e-ISSN: 0975-1556, p-ISSN:2820-2643

Available online on www.ijpcr.com

International Journal of Pharmaceutical and Clinical Research 2022; 14(8); 742-749

Original Research Article

Prevalence of Patients with Anorectal Diseases Presenting to RIMS Adilabad Hospital

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Received: 25-06-2022 / Revised: 25-07-2022 / Accepted: 24-08-2022
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Conflict of interest: Nil

Abstract

Anorectal disorders result in many visits to healthcare specialists. These disorders include benign conditions such as hemorrhoids to more serious conditions such as malignancy; thus, it is important for the clinician to be familiar with these disorders as well as know how to conduct an appropriate history and physical examination. The patients do not often discuss perianal symptoms leading to late diagnosis and treatment. There is a need of doing systematic questioning and clinical evaluation of the population to assess the prevalence of anorectal disorders. This study was done to find prevalence of patients with Anorectal diseases presenting to RIMS Adilabad hospital. The patients with benign anorectal diseases presenting to surgery department OPD with ages more than 20 years old, both genders were included. All patients were examined by surgeon . 100 patients with anorectal diseases were included in study . Most common presenting complaints were anal pain (85 %) , constipation (70%) and anal itching (60%) .Most common anorectal diseases were Anal Fissure (40%) , Haemorrhoids (25%) , Fistula in Ano (10%).Out of 100 patients with anorectal disease , 58 were given surgical treatment and 42 were managed with conservative treatment. This study may contribute to epidemiological knowledge about the prevalence of anorectal disorders.

Keywords: Anorectal diseases, Benign, Prevalence.

Introduction

Anorectal disorders are one of the most common reluctant disorders and affect about one-fourth of the population [1]. Anorectal disorders are either structural or functional abnormalities of the pelvic floor in patients with symptoms, such as difficulty in defecation, fecal incontinence, rectal bleeding, anorectal pain, and rectal prolapse [2,3]. Anorectal disorders include benign conditions such as haemorrhoids to severe conditions such as anorectal cancers. The most common anorectal disorders are haemorrhoids, anal fissures, anorectal abscesses and fistulae, fecal incontinence and pruritus ani. A careful history taking of presenting symptoms, visual inspections, digital rectal examinations along with relevant tests help in diagnosis of anorectal disorders [4]. Most of the studies have evaluated anorectal disorders based only on

questionnaires and without any clinical examinations of the patients. Thus, the prevalence of anorectal disorders differs from 20% to 40.5% [5-7]. Most of the patients are reluctant to disclose the anorectal problems and do not seek medical attention [8-11]. Furthermore, physicians seldom performed the perianal examination [10]. Anorectal disorders seem to increase progressively and their prevalence in the general population probably tends to be higher than seen in clinical practice. After targeted systematic questioning to the patients, the prevalence of proctological symptoms seems to be increased [10,11]. In conservative society or due to illiteracy, the anorectal disorders are considered as some sort of a divine curse and a matter of disgrace for a person in backward social set up. Due to this, the patient often put up with symptoms for long time, before seeking medical care. These conditions are extremely distressing and embarrassing for the patients and usually these patients put up with their symptoms for long time, before seeking any medical advice or care. Literature has reported that up to 80 % of the population with symptomatic benign anorectal pathologies have not consulted a specialist regarding their issues [12.13]. Statistically, this volume is a huge burden over health services and society too. The commonest factors which make these diseases a phenomenal burden on society comprises of Illiteracy, social taboos, negligence, poverty, maltreatment, self-treatment, mismanaged obstetric events, anal sexual habits and unsupervised surgical interventions [14]. Brief description of the anal canal - The anus is the outlet to the gastrointestinal tract, and the rectum is the lower 10 to 15 cm of the large intestine. The anal canal starts at the anorectal junction and ends at the anal verge. The average length of the anal canal is 4 cm. The midpoint of the anal canal is called the dentate line. This dentate or pectinate line divides the squamous epithelium from the mucosal or columnar epithelium. Four to eight anal glands drain into the crypts of Morgagni at the level of the dentate line. Most rectal abscesses and fistulae originate in these glands. The dentate line also delineates the area where sensory fibers end. Above the dentate line, the rectum is supplied by stretch nerve fibers, and not pain nerve fibers. This allows many surgical procedures to be performed without anesthesia above the dentate line. Conversely, below the dentate line, there is extreme sensitivity, and the perianal area is one of the most sensitive areas of the body. The evacuation of bowel contents depends on action by the muscles of both the involuntary internal sphincter and the voluntary external sphincter.

