G Chir Vol. 37 - n. 3 - pp. 133-135
May-June 2016

clinical practice

Rectal bleeding and prolapse… not always benign diseases rather anal cancer. The importance of a correct decision making since primary care

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SUMMARY: **Rectal bleeding and prolapse… not always benign diseases rather anal cancer. The importance of a correct decision making since primary care.**

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Rectal bleeding is very common in general population with a prevalence of 10-20 %. Primary care physicians have to stratify patients basing on urgency and on the colo-rectal cancer risk and to conduct a decision making for the correct management. We report a case of a 61-years-old woman, complaining rectal bleeding and an anal mass attended to their family doctor who does a visit but without a digital rectal examination and diagnosed a hemorrhoidal prolapse suggesting medical therapy. For the persistence of symptoms she comes to our service from emergency attention. Inspection and digital rectal examination revealed an anal mass. CT scan was performed showing a large anal mass involving half anal circumference. Histologic samples showed an epithelial proliferation compatible with a squamous carcinoma. Oncological consult was requested and a chemo-radiotherapy treatment was proposed. This case report highlights the difficulty when physicians assess patients with anorectal complaints in differentiating anal cancer from benign disease, presumably because symptoms are similar. Primary care physicians must maintain a high index of suspicion of cancer in high-risk population. Sensitization of these colleagues is required since digital rectal examination is of inestimable value to verify the presence of a rectal or an anal mass.

KEY WORDS: Rectal bleeding - Anal cancer - Prolapse - Digital rectal examination.

Introduction

Rectal bleeding is very common in general population with a prevalence of 10-20 % (1). Its incidence is around 1.6/1000 inhabitants; 2.4-11% of them harboring colorectal cancer (2). The number of patients that recur to primary care for rectal bleeding is 4-6/1000 inhabitants (1). Nevertheless around the 30% of the patients never consult a physician for this problem (3). Primary care physicians have to stratify patients basing on urgency and on the colo-rectal cancer risk and to conduct a decision making for the correct management (2).

Case report

A 61-years-old woman, complaining rectal bleeding and an anal mass, attended to their family doctor who does a visit with inspection but without a digital rectal examination (DRE). He concluded that the matter was a hemorrhoidal prolapse and suggested a medical therapy. Because of the persistence of the rectal bleeding, the patient attended to the emergency attention of a city hospital where the already proposed diagnosis was confirmed and the patient dismissed.

Finally, she comes to our emergency attention and she was referred to the Emergency and General Surgery Department for the presence of "rectal bleeding in patient with anal mass" (Fig. 1).

At the admittance she has an arterial pressure of 90/70 mmHg and a pulse of 100 bpm. Laboratory tests showed Hgb 9 g/dl; Hematocrit 30.6 %; MCV 93.9 fL; WBC 16620; PLT 340000; metabolic panel, liver function tests and coagulation were within normal limits.

The visit assessed the presence of an anal malignancy arising from the anal verge that allowed the passage of the finger and occupied almost half circumference (Fig. 2).

A gynecological consult was undertaken and it verified the integrity of the vagina.

It was done a thorax-abdominal CT scan that showed the presence in the anus of a neoplasm (DAP 8 cm; DT 3 cm) extending in the cutis until the vulva, with copro-

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Fig. 1 - Anal mass confounded with a rectal prolapse at inspection.

Fig. 2 - Rectoscope inserted in the anal verge to demonstrate the passage.

stasis. No lesion suspected for secondarism (Figs 3, 4).

The mass was submitted to biopsy for the histologic confirmation, which showed an epithelial proliferation compatible with a squamous carcinoma.

Oncological consult was requested and a chemo-radiotherapy treatment was proposed.

Discussion

Rectal bleeding can be related to several diagnoses but the presence of malignancies is a matter that has to be considered in each of these cases.

Anal squamous cell carcinoma (ASCC) is an uncommon malignancy; its incidence has been increasing markedly in recent decades, in association with human papilloma virus infection (4).

In 2016, it is estimated that 8,080 new cases of anal cancer will be diagnosed and 1,080 deaths will be caused by this disease in the United States. Five-year survival has remained fairly constant since 1975 and on the basis of data from 2005 to 2011, is 65.7% (5).

