# Dr Alasdair Patrick
# Gastroenterologist

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

Royal Free Hampstead NHS
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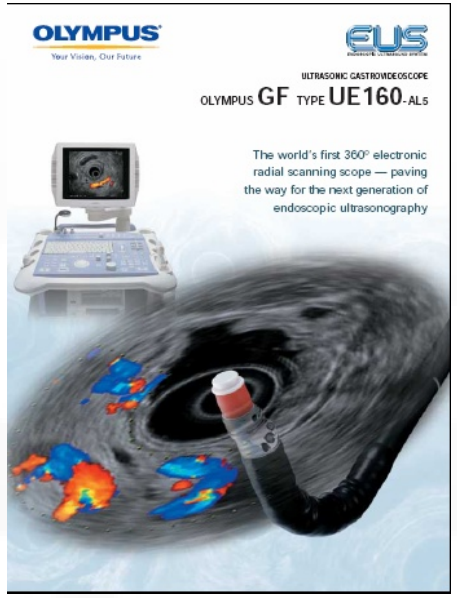
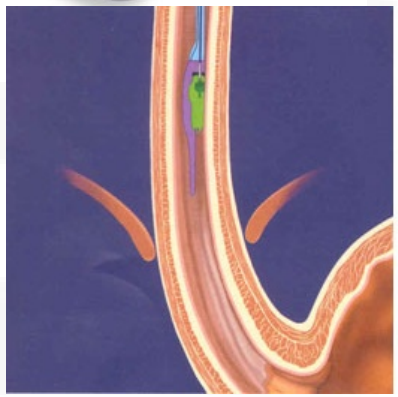
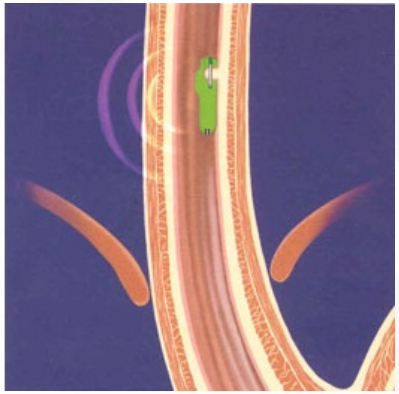
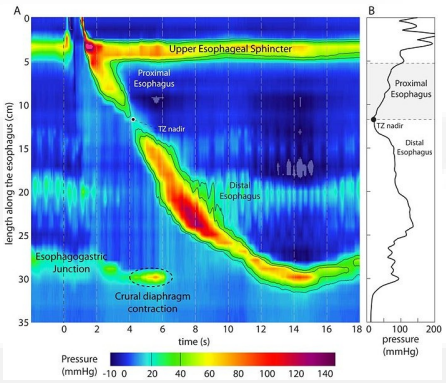
MACMURRAY
GASTROENTEROLOGY
DIGESTIVE DISEASES & ENDOSCOPY

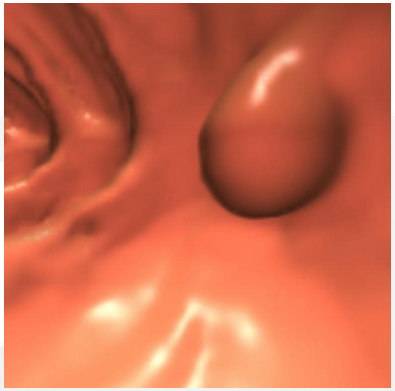










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MACMURRAY CENTRE

# Brand new facility in Remuera

5 Gastroenterologists
Upper GI surgeons
Lower GI surgeons
Dietician
Psychologist
Clinical nurse specialists

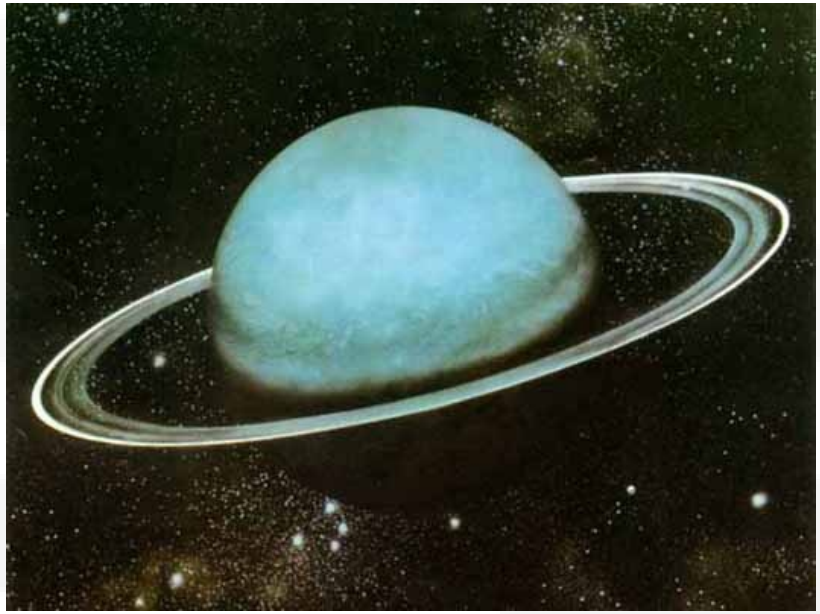
<u>Comprehensive digestive disease centre</u>
Consultations
BRAVO
pH/Impedance
Manometry
CT colonography
Full endoscopy services

MACMURRAY GASTROENTEROLOGY
DIGESTIVE DISEASES & ENDOSCOPY

MACMURRAY
GASTROENTEROLOGY
DIGESTIVE DISEASES & ENDOSCOPY

# Bleeding From Uranus
# Sigmoidoscopy/proctoscopy


Dr Alasdair Patrick
Gastroenterologist
MacMurray Gastroenterology
CMDHB
University of Auckland

