Diagnosis and Management of Anorectal Disorders in the Primary Care Setting

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KEYWORDS

• Rectal prolapse • Hemorrhoids • Anal fissure • Proctalgia fugax • Levator ani

KEY POINTS

- Avoiding constipation through diet modification and use of over-the-counter medications can prevent many of the common anorectal disorders that present to the primary care physician.
- Rectal prolapse should be reduced when possible and can be treated conservatively in most situations, although patients with recurrence may require surgical intervention.
- Pruritus ani often has an inciting event, but treatment should focus on stopping the itch–scratch cycle that worsens the symptoms.
- Thrombosed external hemorrhoids can be excised in the office when patients present within 72 hours of onset and when they do not have improvement in symptoms.
- Internal hemorrhoids can be successfully banded in the office, although postprocedure pain is common.

INTRODUCTION

Anorectal disorders are very common among a wide population of patients. Because patients may be embarrassed about the anatomic location of their symptoms, they may present to care late in the course of their illness. Care should be taken to validate patient concerns and normalize fears. This article discusses the diagnoses and management of common anorectal disorders among patients presenting to a primary care physician.

RECTAL PROLAPSE

Rectal prolapse, also known as rectal procidentia, occurs when the rectum protrudes through the anus. This protrusion may involve just the mucosa and submucosa (partial

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prolapse) or the full thickness of the wall of the rectum (complete prolapse).[1] The exact prevalence has not been well-characterized, but a small study estimated the incidence to be approximately 2.5 per 100,000 people annually with women being 9 times more likely to be affected.[2] Rectal prolapse can also be seen in children, most commonly in infancy. Rectal prolapse more commonly occurs in patients who are younger than 4 years of age than in those who are older.[3]

The exact cause of rectal prolapse has not been completely delineated. Risks factors seem to include constipation, multiparity, and pelvic floor dysfunction, among others.[1] Underlying conditions that are often associated with rectal prolapse in children include constipation, weakened pelvic floor muscles, and increased intraabdominal pressure. Additional consideration should be given to the presence of infectious diarrhea, diseases of the rectum including parasites and neoplasia, malnutrition, and cystic fibrosis.[2]

Because the process of rectal prolapse typically develops over time, affected adults often present complaining of a rectal bulge with defecation. Patients might also complain of fecal incontinence, bleeding, and pain. Diagnosis in the office setting usually involves reproducing the prolapse by having the patient perform the Valsalva maneuver in a squatting position or while on a commode. Partial prolapse involves just the rectal mucosa and is usually less pronounced than a complete prolapse, which involves the full thickness of the rectal wall. A complete prolapse typically involves a thick, fully circumferential red-colored prolapse demonstrating mucosal folds in circumferential rings. The orientation of the rectal mucosa folds in a partial prolapse run linearly from proximal to distal on the long axis of the intestine.[1] Rectal procidentia is described by grade in the case of a full-thickness prolapse and by degree in the case of mucosal prolapse (**Tables 1** and **2**).

If prolapse cannot be reproduced upon evaluation but is suspected by the history, defecography can be useful in making a diagnosis but cannot completely rule out prolapse.[4] Defecography, also referred to as evacuation or voiding proctography, involves the use of a barium paste inserted into the rectum followed by fluoroscopy or MRI while the patient passes the paste while sitting on a commode.[5] In children, the condition is often noticed by family members and has typically spontaneously reduced at the time of presentation. The diagnosis is inferred through the history.[3]

Rectal prolapse may or may not present with incarceration. Incarcerated rectal prolapses should have manual reduction attempted. Irreducibility is rare. Reduction is performed by encircling the prolapsed bowel with the fingertips and applying steady pressure, which may need to be quite firm if there is edema. Successful reduction should be followed by digital rectal examination.[3] If unsuccessful, subsequent attempts at reducing the prolapse can include use of local or general anesthesia to achieve relaxation of the pelvic floor musculature. Cold compresses can be applied to reduce swelling. In a case study of 15 patients with initially irreducible rectal procidentia, 4 patients had successful replacement with diclofenac or tramadol for pain relief, and 2 were successfully replaced after the application of simple table sugar

Table 1
Degree of partial rectal prolapse

Degree	Level of Mucosal Prolapse
First	Into anal canal
Second	To dentate line
Third	To anal verge