Presentation

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A perianal abscess, confined by the terminal extensions of the longitudinal muscle, is usually associated with a short (2–3 day) history of increasingly severe, well-localised pain and a palpable tender lump at the anal margin. Examination reveals an indurated hot, tender perianal swelling. Patients with infection in the larger fatty-filled ischiorectal space, in which Caspar Bartholin (Secundus), 1655–1709, Professor of Medicine, Anatomy and Physics, Copenhagen, Denmark, described these glands in 1677. William Cowper , 1666–1709, surgeon, London, UK, described these glands in 1697. - - - tissue tension is much lower, usually present later, with less well-localised symptoms but more constitutional upset and fever. On examination, the a ff ected buttock is di ff usely swollen with widespread induration and deep tenderness. If sepsis is higher, - deep rectal pain, fever and sometimes disturbed micturition may be the only features, with nothing evident on external examination but tender supralevator induration palpable on digital examination above the anorectal junction.

5 Figure 80.27 Coronal section of pelvis showing the anatomy relevant to anorectal infection and sites of 4 abscess formation. 1, Levator ani muscle; 2, super /f_i cial perineal fascia; 3, super /f_i cial perianal space; 4, ischi

orectal space; 5, supralevator space. 3 C A, Intersphincteric; B, ischiorectal; C, /uni00A0 super /f_i cial perianal; D, supralevator; E, submucosal. Figure 80.28 Axial magnetic resonance imaging scan (short tau inver

sion recovery [STIR] sequence) showing posterior horseshoe spread of sepsis within the intersphincteric space (arrow).

Presentation

Patients usually complain of intermittent purulent discharge (which may be bloody) and discomfort, which increases until temporary relief occurs when the pus discharges. There is often a history of anorectal sepsis. The passage of flatus or faeces through the external opening is suggestive of a rectal rather than an anal internal opening. - - xperi - - -

Intersphincteric Supra-sphincteric Trans-sphincteric low Extra-sphincteric Trans-sphincteric high Figure 80.29 Coronal section of pelvis showing Parks' classi /f_i cation of anal /f_i stula tracts.

Presentation

The condition is not seen before puberty and rarely presents after the fourth decade of life. Overall, it is three times more common in women than in men, although anogenital disease is more common in men. Obesity is a common association. When a ff ecting the perineum, lesions begin as multiple raised boils, with recurrent lesions within the same vicinity leading to sinus tract formation, bridged scarring and multiple points of discharge. Rarely , it may involve the anal canal anoderm, but it does not extend above the dentate line or involve the sphincter muscle.

Figure 80.39 Preoperative image (a) of a giant condyloma acuminatum (Buschke–Löwenstein tumour) with sagittal T2-weighted magnetic res onance imaging (b) demonstrating the large exophytic frond-like mass protruding from the anal verge. Bilateral inferior gluteal artery perforator (I-GAP) /f_l ap reconstruction following perineal resection (c) (courtesy of Mr Anthony Antoniou,

Consultant Colorectal Surgeon, St Mark’s Hospital, London, UK).

Presentation

Many are asymptomatic but pruritus, discharge, bleeding and pain are usual presenting complaints. In the early stages, examination reveals separate pinkish-white warts close to the anal margin and also often on the anoderm within the distal anal canal. Later, the warts enlarge, coalesce and carpet the skin. Rarely , relentless growth results in giant condylomata (Buschke–Löwenstein tumour), which may obliterate the anal orifice (Figure 80.39). The diagnosis is aided by aceto-whitening on application of acetic acid but confirmed by biopsy , which will also indicate the presence or absence of dysplasia. Presentation

Around 10% of AIN lesions are diagnosed by the pathologist after excision of abnormal skin lesions. Low-grade lesions may be raised and similar to anal condylomata; however, high-grade AIN /uni00A0 III lesions may be characterised by hyperkeratosis or by changes in the pigmentation of the epithelium, so this may appear white, red or brown with the pigmentation commonly being irregular. The lesions may be flat or raised, but ulceration is suggestive of invasive disease. It is important that any suspi cious areas are biopsied and examined histologically . Patients’ symptoms include pruritus, pain, bleeding and discharge. AIN is present in 28–35% of excised anal warts. Approximately 10% of AIN /uni00A0 III lesions will progr ess to anal carcinoma at 5 years. Regression of AIN /uni00A0 III rarely occurs, but AIN /uni00A0 I and AIN /uni00A0 II may regress. The association between AIN /uni00A0 III and carcinoma is strengthened by the findings of AIN /uni00A0 III in 80% of anal cancer biopsies.

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