Diagnosis in the rectal clinic

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MANY general practitioners are clinical assistants in hospitals and gain special experience in some branch of medicine, and some of them could, through the pages of this *Journal*, share with their fellow general practitioners useful information drawn from such experience. For example, this article on the diagnosis of common diseases of the anus and rectum is based largely on experience as a clinical assistant in a rectal clinic, and on the study of the case records of the patients seen over a five-year period by the consultant surgeon and myself. First I shall outline the important points in taking the history and the technique of examination, and I shall then describe the clinical picture of ten common rectal conditions, hoping that colleagues may find some points of interest.

Taking the history

When a patient has described his main symptom we run through a check-list of nine symptoms, namely:

1. *Bleeding*

(*a*) The amount; eg, whether it is only traces on the toilet paper or whether there is enough to run into the pan.

(*b*) The colour; the passage of bright red blood on defaecation only is unlikely to be due to a carcinoma, whereas the passage of pink or dark blood, not only with faeces but also with flatus, is an ominous symptom.

(*c*) Occasionally a patient feels the call to defaecate and is surprised at passing a large volume of blood on one occasion only. This is almost diagnostic of diverticulosis.

(*d*) Rarely, women confuse rectal bleeding with either vaginal bleeding or haematuria.

2. *Pain*

(*a*) In the anus at defaecation suggests the diagnosis of an anal fissure.

(*b*) In the rectum in acute spasms, especially at night, suggests proctalgia fugax.

(*c*) In the abdomen of a griping nature may be due to carcinoma, diverticulosis or an irritable colon.

3. *A lump*

(*a*) Constantly present at the anus may be an anal haematoma, a skin tag, a sentinel pile, or third degree internal haemorrhoids.

(*b*) Appearing on defaecation indicates second degree internal haemorrhoids, an anal polyp or a minor rectal prolapse.

4. *A discharge*

(*a*) Of mucus may be due to carcinoma, procto-colitis, villous papilloma (sometimes considerable), or protruding internal haemorrhoids or rectal prolapse.

(*b*) Of pus from an abscess or anal fistula.

5. *Pruritus*

6. *Movements of the bowels*

When the complaint is of diarrhoea it is worth enquiring carefully whether its onset

followed a course of an antibiotic. Morning diarrhoea, true not spurious, and without other symptoms is unlikely to be due to organic disease.

7. *The general health*
8. *The weight*
9. *The previous history*

The examination

On examination the general condition is assessed and it is noted whether the patient appears to be anaemic. The abdomen is examined carefully, and also enlargement of the inguinal nodes is sought, but rarely found. Inspection of the perineum with a good light from an Anglepoise lamp is valuable, and may reveal a pilonidal sinus, the external opening of an anal fistula, anal warts, condylomata lata, excoriation of the skin associated with pruritus ani, flexural eczema, psoriasis, an anal haematoma, skin tags, a sentinel pile, an anal carcinoma, or third degree internal haemorrhoids. If the patient can be persuaded to bear down strongly second degree internal haemorrhoids, a rectal prolapse or an anal polyp may appear. It is not sufficiently appreciated that an anal fissure is often hidden from view in the anal canal and will be missed unless the anal margins are separated very firmly by fingers which are placed on either side of the midline, first posterior and then anterior to the anus. Gauze swabs or tissues may be needed to enable the gloved fingers to get a sufficient purchase on the skin.

Digital examination of the rectum is painful, and unnecessary, in the diagnosis of anal fissure. In rectal prolapse the anal sphincter often feels weak. Internal haemorrhoids are not palpable unless thrombosed or fibrosed. An anal polyp may be difficult to identify, but an anal stricture is obvious. There may be induration on one side of the rectum around an anal fistula, and with counter-pressure from a thumb on the perineum a bead of pus may be expressed from its external opening. The prostate or cervix uteri should be felt carefully to distinguish them from rectal growths, and to note any abnormality of these organs which could be confused with rectal disease. A faecal lump may be mistaken for carcinoma of the rectum, but can be indented and moved. After feeling an ulcerated carcinoma one would expect to find a little pink blood on the examining glove finger. It is important to feel as high as possible with the finger and it may help to bring a growth within reach if the patient is asked to bear down. Not uncommonly an ominously hard mass felt per rectum is not in the rectum itself but in the recto-uterine or rectovesical pouch, in which case the rectal mucosa is movable over the mass and blood is not found on the glove finger. Such a mass may be in the sigmoid colon, eg, due to diverticulitis or carcinoma, or of gynaecological origin, eg, a retroverted corpus uteri or calcified fibroid, and in these latter cases vaginal examination may establish the diagnosis.

Proctoscopy is of most value in the diagnosis of internal haemorrhoids, as in patients with thick buttocks only the upper anal canal can be seen. The presence of dark blood in the lumen of the bowel is suggestive of carcinoma but may be due to proctitis, in which case the mucosa is reddened. The finding of a lot of clear mucus is almost diagnostic of a villous papilloma.

Sigmoidoscopy is of great importance in the diagnosis of carcinoma in the upper part of the rectum and lower sigmoid, especially in the dangerous gap between the highest level which the finger can reach and the lowest level which the barium enema is likely to outline. Inflammation of the bowel may be found confined to the rectum, in which case normal mucosa is reached above the level of the proctitis, or it may continue into the colon as procto-colitis. Melanosis coli is observed in those who habitually take anthracene purgatives.