The presentations of symptoms in patients with anorectal pathologies are mostly typical, but they may be misleading due to the patient's understatement or underplaying of symptoms.

Symptomatology of anorectal pathologies

1. Anal pain
2. Bleeding per rectum
3. Pus discharge from and around anus
4. Prolapse
5. Anal pruritus
6. Presence of swelling or lumps in or around anus
7. Passage of mucus per rectum
8. Constipation or fecal obstruction
9. Frequency of stool
10. Difficulty in passing stool
11. Incontinence to flatus or feces.

A systematic approach to patients with anorectal complaints allows for an accurate and efficient diagnosis of the underlying problem. The process can be divided into the interview, the examination, and conveyance of information. Throughout this process, the patient must be reassured and made as comfortable as possible. The key to diagnosis remains the patient history, with confirmation by visual inspection and anoscopy. Expensive workups are usually not required. Based on the symptoms and possible differential diagnosis, further investigation may be necessary. The most

common anorectal lesions encountered in family practice are- (in the order of frequency)

Common anorectal

- Hemorrhoids [Internal or external]
- Anal fissures [Acute or chronic]
- Anal fistula [Low or high]
- Abscesses [Perianal, ischio-rectal, submucus]
- Polyps [Adenomatous, fibrous anal, juvenile]
- Rectal Prolapse [Mucosal or complete]
- Anal skin tags or sentinel pile
- Anorectal sepsis [Hyderadenitis suppuritiva, AIDS, syphilis]

Investigating a case of anorectal lesion- The patient's history, and inspection and palpation of the anorectum remain the basic, essential features of diagnosis. A successful interaction with the patient leads to a diagnosis and a treatment plan that is acceptable to both the physician and the patient. Anoscopy [proctoscopy] remains the mainstay in the detection of anal pathologies. When a more proximal lesion is suspected, a sigmoidoscopy or colonoscopy along with biopsy is needed. Anorectal physiology and endoanal ultrasonography are also regarded as essential investigative techniques in a colorectal laboratory. Anal manometry and defecography are more advanced investigative tools for colorectal workup. Fistulograms, magnetic resonance imaging, and tomographic scanning are other investigations to be mentioned.

Treatment of anorectal diseases: Family physicians, surgeons , can treat most of the common anorectal disorders they see in general practice. Most cases can be treated by conservative medical treatment (e.g., dietary changes, sitz baths, analgesics, antibiotics, stool softeners, hemorrhoidal creams and suppositories) or nonsurgical procedures. In recent years, great interest has been generated in the field of proctology. The availability of new diagnostic and operating tools and a refinement in technique, coupled with new therapeutic modalities, have contributed to interesting research results in providing relief for patients needing proctological intervention. Anorectal disorders such as haemorrhoids, anal fissures and fistula-in-ano are bothersome benign conditions that warrant special attention. They can all be diagnosed by inspection, digital rectal examination or proctoscopy. Constipation which is one of the most common anorectal symptoms and constitutes about 25% of presenting symptoms in patients consulting for benign anorectal diseases; can play an underlying role in haemorrhoids and anal fissures, and it is important to treat these conditions in order to avoid recurrences. Haemorrhoids and anal fissures are generally initially treated conservatively, and surgery is offered if conservative management fails for 6–8 weeks. This study was done to find prevalence of patients with Anorectal diseases presenting to RIMS Adilabad hospital.

Material and Methods

This observational descriptive study was conducted in the tertiary care setup of Surgery department of RIMS Medical College Hospital from Jan, 2022 to June 2022. Simple random sampling technique was employed to collect the data. The patients with benign anorectal diseases presenting to surgery department OPD with ages more than 20years old, both genders were included. The patients who diagnosed anorectal carcinoma were excluded from study. All patients were examined by surgeon . 100 patients with anorectal diseases were included in study .All necessary investigations were arranged for the diagnosis of these disorders. The frequency and possible causes of adverse outcomes in a large cohort of benign anorectal disease patients were observed carefully and recorded on performa for analysis. Proforma was filled prospectively highlighting patients complain of presentation, the diagnosis and treatment plan . The objective of the study was to

estimate the prevalence of anal fissure, haemorrhoids, fistula-in-ano and perianal abscess among the patients of anorectal ailments visiting the surgical OPD. Observations were made based on inspection findings of the ano rectum and examination of the ano rectal canal comprising of digital rectal examination (DRE) and proctoscopy.

