Painful anal conditions

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The most surgical conditions presenting with anal pain are anal fissure, fistulainano, anorectal suppuration, secondary infected or thrombosed piles and carcinoma of the anal canal spreading into pelvic cellular tissues.The anal canal begins above as the continuation of the rectum where it passes through the pelvic diaphragm, it is supported by anal sphincters, anococcygeal body, the perineal body and the pelvic diaphragm.The arterial blood supply of the anal canal is derived from the superior haemorrhoidal, middle haemorrhoidal, infe-rior haemorrhoidal and median sacral artery, with veins acco-mpany the corresponding arteries. The cutaneous sensation below the anal valves is conveyed by the afferent fibres in the inferior haemorrhoidal nerves, and dull sensation in the mucosa above the anal valves is mediated via the parasympa-thetic nerve, lymphatic drainage of the anal canal to the aortic glands, internal iliac glands and inguinal lymphglands.Pain is among the commonest of all symptoms and more presenting symptom for surgeons than it is for other. A pai-nful stimulus causes a sharp localized sensation followed by-119 -a dull, intense, diffuse and unpleasant feeling. Pain sensa-tions are produced by stimulation of the skin only over the spots where the sense organs for these modalities are located.The anal fissure is a crack in the skin lined part of the anal canal commonly in the posterior wall but sometimes in the anterior wall, anal fissure may be acute or chronic. Infection and spesm of the internal sphincter are responsible for chronicity. Both sexes are equally affected, with females having a higher percentage of anterior fissures (10 %) than males (1 %). Pain is the cheif symptompshwp cutting occurs during and after defaecation.The acute superficial fissure usually responds to conservative treatment in the form of local anaesthetic ointments and anal dilatation and avoiding constipation. The chronic fissures need operative treatment includes anal stretch, fissurectomy, posterior sphincterotomy and lateral subcutaneous internal sphincterotomy. Anal stretch is indicatedin superficial fissure with no sentinel tag or hypertrophied anal papillae. Excision of the fissure is indicated in old standing anal fissure with extensive fibrosis or with infective complications.Internal aphincterotomy is indicated in case of anal fissure without complications.Lateral subcutaneous internal sphincterotomy has advantage of a lower percentage of postoperative incontinence, anal fissure with first degree anal piles treated by lateral subcutaneous sphincterotomy and the piles are treated by injections when the fissure has healed. Third degree piles are treated by haemorrhoidectomy and an internal sphincterotomy through one of the haemorrhoid wounds.Anorectal abscesses are common surgical emergency, more common in men. It was suggested that it starts in an abnormal or obstructed anal

glands but Goligher suggested that the infection arises by colonization of blocked apocrine glands. Also from blood-borne infection or chronic diseases. Anorectal abseesses were classified into perianal, ischiorectal, submucons, pelvirectal and atypical type. The acute throbbing pain is the initial symptom may accombanied by a moderate fever.It appear a red, tender, localized swelling close to the anus and on digital examination a tender swelling with indurationmay be felt. The diagnosis is very obvious, but not so easy when the suppurative process has spread from one space to another, thus it may be difficult to differentiate before operation between a pelvirectal abscess with a downward extension into the ischiorectal fossa, and a large primary ischiorectal abscess.No place of antibiotics therapy incision and drainage of anorectal abscess with unroofing of the intersphincteric abscess by an internal sphincterotomy to avoid recurrence and fistula formation,primary suture under systemic antibiotic therapy was used, but this method has not been widely accepted. In the presence of an internal fistulous opening with an abscess, the abscess should be drained in the first instance and the fistulous track is treated at a later stage, the high intermuscular abscess is treated by the method of strangulating ligatures just outlined or by cutting diathermy. The supralevator abscess is treated by preoperative correction of dehydration or ketoacidosis if present and broad spectrum antibiotics and the abscess cavity is explored, curetted, lavaged and packed. The underlying cause of the pelvic infection resulting in the formation of the pelvirectal abscess also need to dealt with.Fistula is an abnormal communication between two epithelial surfaces, anal fistula represents about 10 % with age incidence between 25 - 50 y. More common in male. In most common cases the fistula arises from anorectal abscess which was neglected to burst spontaneously or was in adequately drained. Also may occur on top of specific infections, as a complication of the carcinoma of the rectum or anal canal or may be traumatic, different classification were reported, Parks (1976) classified anal fistulae into: intersphincteric, transsphincteric, supra-sphincteric and extrasphincteric. Usual presentation of the fistula is discharge, pain, pruritis and swelling. Severe pain occur when the fistula is obstructed with the accumulation of pus or in the malignant fistula. Proctoscopy, sigmoidoscopy are important procedures in the diagnosis.Treatment of anal fistula is mainly surgical, to cure the fistula without recurrence and with preservation of continence, this is by laying the fistula track widely open or to excise it completely, which is the widely practised treatment. Immediate skin grafting when successeful gives the patient a completely healed wound in 1 - 2 wks.Cryosurgery may be used in direct low anal fistula. Carbon dioxide laser is a new line of treatment in high anal fistula.Anal fistula may be complicated by abscess formation and multiplication of the fistula, pruritis ani, eczema and Malignant change might occur in long standing cases of anal fistula.Thrombosis of the internal piles is a complication of large prolapsing haemorrhoids which has been regarded as varicosities of the venous plexuses in the wall of the anal canal due to obstruction of the portal circulation or may be idiopathic. It appears as a painful swelling at the anus which appears oedematous, tender with hard areas of thrombosis may be felt.Its course in the majority of cases is spontaneous reso-lution, but may spread with sloughing and ulceration and may extend to the rectal wall and sloughing followed by infection and abscess formation

