DHA TELEHEALTH CLINICAL GUIDELINES

FOR VIRTUAL MANAGEMENT OF

ANORECTAL PAIN – 02

Version 1

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Health Policies and Standards Department

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INTRODUCTION

Dubai Health Authority (DHA) is the responsible entity for regulating, licensing and monitoring health facilities and healthcare professionals in the Emirate of Dubai. The Health Regulation Sector (HRS) is an integral part of DHA and was founded to fulfil the following overarching strategic objectives:

Objective #1: Regulate the Health Sector and assure appropriate controls are in place for safe, effective and high-quality care.

Objective #2: Position Dubai as a global medical destination by introducing a value-based, comprehensive, integrated and high-quality service delivery system.

Objective #3: Direct resources to ensure happy, healthy and safe environment for Dubai population.

ACKNOWLEDGMENT

This document was developed for the Virtual Management of Anorectal Pain in collaboration with Subject Matter Experts. The Health Policy and Standards Department would like to acknowledge and thank these professionals for their dedication toward improving the quality and safety of healthcare services.

The Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

Telehealth is based on Evidence Based Practice (EBP) which is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence and guidelines from systematic research.

EBP is important because it aims to provide the most effective care virtually, with the aim of improving patient outcomes. As health professionals, part of providing a professional service is ensuring that practice is informed by the best available evidence.

This guideline is presented in the format comprising of clinical history/symptoms, differential diagnosis, investigations and management. Identification of 'Red Flags' or serious conditions associated with the disease is an essential part of this telehealth guideline as it aids the physician to manage patients safely and appropriately by referrals to ER, family physicians or specialists for a face to face management.

Functional anorectal pain is a relatively common symptom. It occurs in the absence of any clinical abnormality. Patients often delay consulting a healthcare practitioner about this problem, due to embarrassment and fear of a sinister diagnosis, tolerating disturbing symptoms for long periods.

DEFINITIONS/ABBREVIATIONS

Virtual Clinical Assessment: Is the evaluation of the patient's medical condition virtually via telephone or video call consultations, which may include one or more of the following: patient medical history, physical examination and diagnostic investigations.

Patient: The person who receives the healthcare services or the medical investigation or treatment provided by a DHA licensed healthcare professional.

ABBREVIATIONS

DHA	:	Dubai Health Authority
EBP	:	Evidence Based Practice
ER	:	Emergency Room
FBC	:	Full Blood Count
LAS	:	Levator Ani Syndrome
PF	:	Proctalgia Fugax

1. BACKGROUND

1.1. There are two functional anorectal pain syndromes:

1.1.1. Proctalgia fugax (PF) is a fleeting pain in the anus, lasting less than 20 minutes

1.1.2. Levator ani syndrome (LAS) is a pain which lasts for longer, but for which no cause is found.

1.2. They are both characteristic, benign, anorectal-pain syndromes of uncertain etiology. Despite their benign nature, they can cause severe distress to the sufferer.

1.3. Causes:

1.3.1. Anal fissure (a small tear in the lining of the anal canal)

1.3.2. Anal itching (pruritus ani)

1.3.3. Anorectal fistula (an abnormal channel between the anus or rectum usually to the skin near the anus)

1.3.4. Anal Cancer

1.3.5. Coccydynia or coccygodynia (tailbone pain)

1.3.6. Constipation

1.3.7. Crohn's disease

1.3.8. Diarrhea causing anal irritation

1.3.9. Fecal impaction (a mass of hardened stool in the rectum due to chronic constipation)

1.3.10. Hemorrhoids (swollen and inflamed veins in your anus or rectum)

1.3.11. Levator ani syndrome (spasm in the muscles that surround the anus)

1.3.12. Perianal abscess (pus in the deep tissue around the anus)

1.3.13. Perianal hematoma (a collection of blood in the perianal tissue caused by a ruptured vein, sometimes called an external hemorrhoid)

