Common Problems of the Abdomen and Gastrointestinal System - II

diarrhea, constipation, rectal pain & itching

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Diarrhea

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Acute Diarrhea*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Viral gastroenteritis (e.g., Norwalk or rotavirus viral agents)	Abrupt onset 6-12 hr after exposure; nonbloody, watery diarrhea; lasts <1 wk; nausea/ vomiting, fever, abdominal pain, tenesmus	In children may see severe dehydratioin; hyperactive bowel sounds, diffuse pain on abdominal palpation	None
Shigella (gram-negative rod; fecal-oral transmission; common in day care setting; common in gay bowel syndrome)	Acute onset 12-24 hr after exposure; lasts 3-7 days; large amounts of bloody diarrhea with abdominal cramping and vomiting	Lower abdominal tenderness, hyperactive bowel sounds, no peritoneal irritation	Fecal leukocytes, positive stool culture
Necrotizing enterocolitis (NEC)	Premature or low-birth weight infant who presents with feeding intolerance	Vomiting, abdominal distention, lethargic, loose, bloody, mucousy stools	refer

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Acute Diarrhea*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
S. Aureus food poisoning (gram-positive cocci; from improperly stored meats or custard-filled pies)	Acute onset 2-6 hr after ingestion; lasts 18-24 hr; large amounts of watery, nonbloody diarrhea; cramping and vomiting	Hyperactive bowel sounds	Fecal leukocytes, negative stool culture
Clostridium perfringens food poisoning (gram-positive rod; from contaminated food)	Acute onset 8-20 hr after ingestion; lasts 12-24 hr; large amounts of watery, nonbloody diarrhea; abdominal pain and cramping	Hyperactive bowel sounds, diffuse pain on abdominal palpation	Fecal leukocytes, negative anaerobic cultures of stool
Salmonella food poisoning (gram-negative bacilli; ingestion of contaminated food, poultry, eggs)	Acute onset 12-24 hr after ingestion; lasts 2-5 days; moderate to large amounts of nonbloody diarrhea; abdominal cramping and vomiting	Fever of 38.3-38.9度C (101-102度F)common; hyperactive bowel sounds, diffuse abdominal pain	Fecal leukocytes, positive stool culture, WBC count normal

DIFFERENTIAL DIAGNOSIS OF *Common Causes of* *Acute Diarrhea-cont'd*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Campylobacter jejuni (gram-negative rod; fecal- oral transmission; household pet)	Acute onset 3-5 days after exposure; lasts 3-7 days; moderate amounts of bloody diarrhea	Fever, lower quadrant abdominal pain	Fecal leukocytes, positive stool culture
Vibrio cholerae (gram-negative rod; fecal-oral transmission; ingestion of contaminated water, seafood, or food)	Acute onset 8-24 hr after ingestion of contaminated food; lasts 3-5 days; large amounts of nonbloody, watery, painless diarrhea; can be mild or fulminate	Cyanotic, scaphoid abdomen, poor skin turgor, thready peripheral pulses, voice faint	Fecal leukocytes, negative stool culture
Enterotoxic E. coli (gram-negative rod; fecal – oral transmission; ingestion of contaminated water or food)	Acute onset 8-18 hr after ingestion of contaminated food/water; lasts 24-48 hr; moderate amounts of nonbloody diarrhea; pain, cramping, abdominal pain;	No fever; dehydration is major complication	Fecal leukocytes, positive stool culture

DIFFERENTIAL DIAGNOSIS OF *Common Causes of* *Acute Diarrhea-cont'd*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Entamoeba histolytica parasite (cysts in food and water, from feces)	Acute onset 12-24 hr after ingestion of contaminated food or water; large amounts of bloody ; diarrhea; abdominal cramping and vomiting	Right lower quadrant abdominal pain; in small number of cases hepatic abscess forms	IHA: antibodies to E. histolytica; positive titer is >1:128
Antibiotic-induced (begins after taking antibiotics)	Mild, watery diarrhea; crampy abdominal pain	Diffuse abdominal pain on palpatioin, fever absent	Usually not needed
Pseudomembranous colitis (Clostridium difficile antibiotic induced)	Induced by antibiotics, most commonly ampicillin, clindamycin, or cephalosporins; symptoms range from transient mild diarrhea to active colitis with bloody diarrhea, abdominal pain, fever	Lower quadrant tenderness, fever	CBC: leukocytes; sigmoidoscopy/colonoscopy; C. difficile toxin assay or stool culture; C. difficile toxin

