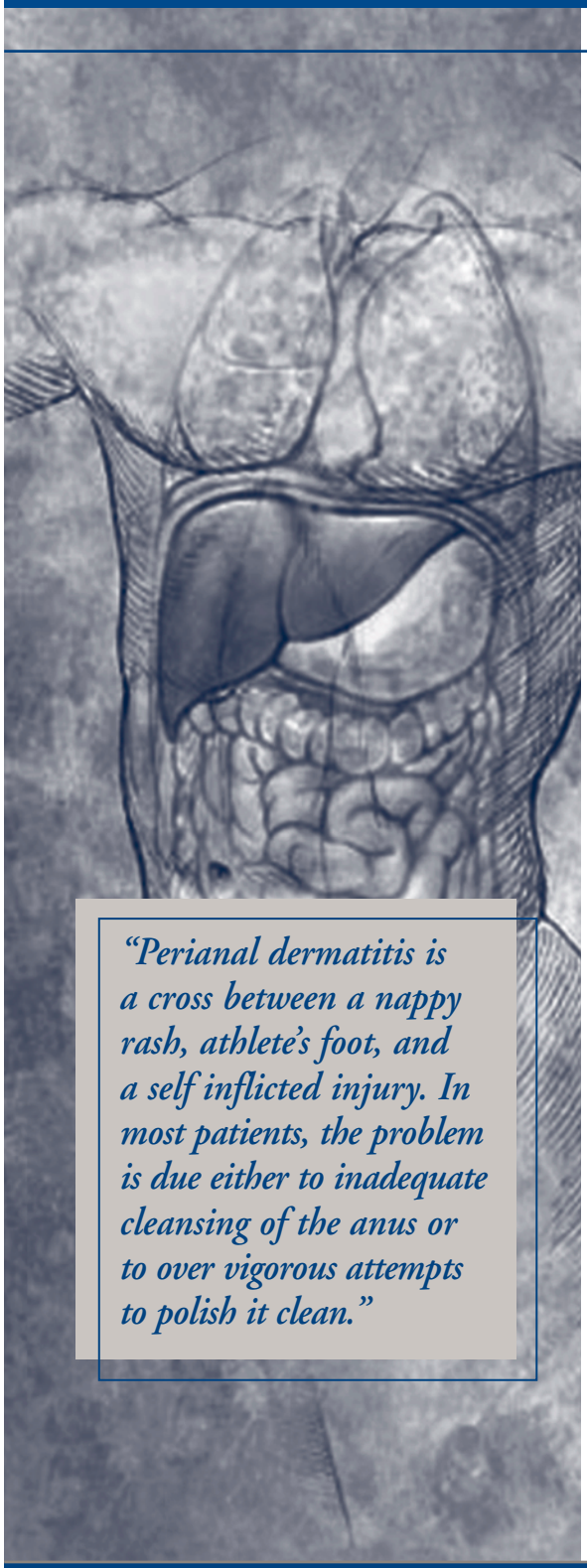
LOS ANGELES

COLON AND RECTAL SURGICAL ASSOCIATES

Norman N. Hoffman M.D., Inc. | Gary H. Hoffman M.D. | Eiman Firoozmand M.D. | Liza M. Capiendo M.D. | Stephen Yoo M.D.

www.lacolon.com



"Perianal dermatitis is a cross between a nappy rash, athlete's foot, and a self inflicted injury. In most patients, the problem is due either to inadequate cleansing of the anus or to over vigorous attempts to polish it clean."

Pruritus Ani

To itch is human. To scratch, divine (but not advisable).

THE ITCH. THE SCRATCH. AHHH, THE RELIEF ...OR NOT

Anal itching. Pruritus ani. At one time or another, everyone has experienced this unpleasant sensation. Most often, the delightful scratching of the itch relieves the discomfort and puts a stop to the maddening sensation. Not uncommonly however, the itch occurs at an inconvenient moment, in public, during an intimate social situation or at a time when scratching is not possible without looking a bit ridiculous. Worse, the itching may become chronic, with the need to scratch becoming a constant annoyance, bordering on pain. What to do?

The best advice is to remedy those clinical situations that are associated with pruritus and put a stop to the symptom.

ITCHING 101: PATHOPHYSIOLOGY, HISTORY AND PHYSICAL EXAMINATION

First, some itching pathophysiology. Pain fibers in the epidermis mediate the itch pathway. The itch pathway may have a lower threshold for stimulation than pain pathways. Because the receptors are superficial, less noxious stimuli, such as clothing, anorectal mucus or other minor mechanical stimuli may trigger an intense response leading to pruritus. The normal negative feedback loop whereby scratching would be expected to stop the itching may be inadequate, causing further scratching, cutaneous injury, more scratching and a self-propagating feedback loop. Hence the common attempt to inhibit the urge to scratch by quelling the feedback loop through the use of stronger remedies such as heat or cold, in the form of pepper extract, ice, alcohol or warm baths.

What ailments are associated with anal itching? Can they be treated and resolve the itch syndrome? Clearly, a thorough history must be taken and physical examination of the affected area must be performed. Needless to say, anal itching is an uncomfortable discussion for both the physician and patient, and care must be taken to help the patient avoid the natural embarrassment that may attend the discussion.

The simplest way in which to approach the understanding and treatment of anal itching is to obtain a history as to when the itching began and inquire as to whether the patient noticed any other concomitant problems or was told of any new systemic diagnoses. If

continued on back...

...continued from front

these answers are helpful then further diagnostic effort and treatment should be focused in this direction. Obviously, other diseases which may cause pruritus ani must be treated.