1.3.14. Proctalgia fugax (fleeting pain due to rectal muscle spasm)

1.3.15. Proctitis (inflammation of the lining of the rectum)

1.3.16. Solitary rectal ulcer syndrome (ulcer of the rectum)

1.3.17. Anogenital warts – these are sexually transmitted and may be associated with blister or rash

1.3.18. Thrombosed hemorrhoid (blood clot in a hemorrhoid)

1.3.19. Trauma

1.3.20. Ulcerative colitis

1.3.21. Ulcerative proctitis (a type of inflammatory bowel disease)

1.3.22. Rectal prolapse

2. SCOPE

2.1. Telehealth services in DHA licensed Health Facilities.

3. PURPOSE

3.1. To support the implementation of best practice in Telehealth services for patients with complaints of Anorectal Pain in Dubai Health Authority (DHA) licensed Health Facilities

4. APPLICABILITY

4.1. DHA licensed physicians and health facilities providing Telehealth services.

4.2. Exclusion for Telehealth services are as follows

4.1.1. Emergency cases where immediate intervention or referral is required.

4.1.2. Prescribe Narcotics, Controlled or Semi-Controlled medications.

5. RECOMMENDATION

5.1. Virtual Clinical Assessment

5.1.1. A careful history focusing on the nature of the pain and its relationship to bowel movements frequently provides the diagnosis of pain in the anorectal area. The characteristics of pain varies with the cause of the condition.

5.1.2. Patients with proctalgia fugax experience sudden severe episodes of spasm-like pain that often occur at night. Proctalgia fugax may only occur once a year or may be experienced in waves of three or four times per week. Each episode lasts only minutes, but the pain is excruciating and may be accompanied by sweating, pallor and tachycardia. Patients experience urgency to defecate yet

pass no stool. In between episodes, there is no pain at all. Proctalgia fugax does not cause any bleeding. Pain may be triggered by

a. Opening your bowels
b. Being constipated
c. During menstruation
d. Stress

5.1.3. In Levator ani syndrome, there is an aching pain high up in the back passage. It tends to be worse when sitting down and walking around can make it feel better. The pain is constant or regular and lasts for longer than 20 minutes. It continues, either constantly or on and off, for months. It is also known as chronic anal pain syndrome.

5.1.4. In Levator ani syndrome, there is an aching pain high up in the back passage. It tends to be worse when sitting down and walking around can make it feel better. The pain is constant or regular and lasts for longer than 20 minutes. It continues, either constantly or on and off, for months. It is also known as chronic anal pain syndrome.

5.1.5. Aching after a bowel movement can occur with internal hemorrhoids

5.1.6. Pain during bowel movements that is described as “being cut with sharp glass” usually indicates a fissure. This pain is most intense during the bowel movement and usually persists for an hour or so afterward. It may then either

abate until the next bowel movement or continue, usually to a lesser degree. The pain of anal fissure is frequently accompanied by bright red rectal bleeding and often begins after a hard, forced bowel movement.

5.1.7. The acute onset of pain with a palpable mass is almost always due to a thrombosed external hemorrhoid. This intense pain typically lasts 48 to 72 hours and then subsides spontaneously but may take several days to abate. Internal hemorrhoids, because they start above the dentate line, are not painful even if prolapsed or thrombosed.

5.1.8. Similarly, rectal cancer seldom causes pain unless it is extremely advanced because of the innervation of the rectal area. Anal cancers more commonly cause pain after invasion of the sphincter muscle.

5.1.9. Anorectal pain that begins gradually and becomes excruciating over a few days may indicate infection. A localized area of tenderness could signal an abscess. Anal pain accompanied by fever and inability to pass urine signals perineal sepsis and is a medical emergency.

