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Saturday, June 22, 2019
16:30 - 17:25 WS #181: Perianal Conditions and Pilonidal Disease
17:35 - 18:30 WS #193: Perianal Conditions and Pilonidal Disease
(Repeated)
PERIANAL CONDITIONS & PILONIDAL DISEASE

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PERIANAL CONDITIONS

- Take a long time to present
- Can take a long time to fix
- Set expectations early
- Take a good history – lots of clues
- Lifestyle modification to prevent recurrence/ allow healing
THE ANAL CLOCK

12 o’clock front

6 o’clock back
PERIANAL CONDITIONS

12 important perianal conditions

• Spot diagnoses
• What to say to your patient
• What to do for your patient
• When to refer
• What the specialist does
WHAT IS IT?

a) Prolapsed haemorrhoid
b) Perianal hematoma
c) Abscess
CONFUSION CLEARED!

Prolapsed Internal haemorrhoids

“Bunch of grapes”

Prolapsed swelling of anal cushions (superior haemorrhoidal venous plexus)

Perianal hematoma (external haemorrhoids)

“Perianal bruise”

Thrombosis inferior haemorrhoidal venous plexus
ANATOMY

Dentate line

Superior haemorrhoidal venous plexus

Inferior haemorrhoidal venous plexus
PERIANAL HAEMATOMA
(EXTERNAL HAEMORRHOID)
PERIANAL HEMATOMA – WHAT TO LOOK FOR?

- Sudden pain and swelling
- Anal margin
- With straining or heavy lifting

- Raised
- Blue tinged
- Painful lump
- Just under skin
- Coloured perianal area
PERIANAL HEMATOMA – WHAT TO TELL PATIENT?

- It will go away over 1-4 weeks
- It will get less painful gradually
- Take pain relief
- Sitz baths helpful for comfort
PERIANAL HEMATOMA – WHEN TO REFER?

REFER ACUTELY

If skin necrotic or infected

FOR DEROOFING and EVACUATION HEMATOMA
WHAT IS IT?

(a) Worms
(b) Prolapsed haemorrhoids

Haemorrhoids
INTERNAL HAEMORRHOIDS
WHY DO HAEMORRHOIDS OCCUR?

- Increased intraluminal pressure
  - Obstruction and dilatation of venous plexus
- Shearing forces
  - Loss of elasticity of the fibrous scaffolding around submucosal venous plexus

Swollen prolapsing haemorrhoids

+ Shearing forces (constipation)

Bleeding
## Internal Hemorrhoid Grades

<table>
<thead>
<tr>
<th>Grade</th>
<th>Diagram</th>
<th>Picture</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><img src="image1.png" alt="Diagram 1" /></td>
<td><img src="image2.png" alt="Picture 1" /></td>
<td>No prolapse, just prominent blood vessels</td>
</tr>
<tr>
<td>2</td>
<td><img src="image3.png" alt="Diagram 2" /></td>
<td><img src="image4.png" alt="Picture 2" /></td>
<td>Prolapse upon bearing down, but spontaneous reduction</td>
</tr>
<tr>
<td>3</td>
<td><img src="image5.png" alt="Diagram 3" /></td>
<td><img src="image6.png" alt="Picture 3" /></td>
<td>Prolapse upon bearing down requiring manual reduction</td>
</tr>
<tr>
<td>4</td>
<td><img src="image7.png" alt="Diagram 4" /></td>
<td><img src="image8.png" alt="Picture 4" /></td>
<td>Prolapse with inability to be manually reduced</td>
</tr>
</tbody>
</table>
WHAT TO LOOK FOR?

• Painless Bleeding
• Outlet type bleeding
• Itch

• Painful prolapsed/ thrombosed
• Necrotic skin/infection

mass
WHO NEEDS A COLONOSCOPY?

- age >50y
- Red flag symptoms – pain on defecation, change in BH, PR mass
- Significant family history
- Ongoing bleeding despite adequate treatment of haemorrhoid

not everyone with haemorrhoids needs a colonoscopy
ACUTE THROMBOSED PAINFUL - WHAT TO TELL PATIENT?

