Dr Nagham Al-Mozany
Colorectal Surgeon
Auckland City Hospital
Clinical Senior Lecturer
University of Auckland

Friday, June 8, 2018
12:05 - 13:00  WS #33: Management of Benign Rectal Bleeding
Management of Benign Rectal Bleeding and Red flags

DR. NAGHAM AL-MOZANY
Declaration of conflict of interest

I CONFIRM THAT I DO NOT HAVE ANY CONFLICT OF INTEREST TO DECLARE
“I never ate sweet things before I met you, I didn’t know someone could be so passionate working with poo”
Who am I?

- Colorectal & General Surgeon
- Auckland City Hospital
- MacMurray Centre (private)
- Mercy Hospital
- University of Auckland
- RACS
Presentation Objectives

- Classification of rectal bleeding
- Identifying red flags
- Overview of common rectal bleeding presentations
- Cases
- Take home messages

QUIZ with Prize for the winner! Mercy Stand
COLONSCOPY

YAY.
Classification of rectal bleeding

- Age of patient
Classification of rectal bleeding:

- Age of patient
- **Site** of bleeding

**Upper GI source**

**Anything in the middle**

**Lower GI source**

- Ischemic colitis
- Colitis (infections, irritable bowel syndrome)
- Anglo-dysplasia
- Polyps
- Carcinoma
- Hemorrhoids
- Diverticula
Site of bleeding - anything in the middle

Small bowel GIST tumour
Classification of rectal bleeding

- Age of patient
- Site of bleeding
- Painful or Painless
Nature of Perianal pain

Think Anal Fissure…

• ‘Tearing sensation’
• ‘Burning’
• ‘Glass shards/Sharp’
• ‘Razor blades coming out of my bottom’
• ‘Hot poker’
Nature of Perianal pain

THINK
HAEMORRHHOIDS...

- ‘Dull ache’
- ‘Throbbing’
- ‘Discomfort’
- ‘Worse on sitting’
Classification of rectal bleeding

- Age of patient
- Site of bleeding
- Painful or Painless
- Colour of blood
Colour/Nature of bleeding
- Fresh
- Malaena
- Clots
- Mixed in or separate to stool

Volume
Frequency
Stool type
Blood in My Stool: What Does it Mean?
Patient History Key Points

- Painful/Painless
- Duration
- Frequency
- Colour of blood
- Blood mixed or separate from stools +/- mucus
- Change in bowel habit
- Unintentional weight loss
Patient History Key Points

- Blood dripping/on wiping
- Prolapsing masses
- Type of Stool (Bristol stool chart)
- Straining on defecation
- Anti-coagulants/NSAIDS/Laxatives
- Topical ointments
- Previous colonoscopy/gastroscopy
Patient Examination

- Abdominal examination
- Rectal examination

WHEN THE DR. SAYS.....

"TIME FOR YOUR RECTAL EXAM"
What do you look for during a rectal examination

- **Inspect:**

  - Signs of Pruritis Ani / “anal irritation”
  - Hygiene
  - External haemorrhoids/Skin tags
  - Fissures
  - Fistulas/Sinus opening
‘If you don’t put your finger in, you might put your foot in it’

*Bailey & Love’s Textbook of Surgery*
Rectal examination

- Anal tone (hyper-/hypo-/normal)
- Mass ?
- Prostate/Cervix
- Tender or not?
- Blood on glove ?

