Chronic anal pain: Can we really help?

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A colorectal surgeon presents a diagnostic and treatment algorithm for chronic anal pain, emphasizing the importance of excluding proctological and neuropathic mimics before diagnosing functional anorectal pain disorders.

KEY POINTS

- The speaker categorizes perianal pain into three groups: proctological and pelvic causes (occult fissures, intersphincteric sepsis, neoplasia, proctitis), neuropathic and skeletal problems (pudendal neuralgia, coccydynia), and Rome 5 anorectal pain disorders (levator ani syndrome, unexplained anorectal pain, proctalgia fugax).
- Pudendal neuralgia is likely underdiagnosed; the speaker stated it presents with burning pain that worsens throughout the day, is often better when lying or sitting on a toilet seat, and can be caused by entrapment at four locations along the pudendal nerve course.
- Diagnosis relies on symptom duration and examination findings: pain lasting seconds to minutes suggests proctalgia fugax, while pain lasting 30 minutes or more with levator tenderness on digital exam indicates levator ani syndrome.
- The speaker reported that biofeedback works for 87 percent of patients with levator ani syndrome who have dyssynergia, but patients with unexplained anorectal pain do not benefit from biofeedback.
- Randomized controlled trials showed no benefit of Botox compared to placebo for these conditions, and there is very little evidence supporting muscle relaxants, diazepam, or sacral nerve stimulation.
- The speaker emphasized that if the condition is functional, there is no surgical target, and a thorough digital rectal examination checking all four quadrants of the pelvic floor is essential to avoid missing structural causes.

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