• It will take 1-2 weeks to settle completely
• Topical: proctosedyl, ultraproct, voltaren
• Oral: paracetamol, Voltaren
• Sitz baths, ice, glucose syrup soaked gauze
• Banding or surgery can help once it settles
• Prevention of recurrence – fix constipation
LIFESTYLE CHANGE: WHAT TO TELL PATIENT?

MODIFIABLE FACTORS

The Four “F”s
- Fruit
- Fibre
- Fluid
- Fitness & Routine

RECUR UNLESS WE FIX CONSTIPATION
HAEMORRHOIDS – WHEN TO REFER?

REFER ACUTELY
- necrotic skin
- infection
- acute symptoms can’t be managed in community

REFER ELECTIVELY
- Ongoing bleeding – needs banding or surgery
- Red flags

Deroofing
Not
haemorrhoidectomy
ELECTIVE SURGICAL MANAGEMENT

• Banding/infrared coagulation

• Sclerotherapy

• Single pedicle haemorrhoidectomy

• Stapled haemorrhoidectomy

• HAL-RAR

5% phenol in almond oil

Into submucosa around plexus

Care to leave skin bridges

Grade 3-4

Prostatitis

Impotence

Mucosal ulceration

Pelvic sepsis

Rectovaginal fistula

Circumferential

USS guided ligation

Less bleeding and pain

For high risk patients
WHAT TO TELL PATIENTS AFTER TREATMENT

POST BANDING:
- Sensation of fullness for ≥ 5 days
- Do not strain
- Bleed 1-2 days now normal
- 7-10 day bleed normal
- Repeatable
- Lifestyle change

POST HAEMORRHOIDECTOMY:
- Take regular pain relief
- Avoid constipation – laxatives
- Sitz bath
- Shower/wet wipes after BM
- Takes 6-12 weeks to heal
- Needs 2 weeks off work
WHAT IS IT?

(a) Fistula in ano
(b) Pilonidal disease

Pilonidal sinus disease
Combination of factors:

- deep cleft
- ingrown hairs
- Friction/shearing forces
- Hygiene
- Occupations
PIOLONIDAL SINUS – WHEN TO REFER

Incidental, asymptomatic
leave it alone

REFER elective surgery
Symptomatic discharging

REFER elective surgery
Lateral swelling & pits
No inflammation

Pilonidal cyst

REFER acute surgery
Swelling with inflammation

Pilonidal abscess
PILOMIDAL SINUS – ELECTIVE SURGERY

Purpose of surgery
- decrease the depth of the cleft
- take the cleft off the midline

Karydakis
Off-midline closure

Limberg rotation flap
PILONIDAL SINUS - AFTER ELECTIVE SURGERY

- It is skin surgery
- BUT IT IS NOT MINOR SURGERY
- Time of work/school – minimum 2 weeks
- Recovery can take 2-12 weeks
- Drains can be in for a while
- 50% wound breakdown risk – variable extent
- Recurrence prevention – hygiene and epilation once healed
FIRST QUARTER TAKE HOME MESSAGES

- Perianal hematoma & haemorrhoids
  - Acute referral - necrotic/infected/unmanageable
  - Red flags
  - Lifestyle modification for recurrence prevention

- Pilonidal sinus
  - Risk factor elimination – hairs, hygiene
  - Don’t treat asymptomatic
  - Surgery – cleft off midline and decrease depth
  - Acute – abscess only
  - Set expectations early – recoperation, complications
WHAT IS IT?

(a) Fistula in ano
(b) Pilonidal sinus
(c) Abscess

Fistula in ano
FISTULA IN ANO – WHAT IS IT?

An abnormal chronic granulation tissue lined tract between the anorectal mucosa and skin

CRYPTOGLANDULAR THEORY

Secondary causes: Crohns, tb, malignancy, trauma, foreign body, iatrogenic, HIV
FISTULA IN ANO - WHAT TO LOOK FOR?

- Recurrent discharge/fistula only
- perianal or ischioanal abscesses
- Assess risk factors for secondary causes
- Pruritis

small hole perianal – base of scrotum
Inflammation/abscess
FISTULA IN ANO – ABSCESS – PERIANAL VS ISCHIOANAL?