- Bed Side Adjuncts….
Proctoscopy
Rigid Sigmoidoscopy
Investigations

- FBC, Iron studies
- Faecal specimen
- Faecal calprotectin >200mcg/g ‘normal range 0-50mcg/g’
- Sensitivity 70%, specificity 92% for intestinal inflammation
- Don’t check FOBT using Faecal Immunochemical Test (FIT)
- It is only suitable for, and validated as a screening test for colorectal cancer when applied to an average risk, asymptomatic population
Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography

- **2/52 category:**
- Known or suspected CRC (on imaging, or palpable, or visible on PR exam)
- Unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia
- Altered bowel habit > six weeks duration + unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years
6/52 category

Altered bowel habit > six weeks duration + unexplained rectal bleeding (benign anal causes treated or excluded), aged 40-50 years

Unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years

Unexplained iron deficiency anaemia

NZGG Category 2: family history plus one or more of altered bowel habit > six weeks duration + unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 40 years

NZGG Category 3: family history plus one or more of altered bowel habit > six weeks duration + unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 25 years

Suspected/assessment inflammatory bowel disease

Imaging reveals polyp > 5mm
Urgent referral triage

- Rectal bleeding?
- Tenesmus?
- Change in bowel habit >6/52?
- Unexplained weight loss?
- Abdominal pain or mass?
- Mass on rectal examination?
- Iron deficiency anaemia?
Common presentations of rectal bleeding

- Anal fissure
  - Haemorrhoids
  - Diverticular disease
  - Colorectal cancer
Anal Fissure

- Tear in anoderm of the anal canal
- Any age group 15-50y
- Main symptoms:
  - Severe pain during defecation
  - Burning/Sharp/Glass shards
  - Pruritis ani +/- discharge
  - Bright red bleeding on wiping
Aetiology?

- Trauma

  ➔  Sphincter spasm

  ➔  Ischaemia
Classification of fissures - Think 6/52!

ACUTE FISSURE
- Painful to examine
- Bleeding
- Hypertonic sphincter (anal spasms)

CHRONIC FISSURE
- Sentinel pile posteriorly at edge of anus
- Hypertrophic anal papilla anteriorly
- Muscle fibres of internal sphincter seen
Acute fissure
Chronic fissure

Hypertrophic papilla
Fissure
Sentinel pile

Rectum
Pelvic floor muscle
Internal anal sphincter
External anal sphincter
Anal fissure
Sentinel pile
Anus
Skin

Anal Fissure
Anal Fissures

- Fissures occurring off to the midline think of Crohn’s disease, anal cancer, STI’s, TB, HIV

- 4% of Crohn’s disease patients will have an anal fissure as the *first* manifestation of Crohn’s disease
Treatment

Relieve Sphincter Spasm

Alleviate Ischaemia

Promote healing
How to relieve sphincter spasm?

- **Chemical:** GTN, Calcium channel blockers
- **Neurotoxic:** Botox
- **Mechanical:** Sphincterotomy
Treatment of fissures - Think 6/52

NON-OPERATIVE

- Dietary Modification
- Laxatives e.g. Metamucil, Lactulose
- Topical therapy
- Avoid steroid creams

OPERATIVE

- Botox
- Surgery (Lateral sphincterotomy)
Nitroglycerin (GTN topical therapy)

- Relaxes the internal anal sphincter
- Reduces anal sphincter spasm
- Promotes blood flow to fissure site and promotes healing
- 0.2% concentration
- Efficacy 46-86%
- TDS for 6/52
- Headaches (dose related)
- If elderly on GTN for angina, then use BD for 6/52
- Contraindicated in pregnancy and lactation
- Not indicated in chronic fissures
Topical Calcium channel blockers (2% Diltiazem ointment)

- Vasodilator
- Promotes blood flow to the anal sphincter muscle
- Relaxes sphincter muscle tone
- Reduced frequency of headaches

- Itchiness/perianal skin irritation
Diltiazem versus GTN

2% diltiazem ointment applied twice per day for 8 weeks

- Randomised trial of 43 patients showed similar rates of healing with diltiazem and GTN (86% versus 85%) with better side-effect profile (0% versus 33%)
  
  Bielecki et al Colorectal Disease 2003; 5: 256-7

- Randomised trial of 60 patients showed similar rates of healing with diltiazem and GTN (86% versus 77%) with better side-effect profile (41% versus 72%)

Kocher et al Br J Surg 2002; 89; 413-7
When to refer patients with fissures?

