Getting to the Bottom of Anorectal Pathology

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Disclosure

- I, Jonathan Baker, have no relevant financial, professional or personal relationships to disclose.
- I will discuss off-label use of medications and procedures:
  - Topical nifedipine
  - Topical diltiazem
  - Injected botulinum toxin
  - Electrocautery
  - 3.5-5% Imiquimod
  - 5-fluorouracil
  - 80% trichloroacetic acid (TCA)
  - Infrared coagulation (IRC)

*Off label medications and procedures will be identified on the slides

Objectives

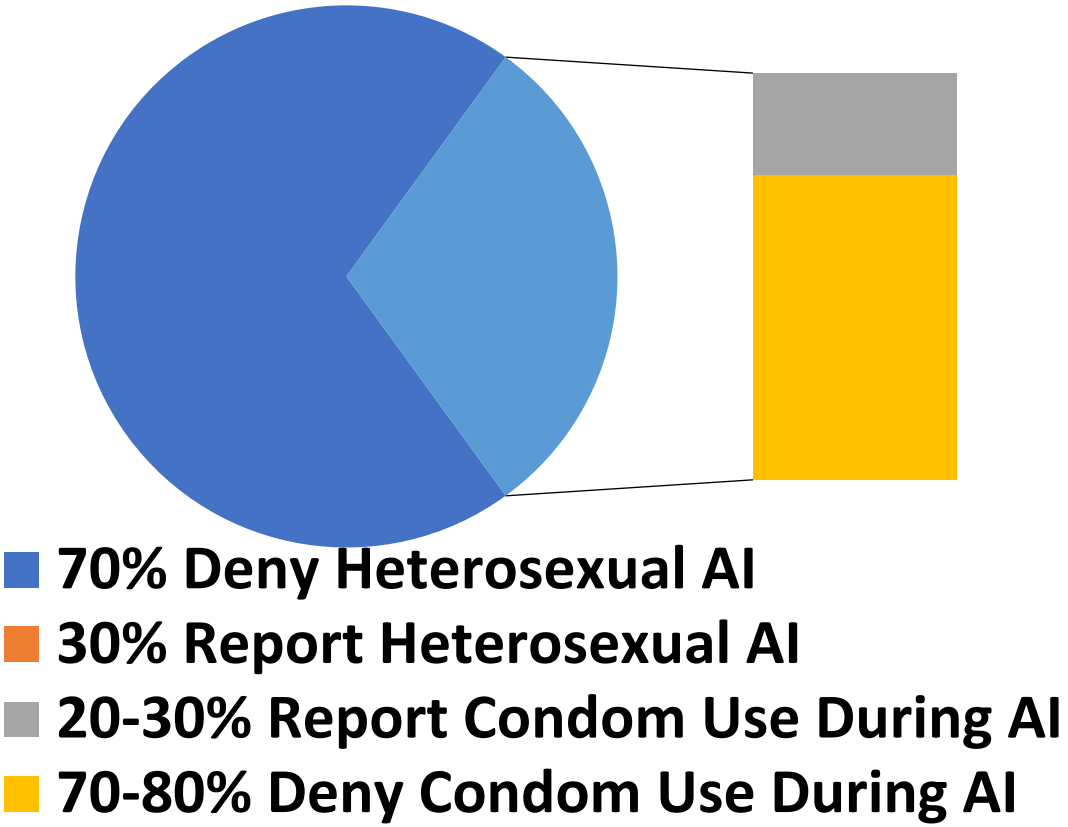
Participants should be able to:

- Identify anal and rectal anatomy in relation to anorectal pathology
- Develop an appropriate differential diagnosis for common anorectal symptoms
- Discuss clinical presentation, workup, and treatment of anorectal STIs
- Discuss HPV associated anal dysplasia screening and management

History

General medical hx	Constipating medications, pregnancy causing hemorrhoids
Anal history	Prior anal diagnosis, STIs
Anal medications	Steroids, imiquimod, etc.
Anal procedures	Prior surgery, procedures, cryotherapy
Sexual behaviors	RAI/IAI, anolingus, toys, fingers
Sexual partners	HIV status, STIs, monogamy?

Domestic Heterosexual AI



Habel 2018

Anal Intercourse (AI)

- Receptive Anal Intercourse Increase:
  - Fissure
  - Fistula
  - Abscess
  - Ulceration
  - Herpes simplex
  - HPV/dysplasia/cancer
  - HIV and other STIs

AI and HIV Risk

Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act

Type of Sexual Exposure	Risk per 10,000 Exposures
Receptive anal intercourse	138
Receptive penile-vaginal intercourse	8
Insertive anal intercourse	11
Insertive penile-vaginal intercourse	4
Oral intercourse	low

CDC 2015

Physical Examination

External exam	melanoma, Bowen's disease, age associated pigmentation, condyloma, tags,
Digital anorectal exam (DARE)	condyloma, fissure, sphincter tone, anal cancer, prostate
Anoscopy- in office	anus and distal rectum- condyloma, hemorrhoids, fissure

Fissure

- Linear tear in the mucosa
- Presentation: extreme pain with defecation, bleeding
- New sentinel tag and papilla
- Typically extending towards the perineum or coccyx
- *Intensity of the pain out of proportion to the size of the lesion*

Fissure

- Conservative treatment: Sitz baths, stool softeners, fiber, hydration
- Medical treatment: Topical
  - Nitrogylcerine .4%
  - *Diltiazem 2.0%
  - *Nifedipine 0.5%
- *Botulinum Toxin Injection
- Definitive treatment: lateral sphincterotomy, fissurectomy,

*off label

Carapeti 2000, Brisinda 1999, Perrotti 2002

Anal Ulcers

- Breakdown in skin
- Differential
  - HSV, LGV, Syphilis
  - Malignancy (SSC)
  - Fissure
  - Traumatic
  - Severe dermatitis