# Overview-Fresh PR bleeding

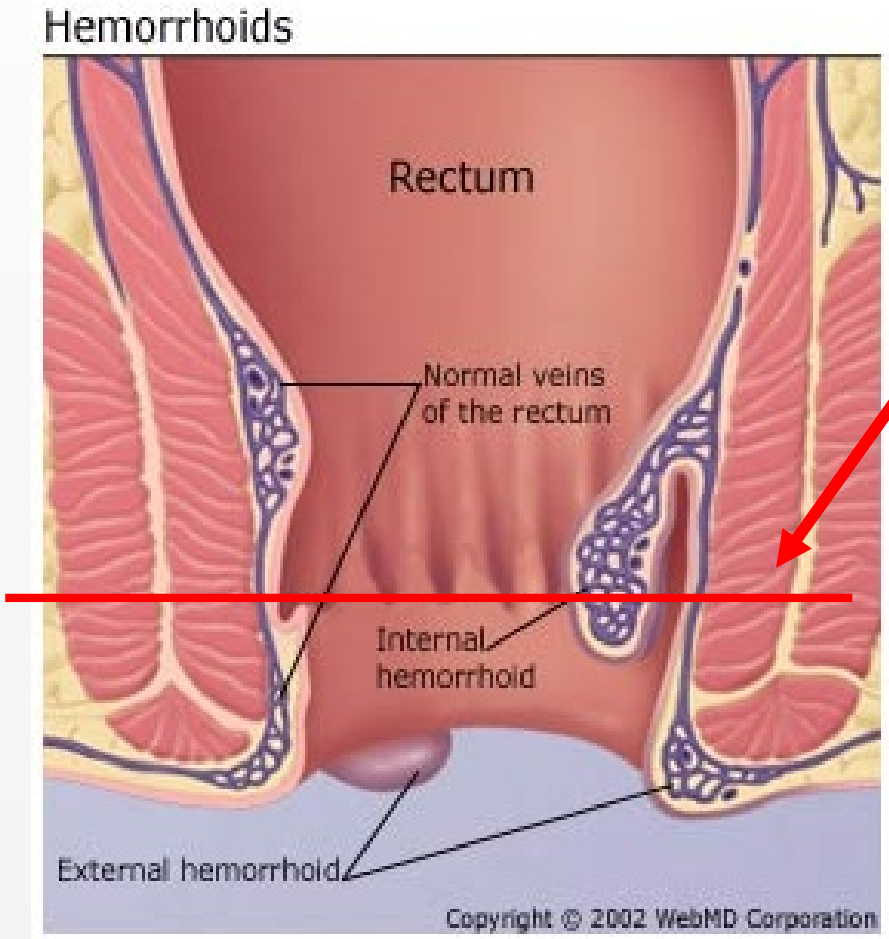
- Hemorrhoids
- Anal fissures
- Solitary rectal ulcer
- Cancer
- Other causes

- Sigmoidoscopy/ proctoscopy
  - ANY VOLUNTEERS?

# Hemorrhoids

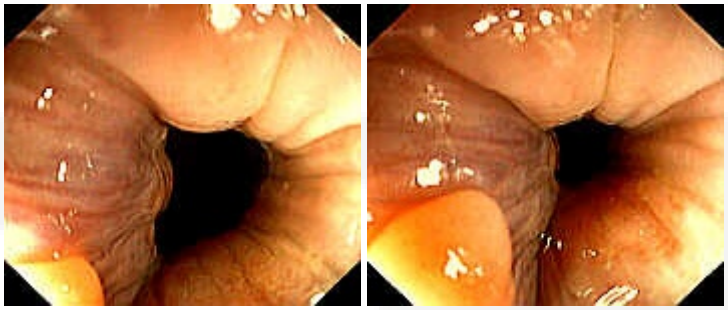
- Normal
  - Connective tissue cushions
  - AV plexus between superior rectal arteries and the superior/inferior/middle rectal veins
- Account for 15-20% of resting anal tone
- Conformable rectal plug
- Provide important sensory information
- Abnormal when enlarged