Statistical analysis: Characteristics for categorical variables were expressed as frequencies and percentage.

Results

Table 1 : Age distribution of patients with Anorectal diseases.

Age group in years	Males	Females	Total
20-30 years	03	05	08
31-50 years	40	20	60
51-60 years	10	10	20
>60 years	07	05	12
Total patients	**60**	**40**	**100**

Table 1 shows Age distribution of patients with Anorectal diseases. Out of 100 patients with anorectal diseases 60 were male and 40 females. Maximum patients were in age group between 31- 50 years.

Table 2 : Presenting symptoms of patients .

Presenting symptoms	Percentage of Patients % n = 100 Patients
Rectal bleeding	20 %
Anal pain	85 %
Constipation	70 %
Prolapse	10 %
Anal itching	60 %
Pus discharge	15 %
Sweeling	25 %
Weight loss	12 %

Table 2 shows Presenting symptoms of patients. Most common presenting complaints were anal pain (85 %) , constipation (70%) and anal itching (60%).

Table 3 : Different Anorectal diseases in patients .

Anorectal diseases	Percentage of Patients % n = 100 Patients
Polyps	09 %
Anal Fissure	40 %
Haemorrhoids	25 %
Fistula in Ano	10 %
Perianal Abscess	05 %
Gluteal Abscess	06 %
Rectal prolapsed	05 %

Table 3 shows Different Anorectal diseases in patients . Most common anorectal diseases were Anal Fissure (40%) , Haemorrhoids (25%) , Fistula in Ano (10%).

Table 4 : Treatment of patients

Anorectal diseases	Surgical treatment	Conservative treatment	Total n = 100 Patients
Haemorrhoids	15	10	25
Fistula in Ano	09	01	10
Anal Fissure	15	25	40
Perianal, Gluteal Abscess	10	01	11
Polyps	05	04	09
Others	04	01	05
Total	**58**	**42**	**100**

Table 4 shows Treatment of patients . Out of 100 patients with anorectal disease , 58 were given surgical treatment and 42 were managed with conservative treatment.

Discussion

The benign ano-rectal disorders comprise of a good number of common pathologies having a varied type of clinical presentations. These disorders comprise of a long list of diseases which make up a significant burden of patients reporting in routine clinics, or in emergency room. The literature shows that haemorrhoids, anal fissure, anal fistula, rectal prolapse are among the commonest pathologies reported[15,16]. In our study Out of 100 patients with anorectal diseases 60 were male and 40 females. Maximum patients were in age group between 31- 50 years. Most common presenting complaints were anal pain (85 %) , constipation (70%) and anal itching (60%) . Most common anorectal diseases were Anal Fissure (40%) , Haemorrhoids (25%) , Fistula in Ano (10%). Out of 100 patients with anorectal disease , 58 were given surgical treatment and 42 were managed with conservative treatment.

Sometime these benign disorders concomitantly presented with colorectal malignancy, or as a part of symptom of cancer. So, it important that the clinician should be meticulous and careful in ascribing patients' clinical presentation in the diagnosis of benign anorectal pathology only. Certain anorectal pathologies, such as incontinence, pruritis ani or rectal prolapse, pose a devastating impact on QOL of the patients. Therefore, the precise diagnosis and appropriate treatment strategies, a multidisciplinary approach, along with meeting patients' expectations where appropriate, usually improve the outcomes to the patient [17]. The Quality of life (QOL) is generally assessed or taken care of for individuals and in the modern or developed societies for their well-being. The education and awareness play a crucial role in improving the QOL of a patient with the particular diseas [18]. Literature shows that to define and assess the QOL of a patient is crucial with majority of anorectal disorders before planning a treatment . The Ferrer-Ma´rquez et al [19], in their series of patients with anal fistula has reported that a moderate to high impact is exerted on the QOL of their participants which was higher in female as compared to male. The Owen et al and McKenna et al [20] has also shows a reduction in QOL as compared to the population having no anorectal disorder. However, only few studies indicate that in some patients the anorectal diseases are relatively well tolerated, which they corroborated with the fact that in initial six months of presentation of these symptoms, patients have worst QOL as compared to those having these symptoms for longer duration. [21]

