Proctalgia Fugax and Anal Pain

Synonyms: functional anorectal pain, chronic proctalgia, pyriformis syndrome, pelvic tension myalgia, levator ani syndrome

Functional anorectal pain occurs in the absence of any clinical abnormality.[1] It's a relatively common symptom - first described by the Romans. Patients will often delay consulting a healthcare practitioner about this problem, due to embarrassment and fear of a sinister diagnosis, tolerating disturbing symptoms for long periods.

There are two functional anorectal pain syndromes, defined by the Rome III criteria (2006):[3]

- Proctalgia fugax (PF) (fugax = fugitive/fleeting in Latin)
- Levator ani syndrome (LAS)

They are both characteristic, benign, anorectal-pain syndromes of uncertain aetiology. Despite their benign nature, they can cause severe distress to the sufferer.

Aetiology

- They are thought to occur due to spasm of the anal sphincter (in PF) or pelvic floor muscles (in LAS) but are something of an enigma.
- It is important to elicit a precise history of defecation.
- They may be associated with irritable bowel syndrome (IBS).
- The two affected muscles are anatomically contiguous so the two conditions may co-exist, or be different manifestations of the same underlying dysfunction.[4]
- The diagnosis of these conditions can usually be made on the basis of the symptoms. However, more serious diagnoses can present similarly. Thus, it is essential to conduct a thorough clinical assessment to exclude other pathology before offering reassurance.
- A history of anxiety or depression is often associated and this should be evaluated.[5]
- They have been associated with a variety of other pathologies which may have aetiological significance; for example, pudendal nerve neuralgia.[6]

Epidemiology

- Proctalgia fugax (PF) is estimated to affect 8-18% of the population in the developed world, and levator ani syndrome (LAS) around 6%.[7]
- LAS seems to affect women more than men whereas PF seems to affect both sexes equally.[8]
- It is thought that only 20-30% of those who experience these conditions consult a healthcare practitioner.[8, 9]

Differential diagnosis

- Irritable bowel syndrome.
- Haemorrhoids ± thrombosis.
- Anal fissure (usually causes intense localised pain associated with and following defecation) - should be visible on proctoscopy.
- Solitary chronic rectal ulcer.
- Colorectal cancer.
- Perirectal abscess or fistula; hidradenitis suppurativa.
- Proctitis (especially gonococcal/chlamydial infection).[10]
- Crohn's disease/ulcerative colitis.
- Rectal foreign body.
- Pruritus ani.
- Diverticular disease.
- Rectal prolapse.
- Coccygodynia (neuralgic pain around the region of the coccyx).
- Retorectal cysts.[11]
- Condylomata acuminata (anogenital warts).
- Testicular tumours.
- Prostatitis.
- Proctitis.
- Cystitis.
- Psychological cause (some hypothesise that these conditions are psychological rather than physical in origin).[4]
- Alcock’s canal syndrome (pudendal neuralgia due to entrapment, may present similarly to PF/be aetiologically relevant).[4, 6]
- Hereditary anal sphincter myopathy.[12]
- Bilateral internal iliac artery occlusion.
Investigations

- Endoscopy (flexible rectosigmoidoscopy or colonoscopy) should be considered in patients with chronic anorectal pain.
- If this is normal and there is tenderness of the puborectalis muscle then other investigations such as anorectal manometry, balloon expulsion test and MRI-Defecography should be considered.[6]
- Depending on the level of clinical uncertainty, other useful investigations can be FBC, pelvic ultrasound and anorectal endosonography.

Intermittent chronic anal pain syndrome: Proctalgia fugax

Presentation

- Symptoms:
  - Recurrent episodes of sudden, severe cramping pain localised to the anus or lower rectum.
  - Last from seconds to minutes and resolve completely.
  - The patient is entirely pain-free between the episodes.
  - Symptoms often occur at night and may wake the person who has the condition. Attacks are infrequent (<5 times yearly in 51% of patients).
  - Attacks may come in clusters (occurring daily) then abate for long periods.[8]

- Signs:
  - PF has no signs and the diagnosis is made on the basis of characteristic symptoms and the absence of signs of other pathology.
  - Abdominal and digital rectal examination should constitute the minimum assessment of anal pain.
  - Ideally, anoscopy/proctoscopy should be carried out.[13]
  - Consider gynaecological/scrotal examination if relevant.
  - Further examination with a sigmoidoscope or colonoscope may be necessary in selected patients where there is suspicion of pathology higher in the colon.
  - It is worth checking for signs of anaemia if gastrointestinal bleeding is suspected.

Management

- Once the diagnosis is made, reassurance is usually sufficient.
- The symptoms are so transient that drug therapy is rarely needed.
- In patients who experience frequent, severe, prolonged attacks, inhaled salbutamol has been shown to reduce their duration.
- Most other treatments (such as oral diltiazem, topical glyceryl nitrare and nerve blocks) act by relaxing the anal sphincter spasm but are not supported by randomised controlled trials.[14]
- Co-existent psychological issues should be addressed with behavioural and/or pharmacological therapies.[7]

Chronic anal pain syndrome: Levator ani syndrome

Presentation

- Symptoms:
  - Vague, aching or pressure sensation high in the rectum often worsened by sitting and relieved by walking.
  - Pain tends to be constant or recur regularly and to last >20mins.
  - Lasts from hours to days.
  - To satisfy diagnostic criteria the symptoms must be present for three months with symptom onset at least six months prior to diagnosis.[3]
  - Other causes of similar pain (see 'Differential diagnosis', above) must have been excluded.

- Signs:
  - In LAS, posterior traction on the puborectalis reveals tight levator ani muscles and tenderness or pain. (This differentiates between LAS and Unspecified Functional Anorectal Pain).[5]
  - Tenderness may be predominantly left-sided and massage of the puborectalis muscle may elicit the characteristic discomfort.

Management

- The recently-published Guidelines on Chronic Pelvic Pain (European Association of Urology) suggest (in decreasing robustness of clinical evidence) :[5]
  - Biofeedback treatment
  - Botulinum toxin A and electrogalvanic stimulation
  - Percutaneous tibial nerve stimation
  - Sacral neurostimulation
  - Inhaled salbutamol

- If all functional tests are normal, consider referral to a specialist pain management unit.
Medicolegal note

- When examining the anogenital area ensure that the patient is fully informed about what to expect and the reasons why the examination is necessary.
- An appropriate chaperone should be offered and be in attendance for intimate examinations.
- Document the presence of a chaperone and their identity along with the examination findings.
- Ensure patient privacy and dignity, and discontinue the examination if at any time you or the patient are unhappy or uncomfortable with the situation.
- Do not assume that because you are the same sex as the patient, a chaperone isn't needed.
- For further information, see separate article Rectal Examination.

Further reading & references

2. Rome III Diagnostic Criteria for Functional Gastrointestinal Disorders

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