Differential diagnosis for:

**Anal pain**
If presented with a patient who has anal pain, check for the following: thrombosed, inflamed external hemorrhoids, perianal abscess, anal fistulae, anal fissure, carcinoma perianal infection (herpes, syphilis, etc).

**Bright red blood per rectum (BRBPR)**
If presented with a patient who has BRBPR, check for the following causes: hemorrhoids, rectal cancer, anal fissure, anal cancer, diverticulosis, inflammatory bowel disease, and colorectal cancer.

Risk factors in perianal disease
The following risk factors have been identified in perianal disease: male homosexual behavior, history of genital warts, other sexually transmitted diseases, smoking, physical inactivity; vulvar/cervical cancer or high-grade lesions in women (Tseng, et al 2003; Mladenovic 225).

Anal manifestations of Crohn’s disease
Diarrhea and anal disease are typical symptoms of Crohn’s, an inflammatory bowel disease. Anal involvement is common, with fistulas, abscesses, fissures, and ulcers often observed. Other potential complications include stricture, perforation, toxic megacolon, colovesical fistula, enterovaginal fistula, hemorrhage, obstruction, and cancer. (Blackbourne, 340-341).

Fissures
A fissure is a painful linear tear in the lining of the anal canal below the level of the dentate line. It is the most common cause of severe localized anorectal pain. The pain worsens upon bowel movements, and streaks of bright red blood may be observed in the stool. Fissures usually arise secondary to local trauma, such as constipation or diarrhea.

Fissures are found in the posteroanterior plane (anterior and posterior midline), where the pelvic muscular support is weakest. Anterior fissures are more often found in women than men. Defects forum in the lateral portions of the anal canal should spur the clinician to
look for other diagnoses such as Crohn’s Disease, leukemia, sexually transmitted infections, and malignancy (most commonly squamous carcinoma of the anus).

Rectal exam will evoke severe pain and significant sphincter spasm. Chronic recurrent anal fissures present with the following triad: external skin tag, fissure exposing internal sphincter fibers, hypertrophied anal papilla at level of dentate line. Treatment may vary, depending on duration and severity of symptoms. Acute fissures generally respond to conservative treatment, bulk laxatives, avoidance of diarrhea/constipation, mild non-narcotic analgesics, sitz baths for comfort, and in cases of chronic or unresponsive fissures, surgery (internal sphincterotomy - a division of a portion of the internal sphincter) is indicated to relieve pain and sphincter spasm (Lawrence, 331).

References:


