EM CASE OF THE WEEK.
BROWARD HEALTH MEDICAL CENTER
DEPARTMENT OF EMERGENCY MEDICINE

BROWARD HEALTH
Care Warriors

Author: Jared Herman | Editor: Ajith Susai D.O.

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Perirectal Abscess

A 52 year old male with no past medical history presents to the ED with 4 days of sharp, constant 9/10 rectal pain worsened with prolonged sitting, bowel movements and palpation. He has never experienced these symptoms prior to this episode. He denies fever, chills, change in bowel habits or blood in the stool. Patient is afebrile and vitals are within normal limits. On physical exam, patient has right inferior gluteal tenderness to palpation. Rectal exam is unremarkable, with no fissures or external hemorrhoids visualized and no internal masses palpated. Patient does complain of pain with rectal examination but there is no redness or swelling appreciated. Lab results show a WBC count of 13.65. While the definitive treatment for this problem is surgical drainage, what is the best next step?

A. Discharge the patient home with instructions for Sitz-baths twice a day

B. ciprofloxacin and metronidazole for 7-14 days

C. Bedside incision and drainage

D. Topical bactrim

E. Needle drainage

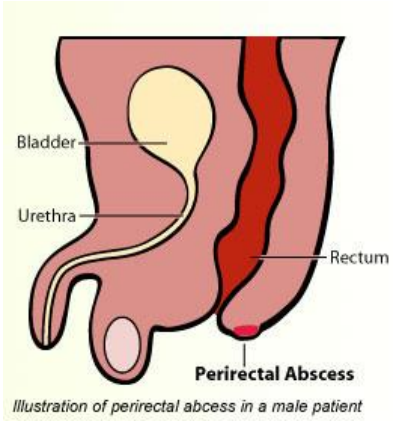

Illustration of perirectal abcess in a male patient

Illustration of perirectal abscess

Perianal and perirectal abscesses are common anorectal problems. The infection originates most often from an obstructed anal crypt gland, with the resultant pus collecting in the subcutaneous tissue, intersphincteric plane, or beyond (ischiorectal space or supralevator space) where various types of anorectal abscesses form.

EM Case of the Week is a weekly "pop quiz" for ED staff.

The goal is to educate all ED personnel by sharing common pearls and pitfalls involving the care of ED patients. We intend on providing better patient care through better education for our nurses and staff.

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Department of Emergency Medicine
1625 SE 3rd Avenue
Fort Lauderdale, FL 33316

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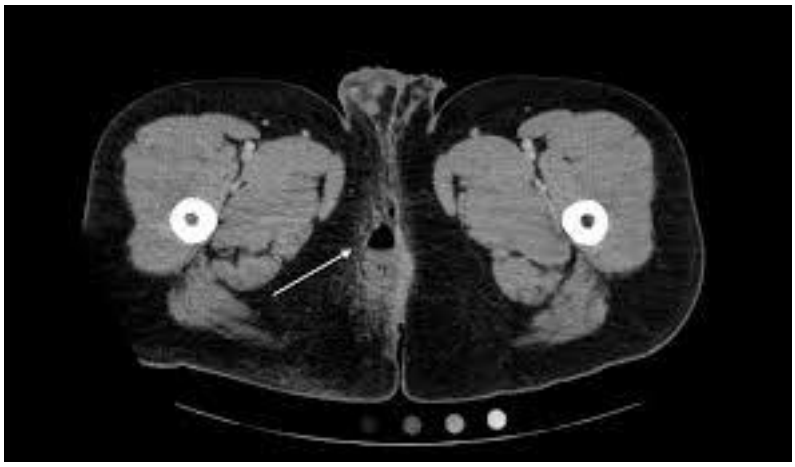
The correct answer is B. A course of ciprofloxacin and metronidazole for a course of 7-14 days along with definitive treatment of surgical drainage. CT scan showed perirectal abscess along the posterior margin of the rectum with extension bilaterally around the rectum.

Perianal and perirectal abscesses are common anorectal problems, originating most often from an obstructed anal crypt gland, with the resultant pus collecting in the subcutaneous tissue, intersphincteric plane, or beyond (ischiorectal space or supralevator space). An undrained anorectal abscess can continue to expand into adjacent spaces as well as progress to generalized systemic infection. Prompt surgical drainage is recommended. It is estimated that there are approximately 100,000 cases of anorectal infection per year in the United States. The mean age of presentation is 40 years (range 20 to 60), and adult males are twice as likely to develop anorectal abscesses when compared to females.



