**9. Anorectal Complaints/Constipation By Casey Sanossian**

**Overview:**

**(a) Constipation**

* Risk factors: advanced age, physical inactivity, low income and education status, depression
* Rome III Constipation definition:
	+ 1-2+ of following for 12 weeks in 6 month period:
		- Straining during >=25% defecations
		- Lumpy or hard stools >=25% defecations
		- Sensation of incomplete evacuation >=25% of time
		- Manual maneuvers to facilitate defecation of >=25% of time
		- <3 defecations/week
		- Loose stools rarely present w/o laxative
		- Insufficient criteria for IBS
* Causes include:
	+ Normal transit/functional constipation, slow transit (medications, hypothyroidism, hypercalcemia, spinal cord disease), outlet obstruction (rectal mass, pelvic floor dysfunction), lifestyle (low fluid/fiber intake), eating disorders
* Treatment:
	+ Address underlying cause if one exists
	+ Drink at least 2L/water/day
	+ Recommend 20-35 g fiber/day
	+ Encourage regular exercise
	+ If needed, use fiber supplements/bulk-forming laxatives🡪 osmotic laxatives🡪 stimulants and stool softeners (see below)
	+ If refractory, biofeedback (effective to re-train muscles used in defecation if pelvic floor dysfunction) or surgery (abdominal colectomy + ileorectal anastomosis)

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|  | **Medication** | **Mechanism of Action**  |
| Fiber supplements/Bulk forming agents | Methylcellulose (Citrucel)Polycarbophil (FiberCon)Psyllium (Metamucil) | Absorb liquid in the intestines to form bulky stools  |
| Osmotic laxatives | Milk of magnesiaLactulosePolyethylene glycol (Miralax) | Pulls water into the intestinal lumen |
| Stimulant laxatives  | Senna (senokot)Bisacodyl (dulcolax) | Stimulate colonic contractions to propel stool forward  |
| Stool softeners | Docusate sodium (Colace)  | Soften stool to make it easier to pass |
| Newer medications  | LubiprostoneLinactolide | Stimulate chloride and water secretion into the intestinal lumen  |

**(b) Hemorrhoids**

* Symptoms: itching, pain, bleeding; ~75% of patients will have at some point in their life!
* Types:
	+ External: painful 2/2 innervation by somatic nerves
	+ Internal: generally present as painless rectal bleeding because covered by insensate columnar epithelium
* Treatment:
	+ Anesthetics
	+ Astringents and protectants🡪 witch hazel, zinc oxide
	+ Bulk-forming laxatives
	+ Topical corticosteroids (Preparation H)
	+ Stool softeners
	+ If more severe: external (surgical excision); internal (band ligation, radiofrequency treatment

**(c) Pruritis Ani**

* Symptoms: itch or burn in perianal area
* Etiology: usually idiopathic or due to “ITCH:” Infection, Topical irritants, Cutaneous/Cancer, Hypersensitivity
* Treatment:
	+ Keep stools soft, stop itching and/or excessive cleansing, sitz baths (4X/d), avoid tight clothing/moisture trapping fabrics, witch hazel pads (topical anti-pruritic), topical hydrocortisone (max 1-2 weeks otherwise risk skin atrophy), antihistamines (atarax for symptom relief)



 **(d) Anal Fissure**- tears occurring distal to dentate line in anal canal

* Etiology: usually due to hard BMs/straining
	+ *Usually ANTERIOR or POSTERIOR to ANUS*
* Treatment:
	+ Keep stools soft, sitz baths, rectal suppository (containing topical steroids, local anesthetics), topical lidocaine, NTG ointment or topical CCB (relaxes internal anal sphincter)

**(e) Rectal Bleeding**

* Causes of bright red blood:
	+ Hemorrhoids, diverticula, UC, infectious colitis, cancer, polyps, AVM, fistula, fissure, chronic solitary ulcer
* Causes of occult bleeding:
	+ Gastritis, gastric ulcer, gastric CA, esophageal varices, AVM, esophagitis, duodenitis, duodenal ulcer, polyps, cancer

**(f) Condyloma acuminatum**

* Etiology: HPV
	+ Once infected with HPV, entire anogenital tract is involved!
	+ If one lesion present🡪 complete anogenital exam to detect additional growths
* Higher risk if anal intercourse, but majority of patients with perianal condylomata have NOT engaged in anal intercourse!
* HPV infection also increases risk of anal cancers🡪 high risk patients need annual anal pap smears

**(g) Fistula**

* Most common cause = infection of anal glands
* High index of suspicion for Crohn’s Disease

**(h) Skin tags**

* Usually asymptomatic, remnants of previously thrombosed external hemorrhoids (removed only if symptomatic)

**At IMA:**

* History—ask patients about:
	+ BM frequency, consistency, any change in stools, fluid intake, diet, opioid use
* Evaluate for tenderness, skin breakdown, fistulae, fissures, masses on exam
* Labs: CBC, TSH, BMP
* Consider colonoscopy in patients with alarm symptoms or age >50
* Diet/exercise counseling!

**Social determinants of health:**

* Many patients are uncomfortable discussing this topic, but be sure to ask about it in your ROS!
* Major sources of dietary fiber include fruits and vegetables which may not be as available (physically- and financially-speaking) – look into whether patients would qualify for SNAP; discuss farmer’s markets and other creative ways of increasing their intake of fruits/vegetables/whole grains