Proctalgia fugax and anal pain

Synonyms: functional anorectal pain, chronic proctalgia, pyriformis syndrome, pelvic tension myalgia, levator ani syndrome

Functional anorectal pain occurs in the absence of any clinical abnormality[1]. It's a relatively common symptom[2]. Patients will often delay consulting a healthcare practitioner about this problem, due to embarrassment and fear of a sinister diagnosis, tolerating disturbing symptoms for long periods.

The functional anorectal pain syndromes, defined by the Rome IV criteria, are based on symptom duration and digital rectal examination findings. The term 'chronic proctalgia' was removed in the Rome IV criteria. In Rome III, chronic proctalgia was further subdivided into levator ani syndrome if traction on the levator muscles during digital rectal examination elicited a report of tenderness or pain, whereas the term 'unspecified functional anorectal pain' was used if such digital traction did not elicit a report of tenderness. However, a study of young adults did not identify distinct clusters of symptoms for chronic proctalgia versus proctalgia fugax, so the term 'chronic proctalgia' was removed. However, because the pathophysiological mechanisms and indications for treatment may differ, the following terms were retained[3]:

- Acute proctalgia - proctalgia fugax (PF) (fugax = fugitive/fleeting in Latin).
- Levator ani syndrome (LAS).
- Unspecified functional anorectal pain (UFAP).

The conditions are characteristic, benign, anorectal-pain syndromes. Despite their benign nature, however, they can cause severe distress to the sufferer.

Aetiology

- These conditions are something of an enigma. PF is thought to occur due to spasm of the anal sphincter. LA is thought to be due to spasm of the pelvic floor muscles. The aetiology of UFAP is unknown. There is considerable overlap between the three conditions [4].
- It is important to elicit a precise history of defecation.
- They may be associated with irritable bowel syndrome (IBS).
- The levator ani and anal sphincter muscles are anatomically contiguous in PF and LA so may co-exist, or be different manifestations of the same underlying dysfunction [5].
- The diagnosis of these conditions can usually be made on the basis of the symptoms and digital rectal examination. More serious diagnoses can present similarly, so it is essential to conduct a thorough clinical assessment to exclude other pathology before offering reassurance.
- A history of anxiety or depression is often associated and this should be evaluated [4].
- They have been associated with a variety of other pathologies which may have aetiological significance; for example, pudendal nerve neuralgia [6].

Epidemiology

- PF is estimated to affect 8-18% of the population in the developed world, and LAS around 6% [7].
- LAS seems to affect women more than men, whereas PF seems to affect both sexes equally [8].
- It is thought that only about a third of people of those who experience these conditions consult a healthcare practitioner [9].

Differential diagnosis

- Irritable bowel syndrome.
- Haemorrhoids ± thrombosis.

- Anal fissure (usually causes intense localised pain associated with and following defecation) - should be visible on proctoscopy.
- Solitary chronic rectal ulcer.
- Colorectal cancer.
- Perirectal abscess or fistula; hidradenitis suppurativa.
- Proctitis (especially gonococcal/chlamydial infection) [10].
- Crohn's disease/ulcerative colitis.
- Rectal foreign body.
- Pruritus ani.
- Diverticular disease.
- Rectal prolapse.
- Coccygodynia (neuralgic pain around the region of the coccyx).
- Retrorectal cysts [11].
- Condylomata acuminata (anogenital warts).
- Testicular tumours.
- Prostatitis.
- Proctitis.
- Interstitial cystitis.
- Psychological cause (some hypothesise that these conditions are psychological rather than physical in origin [5]).
- Alcock's canal syndrome (pudendal neuralgia due to entrapment, may present similarly to PF/be aetiologically relevant) [5] [12].
- Hereditary anal sphincter myopathy [13].
- Bilateral internal iliac artery occlusion.

Investigations

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

- If this is normal and there is tenderness of the puborectalis muscle then other investigations such as anorectal manometry, balloon expulsion test and MR defecography should be considered [14].
- Depending on the level of clinical uncertainty, other useful investigations can be FBC, pelvic ultrasound and anorectal endosonography.

Proctalgia fugax

Presentation [15]

- Symptoms:
    - Recurrent episodes of sudden, severe cramping pain localised to the rectum.
    - Last from seconds to up to 30 minutes and resolve completely.
    - The patient is entirely pain-free between the episodes.
    - Symptoms often occur at night and may wake the person who has the condition. Attacks are infrequent (<5 times yearly in 51% of patients) [7].
- Signs:
    - PF has no signs and the diagnosis is made on the basis of characteristic symptoms and the absence of signs of other pathology.
    - Abdominal and digital rectal examination should constitute the minimum assessment of anal pain.
    - Ideally, anoscopy/proctoscopy should be carried out [14].
    - Consider gynaecological/scrotal examination if relevant.
    - Further examination with a sigmoidoscope or colonoscope may be necessary in selected patients where there is suspicion of pathology higher in the colon.
    - It is worth checking for signs of anaemia if gastrointestinal bleeding is suspected.

Management

- Once the diagnosis is made, reassurance is usually sufficient.
- The symptoms are so transient that drug therapy is rarely needed.
- In patients who experience frequent, severe, prolonged attacks, inhaled salbutamol has been shown to reduce their duration [7].
- Most other treatments (such as oral diltiazem, topical glyceryl nitrate and nerve blocks) act by relaxing the anal sphincter spasm but are not supported by randomised controlled trials [2].
- Co-existent psychological issues should be addressed with behavioural and/or pharmacological therapies [7].

Levator ani syndrome

Presentation

- Symptoms:
    - Vague, aching or pressure sensation high in the rectum often worsened by sitting and relieved by walking.
    - Pain tends to be constant or recur regularly and to last >30 minutes.
    - Last from hours to days.
    - To satisfy diagnostic criteria the symptoms must be present for three months with symptom onset at least six months prior to diagnosis [7].
    - Other causes of similar pain (see 'Differential diagnosis', above) must have been excluded.
- Signs:
    - In LAS, posterior traction on the puborectalis reveals tight levator ani muscles and tenderness or pain. (This differentiates between LAS and unspecified functional anorectal pain (UFAP) [14].)
    - Tenderness may be predominantly left-sided and massage of the puborectalis muscle may elicit the characteristic discomfort.

Management

Patient education and reassurance are an important part of management. Biofeedback has proved effective in randomised trials, but if not available, electrical stimulation is a suitable alternative. Other treatments that have shown some benefit include digital massage, muscle relaxants and sitz baths [4].

Unspecified functional anal pain

Patients with UFAP tend not to respond to biofeedback. Biofeedback-responsive patients can often be identified by a simple balloon evacuation test using a Foley catheter. Depression and anxiety are both frequently reported in non-responsive proctalgia patients, and addressing these conditions may prove beneficial [9]. One study of botulinum toxin injections produced good results in patients with chronic functional anal pain, a high proportion of whom had UFAP [16].

Medicolegal note

- When examining the anogenital area ensure that the patient is fully informed about what to expect and the reasons why the examination is necessary.
- An appropriate chaperone should be offered and be in attendance for intimate examinations.
- Document the presence of a chaperone and their identity along with the examination findings.
- Ensure patient privacy and dignity, and discontinue the examination if at any time you or the patient are unhappy or uncomfortable with the situation.
- Do not assume that because you are the same sex as the patient, a chaperone isn't needed.
- For further information, see the separate Rectal Examination article.

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