Dermatitis

Clinical Presentation: perianal itch, bleeding with wiping, ulceration

Cause	Intervention
Fungal	Oxiconazole, ketoconazole, clotrimazole/betamethasone
S. aureus, *Strep species*	Mupirocin BID x 7 days
Chemical (soap, shampoo, topicals)	Remove offending agent Topical steroid/anesthetic
Overwiping	Lifestyle modification *Medicated wipes/wet wipes*

Overwiping Dermatitis

- Very common
- Circumferential or unilateral around the anal verge
- Treat with lifestyle modification and OTC (ie. Zinc oxide)
- Short course of HCT if severe

Fungal Dermatitis

- Fungal Dermatitis is uncommon
- More likely to affect natal cleft
- Look for satellite lesions

Herpes Simplex

- Painful anal ulcers
- Anal pain, burning, itching, bleeding
- HSV-2 or HSV-1
- Diagnosis: PCR, culture
- Treatment: acyclovir, valacyclovir
- Px if >6 outbreaks/year

Syphilis

- Primary syphilis - painless Chancre
  -anal chancre can be painful
- Firm, well-demarcated ulcer
- Appears 2-6 weeks post infection
- Dx: EIA, syphilis serology
- Rx: Benzathine Penicillin

“Bumps” Differential Diagnosis:

- Condyloma Accuminata
- Condyloma Lata (Syphilis)
- Skin Tags
- Sentinel Tag (Fissure)
- Molluscum Contagiosum
- Hemorrhoids

Skin Tags

- Redundant perianal skin
  - Can be mistaken for hemorrhoids or warts
- Benign
- Often asymptomatic
- Treatment conservative
- New tag may indicate fissure (sentinel tag)

Hemorrhoids

- Dilated vessels associated with constipation, straining, prolonged sitting on toilet leading to pooling of blood
- Prevention: fiber, stool softeners, and hydration straining avoidance, exercise,
  reduce time sitting on toilet
- Presentation: itching, irritation, mass sensation, pain, bleeding (internal)

Internal Hemorrhoids

Grade 1-4

1. Non-prolapsing
2. Spontaneously reduced
3. Manually reduced
4. Incarcerated

- Emergency: thrombosed incarcerated hemorrhoids

Internal Hemorrhoids

- Dilation of hemorrhoidal plexus under rectal or anal epithelium
- Typically not appreciated on digital exam
- Sx: Bleeding, itching,
  discharge, prolapse
- Treatment: hydrocortisone topical/suppository, Sitz bath, rubber band ligation, cautery, surgery

External Hemorrhoids

- Dilation of hemorrhoidal plexus under squamous epithelium
- Thrombosis self limited, and may be painful or painless
- Treatment: hydrocortisone, Sitz bath, surgery (within 72 hours)
- Do not attempt to reduce

Abscess

- Clinical Presentation: perianal pain, fluctuant nodule, discharge, fever
- Common organisms: *E. coli*, *S aureus*, *Streptococcus species*, *Bacteroides*, *Clostridium, Fusobacterium*
- Fistulas are a common complication
- Treatment: I&D +/- antibiotics
  - Amox/Clav (broad spectrum)
  - Change Abx pending culture

Fistula

- Secondary communication between the anal canal and skin
- Complication of abscess and IBD
- Presentation: recurrent drainage, fistula opening and tract
- Treatment: conservative treatment if asymptomatic drainage of abscess, seton stitch, fistulotomy, fistulectomy

Condyloma Acuminatum

- Secondary to low risk HPV infection
- Clinical Presentation: mass, irritation, itching
- Treatment: imiquimod, podofilox, sinecatechins; cryotherapy, surgery
- electrofulguration,

Anal Cancer

- Anal Squamous Cell Carcinoma
  - Caused by High-Risk HPV
- Excision +/- radiation +/- chemotherapy
- Symptoms include:
  - Pain, mass, itching, bleeding, discharge
  - Symptoms typically in advanced disease

HPV-9 Vaccine

- Prophylactic Nonavalent Vaccine
  - **6, 11 ,16 ,18** + 31, 33, 45, 52, and 58
- CDC/ACIP recommendation
  - Women 11-12y; catch-up to 26y
  - Men 11-12y; catch-up to 21y; *(permissive to 26y)*

Petrosky 2015, FDA 2018

Rectal Gonorrhea/Chlamydia

- Clinical Presentation: most commonly asymptomatic
- Symptoms often 5-7 days post infection
- Diagnosis: rectal NAAT
- Treatment: antibiotics
- GC: IM Ceftriaxone 250 mg plus PO Azithromycin 1g
- Ct: PO Azithromycin 1g

CDC 2012

Proctitis

- Rectal inflammation presenting with pain, discharge, bleeding +/- tenesmus and spasm
- Differential:
  - Inflammatory Bowel Disease
  - Infection: ie *C Diff*
  - Ct/gc/**LGV**
  - HSV
  - Syphilitic proctitis (rare)

Gonorrhea/Chlamydia Screening

- CDC: Screen for urethral, rectal, and pharyngeal* gc/Ct based on exposure route, local guidelines, and considering population prevalence
  - Screen women ≤25y annually
  - Consider screening men ≤25y in areas of high prevalence or with risk factors
  - Screen MSM annually, Q3-6 mo for MSM at ↑risk

*Screening for pharyngeal Ct is not recommended due to low prevalence

CDC

MSM Health

- HPV vaccination (up to age 26+)
- STI Screening based on exposure
  - Gc, ct, syphilis
  - HIV screening IN ALL PATIENTS
- Hepatitis A and B vaccination
- HIV PrEP if appropriate
- Consider anal pap if appropriate

Questions?

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