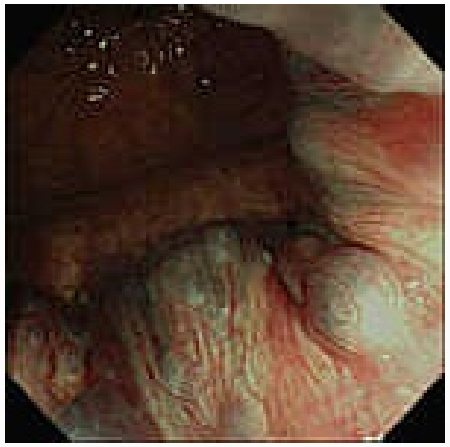
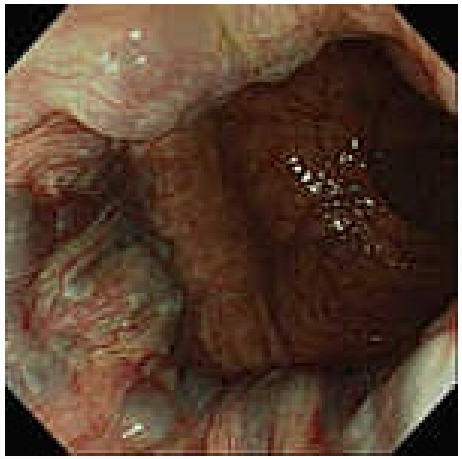
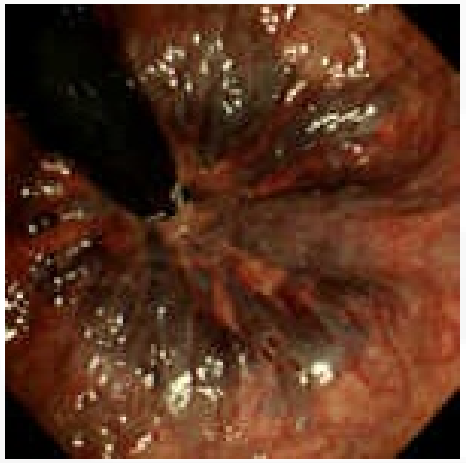
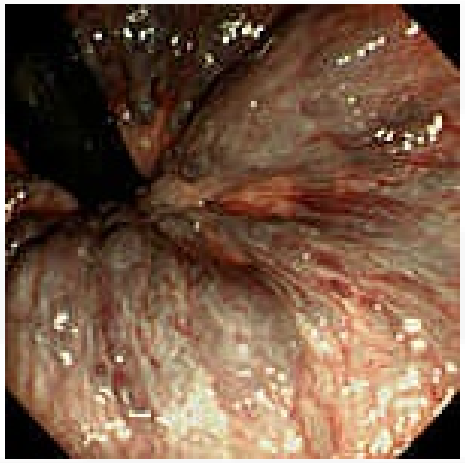
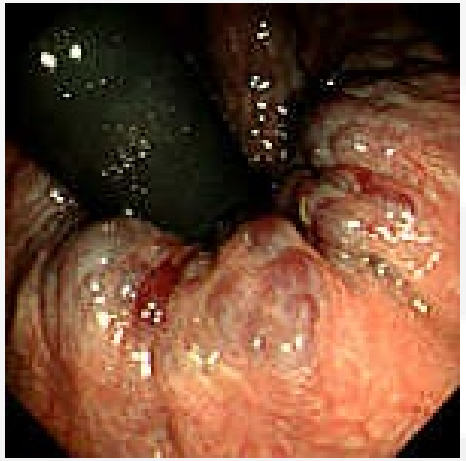
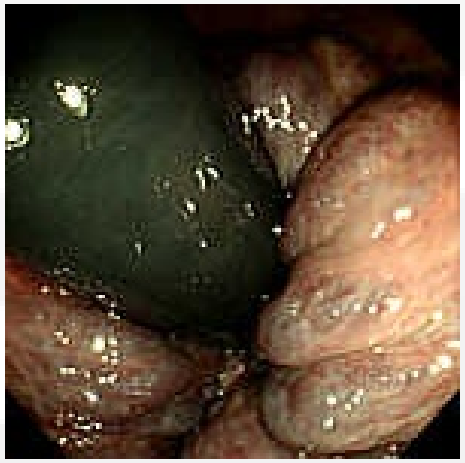
# Hemorrhoids




Internal above the dentate line

External asymptomatic unless become thrombosed



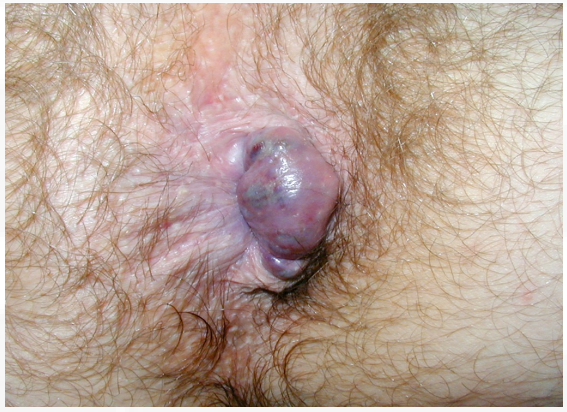







# Hemorrhoids

- First degree
  - Remain internal
- Second degree
  - Prolapse on defecation but reduce spontaneously
- Third degree
  - Require digital replacement
- Fourth degree
  - Remain persistently prolapsed
    - » Banov et al 1985