may occur. The thrombosis may occur in external or subcutaneous haemorrhoidal plexus producing thrombosed external piles or anal haematoma.The patient complains of sudden development of a painful lump at the anus, pain is continuous aggravated by defaecation and sitting, the examination showing bluish coloured swelling at the anal orifice, spontaneous resolution may occur also it may rupture and liable to infection with abscess or fistula formation.The management of prolapsed thrombosed internal haemorrhoids rests between strictly conservative management of the piles and immediate haemorrhoidectomy. While the thrombosed external piles are treated either by expectant treatment, conservative treatment is designed to assist this process or operative treatment including evacuation of the clot with a short incision followed by frequent baths.Rubber band ligation has been shown to treat haemorrhoid symptoms almost as effectively as haemorrhoidectomy and it was concluded that it should be considered as the first line treatment for prolapsing haemorrhoids. Cryotherapy was found to be effective method in dealing with advanced piles. With important advantages of less postoperative haemorrhage, pain or stenosis, while the serous discharge is the principle disadvantage.Haemorrhoid ligation with anorectal bandatomy was used in the advanced piles, the anorectal bandatomy achieves post operative normalization of the rectal neck pressure and does not interfere with continence.Unlike the other haemorrhoid operations, such as band ligation, cryotherapy, infrared coagulation and excision liga-tion, this technique deals with the cause of the haemorrhoiddisease.Malignant disease of the anal canal represents 1.7 - 5 % of all tumours in the anorectal region. The majority are squ-amous cell carcinomas, rarely basaloid cell carcinoma and mal-ignant melanoma, perianal Pagetts disease is a rare condition. Low rectal carcinoma may spread downward invading the analcanal.Squamous anal carcinoma more in women as regard the upper anal canal tumours, those of anal margin more in men with med-ian age between 44 - 58 years. It is classified into 3 stages, that of the anal margin is well differentiated and anal canal tumours are poorly differentiated, there are intermediate types of growth such as basisquamous, mucoepidermoid and transitional cell tumours also known as cloacogenic carcinomas or basaloid carcinomas.The majority of patients presented with pain (78 %) and the carcinoma may present as ulcer, or raised warty growth, the inguinal lymph glands on both sides may be enlarged due to septic absorption or metastases also external iliac glands may be involved in advanced cases. The diagnosis should alw-ays be confirmed by biopsy.The proper course of treatment of a locally advanced lesion by abdominal perineal resection with combined radiation therapy. Supervoltage therapy used for advanced cases and recently introduced method of irradiation with fast neutrons to avoid necrosis and a permanant colostomy. Widespread dis-ease treated by compination of surgery, radiotherapy and che-motherapy. Surgical treatment commonly used at the present day including rectal excision by perineal or abdomino-peri-neal route according to the site and extent of the lesion. When the inguinal lymph nodes are involved treated by radi-otherapy but a block dissection is probably preferable. In the inoperable cases using mainly the radiotherapy with seda-tives and intrathecal phenol or chordotomy may be required. Recently using the pre-operative irradiation combined with chemotherapy is of the great help of the surgical treatment.Basal cell

carcinoma treated by surgical excision and follow up. Malignant melanoma is rare -and not sensitive to radiotherapy and treated by a radical abdominoperineal exci sion followed by bilater block dissection, with very bad prognosis.The adenocarcinoma of the anal region may be confused with an inflammatory conditions and a deep biopsy is impor-tant for its diagnosis.The treatment of the adenocarcinoma as the squamous cell carcinoma of the anal canal but many cases are inope-rable and have to be managed by radiotherapy or symptomatic treatment with bad prognosis in general.