This paper represents the summary of the ano-rectal pathology in patients who have special conditions or are in certain age. Author offers his experience in handling the proctological entities in children, elderly, pregnant women, and patients with haemorrhoids who have inflammatory bowel conditions, malignancy or are HIV positive. These patients require special approach and are not seen every day in proctological ambulances, what rises many questions in the appropriateness of standard treatments.

Key words: anorectal, proctology, haemorrhoids, children, elderly, pregnant, UC, Mb Crohn, HIV

INTRODUCTION

Ano-rectal lesions in children is not uncommon to found children in a proctology clinic. However, the approach to proctologic disorders has been little studied in the child, even though the region is easily accessible for direct examination. The predominant abnormalities are the rectal consequences of passing hard and/or voluminous stools that are often responsible for pain and bleeding. Children may present with congenital lesions like imperforate anus and its sequel, congenital megacolon or rectal polyps.

More frequently, children are brought in the clinic with symptoms of constipation, rectal prolapse, anal fissures, hemorrhoids, and pruritus ani. Rarely, they may present with anal abscess and fistula.

Constipation is common in children. It is estimated that between 5% and 10% of pediatric patients have constipation. Constipation is the second most referred condition in pediatric gastroenterology practices, accounting for up to 25% of all visits. The diagnosis of constipation requires careful history taking and interpretation. Diagnostic tests are not often needed and are reserved for those who are severely affected. Infants and young children with chronic constipation and anal fissure are often found consuming larger amounts of cow milk than children with a normal bowel habit. Additionally, shorter duration of breastfeeding and early bottle-feeding with cow’s milk are reported to be responsible for development of constipation, which in turn may result in anal fissures in infants and young children.

The definitive therapy begins with rectal emptying of impacted stool followed by maintenance of regular soft stools to eliminate fear of pain with defecation. It often requires prolonged support by physicians and parents, detailed counseling, explanation, medical treatment, and, most importantly, the child’s cooperation.

Acute anal fissure is one of the most common ano-rectal lesions seen in the childhood. It is usually associated with a history of constipation, painful defecation and bleeding. On examination, the anal verge seems to be inflamed while the fissures may not be visible due to tight sphincters. Anoscopic examination done after applying anesthetic cream may reveal fissure or ulcerations more commonly on the lateral aspect than posterior.

Initial treatment should consist of stool softeners along with application of local anesthetic cream and hot sitz bath. The anal area should be wiped off with a moist and warm cloth. Diet should consist of more fibers and less of spices and milk. Usually the response is good and the fissure heals quickly. Topical glyceryl trinitrate ointment has also been found effective in healing chronic anal fissures in children.

Hemorrhoids in children are not common. There is almost no evidence of presence of hemorrhoids in children who were examined for sex abuse or even in the postmortem perianal findings.

The most common cause of hemorrhoid in the young children is portal hypertension. Rarely, hemorrhoids may be found in association with colorectal malignancies, rectal mucosal prolapse and as pseudo-hemorrhoidal vascular
swellings. Hemorrhoids in children present themselves with bleeding, mucus discharge, protrusion and pruritus.

Rectal polyps, hemorrhoids require definitive treatment. Mucosal prolapse should be approached with a conservative attitude including use of laxative to avoid straining and strengthening of pelvic musculature with biofeedback techniques. Injection of sclerosant in the prolapsing mucosa to induce fibrosis has also been found useful. Surgery is resorted to only in cases of intractable lesions or complete prolapse.

The other causes of rectal bleeding in this age group are due mainly to juvenile rectal polyp, infective pathologies like colitis, bleeding disorders, gastro-intestinal allergy, colorectal hemangiomas or Meckel’s diverticulum. Fistula-in-ano in children is thought to begin with a cryptitis that proceeds to a perianal abscess and subsequent fistula formation. They are most commonly encountered in otherwise healthy boys of less than a year. The primary treatment of perianal abscess in childhood should involve a careful search for a coexisting fistula and treatment thereof by fistulotomy. Simple drainage of a perianal abscess is frequently followed by a fistula.

Children can suffer from variety of ano-rectal pathologies, however, at times these diseases are not recognized and so the potential to treat them in time is realized. In dealing with anorectal disease of childhood, it must be remembered that the pathogenesis is similar to that of the adult: Careful examination, including endoscopy, is necessary to establish a diagnosis, and can easily be accomplished, even in the neonate. Treatment of anal fissures, hemorrhoids, fistulas and/or rectal abscesses in children parallels that of the same diseases in the adult.

ANAL DISORDERS IN PREGNANCY AND POST-PAR-TUM PERIOD

Although anorectal disorders in pregnancy are rare they may cause much distress, particularly during labor and in the puerperium. Pregnancy and the puerperium predispose to symptomatic hemorrhoids, being the most common ano-rectal disease at these stages. They tend to be inadequately investigated and treated, and the patients are reluctant to complain, regarding them as a penalty of pregnancy.