- Chronic fissure
- Failure to improve post 6/52 treatment
- Atypical fissures (OFF to the midline), suspected Crohn’s patients
- Painless fissures
What would I do…

- Botulinum Toxin A
- Lasts 3-6 months
- Costs $ 400-500
- Prevents release of acetylcholine by presynaptic nerve terminals
- Minor *temporary* flatus incontinence and leakage
What would I do…Sphincterotomy

- Requires anaesthesia
- Day case admission
- Efficacy 90-95%
- 1-2% risk of permanent incontinence
Common presentations of rectal bleeding

- Anal fissure
- Haemorrhoids
  - Diverticular disease
  - Colorectal cancer
Hemorrhoidal cushion

- There are three prominent cushions
  - left lateral
  - right posterior
  - right anterior

Located at the 3, 7 and 11 o’clock position when patient is lying in lithotomy
40% of people are asymptomatic
“I have roid rage. It’s not from taking steroids but actually from an extremely painful haemorrhoid”
Symptoms

- **Haematochezia** - “drips in toilet bowl”, “splashes”
- Pruritis ani
- Mucus discharge
- Prolapse
- Pain

Anaemia from haemorrhoidal bleeding is rare
Hemorrhoidal cushion

- There are three prominent cushions
  - left lateral
  - right posterior
  - right anterior

Located at the 3, 7 and 11 o'clock position when patient is lying in lithotomy
Classification of haemorrhoids

Internal:
- **Above** dentate/pectinate line
- Usually not painful
- Painful if thrombosed or necrotic
- May prolapse
- 4 grades
Internal hemorrhoid grades:

**GRADE I**
Protrudes into the anal canal but does not prolapse

**GRADE II**
Prolapses but reduces spontaneously

**GRADE III**
Prolapses and requires manual reduction

**GRADE IV**
Irreducible prolapse
Refer acutely: Gangrenous/Necrotic internal haemorrhoids
External thrombosed haemorrhoid

- Very painful
- Pain resolves in 3-4 days
- Swelling takes few weeks to disappear
- Skin tag
Management of thrombosed external haemorrhoids: (Naghams’s cocktail)

- Analgesia (Paracetamol, NSAID, Tramadol)
- Stool softeners
- Lignocaine gel
- Ultraproct
- Ice “Gloved”
Perianal haematoma

- ? external thrombosed haemorrhoid
- Collection of blood around the anus
- Caused by ruptured vein
- Severe pain and sudden onset of perianal skin swelling
- Cannot be pushed in
- Pain settles after 5 days “Five day wonder”
- Blue tinge to skin
- Marble
When to refer a perianal haematoma?

Refer acutely if:
Not settled
Complications of haemorrhoids

- Bleed
- Prolapse
- Ulcerate
- Thrombosis
- Strangulate
- Gangrene
- Fibrosis → Skin tag
If in doubt, send a photo with the referral

REMEMBER TO ASK PERMISSION FROM YOUR PATIENT FIRST!
What can you do?
You don’t defecate in a library so you shouldn’t read in the bathroom
The effectiveness of Sitz bath in managing adult patients with anorectal disorders: A systematic review
Siew Ping DL(1), Chi TP, Li GJB Libr Syst Rev. 2010;8(11):447-469M, Nk EA.

- 4 RCTs
- No significant impact in reducing overall intensity of pain and postoperative pain
- No impact in accelerating wound healing
- Patients satisfied using Sitz bath

CONCLUSION:

- No strong evidence to support the use of sitz bath for pain relief, and accelerate wound healing. No complications were reported
Sitz Bath

- Useful in the treatment of hemorrhoids & other conditions associated with the anal & genital areas
- Lightweight, durable & easy to clean
- Convenient on/off control clip
- Fits all standard toilets

Well at Walgreens

1 SITZ BATH BASIN & BAG
¼ cup of salt
**SOOTHING SITZ BATH RECIPE**

**EPSOM SALT**

**Magnesium Sulfate**

- Helps relieve muscle pain & tension naturally
- Helps restore energy levels & reduce adrenaline
- Helps relieve cramping, tightness, & stiffness
- Helps improve circulation & decrease inflammation

**Wormwood Steam Sitz (hip) bath**

The seated steam treatment with medicine-infused water vapor. This vaginal steam treatment encourages female pelvic and uterine health by boosting the blood circulation in the body.
What Laxative do I prescribe?