Perianal
- Coloured area perianal
- Painful fluctuant lump
- Few systemic symptoms
- Earlier presentation 1-2d

Ischioanal
- Further from anal verge
- Between Ischial tuberosity and anal verge
- Induration and pain - days
- High fevers
- Fluctuance is a late sign
- Later presentation 5-7d
FISTULA IN ANO – WHAT TO DO?

Refer acutely if abscess

Refer electively to a colorectal surgeon if fistula

Antibiotics do not get rid of perianal abscesses – they need drainage

Do not drain under local anaesthetic in clinic – severe vagal responses

Set expectations early
15% have troublesome recurrent disease
SURGICAL TREATMENT PRINCIPLES

DEFINE THE ANATOMY

- EUA
- MRI

MANAGE THE SYMPTOMS

- Analgesia
- Sitz bath

DRAIN THE SEPSIS

- Antibiotics
- Drainage
- Seton

ERADICATE THE SURGICAL TRACT & PRESERVE SPHINCTERS

- Surgical techniques

Manage underlying conditions eg: IBD/cancer
WHO NEEDS COLONOSCOPY

MOST DO NOT NEED COLONOSCOPY

• Recurrent problems
• Multiple fistulae
• History red flags for secondary causes
## SURGICAL OPTIONS

All have only average of 50% success

<table>
<thead>
<tr>
<th>Method</th>
<th>Success</th>
<th>Incontinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laying open</td>
<td>45-80%</td>
<td>20-30%</td>
</tr>
<tr>
<td>Cutting seton (no longer used)</td>
<td>30%</td>
<td>50% Painful and no better than non cutting</td>
</tr>
<tr>
<td>Non cutting seton</td>
<td>Low fistula: 30%</td>
<td>High fistula: 50%</td>
</tr>
<tr>
<td>Mucosal advancement flap</td>
<td>45-80%</td>
<td>20-35%</td>
</tr>
<tr>
<td>Surgissis plug</td>
<td>50%</td>
<td>Nil significant 3% sepsis</td>
</tr>
<tr>
<td>Ligation Intersphincteric Fistula Tract (LIFT)</td>
<td>Low fistula 50-80%</td>
<td>10-15%</td>
</tr>
</tbody>
</table>
WHAT IS IT?

(a) Perianal wart
(b) Perianal tag
(c) Thrombosed haemorrhoid
PERIANAL TAG – WHAT TO TELL PATIENT

- Cause: Scar tissue from attempts at healing
- Need to check for & treat underlying cause if any
- Not a cancer
- Can leave it alone unless it causes problems
PERIANAL TAG – WHAT TO DO

• Look for underlying cause
• Treat underlying cause
• Reassure patient

- fissure
- haemorrhoids
- previous surgery
PERIANAL TAG – WHEN TO REFER

REFER ELECTIVELY:
• Hygiene issue
• Swelling and irritation
• Underlying cause requires specialist input
• Patient wants it excised
WHAT IS IT?

Anal fissure
ANAL FISSURE – WHAT TO LOOK FOR?

- Constipation
- burning pain on defecation

Splay to see
Not always possible – pain/muscle spasm
PR exam – often not feasible
SPOTTED AN ANAL FISSURE – WHAT TO DO?

- Constipation
- Rectal tear in skin
- Muscle spasm

- Fruit
- Fibre
- Fluid
- Fitness
- Routine
- Laxatives

- Rectogesic 0.2%
- Diltiazem 2%

Haemorrhoid topical agents don’t help
ANAL FISSURE – WHEN TO REFER?

