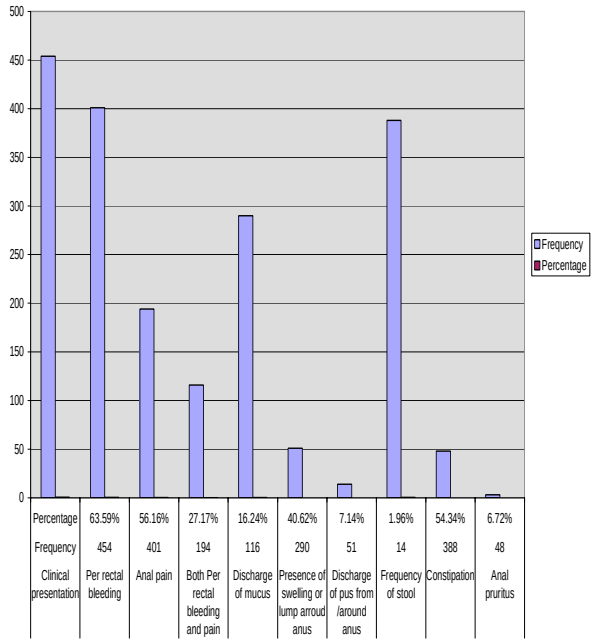


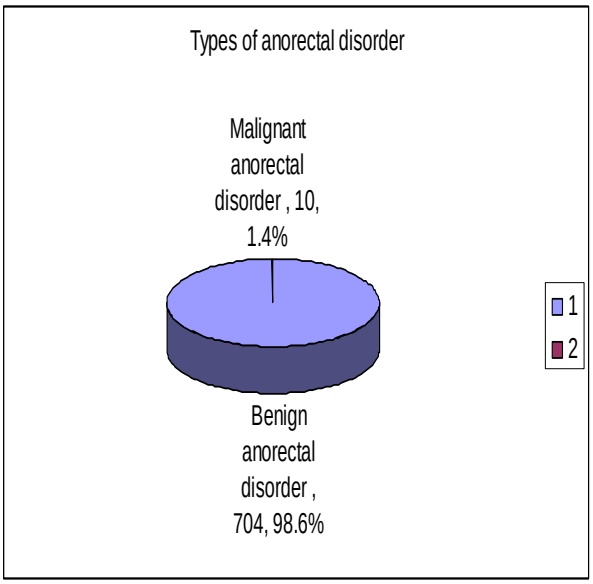
Table- 6: Incidence of various hemorrhoids

Types of hemorrhoid	No of patients	Percentage
Internal hemorrhoid	236	96.85%
Ext hemorrhoid	14	3.15%

Table -7: Incidence of various types of internal hemorrhoid

Types of inter hemorrhoid	Total	Percentage
1st degree	100	42.37%
2nd degree	83	35.17%
3rd degree	17	7.2%
1st + 2nd degree	36	15.25%

Chart-2: This pie chart showing incidence of malignancy



Discussion

Among 714 patients, 71.71% patients were male and female was only 28.29% .So male: female = 2.5: 1. The less percentage of females may be due to social and religious bindings and shy to attend male doctors. Moreover our female patients are neglected. In this study it is seen that the disease is more advanced in female, as well as their duration of symptoms are also higher than male. It also shows that the disease is more common in third decade of life (40.06%). Among the anorectal symptoms the most common was per rectal bleeding which was 63.59% , the second most common was anal pain , 56.16% , the third was constipation 54.34% , and the fourth one was present of swelling or lump in or around the anus , 40.62% . D/R/E and proctoscopy reveals that 98.6% cases are benign and 1.4% is malignant. The most common benign disease was internal hemorrhoid 33.05%, the next was internal hemorrhoid with anal fissure 27.17%. Only anal fissure was 23.25%. Other benign conditions were- external hemorrhoid 1.96% , fistula in ano 5.88% , perianal abscess 4.20% , pruritus anus 0.84% , pilonidal sinus 0.56% , anal wart 0.56% , fecal impaction 1.12% . The incidence of various degree of internal hemorrhoid was as – 1st degree – 42.37%, 2nd degree – 35.17%, 3rd degree – 7.2% and both 1st and 2nd degree was 15.25%.

Conclusion

Many times the omission of a rectal examination has been a cause of regreat. So many anorectal disorders are wrongly diagnosed and treated. As a result not only patients sufferings increases but also the disease become more advanced and it is one of the main cause of late presentation of anorectal carcinoma. Before starting treatment of any anorectal disorder all doctors should remind that “If you don’t put your finger in it, you put your foot in it”.

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