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Chronic Diarrhea*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Irritable bowel syndrome (IBS)	Intermittent diarrhea alternating with constipation; mucus with stool; seldom occurs at night or awakens patient; commonly present in morning; may have rectal urgency; episodes usually triggered by stress or ingestion of food; affects women 3 times as often as men	Tender colon on palpation; may have abdominal distention; no weight loss; afebrile	Diagnosis of exclusion; sigmoidoscopy, proctoscopy
Ulcerative colitis (distal colon is most severely affected and rectum is involved)	History of severe diarrhea with gross blood in stools, no growth retardation; few complaints of pain; age of onset second and third decades with small peak during adolescence; positive family history	Overt rectal bleeding; initially no fever, weight loss, or pain on palpation of abdomen; moderate colitis: weight loss, fever, abdominal tenderness	CBC shows leukocytosis or anemia, ESR elevated; stool cultures to rule out other causes of diarrhea; colonoscopy

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Chronic Diarrhea*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Crohn's disease (associated with uveitis, erythema nodusum)	History of chronic bloody diarrhea with abdominal cramping, tenderness, and rectal bleeding; in children a history of growth retardation, weight loss, moderate diarrhea, abdominal pain, and anorexia	Weight loss, rare gross rectal bleeding, fistulas common	Colonoscopy with biopsies
Carbohydrate malabsorption	Bloating, flatus, diarrhea exacerbation by ingestion of certain disaccharides (eg. Lactose, milk, milk products); may fallow viral gastroenteritis	Diffused abd. pain	Trial elimination of offending foods
Fat malabsorption	Greasy, fatty, malodorous stool; associated with deficiencies of Vit. K, A, and D; cystic fibrosis (present before lung involvement)	Rectal prolapse, poor weight gain, abdominal distension	72-h fecal test, sweat test,
Celiac sprue/protein hypersensitivity (reaction to protein in wheat, rye, barley and oats)	Increased stool frequency, loose, pale, and bulky stool with 3-6 mo of dietary onset. Children are lethargic, irritable, and anorectic, peak frequency 9-18 mo.	Failure to thrive, abdominal distention, irritability, muscle wasting.	Improvement on gluten-free diet, CBC, anemia, folate deficiency,

Type of Diarrhea

- Osmotic
  - Malabsorbtive, non absorble water-soluble solutes in the bowel and retain water
  - As in lactulose intolerance
- Secretory
  - Secretion and absorption lost balance, as in cholera infection
- Exudative
  - In mucosa inflammation or ulceration
  - As in irritable bowel syndrome

Frequency and duration of diarrhea

- Intermittent diarrhea alternating with constipation suggest IBS
- Acute onset is commonly virus in origin
- Chronic diarrhea lasts for more then 2 weeks.

Pain, color and vomit

- Pain
  - Small intestine: epigastric an umbilicus
  - Large intestine: Lower quadrants
- Color
  - Bright: lower GI track
  - Dark: upper GI track
- Vomit
  - Early in viral gastroenteritis
  - In bacterial etiology, diarrhea occurs before vomiting

Proximal vs. distal colon symptoms

- Proximal
  - Large volume, less frequent, more homogeneous stool,
  - without urgent or tenesmus (painful defecation)
- Distal
  - Small volume, frequent, incontinence and mucus stool,
  - urgent or tenesmus

Medication-related diarrhea

- Pseudomembranous enterocolitis
  - C. diff (*Clostridium difficile*) infection, In patients on ampicillin, clindamacin, cephalosporin
  - Lower quadrant pain and fever
- Other type
  - Antacids with magnesium, methyldopa, beta blocker, systemic anti-inflammatory agents, colchicine, ….