REFER ELECTIVELY
• 6 weeks diltiazem has not worked
• Recurrent problem
• Red flags
• Can’t spot a fissure & history not classical or older patient

It could be a cancer
SURGICAL TREATMENT – RELAX THE SPHINCTER

- Intersphincteric
- Muscle relaxation
- Lasts 3 months
- Fix constipation in interim
- Fissure heals
- Can be repeated

- Upto ½ length of int sphincter men
- Upto 1/3 length of sphincter women
- Very rarely done in women
- Permanent
- Incontinence if weak sphincter already
### SECOND QUARTER TAKE HOME MESSAGES

| Fistula in ano       | • Look for red flags – secondary causes  
|                      | • Set expectations early 15% recurrence, 50% success 
|                      | • Distinguish perianal and ischioanal abscesses 
|                      | • Antibiotics and drainage in clinic can’t fix perianal abscesses |
| Perianal tag         | • Treat underlying cases 
|                      | • Refer if symptomatic |
| Anal fissure         | • Rule out red flags 
|                      | • BREAK THE VISCIOUS CYCLE for resolution 
|                      | • Lifestyle modification 
|                      | • Diltiazem ointment |
WHAT IS IT?

(a) Pruritis ani
(b) Skin lesions
Look for underlying cause
- SCC ANUS
- Bowen’s disease (SCC insitu) anus
- Fissure
- Fistula
- Haemorrhoids
- Warts
- Tags
- Incontinence
- Worms
- Fungal infection
- Dermatitis

Ask about
- Toileting behaviours
- Hygiene practices
- Topical medications
- Recent antibiotics

Perianal and PR examination
PRURITIS ANI—WHAT TO DO?

- Treat any underlying cause

Advise
- Sensitisation of local receptors
- Stop itching
- Cut nails
- Firm up BM
- Keep dry
- Zinc oxide barrier cream
- Don’t overly clean
- 5days 1% hydrocortisone

Refer
PRURITIS ANI – WHEN TO REFER?

- Underlying cause
- Severe skin changes
- Symptoms not manageable

Elective referral to Colorectal surgeon

- Skin protection - Berwicks dye + tincture of benzoin
- Desensitisation - 0.006% capsaicin; Methylene blue with LA
WHAT IS IT?

(a) Prolapsed haemorrhoids
(b) Anal cancer
(c) Rectal prolapse
RECTAL PROLAPSE—WHAT TO TELL PATIENTS?

- Multifactorial - rectum loses scaffolding
- The longer without treatment the more other problems – incontinence
- Not everyone needs surgery
- Surgery is the only definitive treatment
- Avoid constipation
- Use bulking agents for stool
- Supportive garments

Rare condition
- Over 50y
- female
- Developmental delay
- psychiatric problems
- multiple meds
RECTAL PROLAPSE – WHAT TO LOOK FOR?

History – circumferential lump, mucous, soiling, lump falling out, sitting on a ball, obstructed defecation, incomplete emptying, encore defecation

Examination – circumferential not bunch of grapes
PR with straining, strain while squatting (not always seen lying down)
RECTAL PROLAPSE – WHAT TO DO?

REFER TO A COLORECTAL SURGEON
- If well enough to have surgery
- Surgery is the only available definitive treatment
- The longer it is left the more other problems like incontinence ensue
RECTAL PROLAPSE—SURGICAL TREATMENT?

Specialist Colorectal Surgeon

Perineal mucosal sleeve

Perineal approach

Laparoscopic/Open Abdominal rectopexy
RECTAL PROLAPSE—PERIANAL VS SURGICAL?

Perineal approaches

- Less sexual dysfunction
- Young males, older
- Spinal anaesthesia
- Less pain
- 10% recurrence
- 50% continence improvement

Abdominal approaches

- 1-2% sexual dysfunction
- 2-5% recurrence
- GA
- More effective for bigger prolapse
WHAT IS IT?

Proctalgia fugax

MY BUTT HURTS
PROCTALGIA FUGAX—WHAT TO TELL PATIENTS?

• Severe muscle spasms around the anus of unknown cause
• Diagnosis of exclusion
• Can’t necessarily cure – functional disorder
• Can help to manage the pain

Set expectations early

• Can be exacerbated by
  • Stress
  • Intercourse
  • Menstruation
  • Constipation
  • Defecation
PROCTALGIA FUGAX– WHAT TO LOOK FOR?

- Painful spasms minutes to hours
- Can wake them at night
- Associated triggers
- Recent surgery
- Red flags

Exclude other causes:
- Fistula
- Abscess
- Fissure
- Haemorrhoids
- Cancer
- IBD
PROCTALGIA FUGAX – WHAT TO DO?

