PRURITUS ANI

Anal itching may be primary with no underlying cause or secondary to another condition

Aetiology

- Inflammatory dermatoses: seborrhoeic/atopic dermatitis, psoriasis, irritant or allergic contact dermatitis, lichen sclerosis, lichen planus (may be no sign of skin disease elsewhere)
- Infection: viral warts, fungal infection (candida and dermatophyte species), erythrasma (Corynebacterium minutissimum), herpes simplex and zoster, threadworms
- Systemic illness: diabetes mellitus, anaemia
- Pre-malignant conditions/Malignancy: AIN, anal carcinoma,
- Haemorrhoids/fissures
- Medications: corticosteroids, colchicine
- Other: sphincter dysfunction (causing leakage), chronic lichen simplex, skin tags, sweat build up.

History

- Symptoms of itching or pain: identify aggravating or relieving factors. Itching can be worse at night.
- Lumps/lesions
- Bleeding on defecation, bowel habit
- Itching elsewhere on the body, other issues with skin/mucous membranes inc mouth/vagina/glans penis
- Washing and genital hygiene practices: use of soaps, wipes, over-washing.
- PMH inc skin conditions, CIN/VIN
- DH inc allergies and treatments tried so far
- Family history: other household members affected, diabetes, bowel problems
- Social history: recent travel abroad and sexual health

Physical Examination

- Skin and perianal area: assess overall skin morphology and condition, taking into account hairiness, faecal soiling, eczema, excoriations, lichenification, ulceration, haemorrhoids, fissures, skin tags, fistula and sinuses
- Rectal examination (consider digital and proctoscopic exam)

- Skin: assess remainder of integument for clinical clues (psoriatic nails, Wickham's striae)

Investigations

- Ulcer PCR swab if fissures, ulcers or unusual erythematous lesions
- Bacteriology charcoal swab of affected area if infections suspected
- Apply cellotape for threadworm ova
  - ⇒ apply sticky side to perianal area in the morning before defaecation.
  - ⇒ Tape is then applied to a slide for microscopic examination.
- Urinalysis for glucose
- Consider skin biopsy

Management

General Advice

- Clean carefully after bowel motions. Wash (eg with cotton wool and water) and pat dry rather than wipe)
- Use appropriate soap substitute (avoid soap, bubblebaths, shampoo, other potential irritative applications and abrasive agents such as flannels)
- Wear loose soft cotton underwear
- Keep cool and have cooler baths/showers less than 20 mins
- Eat high fibre diet (avoid trauma by facilitating normal anal sphincter function))
- Keep fingernails short
- Avoid spicy foods/alcohol/caffeine
- Try not to scratch: trial of cotton gloves at night.
- Emollient as barrier may be appropriate

Specific conditions

Threadworm

Enterobius vermicularis - small white thread-like (1-2cm) worms

- Females lay eggs in perianal region which are ingested and mature in the caecum (6 weeks incubation)
- Sources of infection: digital/anal/oral contact
  bedding (households/institutions)
  rimming (especially MSM)

Mebendazole 100 mg stat
May need second dose after 2 weeks if recurrence
**Avoid in pregnancy*

Advise hygiene measures in addition for 2 weeks and consider treatment of all household contacts. .

No treatment is licensed in pregnancy. Recommend hygiene measures for 6 weeks.

Other causes

- **Erythrasma:** chronic, itchy, red-brown macules with very fine scale on intertriginous skin, particularly the anogenital area. Treat using topical clotrimazole bd for 2 weeks.

- **Anal Fissure**: If multiple fissures and/or atypical location consider alternative diagnosis – HSV, syphilitic chancre, inflammatory bowel disease (Crohn's, ulcerative colitis), intra-epithelial neoplasia (AIN), trauma. Usual presentation is pain; however, anal itch is also common.
  - **Usually resolve without treatment**.
  - **Recommendations include fibre/fluids** for bowel regularity, laxatives if required, non-constipating analgesics, topical anaesthetic if pain is severe
  - **If fissure is persistent, liaise with GP as patient may need referral to surgeons**

Empirical management: no definitive diagnosis

- Appropriate use of emollients (trial of both water-based and paraffin-based depending on state of skin).

If inflamed, intermittent twice daily use of mild, topical steroid cream combined with antifungal agent (clotrimazole with hydrocortisone).

In severe cases consider potent steroids such as dermovate and/or systemic antipruritic (non sedating cetirizine or sedating chlorpheniramine), sedating agents with nerve-modifying functions such as low dose amitriptyline 10-20mg nocte. (discuss such management with a senior clinician).

If unresolving/diagnostic uncertainty/suspicion of malignancy: consider role of biopsy and referral on to appropriate specialty.

References

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