Clinical features

Clinical features

Although superficial, acute anal fissures are characterised by severe anal pain during defecation (‘passing glass’ or ‘a knife cutting’), which usually resolves only to recur at the next evac uation. Frequently a trace of fresh blood is noticed on tissue paper after wiping. Chronic fissures are characterised by a hypertrophied anal papilla internally and a sentinel tag exter nally (both consequent on repeated healing and breakdown), between which lies an indurated anal ulcer that exposes fibres of the internal sphincter. Patients may also complain of itching secondary to ir ritation from the sentinel tag, discharge from the ulcer or discharge from an associated intersphincteric fistula, which has arisen through infection penetrating via the fissure base. Although most su ff erers are young adults, the condition can a ff ect any age, from infants to the elderly . A fissure that is not midline or one with atypical features should raise the suspicion of a specific aetiology . The inability to be able to conduct an adequate examination in the clinic should prompt early examination under anaesthesia, with biopsy and culture to exclude Crohn’s disease, tuberculosis, sexually transmitted or human immunodeficiency virus (HIV)-related ulcers (syph ilis, Chlamydia , chancroid, lymphogranuloma venereum, HSV , cytomegalovirus, Kaposi’s sarcoma, B-cell lymphoma) and SCC. Clinical features

Bleeding is the earliest symptom. The nature of the bleeding is characteristically separate from the motion and is seen either on the paper on wiping or as a fresh splash in the pan. The bleeding is rarely su ffi cient to cause anaemia and other causes should be excluded. The bleeding is usually painless, although Pain should alert to the possibility of another diagnosis (e.g. anal fissure). Internal haemorrhoids associated with bleeding fi rst-degree haemorrhoids. Patients may alone are called complain of lumps (‘piles’) that appear at the anal orifice during defecation and that return spontaneously afterwards (second-degree haemorrhoids), that have to be replaced manually (third-degree haemorrhoids) (Figure 80.20) or that lie permanently outside (fourth-degree haemorrhoids). By this stage there is often a significant cutaneous component to the haemorrhoidal prolapse, termed ‘ mixed ’ haemor - rhoids, which may be best considered as external extensions of internal haemorrhoids that arise through repeated congestion and oedema. Summary box 80.5 Haemorrhoids: clinical features /uni25CF /uni25CF /uni25CF /uni25CF = Summary box 80.6 - Four degrees of haemorrhoids - /uni25CF /uni25CF - /uni25CF /uni25CF - Summary box 80.7 Complications of haemorrhoids /uni25CF /uni25CF /uni25CF /uni25CF

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Haemorrhoids (‘piles’) are symptomatic enlargements of anal cushions More common when intra-abdominal pressure is raised, e.g. constipation and pregnancy Classically occur in the 3, 7 and 11 o’clock positions with the patient in the lithotomy position Symptoms: bright-red, painless bleeding, pruritus, mucus discharge, prolapse First degree – bleed only, no prolapse Second degree – prolapse but reduce spontaneously Third degree – prolapse but have to be manually reduced Fourth degree – permanently prolapsed Strangulation and thrombosis Ulceration Gangrene Portal

pyaemia

Clinical features

Increasing di ffi culty in defecation is the leading symptom. The patient finds that increasingly large doses of aperients are required and, if the stools are formed, they are ‘pipe-stem’ in shape. In cases of inflammatory stricture, tenesmus, bleeding and the passage of mucopus are superadded. Sometimes the patient comes under observation only when subacute or acute intestinal obstruction has supervened.

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