- Rule out other causes - Colonoscopy
- Reassurance
- Warm bath
- Diltiazem ointment 2%
- Salbutamol 200mcg tds/prn
- Stress counselling

Low level evidence – case series
PROCTALGIA FUGAX – WHEN TO REFER?

REFER TO COLORECTAL PELVIC FLOOR CLINIC

- Red flags
- No organic cause found & Symptoms not settling after 3 months

- MRI
- Colonoscopy
- Manometry

- Clonidine 150mcg bd
- Local anaesthetic injection
- Botox
THIRD QUARTER TAKE HOME MESSAGES

- **Pruritis ani**
  - Treat any underlying causes
  - Advise patients – lifestyle modification – toileting, hygiene, itching
  - Set expectations early

- **Rectal prolapse**
  - IT is circumferential NOT a bunch of grapes
  - Surgery is the only definitive treatment
  - Can manage symptoms with non surgical means

- **Proctalgia fugax**
  - Look for red flags – if could be cancer
  - Diltiazem/salbutamol/stress management
  - Set expectations early
Fecal incontinence
## FECAL INCONTINENCE – WHAT TO LOOK FOR?

### SEVERITY OF SYMPTOMS

- Frequency
- Obstructed defecation, encore defecation
- Type – urge, stress, awareness, flatus/faeces
- Social impact

### SPHINCTER INJURY

- Obstetrics – multiple pregnancies, episiotomy, forceps, big babies
- Perianal surgery
- Trauma
- Neurological disease

### ASSOCIATED SYMPTOMS

- Urinary incontinence
- PR bleeding or mucus
- Change in BH

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**IBD**

**Cancer**
Fecal Incontinence – What to Look For?

Perianal examination: Is the anus level with the ischial tuberosities

PR examination: Bulge touches finger on straining

Pelvic floor issues

Anatomical sphincter issue

Sphincter dysfunction

Rectocele

Prolapse

PR examination: Bulge touches finger on straining

PR examination: Is there a bulge into the vagina

PR examination: Is the sphincter deficient anywhere

Anatomical sphincter issue
Fecal Incontinence – What To Do?

- Colonoscopy to rule out other causes if red flags
- Constipating medications
- Dietary change – alcohol, caffeine
- Bulking agents
- Pelvic floor exercises
Fecal Incontinence – When to Refer?

Refer to Colorectal Pelvic Floor Clinic and Physiotherapist

- Red flags for further investigation
- No organic cause and symptoms not settling after 3 months and are debilitating

- Endoanal ultrasound – sphincter anatomical integrity
- Mamometry – sphincter function
- Defecating proctogram – prolapse/rectocele
Fecal Incontinence – Treatment?

Dependant on the underlying cause for the incontinence

- Management – nappies, hygiene
- Biofeedback/ Bowel retraining
- Pelvic floor exercises
- Sphincter repair
- Sacral Nerve stimulator implantation
- Surgery for rectocele or prolapse
- Anal bulking agents – lipofilling, microspheres, collagen
- Colostomy – last resort for quality of life

50% success
WHAT IS IT?

Anal warts
condylomata
accuminata
ANAL WARTS – WHAT TO ASK/LOOK FOR?

CONTRIBUTORY FACTORS

• Sexual history
• HIV status
• Immunosuppressants

EXAMINATION

• Perianal
• Perineum
• PR – mass
• proctoscopy
ANAL WARTS – WHAT TO DO?

- HPV vaccination – decrease recurrence – not funded in adults for this
- Advise on safe sexual practices
- Treat – symptomatic or dysplasia - Topical treatments +/- surgery

Colorectal referral
- Internal or difficult to treat
ANAL WART – TOPICAL TREATMENT?

• Podophyllotoxin
• Imiquimod tds 16 weeks – 48% response; 34% partial response; 34% recur
• 5-fluorouracil 9-16 weeks bd – 90% response; 50% recurrence
• Photodynamic therapy
• Targeted treatment – infrared, electrocautery, cryotherapy
• Surgical excision – best if combined with cautery

Imiquimod + surgery highest clearance rates Lowest recurrence

Warts are LSIL Yearly surveillance
WHAT IS IT?