Otherwise, after an examination, which should include a visual inspection, an anorectal digital exam, an anoscopy and a proctosigmoidoscopy or total colonic evaluation if indicated, focused treatment may be initiated. A visual exam may disclose nothing more than mild erythema, or may reveal excoriation from scratching with lichenification of the perianal skin (whitening), or scales, vesicles, macules, bulla, papules, pustules or ulcers, suggestive of an infection or contact dermatitis.

ASSOCIATED CONDITIONS

Itching is commonly associated with fissures, hemorrhoids, hemorrhoidal tags, abscesses, fistulas with drainage or mucosal prolapse. Non-specific proctitis or radiation proctitis, condyloma or inflammatory bowel disease affecting the anus not uncommonly cause itching. Obviously, correction or treatment of these problems usually leads to relief of the pruritus.

Herpes simplex viral infections are common, are usually painful, and may also cause pruritus. Red macules progress to vesicles, which rupture and may become infected. Culture of the vesicular fluid is diagnostic and the itching usually resolves spontaneously or with oral antiviral medications. Molluscum contagiosum may itch and can be removed with topical therapy. Anal condyloma acuminata may cause itching. The itching will abate after treatment of the condyloma.

The literature is unclear as to the role of bacteria or fungi in causing pruritus ani. Antifungal preparations such as clotrimazole with betamethasone have shown variable efficacy in resolving symptoms. Other common preparations also contain steroids, making it unclear as to which ingredient is responsible for symptomatic relief.

In most investigative series, psoriasis has been found to be a common cause of pruritus. The typical scaling may not be found because of maceration of the involved skin. A search for psoriasis on other commonly involved body parts may be confirmatory, and a trial of a topical steroid preparation may resolve the symptoms.

Obviously any coexisting perianal or anal pathology such as perianal Paget's disease (a type of apocrine gland carcinoma that spreads through the surface layer of the skin) or perianal Bowen's disease (intraepithelial squamous cell carcinoma in situ) may present with pruritus ani. More important than treating the pruritus is the need to obtain a diagnosis through the use of anal biopsies. Not uncommonly, treatment is delayed while topical therapy is used. Bowen's disease appears as a well-demarcated plaque with crusting and scaling. Paget's disease of the anus may appear as normal skin or erythematous areas which may be crusted and may progress to larger, circumscribed lesions.

DEEPER INQUIRY

In the many patients who do not have an obvious disease entity associated with pruritus ani, attention must focus on more obscure causes. Usually, these are brought about inadvertently or accidentally. "Perianal dermatitis is a cross between a nappy rash, athlete's foot, and a self inflicted injury. In most patients, the problem is due either to inadequate cleansing of the anus or to over vigorous attempts to polish it clean". [1]Patients wearing tight clothing, especially women who wear thong underwear or those who use soap for anal hygiene, should be advised to discontinue this behavior. **Excessive attention to "cleanliness" may actually be harmful.** The use of soap in an attempt to clean the anal area often times causes severe itching. Soap should be avoided. At the other extreme, poor cleanliness may also be a problem. However, although fecal soiling has been shown to cause pruritus, stool and other anal excretions are water soluble, and simple wiping with tissue paper or a damp wash cloth is all that is necessary on a daily basis. Anything more may simply cause or exacerbate pruritus.

RELIEF AT LAST

Contact dermatitis is common and the list of irritants is lengthy. The discontinuance of scented or colored toilet paper is often helpful in relieving itching. The use of wet wipes, which contain potentially astringent alcohol, perfumes, irritating chemicals or herbs and lotions, should be discontinued as they may do more harm than good. The only "natural" cleaning agent that is 100% safe and effective on the anus is water. Numbing medicines in the 'caine' family may also exacerbate the problem and should not be used for prolonged periods of time.

Foods are a much less common cause of itching and their discontinuation alone rarely solves the problem. Foods associated with pruritus are: coffee, spices, citrus, tomatoes, nuts, beer and dairy products (especially if the patient is lactose intolerant and is having frequent loose stools).

Diarrhea, with large or frequent loose stools is excoriating, and efforts should be directed toward diagnosing the etiology of the diarrhea. Diphenoxylate or loperamide will usually relieve the diarrhea. Obviously, if the diarrhea is associated with an underlying etiology, this must be addressed. Vaseline, zinc oxide or other skin protective barriers should be applied so that the irritating effects of the diarrhea may be circumvented. Likewise, these agents may be used in patients complaining of excessive perianal perspiration, especially in athletes. Prolonged perianal moisture is akin to a diaper rash in babies who remain in a wet diaper for prolonged periods of time. Gentle perianal drying with a hair dryer is helpful.

In these patients, and in patients whose itching is truly idiopathic, topical hydrocortisone, applied in small amounts will usually relieve symptoms. This should be used over a short period of time as prolonged usage may thin the perianal skin. Topical antifungal creams may be prescribed for short-term use. Low dose diazepam seems to provide relief over the short term in those with refractory itching or in those patients with anxiety, neuroses, neurodermatitis, or psychosis.

When non-specific folliculitis or superficial skin infections arise after prolonged, intense perianal scratching, short-term broad spectrum oral antibiotic use is often helpful in reversing the infection.

In those few refractory patients, anal tattooing using intradermal and subcutaneous injections of methylene blue, normal saline, bupivicaine with epinepherine and lidocaine is quite effective in stopping pruritus ani. As this regimen has the potential for causing skin necrosis, it is reserved for use by experienced practioners.

Anal itching is preventable and treatable in most cases and attention to the details of this affliction will be gratifying to both the patient and physician.

1. Alexander-Williams, J., Br. Med. J. 1983; 287(6386); 159-160