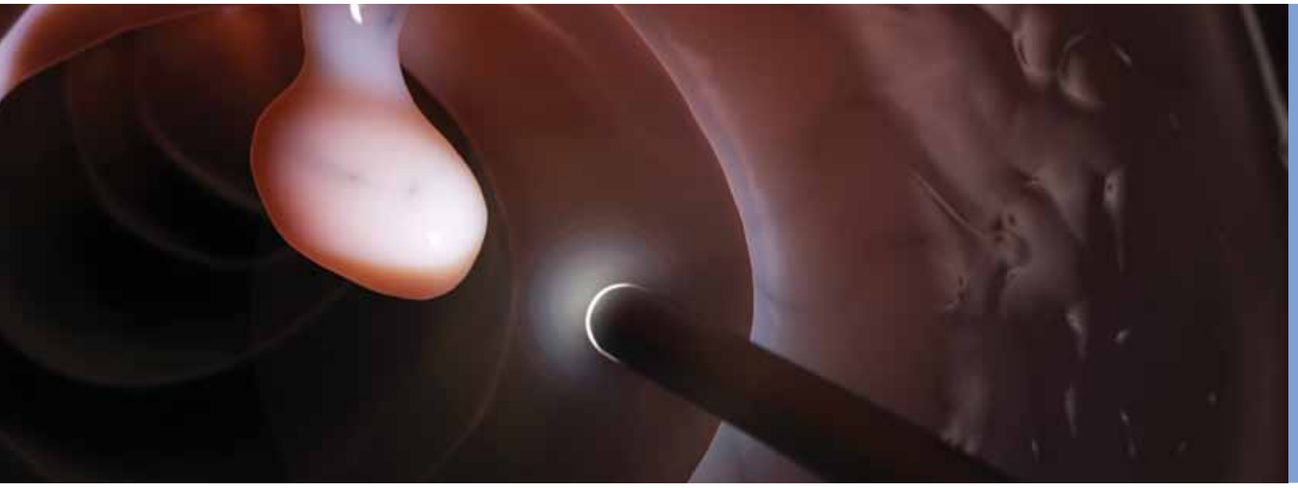

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COMMON PERIANAL CONDITIONS ARISING IN PRIMARY CARE

By Mr Romi Navaratnam

Consultant Laparoscopic Colorectal and General Surgeon, Mr Romi Navaratnam discusses the common types of presentations of rectal bleeding and perianal irritation in primary care

Haemorrhoids

Haemorrhoids *(Fig 1)* affect 50 per cent of the working population and present with rectal bleeding and prolapse. Bleeding over the age of 35 requires flexible and sigmoidoscopy colonoscopy, over the age of 40.

Conservative management involves injection sclerotherapy or banding. Conventional or stapled haemorrhoidectomy and haemorrhoidal artery ligation, have an established but low morbidity and are reserved for refractory symptoms.

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Anal fissures

Patients will present with perianal pain, bleeding and constipation with 90 per cent arising at the posterior anal verge. GTN ointment has a 38 per cent association with headaches, following initial application. Two per cent diltiazem ointment applied in combination with a laxative for two months, results in a 75 per cent improvement.

Refractory fissures may require botox administration under GA or, failing this, a sphincterotomy. Low pressure fissures in women may require anal advancement flaps, although there is a 50 per cent failure rate.

Fistulae *(Fig 2 & 3)*

Cases usually present with recurrent perianal sepsis or perianal abscess formation. An MRI of the perianal region is usually indicated prior to surgery to exclude a complex fistula. Colonoscopy is considered in recurrent sepsis to exclude Crohns disease.

Fistulectomy and seton insertion (Fig 3) is often part of a two stage procedure. Mucous discharge and flatus incontinence (10 - 15 per cent) may arise following surgery in both anal fissures and fistulae. Incontinence to solid and liquid faeces is rare.

Pilonidal sinus

Management involves maintaining the pilonidal region devoid of hair. Local procedures (e.g. Karydakis flap) have been advocated in recurrent sepsis, Rotational flaps in conjunction with plastic surgeons, are associated with low recurrence rates.

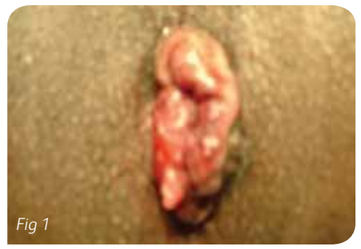

Fig 1

Fig 2 External opening of fistula

Fig 3 Seton

Pruritis ani

This is a challenging condition with no obvious aetiology. Conservative measures include avoidance of perfumed soaps, gels and toilet roll (substituted with wet wipes) and the regular application of a barrier cream, e.g. Sudocrem or Epaderm. Colonoscopy should be considered in the presence of bleeding or diarrhoea, prior to dermatology referral.

> Rectal prolapse: there is a strong presence of these cases in the elderly female population'

Rectal prolapse

Common in the elderly female population. Laparoscopic surgery can be considered; however, perineal procedures (e.g. Delorme's or perineal rectosigmoidectomy (Altemeire's)) are undertaken under locoregional anaesthesia and are very well tolerated in elderly high-risk patients and associated with excellent outcomes.

Faecal incontinence

There are two main types: passive and urge. The latter is common and associated with previous obstetric trauma, often years prior, combined with passive degeneration of the pelvic floor. Management involves endo-anal ultrasound and physiology to assess the anal sphincter integrity, having excluded systemic disease, e.g thyrotoxicosis and proximal colonic pathology.

Surgery was previously indicated for isolated anterior sphincter defects. Long term results are disappointing. More recently, biofeedback therapy or neuromodulation (tibial nerve stimulation) have been associated with encouraging results.

Anal canal malignancies

Anal canal malignancies are rare. They are primarily squamous cell malignancies, although melanoma and distal rectal adenocarcinoma have been identified.

Following histological confirmation, MRI, CT and CT PET, the treatment of choice involves chemoradiotherapy. T1 lesions may be amenable to local resection. Salvage laparoscopic AP resection can be undertaken, where indicated.

The management of perianal conditions remains a dilemma. A high index of suspicion needs to be maintained in patients with recurrent symptoms, irrespective of age.

> The management of perianal conditions remains a dilemma

To find out more information about **Mr Romi Navaratnam**, please visit **www.practicemattersmag.co.uk/contributors**

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Romi Navaratnam trained in Nottingham, Cambridge, London and Sri Lanka. He was appointed Consultant Laparoscopic Colorectal Surgeon, North Middlesex University Hospital, where he is colorectal cancer lead and Honorary Senior Lecturer at Royal Free Medical School in 2002.

He is one of the founding consultants of the GI unit at The Wellington Hospital (2006), widely recognised as an international centre of excellence. Research interests incorporate improving outcomes in laparoscopic surgery and surgical education.

Specialist interests include irritable bowel syndrome (IBS), anal conditions, colonoscopy and endoscopy. He undertakes laparoscopic surgery for conditions of the gall bladder, appendix, groin and abdominal herniae, Crohns, diverticular disease and colorectal cancer, with extremely positive outcomes.