6. RED FLAGS

6.1. Anal pain accompanied by fever

6.2. Inability to pass urine signals perineal sepsis

6.3. Chronic anal pain

6.4. History of weight loss

6.5. The pain is severe and regular

6.6. Infectious rectal discharge

6.7. Not responding to supportive measures

6.8. Chronic anal pain

6.9. Anal bleeding

7. DIFFERENTIAL DIAGNOSIS

7.1. Irritable bowel syndrome

7.2. Haemorrhoids ± thrombosis

7.3. Anal fissure

7.4. Anal abscess

7.5. Solitary chronic rectal ulcer

7.6. Colorectal cancer

7.7. Perirectal abscess or fistula; hidradenitis suppurativa

7.8. Proctitis (especially gonococcal/chlamydial infection)

7.9. Crohn's disease/ulcerative colitis

7.10. Rectal foreign body

7.11. Pruritus ani

7.12. Diverticular disease

7.13. Rectal prolapse

7.14. Coccygodynia

7.15. Anogenital warts

7.16. Testicular tumors

7.17. Prostatitis

7.18. Cystitis

7.19. Bilateral internal iliac artery occlusion

8. INVESTIGATIONS

8.1. A referral to a specialist will be required for the below investigations if deemed necessary based on history via teleconsultation

8.2. Endoscopy (flexible rectosigmoidoscopy or colonoscopy) should be considered in patients with chronic anorectal pain.

8.3. If this is normal and there is tenderness of the puborectalis muscle then other investigations such as anorectal manometry, balloon expulsion test and MRIDefecography should be considered.

8.4. Depending on the level of clinical uncertainty, other useful investigations can be FBC, pelvic ultrasound and anorectal endosonography.

9. MANAGEMENT

9.1. Refer to APPENDIX 1 for the Virtual Management of Anorectal Pain Algorithm

9.2. Management of condition will depend on evaluation with a detailed history via teleconsultation and possible underlying cause.

9.3. For symptoms suggestive of constipation– appropriate treatment like lifestyle advice (high fiber diet and increase fluid intake) and medications are suggested like stool softeners (for more details refer to guidance on constipation).

9.4. For haemorrhoids, appropriate treatment like lifestyle advice (high fiber diet and increase fluid intake) and medications are suggested like topical cream application (for more details refer to guidance on haemorrhoids).

9.5. For most patients with Proctalgia Fugax - symptomatic episodes are brief and infrequent and require no specific treatment. Initial treatment in most patients with mild and infrequent symptoms include reassurance and warm sitz bath.

9.6. Hygiene and sexual advice should be given in relevant cases.

9.7. For anal fissure, the following is recommended:

9.7.1. Sitz bath — Warm sitz baths, which can relax the anal sphincter and improve blood flow to the anal mucosa. During a sitz bath, the anus is immersed in warm water for approximately 10 to 15 minutes two to three times daily. At home, it is possible to use a bathtub for sitz bath by filling it with two to three inches of warm water. Additives such as soap and bubble bath are not recommended. After a sitz bath, it is important to towel or blow dry (with a hair dryer on low heat setting) the anal area well.

9.7.2. Topical analgesics — Although topical analgesic jelly or creams (e.g., 2% lidocaine jelly) are often prescribed for patients with an anal fissure for pain control, their use alone has not been shown to be more effective than other supportive measures.

9.7.3. Stool softener or laxative — A variety of drugs (e.g., docusate) and natural products are available for treating constipation either over-the-counter or by prescription. Constipation may lead to straining, which can exacerbate the anal fissure.

9.7.4. After one month of initial treatment with supportive measures and a topical vasodilator, patients are advised to call back and those with persistent symptoms are prescribed another month of the same medical therapy

9.7.5. At the end of two months, patients who still have persistent symptoms attributable to their anal fissures are referred to specialist

10. REFERRAL CRITERIA

10.1. Refer to Family Physician/Specialist

10.1.1. The pain is severe and regular

10.1.2. Associated with fever

10.1.3. Infectious rectal discharge

10.1.4. Not responding to supportive measures

10.1.5. Chronic anal pain

10.1.6. For local examination and other investigations based on the underlying medical condition

10.2. Refer to ER

10.2.1. There is a large bleed or increasing amount of blood loss

10.2.2. There is history of a recent physical trauma

11. REFERENCES

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12. APPENDIX 1 – VIRTUAL MANAGEMENT OF ANORECTAL PAIN ALGORITHM