Treatment of anorectal diseases

Anal fissures- Acute anal fissures are superficial and are usually multiple. They

respond well to conservative therapies like warm sitz bath, application of various hemorrhoidal creams, analgesics, and dietary modifications. Proper anal hygiene and correction of chronic constipation or diarrhea are essential to prevent recurrence of fissures. Chronic anal fissures are mostly found on the posterior or anterior midline. They are often associated with pathologies like sentinel tags, anal papillae, fibrous polyps or hemorrhoids. Therapies useful for acute fissures may only provide short-term relief in such chronic forms. In addition, they need some sort of internal sphincter manipulation. Such manipulation may be either surgical or nonsurgical.

Medical treatment of hemorrhoids- Although not constituting an etiological treatment of the disease, conservative treatment does have a role in relieving the symptoms of hemorrhoids and associated complaints .

Medical treatment of hemorrhoids

- Control of constipation using bran, mucilage, lactulose or bulk forming laxatives
- Increasing daily intake of fiber
- Avoidance of colonic stimulants like coffee, tea and spices
- Use of flavonoid derivatives [Diosmin] and calcium dobisilate
- Use of hemorrhoidal creams, ointments and suppositories o Use of anti-pruritics o Adequate local hygiene

Treatment of anal fistula- Patients with fistulas are generally referred to a specialist for treatment. In addition to simple fistulotomy, treatments include cutting or draining setons, endo-anal mucosal advancement flaps, sliding cutaneous advancement flaps, fistulectomy with muscle repair and fibrin glue injection.

Treatment of rectal prolapse- Rectal prolapse may be mucosal or full thickness [procedentia]. In mucosal prolapse, there is a complete eversion of the anal mucosa. On the other hand, rectal prolapse is a full-thickness evagination of the rectal wall outside the anal opening. Treatment in both situations is through surgical intervention. Various abdominal and perineal procedures are in vogue and the choice of procedure depends on factors like the age of the patient and the presentation of the disease.

Treatment of rectal polyps- The commonest type is the adenomatous polyp, which may be scattered throughout the colon. A complete colonic evaluation is mandatory to determine the extension of the pathology. These polyps may well be a precursor to malignancy. Occasionally, fibrous anal polyps may be found in association with anal fissures or hemorrhoids. These also have to be removed.

Treatment of malignancies of the rectum and anal canal- Cancer of the anorectum can manifest itself in many different symptoms or may be found incidentally during rectal examination. Pain in the early stages is usually absent, and the pathology may generally be considered to be and treated as ‘piles’ because of intermittent bleeding per the rectum. An external or internal mass may be palpable. Anal cancer can present as an ulcer, as a polyp, or as a verrucous growth. Most anal cancers respond well to treatment with combined chemotherapy and pelvic radiation.

Treatment of Constipation- This is a symptom that is not measurable scientifically. It has more emotional components than physical ones and should therefore be dealt with in a holistic manner. Daily dietary fiber intake should be increased and bulking agents like ispaghula [psyllium], methyl cellulose, bran, karaya gum, and similar preparations that are useful in facilitation of the defecatory process should be prescribed. Lactulose, sorbitol, and lactilol have minimal known side effects and are considered safe in pregnancy and for children. They may also be prescribed for elderly patients. Senna, bisacodyl, sodium picosulfate, and magnesium salts should be used with

caution as they can cause symptoms like bloating, colicky pain, and purging. Low doses of polyethylene glycol and sodium phosphate may be used for intermittent lavage of the bowel. Drugs like cisapride, mosapride, itiopride, and docusates are known to improve intestinal motility and may be prescribed for a prescribed duration. Liquid paraffin is perhaps one of the most widely consumed oral laxatives.

Conclusion

In this study out of 100 patients with anorectal diseases 60 were male and 40 females. Maximum patients were in age group between 31- 50 years. Most common presenting complaints were anal pain (85 %) , constipation (70%) and anal itching (60%) .Most common anorectal diseases were Anal Fissure (40%) , Haemorrhoids (25%) , Fistula in Ano (10%).Out of 100 patients with anorectal disease , 58 were given surgical treatment and 42 were managed with conservative treatment. It is recommended that a great deal of public education is requisite to create perception about anorectal disorders and their proper management with modern ephemeral, remedial and patient friendly surgical options.

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