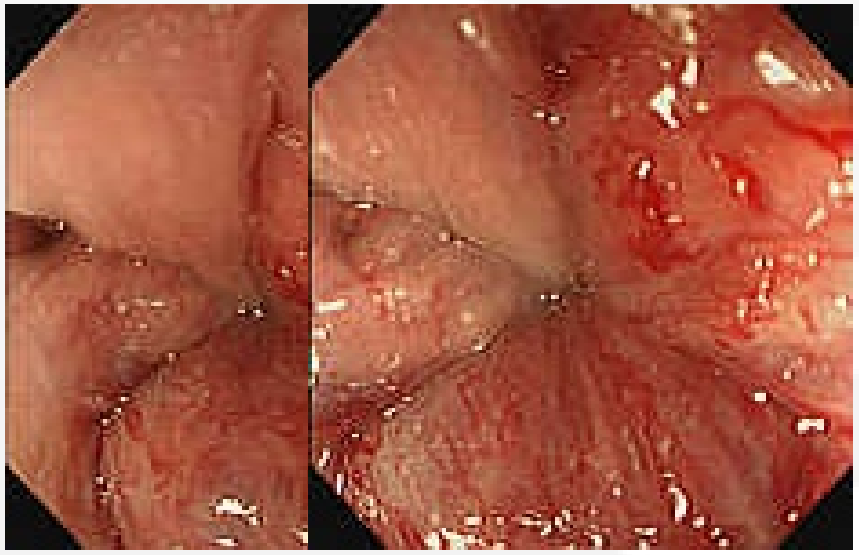
# Hemorrhoids background

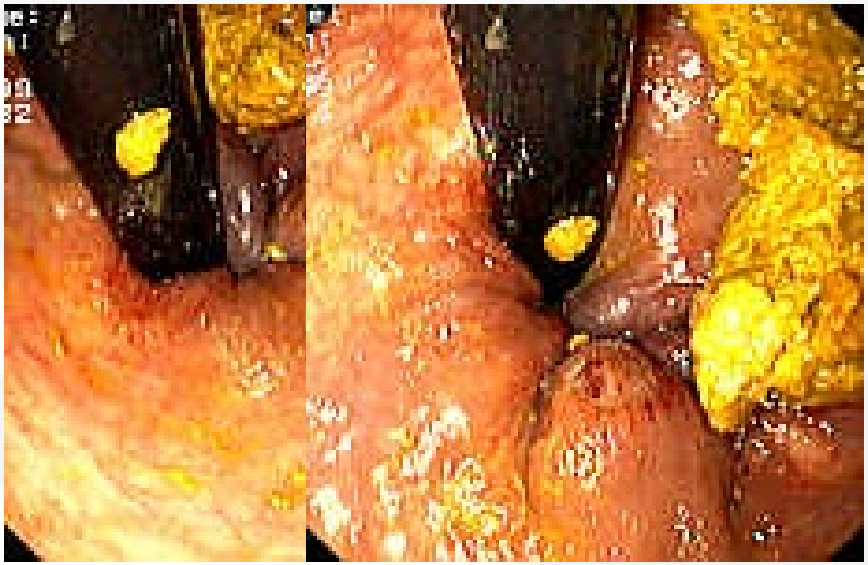
- Majority of patients with anal complaints blame hemorrhoids
  - Ask the patient what they mean!
- Detailed history
  - Color/ character of bleeding
  - Temporal relationship to passing stool
  - Relief/exacerbating factors



# Hemorrhoid symptoms

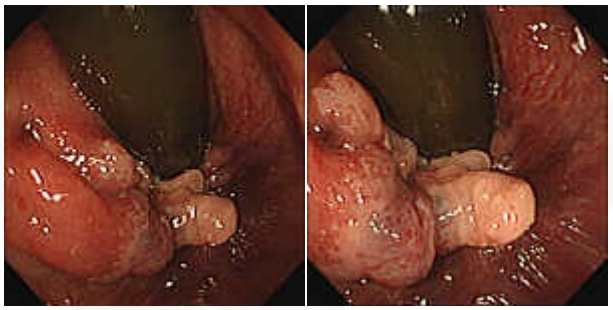
- Bright red bleeding most common
  - Scanty
  - Profuse





# Hemorrhoid symptoms

- Acute painful mass
  - Thrombus formation
  - Pain peak 48-72 hours
- Pruritis
- Soiling
- External hemorrhoids usually do not cause symptoms after thrombosis become skin tags



# Hemorrhoid examination

- General rectal inspection
  - Fistula, fissure, abscess, prolapse
- PR is very important
  - Masses, tenderness, discharge
- If the patient has no findings on PR then a sigmoidoscopy and/or a colonoscopy should be performed

# Hemorrhoid investigations

- FBC
  - Anemia is very rare (1/200,000 cases)
  - Refer for colonoscopy
- Colonoscopy only if there are alarm symptoms
  - Weight loss, strong family history, altered blood, abdominal symptoms, COBH

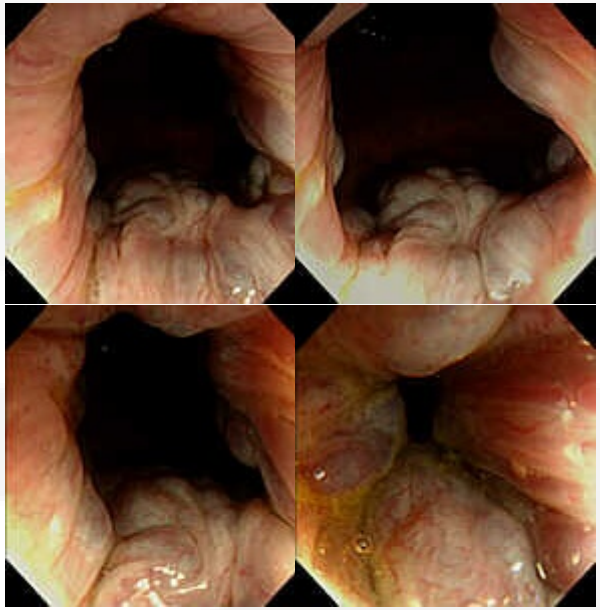
**TABLE 1 Treatment Options for Symptomatic Hemorrhoids**

| | Internal (Grade) | | | | |
|---|---|---|---|---|---|
| Treatment | 1 | 2 | 3 | 4 | External |
| Diet modification | X | | | | |
| Sclerotherapy | X | X | | | |
| Infrared coagulation | X | X | (X) | | |
| Rubber Band Ligation | (X) | X | X | | |
| Surgical hemorrhoidectomy | | (X) | X | X | X |

(X) selected

# Management of Hemorrhoids

- Cornerstone of treatment
  - Adequate intake of fiber and water
  - Add psyllium (Isogel)
    - Aim for soft easy to pass stools
    - >90% effective for pain and bleeding
- Behavioral modification
  - Prevent straining
- Sitz bath
- Warm soaks

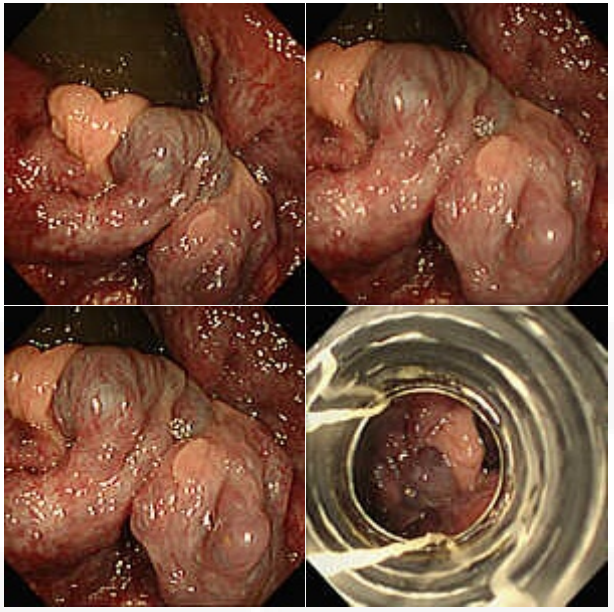


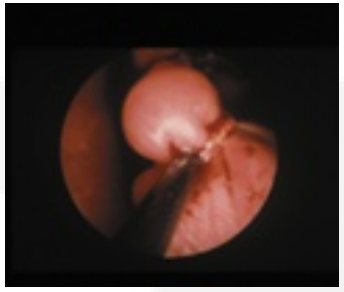
# Management of hemorrhoids

- Topical treatments (little evidence)
  - Rectogesic
    - GTN
  - Xyloproct/Ultraproct/Proctosedyl
    - Anesthetic/ corticosteroid
  - Anusol
    - Zinc/steriod