- **Fiber supplements**: Soften the stool and stimulate a bowel movement e.g. Metamucil

- **Osmotic laxatives**: Increase the amount of fluid secreted within the intestines, resulting in softer and easier-to-pass stools e.g. Lactulose

- **Herbal stimulant laxatives**: contain anthranoids that stimulate the intestines, improving motility in the gut e.g. Senna

- **Stimulant laxatives**: Speed up colonic motility thus inducing a bowel movement e.g. Ducolax
The Natural Stuff....
Topical therapy for haemorrhoids

- Used in haemorrhoids and pruritis ani symptoms
- Contains cinchocaine HCL: provides analgesia, anaesthesia and spasmolytic
- Hydrocortisone: anti-pruritic and anti-inflammatory
- Topical ointments
- Suppository
- $21.00 www.pharmacy-nz.com
Topical therapy for haemorrhoids

- Contains zinc sulphate and pramoxine HCL
- Reduces irritation
- Acts as an astringent
- Anti-pruritic
- Topical ointment and suppositories
- $15.99 online pharmacy www.pharmacy-nz.com
Topical therapy for haemorrhoids

- Long acting
- Fluocortolone: anti-inflammatory, anti-pruritic and anti-allergenic
- Cinchocaine: Local anaesthetic
- Topical BD-QID
- Suppository: OD-TDS
- No more than 1/12 use
Who to refer to colorectal surgeon?

- Symptomatic grade 1-2 internal haemorrhoids that have failed medical treatment
- Grade 3-4 bleeding internal haemorrhoids
- Acute thrombosed external haemorrhoids that are not improving
- Necrotic/gangrenous internal haemorrhoids
- Large skin tags causing pruritis and discharge symptoms
Sclerotherapy with 5% oily phenol
Excisional haemorrhoidectomy (open/closed)
Common presentations of rectal bleeding

- Anal fissure
- Haemorrhoids

- Diverticular disease
  - Colorectal cancer
Diverticular Disease

- Common
- Left-sided
- **Painless** Rectal bleeding
- Alternating diarrhoea/constipation
- Risk Factors: NSAID
Diverticular bleeding

- Massive volumes
- Frequent bleeding, unstable
- REFER acutely for CT Angiogram

- Low volume, frequent, stable refer for scope
CAN WE MAKE THE TRADEMARK SIGN BIGGER?

THIS WILL LOOK GREAT ON A BUSINESS CARD.
## Registrations

<table>
<thead>
<tr>
<th>Cancer (ICD Code)</th>
<th>Number of registrations, 2015</th>
<th>Rate (registrations per 100,000)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Digestive organs - C15-C26</td>
<td>2802</td>
<td>2360</td>
</tr>
<tr>
<td>Oesophagus - C15</td>
<td>214</td>
<td>95</td>
</tr>
<tr>
<td>Stomach - C16</td>
<td>235</td>
<td>148</td>
</tr>
<tr>
<td>Small intestine - C17</td>
<td>63</td>
<td>50</td>
</tr>
<tr>
<td>Colon, rectum and rectosigmoid junction - C18-C20</td>
<td>1607</td>
<td>1474</td>
</tr>
<tr>
<td>Anus - C21</td>
<td>23</td>
<td>38</td>
</tr>
<tr>
<td>Liver - C22</td>
<td>246</td>
<td>110</td>
</tr>
<tr>
<td>Gallbladder - C23</td>
<td>21</td>
<td>46</td>
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<tr>
<td>Other biliary tract - C24</td>
<td>47</td>
<td>35</td>
</tr>
<tr>
<td>Pancreas - C25</td>
<td>294</td>
<td>287</td>
</tr>
<tr>
<td>Other digestive organs - C26</td>
<td>52</td>
<td>77</td>
</tr>
</tbody>
</table>

