

ED QUICK QUIZ

WHAT IS THE DIAGNOSIS?

BACKGROUND

A 27 year old female attends ED due to rectal bleeding.

She is 12 weeks post- partum; delivery required instrumentation but was otherwise uncomplicated.

She noted some rectal bleeding in first post- partum week. This only occurred after moving her bowels, she was aware of two small tender masses at the anus and states that blood was only present on wiping. She put this down to haemorrhoids and indeed this resolved with anusol cream.

For the past 3 weeks she describes new low back/ pelvic pain and rectal bleeding, again on wiping.

The pain is dull and she best describes it as 'something pulling down towards the back passage. It is mainly when she needs to move her bowels and doing so has been painful. She has felt increasingly run down and had intermittent low grade fevers. She initially thought it was haemorrhoids again but she doesn't have any tenderness on wiping.

On examination:

RR 16 SpO2 100% HR 85 BP 110/65 Temp 37.3

Her abdomen is soft and non- tender. When asked to point to where her pain originates she indicates the sacral area just above the buttocks, this area is not tender to light pressure, but firm palpation elicits the pain 'inside'

You perform a PR exam, with a nurse as chaperone. This shows a couple of healing non- inflamed haemorrhoids that are not tender. DR exam reveals an empty rectum; the posterior wall is tender to palpation and feels smooth, possibly swollen and fluctuant. FOB is positive.

Bloods were done by the nurses, this shows CRP= 174, WC= 15.8, Lactate is 2.0 and otherwise normal

QUESTIONS

1. What do you think is going on?
2. How will you manage this?

ANSWERS & DISCUSSION

1. Anorectal (Ischiorectal) abscess

This patient would appear to have developed an ischiorectal abscess. These result from infection of the crypts of Morgagni in the rectal epithelium.

There are four main types of anorectal abscess

- Perianal (pilonidal) (60%)
- Ischiorectal (penetrates into deep postanal space)
- Intersphincteric
- Supralelevator

A wide range of bacteria, both aerobic and anaerobic, may cause the abscess including gut flora e.g. *E. coli* and enterococcus; as well as *Staph aureus* and *Streptococci*.

Non- gut flora species are usually limited to causing perianal (pilonidal) abscesses and are prevented from causing internal infections by the barrier provided by the internal anal sphincter.

Deeper infections may result from inflammatory bowel disease, immunodeficiency e.g. HIV or poorly controlled diabetes, perforated diverticular disease or in this case a tear in the mucosal lining between the internal and external sphincters, which allows bacterial spread into the ischiorectal potential space. This patient's difficult childbirth with the resultant straining and high pressures were the probable cause of the mucosal tear.

The major complications are the same as for diverticulitis i.e. sepsis, perforation and fistula formation

2. How will you manage this patient?

Again, the management is as for Diverticulitis- IV antibiotics as per local intraabdominal sepsis guideline and IV fluids. Stool softeners will help with the pain associated with moving the bowels.

These usually require incision and drainage under anaesthetic, so she should be admitted to the General Surgeons.