# Management of hemorrhoids

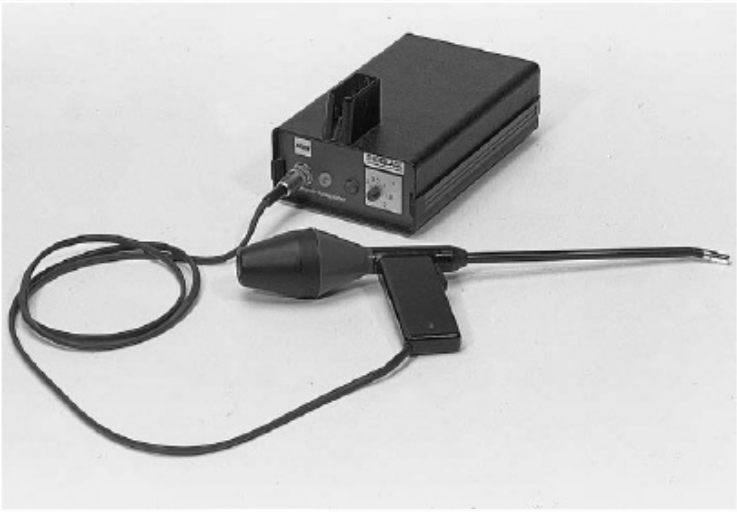
- Rubber band ligation
  - Proctoscope/endoscope
  - Suction
  - 1-2 bands applied
  - At 5-7 days will slough off
  - Morbidity
    - 1% acute pain
    - Sepsis





# Management of hemorrhoids

- Infra-red photocoagulation
  - Short pulse of energy proximal to hemorrhoid
  - 3-4mm protein coagulation
  - Causes minimal pain
  - More sessions



# Management of hemorrhoids

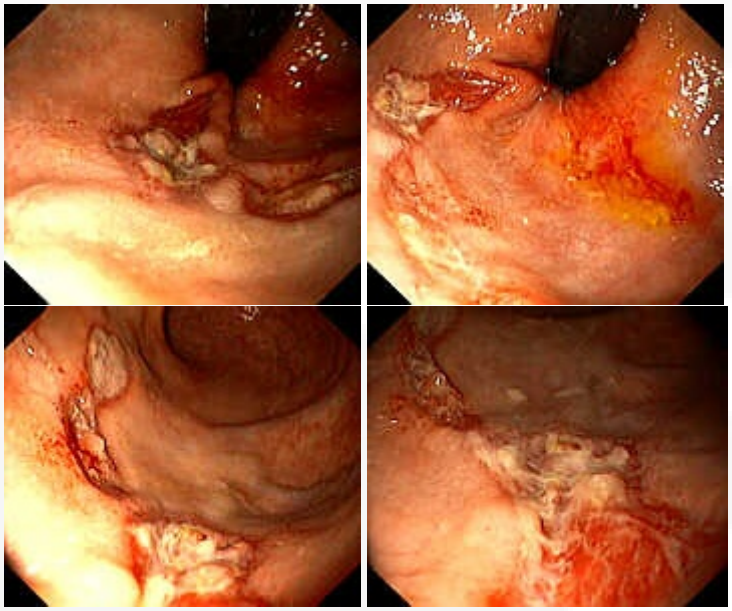
- Sclerotherapy
  - Inject 5% phenol into submucosa of bundle
  - Can cause thrombosis of neighboring one
  - Can cause stricturing
- Electrocautery
  - 24% side effects (pain and bleeding)

# Management of hemorrhoids

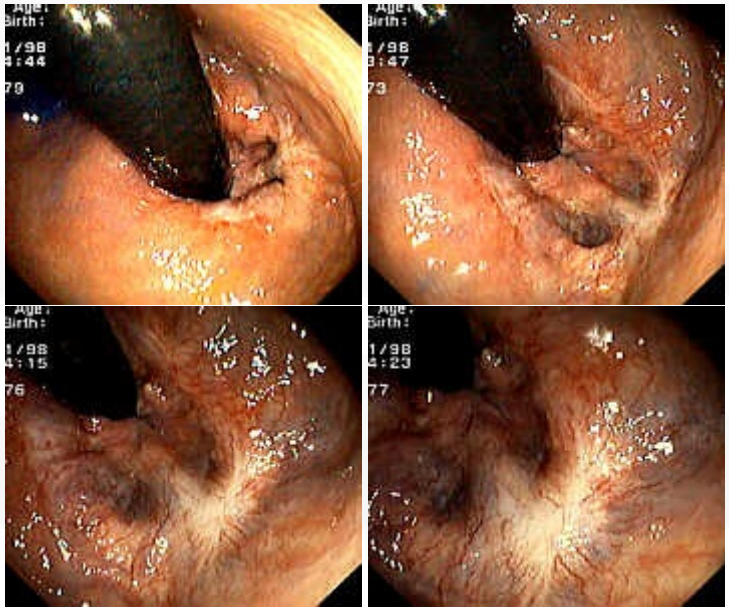
- Complications are rare from treatment
  - Pain
  - Bleeding
  - Stenosis
  - Fissure
  - Incontinence

