

# Tips in Operative Office Proctology

This article will cover 3 simple procedures to deal with common proctology problems encountered by the general practitioner in the clinic:

1 Incision and drainage (I&D) of perianal abscess

2 Excision thrombectomy of perianal haematoma (thrombosed external pile)

3 Rubber band ligation of piles



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## 1) I&D OF PERIANAL ABSCESS

It has long been regarded that the conservative treatment of any abscess is adequate drainage. However, there may be a case for **antibiotics** alone if the abscess is not pointing to the skin and the patient refuses I&D. The chance of success is less than half and that of recurrence is more than half.

**Needle aspiration** (which has proved effective in breast abscesses) may appear attractive as being potentially diagnostic and therapeutic, but it has not been studied in the perianal area.

The relatively simple perianal abscess is to be distinguished from the more complex perirectal and horseshoe ischiorectal abscesses. If the perianal abscess is not **recurrent** or associated with an **anal fistula**, I&D is a safe and effective office procedure, with instant relief of pain. **Refer** to a surgeon for drainage under GA if the abscess is deep ischiorectal, not pointing to the skin, or submucosal (where drainage into the anorectal canal is more appropriate).

**Local anaesthetic** infiltration may be given but is usually unnecessary or ineffective. Pre-emptive oral or intramuscular **analgesics** may be more useful.

While it may be intuitive to make a transverse incision at the most fluctuant point, the correct **incision** is a **radial** one that keeps **close to the anus** as this has the lowest risk of neurovascular injury and results in a short tract should a fistula persist (Fig. 1). If possible, an ellipse of skin should be excised to prevent premature closure of the incision.

It is usually painful and hence not advocated to digitally probe, curette or tightly pack the cavity. Flushing with chlorhexidine, saline or even tap water is adequate. For a large abscess, it is important **not to probe cephalad** and inadvertently create an iatrogenic high anal fistula. In the clinic setting, it is not necessary to look for an associated anal fistula (which may be present in a third or more) but it is important to warn the patient of such.

It is also unnecessary to send for **bacteriologic culture** or continue antibiotics unless there is surrounding inflammation or the patient is immunocompromised.

## 2) EXCISION OF THROMBOSED EXTERNAL PILE

If the patient presents after the first few days, it is usually adequate to treat with analgesics and await **spontaneous resolution** (which takes up to 2-3 weeks) as the most painful period will have been over.



**Fig. 1 – Perianal abscess.**  
Green line shows the correct incision; red line shows an incorrect incision.



**Fig. 2a – Thrombosed external pile**  
(perianal haematoma).



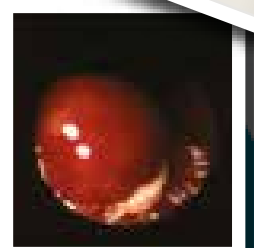
**Fig. 2b – Excision thrombectomy**  
done showing blood clot in the pile.



**Fig. 3a – Haemorrhoidal ligator** set with tissue grasper.



**Fig. 3b – Haemorrhoidal suction ligator**  
(suction machine required, not shown).



**Fig. 3c – Appearance**  
of rubber band ligated pile  
on proctoscopy.

If surgery is to be performed, **excision thrombectomy** is preferred to **I&D** which is essentially done in the same manner as for a perianal abscess except that blood clot is drained instead of pus. Simple I&D may relieve pain instantly but there may be continued bleeding after the clot has been evacuated and also usually results in a remnant skin tag that bothers the patient.

**Local anaesthetic** infiltration around and into the base of the pile is mandatory before excision. The patient must be relaxed, lying in a **lateral position** and retracting his/her own buttock. The pile is grasped and **sharply excised** off the underlying external anal sphincter with either scalpel blade or scissors in a V-incision pointing toward the anal orifice. It is best to **suture** the resulting wound with absorbable sutures for **haemostasis**. (Fig. 2)

## 3) RUBBER BAND LIGATION OF PILES

This procedure is suitable for Grade II (prolapses and reduces spontaneously) and III (requires digital reduction of prolapse) piles that are **NOT** too large, circumferential or associated with significant external component or skin tags.

A bright head-mounted **light** and a **suction ligator** set (Fig. 3b) are recommended for this procedure to be performed by a single operator, only needing an assistant to load the rubber bands onto the ligator cylinder. Local anaesthetic infiltration is not required but local application of lignocaine gel lubricates and soothes the anal canal for **anoscope** insertion.

The apparatus is positioned through the anoscope at the apex of the pile, which is then pulled into the banding cylinder either by suction (preferred) or traction. One or two bands are then ‘fired’ onto the base of the mucosa (Fig. 3c).

The ligature must be applied fairly low to be effective but not too much onto the pain-sensitive anal canal zone to avoid being painful. If there is severe **immediate pain**, the rubber **band must be removed** by division with a scalpel. If **moderate pain** develops during the **first 48-72 hours** or if a secondary thrombosed external pile develops, an **NSAID** and **metronidazole** may be useful. Some practitioners band one pile at a time to avoid excessive pain and perianal haematoma. **Severe pain** at a **later stage** must arouse suspicion of an **extensive perineal infection**; the first signs being **dysuria**, then pain and fever.

The rubber **band** may **drop off early** before necrosis of the ligated bundle if the tissue mass is too small to hold the elastic band or too large leading to tension and breakage. Early defaecation may also cause a band to fall off prematurely. The **banded pile** may also **prolapse** during defaecation and the patient must be instructed to **digitally reduce** it to avoid extensive thrombosis and swelling. Such prolapse does not indicate failure.

**Bleeding** occurs in about 5% at up to 2 weeks post-ligation. This is usually mild but can be severe requiring haemostasis, which can usually be achieved in the office by direct visualisation with an anoscope and submucosal injection of 1-2ml of 1/10000 adrenaline.

## Summary

In conclusion, simple office procedures can offer rapid relief for common anal conditions in properly selected patients who need not be referred for surgery by a specialist.