Pregnancy and vaginal delivery predisposes women to develop hemorrhoids because of hormonal changes and increased intra-abdominal pressure. Symptoms are usually mild and transient and include intermittent bleeding from the anus and pain. Depending on the degree of pain, quality of life could be affected, varying from mild discomfort to real difficulty in dealing with the activities of everyday life. It has been estimated that 25% to 35% of pregnant women are affected by this condition. In certain populations, up to 85% of pregnancies are affected by hemorrhoids in the third trimester. Pain with bowel movements and bleeding are often the first signs of hemorrhoids.

It is important to note, however, that hemorrhoids are not the only cause of rectal bleeding, and the physician should properly confirm the diagnosis before initiating any treatment.
patients who have persistent symptoms after 1 month of conservative therapy. For many women, most symptoms will resolve spontaneously soon after giving birth, and only few cases will require a surgical evaluation during pregnancy or after delivering. At present, there is no reproductive safety data available for any of the compounds commonly used for hemorrhoids.

Anal fissure in women is one of the common lesions seen during the prenatal period. The symptoms may exacerbate in a previously present lesion or may arise de-novo. The most probable cause for these development is constipation, which itself may occur due to several factors. Postpartum anal fissure is associated with reduced anal canal pressures, and surgical interference with the anal sphincter mechanism should be avoided. The appearance of anal fissures can be caused by precipitated labor, large fetus, episio- and perineotomy. The main attention in cases with postpartum anal fissures was given to local treatment by different means, which included relief of pain and prevention of constipation. Long-term results were good.

Anal fissure during the ante partum period may require a surgical procedure. The patient should be explained about the pros and cons of operative and non-operative approaches, which can result in either therapeutic abortion, or timely surgery versus preserving the fetus. There is a need to take care of the unknown factor of delay in treatment resulting into an adverse outcome. Under the situation, there necessarily is a tilt in favor of adopting a conservative approach. Yet, the patient’s ability to tolerate the symptoms of her condition should dictate the need for a definitive operative therapy.

Thrombosed external hemorrhoids and anal fissures may cause severe discomfort during childbirth. While over 90% of thrombosed external hemorrhoids are found to occur during the first day after delivery, the development of anal fissures may be seen in the first two months. The most important risk factor is dyschezia. Traumatic delivery is another precipitating factor. It is estimated that almost 10% of the delivered women develop anal fissure. To summarize, almost 1/3rd of pregnant women develop anal fissures and thrombosed external hemorrhoids after delivery. Managing constipation during and after gestation can minimize most of the ano-rectal lesions and their symptomatic outcome. Fissures can be managed conservatively.

Thrombosed external hemorrhoids could be opened and drained under local anesthesia.

**MANAGING ANO-RECTAL CONDITIONS IN THE ELDERLY**

Constipation, hemorrhoids with their complications, rectal prolapse and malignancy are common in the elderly.

Rectal bleeding can become life threatening in elderly patients. Increased prevalence of atherosclerosis, impaired general health, decreased mobility, and lack of physical activities aggravates the problems. Although hemorrhoids are the commonest cause of rectal bleeding, most patients over 40 years presenting with this symptom should undergo a colonoscopy in order to screen for and treat premalignant polyps and colorectal cancer. Constipation, often related to diet, physical immobility, concurrent illness or multiple medication use, is common in older people. Despite potential for serious complications, constipation may often be overlooked. Management of constipation is a critical part of the care of older patients with chronic conditions.

Hemorrhoidal thrombosis, rectal mucosal prolapse, anal fissure, and constipation should be dealt with a conservative approach or minimum possible surgical interventions. The potential risks of anesthetic and surgical complications may be carefully weighed with the benefits of the surgical procedures.
However, in such patients, the advantages of the endoscopic, angiographic, or surgical intervention need not be withheld for reason of age alone. The timing of tests and the type of intervention could be customized for weak and frail elderly patients. Such a decision should depend upon functional status, its impact on outcome, and the consent process.8

HEMORRHOIDS IN ASSOCIATION WITH ULCERATIVE COLITIS

Hemorrhoids can occur frequently in ulcerative colitis and appear to be one of the complications of diarrhea. A patient may complain of passing bright blood on defecation and be treated as a case of hemorrhoids by injection or actual hemorrhoidectomy. If the symptoms persist, it is not rare to find that the patient has the distal form of ulcerative colitis, which often causes bleeding without diarrhea.

When severe prolapsed hemorrhoids occur during an actual attack of ulcerative colitis, the chances of complications are high. It is best to treat them conservatively until the ulcerative colitis is quiescent and then to carry out hemorrhoidectomy on the usual guidelines. 9 Both surgical and conservative treatment of hemorrhoids in patients with ulcerative colitis has a low complication-rate.

HEMORRHOIDS AND CROHN’S DISEASE

Anal pathology is common in patients with Crohn’s disease. Generally there is a higher incidence of anal pathology in patients with colonic disease than in those with small intestinal disease.