# Complications

- Ulceration

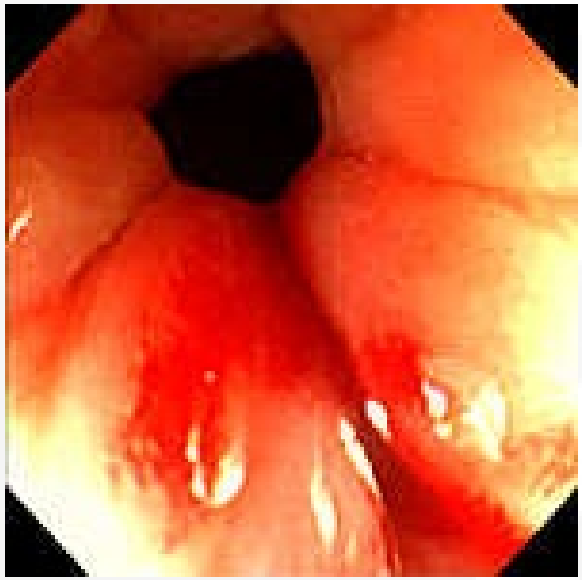


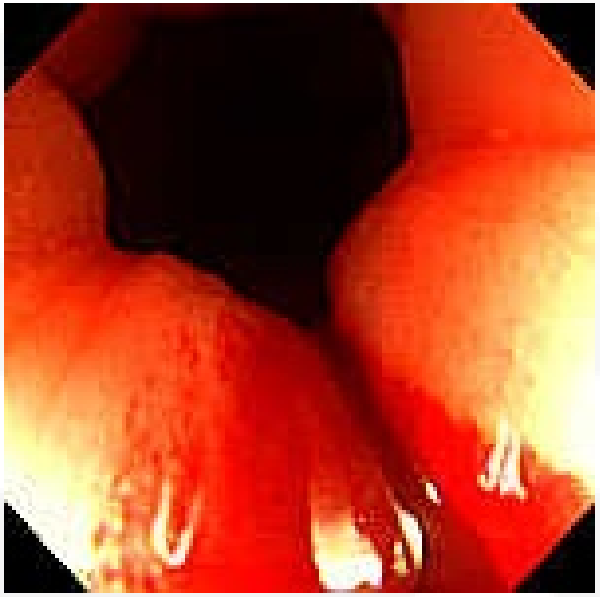
- Scaring



# Acute anal fissure (<6 weeks)

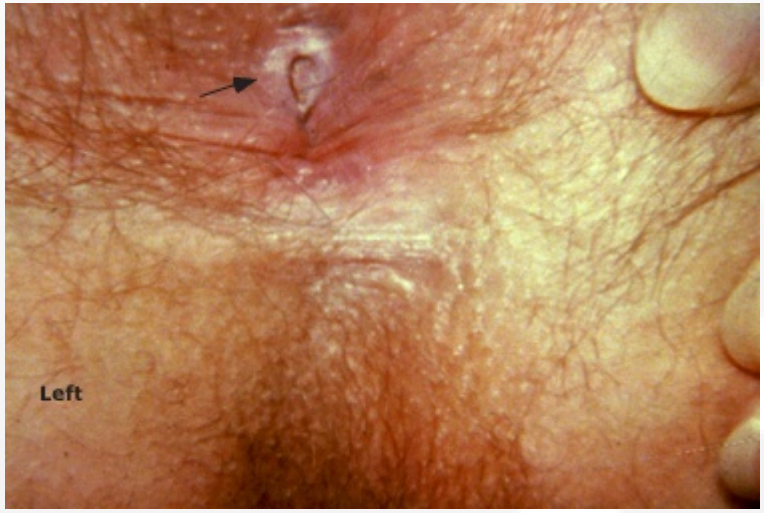
- Disruption of skin at distal anal canal
  - Posterior midline