The barium enema examination (using special techniques if necessary) is most valu-

able in the diagnosis of growths of the upper rectum and colon, and in diverticulosis, irritable colon, colitis, Crohn's disease of the colon, and ischaemic colitis.

The clinical features of ten common diseases as seen in the rectal clinic

1. *Internal haemorrhoids.* (The notes of the first 100 patients were studied.)

Patients usually presented in middle-age though many gave a long history. The cardinal symptom was bleeding, which was considerable in about a sixth. Two thirds admitted to some prolapse of the haemorrhoids, half to pruritus, a third to some pain or discomfort at the anus, a third to some discharge especially when the haemorrhoids were prolapsed, and a sixth to constipation. On examination very few patients appeared anaemic. The haemorrhoids were prolapsed in a sixth of patients and appeared on straining in another two fifths. First degree haemorrhoids were diagnosed by proctoscopy.

2. *Anal haematoma,* syn. acute external haemorrhoid. (9 patients).

These were usually seen in men, over a wide age range. They gave a short history of a painful lump at the anus often with some bleeding, and on inspection of the anus the diagnosis was obvious.

3. *Anal fissure.* (125 patients).

The incidence was equal in the two sexes, and the condition was seen at all ages. The main symptom was pain (sometimes severe) or soreness on defaecation and persisting for a variable time afterwards. Rarely there was an associated abscess causing exquisite pain and preventing sleep. Four fifths of the patients admitted to rectal bleeding which was usually slight. The probable diagnosis was often made on the history alone. On examination the fissures were in or near the mid line and placed posteriorly five times as commonly as anteriorly. Sometimes there was a sentinel pile and sometimes the fissure was easily seen. Occasionally, as described above, firmness and perseverance were needed to expose the fissure.

4. *Anal fistula.* (19 patients).

Most of the patients were middle-aged men, many giving a history of years of rectal trouble. Their chief symptom was the discharge of pus or blood on to their underwear, sometimes after one, or several abscesses had burst, or had been opened. Careful inspection in a good light usually revealed the external opening and sometimes a probe was useful. A few were associated with skin tags or anal fissures. On rectal examination induration around the fistula, or the internal opening, could sometimes be felt, or a bead of pus could be expressed from the external opening.

5. *Pruritus ani.* (47 patients).

Most of the patients were middle-aged men. As well as the itching, nearly two thirds of the patients admitted to bleeding, which in half of these was negligible or clearly due to scratching, and in most of the other half was attributable to first degree internal haemorrhoids. About half the patients felt some discomfort, or soreness or pain, and about half admitted to some discharge. Inspection of the anus nearly always showed redness or excoriation of the peri-anal skin.

6. *Anal polyp.* (28 patients).

Of these patients two thirds were men, mostly over 50-years old. Some polyps were found incidentally, whereas others presented with either a prolapsing lump or bleeding. A few were constantly outside the anus.

7. *Carcinoma of the rectum.* (42 patients).

In this small series none of the patients was under 50 years of age. The commonest

symptoms were bleeding (four fifths), soreness or discomfort, pain or tenesmus (a half), diarrhoea (a half), slight abdominal pain (a half), or an anal discharge (a quarter). Particularly ominous was the history of going frequently to empty the bowels but often only passing 'wind and water'. The general health and weight were usually unaffected. On examination of the abdomen the descending colon was palpable in one sixth of patients and a few had a suprapubic mass. Nearly all the growths were felt on rectal examination and at sigmoidoscopy a routine biopsy was taken.

8. *Proctitis.* (19 patients).

This fairly common condition is insufficiently often recognized. Two thirds of the patients were women, of widely scattered ages. Nearly all noticed rectal bleeding, but two thirds also admitted to passing mucus, and one third moved their bowels more frequently than normal. These patients were usually thought to have internal haemorrhoids, though in some elderly patients the history was suggestive of carcinoma. After rectal examination there was blood and mucus on the glove in one fifth of the patients. Endoscopy revealed dark sticky blood and redness of the mucosa extending to perhaps 5–8 cms, with normal mucosa above this level.

9. *Pilonidal sinus.* (10 patients).

Because of their proximity to the anus these lesions are sometimes seen in the rectal clinic. The sex incidence was equal, and all the patients were between 20 and 50 years of age. The history was similar to that of an anal fistula with pain and tenderness and sometimes a lump in the perineum followed by a discharge of pus. On inspection the pilonidal sinus was in the mid line behind the anus, but secondary sinuses were not median and rarely were far enough forward to be confused with an anal fistula.

10. *Rectal prolapse.* (12 patients).

These were nearly all in middle-aged or old women. The size of the prolapse varied from about an inch in length to the size of a grapefruit. In some patients the rectum prolapsed at varying intervals, especially on defaecation or exertion. In others prolapse was constant and made life miserable because of the leakage of faeces, mucus and blood.

The diagnosis of rectal conditions by the general practitioner

In the general practitioner's surgery a full history of a rectal condition can be taken and by the time enquiry has been made about bleeding, pain, a lump, discharge, pruritus, bowel movements, the general health, the weight and the previous history of the patient, the diagnostic field has been considerably narrowed. By careful, systematic clinical examination the general practitioner is in a position to establish the diagnosis of diseases of the anus and lower rectum such as those outlined above. The possibility of coincident internal haemorrhoids and carcinoma is always in his mind when middle-aged or elderly patients complain of rectal bleeding.

When the rectal condition is beyond the reach of his finger the general practitioner has reached his diagnostic limit, unless he uses a sigmoidoscope and can arrange a barium enema examination.