INTRODUCTION AND AIM OF WORK

INTRODUCTION

It is interesting to note that all pathological conditions below the Hilton's line are painful but above this line they are painless so long as they remain confined within the rectal wall.

Inflammation or infiltration beyond the rectal wall is likely to be painful.

There are innumerable causes of painful anal conditions, those that are of surgical interest:-

1- Anal fissure.
2- Anorectal suppuration.
3- Fistula-in-ano.
4- Secondary infected or strangulated piles.
5- Carcinoma spreading into pelvic cellular tissues.

Enquire about the nature of pain-whether throbbing (anorectal abscess) or sharp cutting (anal fissure) and its relation to defaecation. Pain is the constant and main symptom of an anal fissure; it starts with the defaecation and persists for some time after the act. In a fistula-in-ano, pain is intermittent. When the fistula becomes closed, pain appears and gradually increases as the discharge accumulates until the fistula is forced open; when the collection is

voided and the pain is greatly relieved. Uncomplicated piles are absolutely painless; but when they are complicated by secondary infection or strangulation, they become painful. Carcinoma of the rectum, it must be remembered, is painless to start with; when pain appears it indicates a spread into the pelvic cellular tissues or sacral plexus (Das, 1981).

A few other conditions presenting with anal pain produce an ulcer or crack in the anal region and obviously require more careful discrimination such as pruritis ani with superficial cracks of the anal skin, ulcerative colitis or proctocolitis with associated anal fissure, Crohn's disease with anal ulceration, adenocarcinoma of the rectum invading the anal canal and anus, syphilitic fissures, tuberculous ulcer occurs in the anal canal and idiopathic stenosis of internal sphincter (Goligher, 1980).

In a certain number of cases with anal pain there may be on examination no evidence of an anal lesion of any kind. The surgeon will then have to consider carefully whether the patient might not have had an anal fissure which has recently healed. A superficial fissure may heal without leaving any traces, but in a case of a chronic fissure, even after healing, there is nearly always some evidence of a previous chronic fissure, in the form of a sentinel tag or a deep radial furrow

in the midline covered with thin skin tightly applied to the lower part of the internal sphincter muscle. Only when all possibility of a fissure or other local organic anal cause for the patient's pain has been firmly excluded should less definite conditions be considered, such as proctalagia, fugax, coccygodynia, rectal crisis of tabes, or frank psychoneurosis (Goligher, 1980).

In this study, stress has been made on the anatomy of the anal canal, physiology of pain and special attention to the painful anal condition of surgical importance including their incidence, aetiological causes, pathological basis clinical pictures, diagnosis and their management.

The aim of work is to diagnose the painful anal conditions with proper management to reduce the complications.