The hemorrhoids in Crohn’s disease may present themselves as large edematous external skin tags which could be three in number with a linear ulcer on each, extending longitudinally into the anal canal. These ulcers are lined by pale, edematous granulation tissue but without the deeply undermined edge seen in the anus. 10 Because these lesions are closely related to activity of the disease, they frequently heal when proximal disease is brought under control, either spontaneously by medical measures, or following surgical resection.

Management is not a major problem in uncomplicated cases. As a general principle, local surgery should be avoided when signs of disease activity are present, since healing is likely to be poor. In fact, it may not occur at all, or surgery may precipitate local extension of the disease process. Disease activity is assessed by the usual clinical criteria in relation to the proximal bowel disease, and the anal lesions in terms of edema, ulceration and indolence on the one hand, or decreasing edema and signs of healing on the other. For symptomatic cases, local measures may be used, particularly steroid creams or suppositories.

The large edematous ulcerated pile lesions resolve and are replaced by large skin tags which still are a source of great discomfort. They are readily treated by simple excision but it is wise to be conservative in the removal of the redundant skin.12 Severe complications followed both conservative and surgical treatment of hemorrhoids in over one-half these patients. The importance of anal ex-
HEMORRHOIDS OR MALIGNANCY

Rectal malignancies could be mistaken for hemorrhoids at times, as the presenting symptoms are quite similar in both of them. At times, both these pathologies may co-exist. Anal melanoma is another devastating malignancy, which can be easily confused with hemorrhoids or rectal polyp. The symptoms of all these patients are similar: pain, proctorrhagia, tumors, tenesmus, hemorrhoids and changes in the bowel habit. The melanomatis mass may look similar to a thrombosed hemorrhoid, and thus it is advisable that all of the parts that are removed are biopsied.

By obligatory digital examination in all cases of "hemorrhoidal" complaints and additional rectoscopy, neoplasm of the rectum can be detected at an early time and more patients can be afforded lasting cure. Some well-differentiated adenomas are considered to develop secondarily in the bases of hemorrhoids or in pre-existing fibrous polyp that were the end result of hemorrhoids. In patients older than 40 with hemorrhoids a rectoscopy is highly recommended. Preliminary biopsy studies should be done more frequently if suspicious lesions are present and all tissues removed during minor anorectal operations should always be examined by a pathologist. Any patient with rectal bleeding over the age of 50 years should be considered for colonoscopy regardless of how trivial the bleeding. Below the age of 50, the decision to investigate further will be decided if a family history of colorectal cancer is found or if the following 'high risk' symptoms are present:

- Bleeding which is not bright in nature
- Change in bowel habit
- Unexplained weight loss
- Abdominal pain, or
- Mucous discharge.

HEMORRHOIDS IN HIV POSITIVE PATIENTS

Anorectal disease is now widely recognized as one of the most common problems occurring in patients infected with human immunodeficiency virus. Hemorrhoidal disease is common in these patients, often resulting from chronic diarrhea brought on by medications.15

There seems to be a common belief that anorectal surgery in an HIV positive patient is an invitation to disaster. Early reports describing outcomes of HIV positive patients undergoing anorectal procedures uncovered significant problems in wound healing and excessive perioperative morbidity.16 Recent reports, however, have demonstrated that selective management will result in high rates of symptomatic relief and complete wound healing after hemorrhoid surgery without excessive morbidity and mortality.

Because many investigators have suggested that HIV positive patients frequently have a subclinical coagulopathy, one might expect post hemorrhoidectomy hemorrhage to be more common in HIV positive patients than HIV- patients. However, this was not noticed in reports of many workers operating on hemorrhoids.

Another reason for the colorectal surgeons to be reluctant to perform anorectal operations in HIV positive patients is the reportedly high incidence of impaired wound healing. Wound healing is a significant problem after anorectal operations in patients infected with HIV, especially when the CD4 count is <50/μL.

Besides better patient selection, use of antiviral agents in HIV positive patients may promote healing of anorectal wounds. Malnourished patient could be another cause for delay in wound healing. It is observed that healthy, asymptomatic HIV positive individuals may be treated exactly as HIV-negative patients would be for hemorrhoidal disease.17

SUMMARY

ANOREKTALNA PATOLOGIJA U POSEBNIM OKOLNOSTIMA (SLUČAJEVEIMA)

Ovaj rad predstavlja sažetak anorektalne patologije kod pacijenata koji imaju posebna stanja ili su određenog uzrasta. Autor nudi svoje iskustvo u tretmanu ovih proktoloških entiteta kod dece, starijih, trudnica i pacijenata sa hemorrhoidima koji imaju zapaljenske bolesti creva, maligne bolest ili su HIV pozitivni. Ovakvi pacijenti se ne vidiju svaki dan u proktološkim ambulantama i zahtevaju poseban pristup, što povlači mnoga pitanja o prigodnosti standardnih tretmana.

Key words: anorektum, proktologija, hemoroidi, deca, odrasli, trudnice, UC, Kronova bolest, HIV

REFERENCES