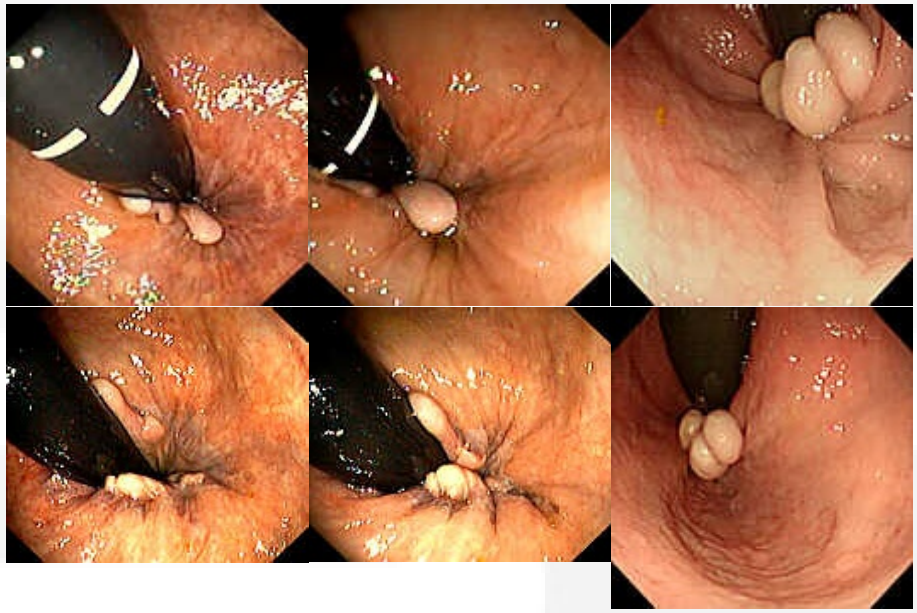


# Chronic anal fissure

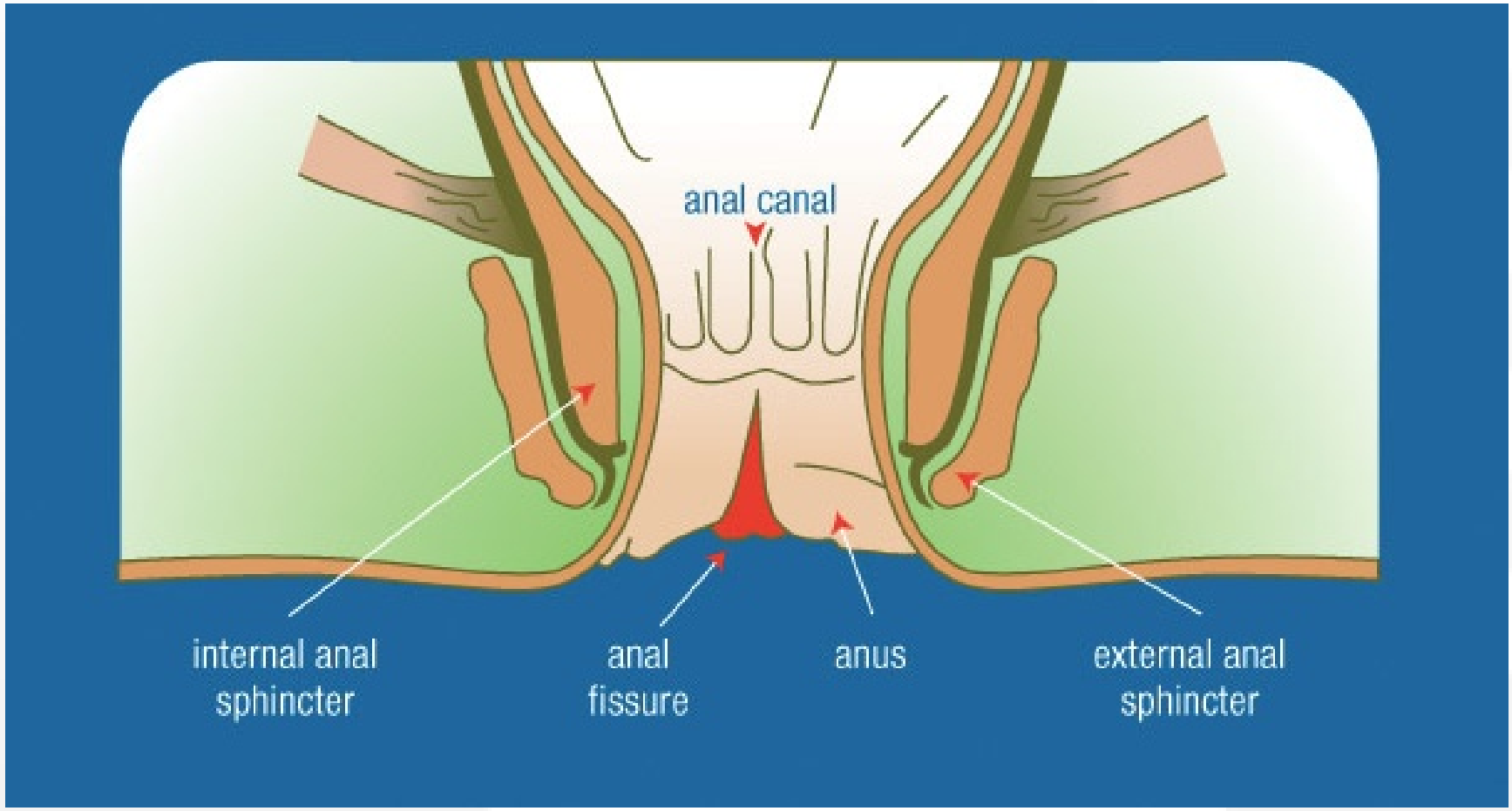
- Thickened skin margins
- IAS fibers visible




- Sentinel skin tag
- Hypertrophied anal papilla in anal canal



# Anal fissure



# Fissure background

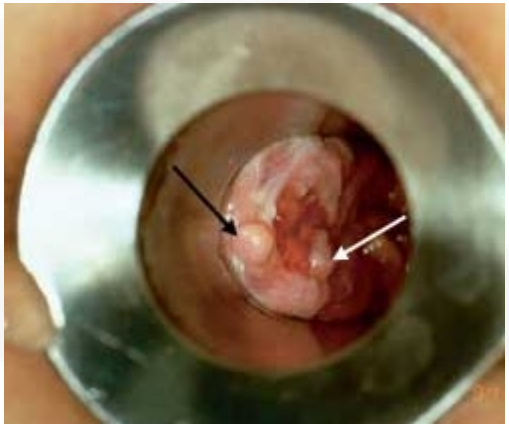
- Patients have a high resting sphincter tone
  - This causes reduced blood flow/ ischemia
- Most frequently in young adults
- If not posterior midline think of other conditions
  - Crohns
  - Anal carcinoma

# Fissure symptoms

- Clinical hallmark
  - Pain during and after defecation
  - Pain can be severe
  - Occasional bleeding

# Fissure examination

- Spread the buttocks
- Look for sentinel skin tag or anal polyp



- High tone and pain on PR
- If diagnosis in doubt refer for EUA

# Fissure management

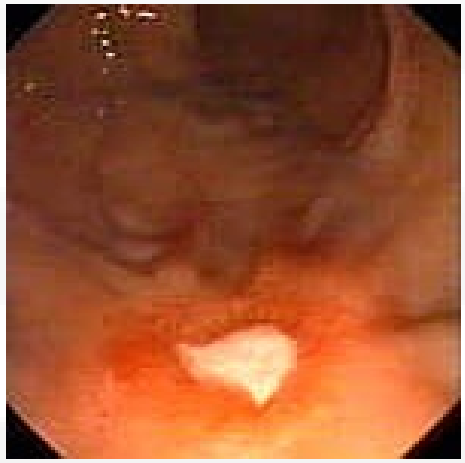
- Up to 90% of acute fissures will heal with conservative care
  - Psyllium, sitz baths, emollient suppository
    - ¼ of these get recurrence in 5 years
- Topical therapy
  - GTN
    - Headache
  - Xyloproct