2018 JETEM Perianal Abscess

Discussion

A perianal abscess is a simple anorectal abscess. Perirectal abscesses are more complex and can involve different planes in the anorectum, have distinct clinical presentations, and require more nuanced management. The classification of perirectal abscesses is based on their anatomic locations. Patients with an anorectal abscess often present with severe pain in the anal or rectal area. The pain is constant and not necessarily associated with a bowel movement. Constitutional symptoms such as fever and malaise are common. Purulent rectal drainage may be noted if the abscess has begun to drain spontaneously. On physical examination, an area of fluctuance or a patch of erythematous, indurated skin overlying the perianal skin may be noted in patients with a superficial (eg, perianal) abscess. Anorectal abscess should be suspected in patients who present with severe pain in the anal or rectal area. Deeper abscesses may be best assessed with imaging such as CT or MRI.

Treatment

Antibiotics (either amoxicillin-clavulanate or a combination of ciprofloxacin and metronidazole) should be provided for patients until surgical treatment is obtained, which is the primary treatment. Lack of fluctuance should not be a reason to delay treatment. Any undrained anorectal abscess can continue to expand into adjacent spaces as well as progress to generalized systemic infection. Most perirectal abscess are complex and best drained and treated in the operating room under regional and general anesthesia. The wound should be packed and the area should be kept clean with instructions for Sitz Baths should be provided. As of now, further studies are needed to determine the benefit of routine antibiotics after incision and drainage of perirectal abscesses.

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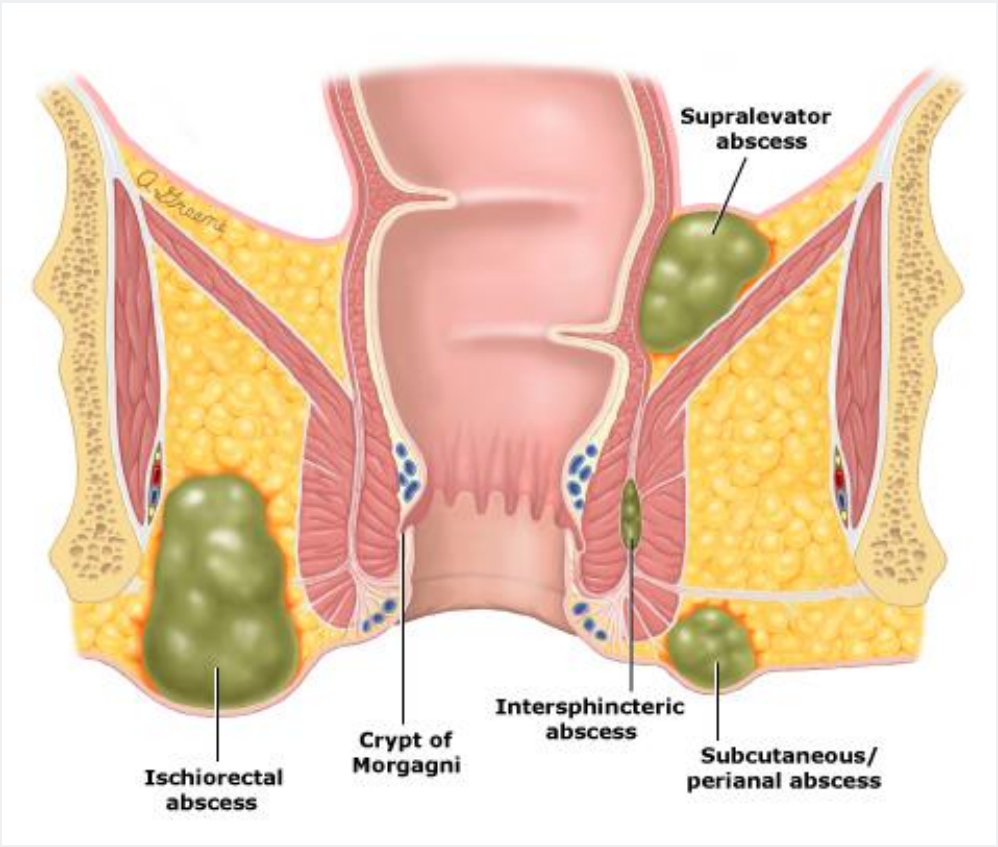

2018 UpToDate Locations of Anorectal Abscesses

Take Home Points

- Perianal and perirectal abscesses are common anorectal problems
- Patients with an anorectal abscess often present with severe pain in the anal or rectal area. The pain is constant and not necessarily associated with a bowel movement
- The primary treatment of anorectal abscess is surgical drainage. Antibiotics (either amoxicillin-clavulanate or a combination of ciprofloxacin and metronidazole) should be provided for patients until surgical treatment is obtained

ABOUT THE AUTHOR

This month's case was written by Jared Herman. Jared is a 4th year medical student from NSU-COM. He did his emergency medicine rotation at BHMC in August 2018. Jared plans on pursuing a career in Anesthesiology after graduation.

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