Source: New Zealand Cancer Registry

Note: rates are expressed per 100,000 population and age standardised to the WHO World Standard Population.
Figure 1: Female cancer registration rates, by site, 25+, Māori and Non-Māori 2010-2012

Māori females had a significantly lower colorectal cancer registration rate than non-Māori females (RR 0.80, CI 0.70–0.92)
- NBSP rolled out across DHBs in 2017
- Entire NZ to offer bowel screening by end of 2021
- Eligible age 60-74
- Tenesmus
- Incomplete evacuation
- Blood
- Usually painless
- Change in bowel habit >6/52
- Iron deficiency anaemia
- PR Mass

Refer urgently!
CEA (Carcinogenic Embryonic Antigen)

- Useful for surveillance (detecting recurrence)
- Not for screening
- Not all bowel cancers secrete the glycoprotein
- Increasing trend is VIP
- Sensitivity 30-80%
  Specificity 40%
CEA (Carcinogenic Embryonic Antigen)

- Auckland ‘normal range’ 0-3 ug/L
- Confounding factors:
  - Smoking
  - Infection
  - IBD
  - Liver cirrhosis
  - Chemo and Radiotherapy
QUIZ TIME
Case

40 yr Female, 3/12 history of prolapsing, bleeding haemorrhoids that require digitation. She has trialled ultraproct and stool softeners without effect.

Q: What type of haemorrhoid does she have and what do you do?

- A. External haemorrhoid. Continue with current management
- B. Grade 2 Internal haemorrhoid. Continue with current management
- C. Grade 2 Internal haemorrhoid. Refer to colorectal surgeon for banding
- D. Grade 3 Internal haemorrhoid. Refer to colorectal surgeon for banding
- E. External haemorrhoid. Refer to colorectal surgeon for surgery
▪ 40 yr Female, 3/12 history of prolapsing, bleeding haemorrhoids that require digitation. She has trialled ultraproct and laxatives without effect.

Q: What type of haemorrhoid does she have and what do you do?

▪ A. External haemorrhoid. Continue with current management

▪ B. Grade 2 Internal haemorrhoid. Continue with current management

▪ C. Grade 2 Internal haemorrhoid. Refer to colorectal surgeon for banding

▪ D. Grade 3 Internal haemorrhoid. Refer to colorectal surgeon for banding

▪ E. External haemorrhoid. Refer to colorectal surgeon for surgery
Case: 27 yr female, with change in bowel habit, mucus discharge and mild perianal pain
Case: 69 yr female, 1/7 history of with rectal bleeding, frequency of 30 minutes, on Warfarin. No previous scopes.

- What is the likely diagnosis?
- What would you do?
Case: 71 yr male with 1/12 intermittent rectal bleeding, mixed with stool, on Clopidogrel, change in bowel habit, difficult emptying and LIF pain

- What are the differential diagnoses?
- What would you do?
Stricture of sigmoid colon
Diverticular stricture vs. Colon cancer
TAKE HOME MESSAGES

- Pain or Painless
- “If you don’t put your finger in it, you put your foot in it!”
- Be aware of atypical/chronic fissures
- Red flags for CRC
If in doubt, please call us…

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- Dietetics
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- Capsule endoscopy
- Endoscopic Weight Loss
- Infusions
- Ambulatory & Wireless pH
- Manometry
- Food Intolerance Testing
- H. Pylori Testing

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PHONE: 09 550 1080  EMAIL: admin@macmurray.co.nz
FIND US ONLINE: macmurray.co.nz  FAX: 09 550 1081
5 MACMURRAY ROAD, REMUERA, AUCKLAND 1050, NEW ZEALAND
Thank you for your time