Tenesmus

Tenesmus is a spurious feeling of the need to evacuate the bowels, with little or no stool passed. Tenesmus may be constant or intermittent, and is usually accompanied by pain, cramping and involuntary straining efforts. It can be a temporary and transient problem related to constipation. The term rectal tenesmus is sometimes used to differentiate from vesical tenesmus, which is an overwhelming desire to empty the bladder.

Aetiology

There are a number of possible causes of tenesmus. The most common is inflammatory bowel disease. Causes include:

- Crohn's disease.
- Ulcerative colitis.
- Anorectal abscess.
- Infective colitis.
- Colorectal tumours, especially polyps.
- Radiation proctitis: this may follow irradiation for tumours of other sites, such as bladder tumours, cervical carcinoma and prostatic tumours.
- Irritable bowel syndrome.
- Thrombosed haemorrhoids.
- Endometriosis: can affect the rectum and cause pain and tenesmus.
- Rectal chlamydia trachomatis infection: this is becoming more common in heterosexual females.

NB: tenesmus can be a common symptom in those patients with advanced colorectal, genitourinary or prostate cancer [1].

Assessment

It is essential to make a thorough assessment to identify the cause of tenesmus. It is particularly important to consider serious underlying causes (eg, malignancy, inflammatory bowel disease) when there may be associated symptoms such as weight loss and rectal bleeding.

Examination

Abdominal examination should be performed followed by both digital rectal examination and proctoscopy. There may be faecal impaction, a large polyp or very congested and inflamed mucosa.

Investigations

- If the cause of the problem is not apparent, FBC, erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) may indicate an underlying inflammatory condition.
- Sigmoidoscopy and even colonoscopy may be required.
- Plain abdominal X-ray may be of value.
- Sexually active females presenting with rectal pain and tenesmus should be screened for chlamydial infection of the rectum [2].

Management

Management will depend on the cause:

- Where the problem is constipation, simple measures such as increasing dietary fibre may help.
- Malignancy requires appropriate intervention. In advanced rectal carcinoma, radiotherapy can relieve tenesmus [3].
- Multidisciplinary laparoscopic treatment is usually undertaken for women with bowel endometriosis [4]. Depending on size of the lesion and site of involvement, full-thickness disc excision or bowel resection is performed by an experienced colorectal surgeon.
- A thrombosed pile requires incision and evacuation.

- In distal ulcerative colitis, although topical treatments can help significantly with distal disease, they often pose difficulty or discomfort for patients with tenesmus [5].
- Modern radiotherapy techniques reduce the risk of radiation proctitis. Although it often responds to conservative management, intervention is required if symptoms persist.
- Endoscopic therapy using argon plasma coagulation has been shown to be more effective and to be safer than other endoscopic techniques for chronic radiation proctitis [6].
- Oral diltiazem has been shown to be beneficial when given as an adjunct therapy for management of chronic malignancy-associated perineal pain, specifically with characteristics of pressure-type pain and tenesmus [1].

Further reading

- Hong J, Lee SY, Cha JG, et al; Unusual Presentation of Anal Pain and Tenesmus from Rectal Arteriovenous Malformation Successfully Treated with Ethanol Sclerotherapy. Case Rep Gastroenterol. 2021 Mar 3;15(1):262-268. doi: 10.1159/000513147. eCollection 2021 Jan-Apr.
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