Chiu et al. report that although most patients sought medical attention promptly, 19% of them waited for more than 6 months. The first visit after rising up some symptoms foresees a rectal examination, which was performed in only 54% of patients and which gives a diagnosis of hemorrhoids in 27% of patients. Further investigations were ordered in only 54% of patients. If a misdiagnosis of hemorrhoids was made, substantially more visits were required to diagnose the cancer. An average of 3.2 months after the

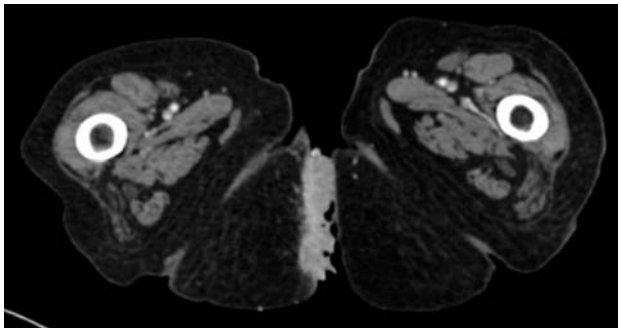

Fig. 3 - Abdominal CT-scan showing anal mass.

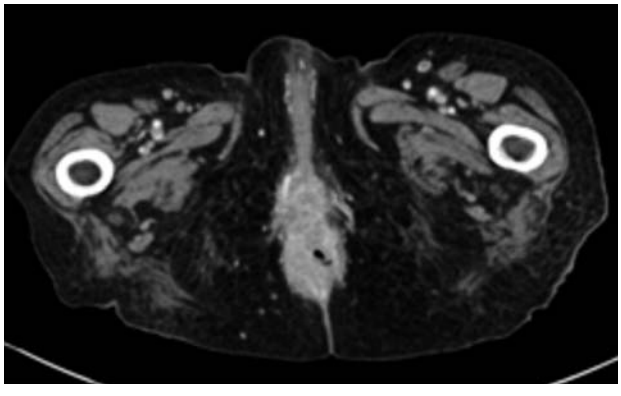

Fig. 4 - Adominal CT-scan showing anal mass.

first visit to a physician and 7.4 months after onset of symptoms was needed to obtain a diagnosis of cancer (6).

Carter suggested it is vital for general practitioners to perform digital rectal examination for even trivial anorectal symptoms and then to proceed to a speedy referral when indicated (7).

Established the diagnosis, the well-established standard of care for localized ASCC consists in the combination of 5-fluorouracil and mitomycin chemotherapy, concurrent with external beam radiation therapy (4).

Delays in diagnosis might lead to higher cancer stages at presentation and, therefore, to worse survival (6).

In the management of rectal bleeding the personal anamnesis comprising age, comorbidities, family history, drugs administration have to be collected (8). The investigation of the accompanying symptoms that arise from fever, abdominal pain, weight loss, bowel changes, mucus dismission, tenesmus and anal pain is of undoubtable value.

Inspection of the abdomen and digital examination are of inestimable value to verify the presence of a mass.

Less than 50% of patients who complain rectal bleeding are submitted to a rectal exploration and this occurs for saving time, for the absence of an accompanying person or to avoid a double examination in patients to send for a specialist consult or to emergency (3).

Patients were referred for a second consult in 70% if < 50 years-old and 76.8% if > 50 years-old (9).

Since in patients <40 years-old there is a 2-9% of CCR, in these patients with a rectal bleeding without other symptoms a sigmoidoscopy should be recommended (3, 10).

Of course, the most possible diagnoses are anal diseases like hemorrhoids and fissures that account to 34% and inflammatory disease (8%). 6% of patients older >40 years presenting a rectal bleeding alone has a colo-rectal cancer. If they have also a change in bowel habits lasting more than 6 weeks have a 7% of possibility to suffer of colo-rectal cancer; if weight loss is present 13% of these patients can have a CCR; if associate anemization 21.6% (2, 11-13).

Patients with rectal bleeding and palpable abdominal or rectal mass, or patients > 40 years with rectal bleeding and change in bowel habits and patients >60 years with rectal bleeding for six weeks need an urgent referral in two weeks. Patients with rectal bleeding and anemization need a consult in four weeks. In patients with a low level suspicion with symptoms not solving in 4-6 weeks a semi urgent referrals have to be done (14).

Conclusion

This case report highlights the difficulty when physicians assess patients with anorectal complaints in differentiating anal cancer from benign disease, presumably because the symptoms are similar. A high index of suspicion for malignant disease has to be maintained. In primary care, physicians should perform digital rectal examination that is instead performed in almost half the cases. Of course further investigations should be proposed according to the risk assessment to avoid misdiagnoses.

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