Diagnostic Reasoning: Focused Hx

- **What Does This Patient Mean by "Diarrhea"？**
  - **How frequent is the stool？**
  - **What is the volume of stools？**
  - **Are the stools formed or liquid ？**
  - **At what intervals does the diarrhea occur？**
- **If This is an Infant, Is There a Risk of Dehydration？**
  - **How many wet diapers has the child produced in the past 24 hours？**
  - **Does the infant seem thirsty？**
  - **Does the child have tears when crying？**

Diagnostic Reasoning: Focused Hx

- If This is an Adult, Is There Risk for Dehydration？
  - How many times have you urinated in the past 24 hours？
  - Are you thirsty？
  - Do you have a dry mouth or dry eyes？
- Is This an Acute or Chronic Problem？
  - How long have you had diarrhea？
  - Have you had this problem before？

Diagnostic Reasoning: Focused Hx

- Does the Presence or Absence of Blood Help Me Narrow the Cause？
  - Is there any noticeable blood in the stool or tissue？ How much？
  - What color is the blood？
  - What color is the stools？
- What Does the Presence or Absence of Pain Tell Me？
  - Are you having any abdominal pain or gas with with the diarrhea？
  - Where is the pain？
  - What does the pain feel like？
  - Is the constant or does it come and go ？
  - Does the pain awaken you at night ？
  - Does the pain interfere with your activities(e.g,.work, sleep, eating) ？

Diagnostic Reasoning: Focused Hx

- **What Do Associated Symptoms Tell Me？**
  - Do you have any fever？ Did you measure your temperature？What was the highest temperature？
  - Do you have any vomiting？
  - What occurred first: the diarrhea or the vomiting？
- **Could This Be Caused by Exposure to Others or to Contaminated Food？**
  - 1. If a child: Does the child attend day care？
  - 2. If a child: Are any of the other children in day care ill？
  - 3. Have you been around others who have similar symptoms？

Diagnostic Reasoning: Focused Hx

- Could This Be the Result of Exposure to Animals Exposure
  - What pets do you have？
  - Have you had contact with or have you handle dogs, cats, or turtles？
- Could This Be Caused by Exposure to Contaminated Water？
  - Have you traveled recently？ where？
- Could Sexual Activities Explain the Diarrhea？
  - Have you been diagnosed with an immune system problem？
  - Do you have frequent colds or other illnesses？
  - Are you receiving chemotherapy？

Diagnostic Reasoning: Focused Hx

- Could This Be Caused by Medication？
  - Have you taken any antibiotics recently？ which one(s) ？
  - What prescription medications are you currently taking？
  - What over-the-counter medications/preparations are you currently using？
- Could This Be Related to a Surgical Procedure？
  - Have you had surgery recently？
- Is This Diet Related？
  - How much apple juice or how many sodas do you drink in a day？
  - Do you drink milk products？
  - Do you eat wheat products ？
  - What have you had to eat in the past 3 day？

Diagnostic Reasoning: Focused Hx

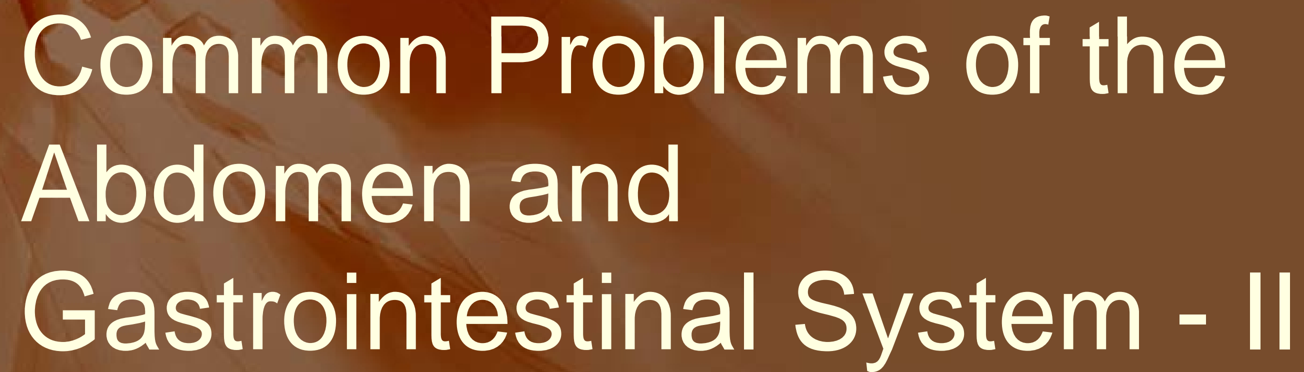
- **Could This Be Caused by Food Preparation Problem？**
  - **Have you recently eaten raw or undercooked poultry, Shellfish, or beef？**
  - **Have you recently ingested unpasteurized milk？**
  - **Do you prepare poultry and/or beef on the same surface as other foods？**
  - **Is anyone else you know ill with similar symptoms？**
- **Is There Any Family Predisposition that May Point to a Cause？**
  - **Have you or anyone in your family been diagnosed with cystic fibrosis？**
  - **Does anyone in your family have a history of chronic diarrhea, ulcerative colitis, or inflammatory bowel disease？**