# Fissure management

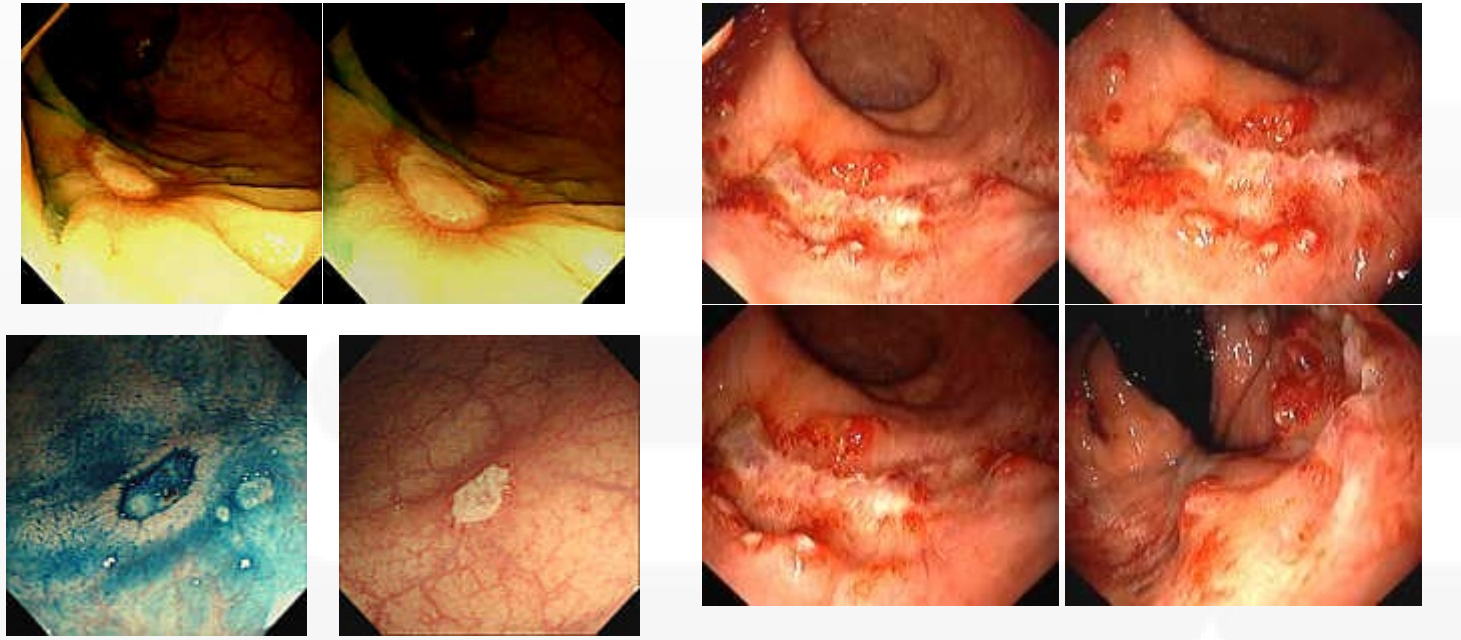
- If not responding to topical therapy
  - Refer
- Botox
  - Effective but recurrence rates uncertain
- Surgery

# Solitary rectal ulcer

- Mean age of presentation 49
- Forceful straining against immobile pelvic floor
- Associated intersussception
- Symptoms
  - Bleeding
  - Passage of mucus
  - Straining
  - Rectal pain



# Solitary rectal ulcer



Diagnosis is by sigmoidoscopy

# Management SRUS

- Diet and fiber modification
- No proof that topical therapy works
- Biofeedback and bowel re-training

# Rectal carcinoma

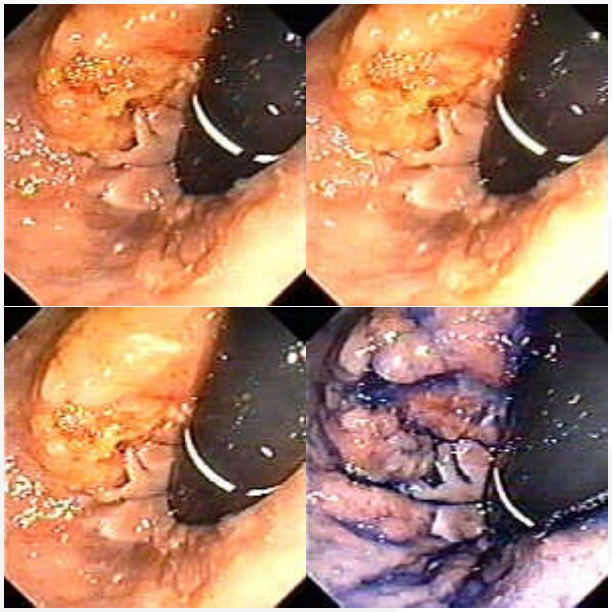
- 1/3 of bowel cancer is in the rectum
  - Incidence peaks in 7$^{th}$ decade
- 75% have no family history
- 98% adenocarcinoma
- SCC can develop in the transition area

# History for rectal cancer

- 60% have PR bleeding
- 43% have change of bowel habit
- 20% have abdominal pain
- Low rectal tumors can cause incomplete evacuation

# Examination for rectal cancer

- Average finger can reach 8cm!



# Other causes

- Diverticular disease
- Angiodysplasia
  - Massive bleeding
- Inflammatory bowel disease

# Take home message
# History and Exam!!

- Bright red blood separate from motion
  - Hemorrhoids or recto-anal cancer
- Associated with pain
  - Anal fissure
- Associated with mucus
  - SRUS (prolapse), large hemorrhoid, cancer
- Bright red blood mixed with stool
  - Polyps, cancer or colitis

# Take home message for PR bleeding

- Examine everybody - PR
  - If you do not stick your finger in it you stick you foot in it


If normal perform sigmoidoscopy and/or refer