Common Anal Problems

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KEYWORDS

• Hemorrhoids • Perirectal abscess • Anal fistula • Anal fissure • Fecal incontinence

KEY POINTS

- Unusual presentations of common anal problems may herald underlying systemic disease.
- There are several medical therapies available for the treatment of anal fissures, including nitroglycerin, diltiazem, and botulinum toxin.
- Management of internal hemorrhoids depends on the severity of symptoms.
- Perirectal abscesses require drainage and commonly result in fistula formation.
- Fecal incontinence is common in elderly populations. In younger patients, it should prompt a thorough evaluation not only for sphincter dysfunction, but also neurologic and gastrointestinal disorders.
- Anal itching is most often related to poor anal hygiene.
- Rectal prolapse typically requires definitive surgical fixation.

INTRODUCTION

The anus has a critical, if thankless, function. It permits the retention and subsequent voluntary, timed evacuation of fecal matter.

Anatomic Pearls

The anus represents the terminus of the gastrointestinal tract and stretches from the pelvic floor (levator ani) to the skin surface (Fig. 1). The dentate line is the embryologic divide between endoderm and ectoderm; as such, tissue proximal to this point does not receive somatic innervation and is insensate. Distal from the dentate line, the anoderm is a transitional zone between columnar and squamous epithelium. The tripartite sphincter complex includes the internal sphincter (located more proximal and closer to the lumen of the anus), the external sphincter (slightly more distal and wrapping around the internal sphincter), and the puborectalis (a U-shaped, sling-like muscle at the anorectal junction).

Physiologic Refresher

The internal and external sphincters are the workhorses of the anus. The internal sphincter receives parasympathetic innervation and relaxes involuntarily with

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Med Clin N Am 98 (2014) 609–623
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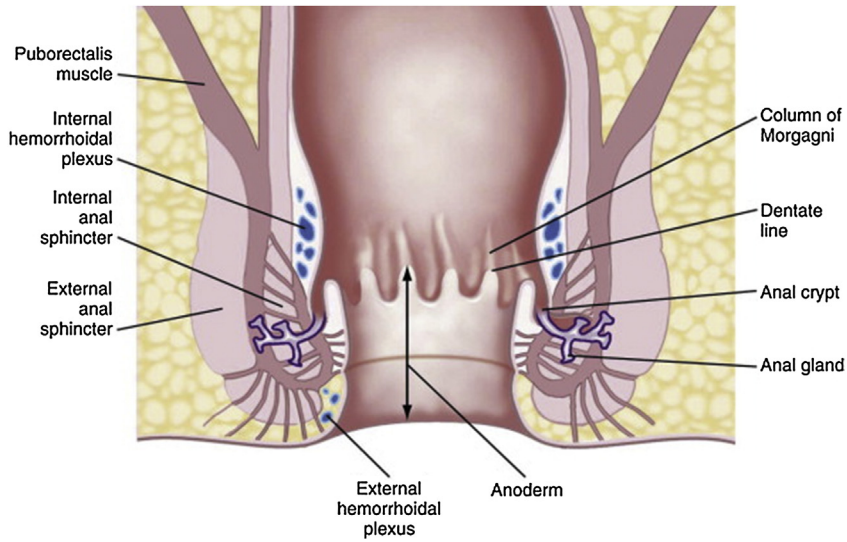

Fig. 1. Anal anatomy. (*From* Marcello PW. Diseases of the anorectum. In: Feldman M, Friedman LS, Brandt LJ, editors. Sleisenger and Fordtran's gastrointestinal and liver disease: pathophysiology, diagnosis and management. 9th edition. Philadelphia: Elsevier; 2010; with permission.)

distention of the rectal vault. This triggers the urge to defecate. The external sphincter, innervated by the pudendal nerve, is under voluntary control, and its integrity is crucial for maintaining fecal continence. The puborectalis plays an adjunctive role in maintaining continence. The anal glands (also called the crypts of Morgagni) and the venous hemorrhoidal plexuses facilitate lubrication during defecation.

ANAL FISSURES

Symptoms

The hallmark of an anal fissure is severe anal pain. This tends to be worse with bowel movements and with direct pressure on the site (eg, sitting). Some fissures are traumatic (eg, passage of hard stool, receptive anal intercourse, or insertion of a foreign body such as enema or endoscope), while others are idiopathic. Acute fissures, which have been present for days to weeks, tend to bleed slightly, and patients may report red blood on the tissue. Chronic fissures have been present for months or longer; they bleed less commonly and tend to have hyperkeratotic edges.

Diagnostic Test/Imaging Study

Anal fissures can be diagnosed with a classic history and simple external examination of the anus and perineum. By applying traction on the buttocks, the fissure can be visualized radiating out from the anus, typically in the midline and usually posterior in orientation. Acute fissures have the appearance of lacerations, while chronic lacerations are more fibrotic and may have a sentinel skin tag at the distal end (**Fig. 2**).[1]

Differential Diagnosis

Other causes of anal pain and bleeding can masquerade as fissures, including abscess, fistula, and hemorrhoids (**Box 1**). Additionally, anal fissures with any lateral orientation (not in the midline) should prompt investigation into secondary causes