(a) Non healing fistula
(b) Anal SCC
ANAL IN SITU NEOPLASIA (AIN) – SCREENING?

- asymptomatic
- Conflicting evidence
- AIN can progress to anal cancer – rates are low
- Some high risk groups may have a higher risk of progression
- Spontaneous regression can occur in some groups

LSIL to HSIL 12-24%
HSIL to SCC 8-11%

No evidence for population based screening – low rate of conversion
## Anal In Situ Neoplasia (AIN) – Refer?

### Refer High Risk Groups

<table>
<thead>
<tr>
<th>LSIL – 12 monthly review</th>
<th>HSIL – 3 to 6 monthly review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• History &amp; Examination</td>
<td>• History &amp; Examination</td>
</tr>
<tr>
<td>• Pap smear – high false positives - anoscopy</td>
<td>• Pap smear – high false positives - anoscopy</td>
</tr>
<tr>
<td>• Anoscopy (acetic acid and lugols iodine)</td>
<td>• Anoscopy (acetic acid and lugols iodine)</td>
</tr>
<tr>
<td>• Biopsy new or suspicious lesions</td>
<td>• Biopsy new or suspicious lesions</td>
</tr>
<tr>
<td></td>
<td>• for progression to HSIL</td>
</tr>
<tr>
<td></td>
<td>• treat for symptoms not preventing progression</td>
</tr>
<tr>
<td></td>
<td>• Control of dysplasia</td>
</tr>
<tr>
<td></td>
<td>• Preservation of function</td>
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</tbody>
</table>
ANAL IN SITU NEOPLASIA (AIN) – TREATMENT?

• Topical treatments – imiquimod/5-fu
• Surgery
• Surveillance

Combination best eradication function preservation
ANAL SCC – WHAT TO DO?

- Risk factors assessment – HPV, AIN, smoking, high risk sexual behavior, HIV, immunosuppression, crohns, females, chronic inflammation

High index of suspicion
REFER EARLY
Ulcer or mass - +/- bleeding/pain/tenesmus/pruritis

Investigations:
- Endoanal USS
- MRI
- CT staging
- PET staging
ANAL SCC – SURGICAL TREATMENT?

Purpose of treatment:
- Ablate the cancer
- Preserve sphincter function

- Most can be treated with radiation and chemotherapy 70% success & 75% 5y survival
- Dermatitis, sexual dysfunction, proctitis, tenesmus, stenosis, bladder dysfunction, DVT
- 30% need surgery – non responsive/recurrence
FOURTH QUARTER TAKE HOME MESSAGES

- Fecal incontinence
  - Detailed history vital
  - Red flag identification – Cancer/IBD
  - Thorough exam

- Anal warts
  - HPV infection
  - Ascertain risk
  - Thorough examination
  - Refer if difficult to treat or internal or symptomatic

- AIN & SCC
  - LSIL – yearly review; treat for symptoms
  - HSIL – 3 to 6 monthly review; treat to control dysplasia and preserve function
  - Anal SCC – high index of suspicion; aim of treatment is cancer ablation and sphincter preservation; most get chemoradiation

- Anus to tuberosity
- Sphincter thickness
- Squeeze
- Bulge into vagina
- Prolapse
- Mass
PERIANAL CONDITIONS

- Perianal sinus & abcess
- Perianal tag
- Perianal hematoma
- Anal fissure
- Fistula in ano
- Perianal tag
- Anal SCC
- Fecal incontinence
- Proctalgia fugax
- Rectal prolapse
- Pruritis Ani
- Anal fissure
- Haemorrhoids
- Pilonidal sinus & abcess
- Rectal prolapse
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- Anal fissure
- Haemorrhoids
- Pilonidal sinus & abcess
- Rectal prolapse
- Pruritis Ani
- Anal fissure
PERIANAL CONDITIONS TAKE HOME MESSAGE

• Spot recognition

• Look for red flags and refer early

• Set patient expectations early

• Advise about lifestyle modification

• Refer if symptoms not manageable in primary care or if red flags or need surgical intervention