Diagnostic Reasoning-Focused PE

- Inspect General Appearance
- Assess Hydration Status
- Indicators of Hydration Status
  - Mucous Membranes
  - Tissue Turgor
  - Fontanel
  - Peripheral perfusion
  - Urine Output/Specific Gravity
  - Take Temperature
- Weight patient and Note Persistent or Involuntary Weight Loss
- Observe Abdomen Contour
- Auscultate the Abdomen
- Palpate the Abdomen for Tenderness
- Perform a Digital Rectal Examination
- Palpate Lymph Nodes

Lab and diagnos tic studies

- Fecal Leukocytes .
- Fecal Occult Blood Testing
- Fecal Immunochemical Testing(FIT)
- Fecal Fat
- D-Xylose Absorption Test
- Stool PH
- Wet Mount
- C. difficaile Toxin Assay
- Stool Culture
- Stool for Ova and Parasites
- Giardia Antigen Test
- Indirect Hemagglutinin Assay
- Complete Blood Cell Count With Differential
- Peripheral Blood Smear
- Blood Urea Nitrogen and Creatinine
- Endoscopic Studies



Common Problems of the Abdomen and Gastrointestinal System - II

Constipation

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Constipation*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Simple constipation	Low dietary fiber and bulk; inadequate fluid intake; physical inactivity; pain before and with bowel movements; anorexia	Normal abdominal and rectal examination; may feel fecal masses in colon and rectum	None if resolved; consider sigmoidoscopy if not resolved
Functional constipation	Preschool and school-age children; history of abdominal pain and stool soiling	Palpable stool in LLQ; large dilated rectum with packed stool; external sphincter intact	Abdominal radiography, unprepped barium radiography
Irritable bowel syndrome (IBS)	Onset in young adulthood; alternating diarrhea and constipation; mucus in stools	May have tender, palpable colon	Sigmoidoscopy if indicated

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Constipation*

CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Obstipation/ impaction	Passage of hard stool at 3- to 5-day intervals; diarrhea, small caliber stools; common in those confined to bed	Hard feces in rectal ampulla; may have palpable faces-filled bowel	Sigmoidoscopy if indicated
Slow transit	Common in older adults; physical inactivity; decreased stool frequency; stool dry and hard	Normal abdominal and rectal examination	FOBT or FIT to rule out tumors
Hirschsprung's disease	Delayed passage of meconium at birth; no urge to defecate	Empty rectal ampulla on examination	Colonoscopy

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Constipation*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Anorectal lesions	Rectal pain on defecation; history of hemorrhoids; blood on stool on toilet tissue, or in toilet	On rectal examination: hemorrhoids, fissures, tears, abrasions; increased sphincter tone	Anoscopy
Drug induced	History of chronic laxative use; history of taking medications that produce constipation	Normal rectal and abdominal examinations	None if resolved;
Tumors (increased incidence over age 40; uncommon in children)	Diarrhea more common than constipation; recent onset: pain and abd. distention, stool leakage, urgency; late onset: weight loss, anorexia;	May have palpable abdominal mass or organomegaly	CBC, FOBT or FIT, sigmoidoscopy, colonoscopy, barium enema

Definition of constipation

- Fewer tha 3 bowel movement per week
- Failure to completely evacuate the lower colon
  - Difficult in defecation
  - Infrequent bowel movement
  - Straining
  - Abdominal pain
- Ostipation
  - Intractable constipation or the regular passage of hard stool at 3- to 5-day interval
- New onset of constipation over 40 is suspicious for colon lesion.

Size or caliber os stool

- Small hard stool:
  - congenital aganglionic megacolon
- Very large stool:
  - functional constipation, with the size of the stool a function of the size of the colon
- Toothpaste-like caliber:
  - Fecal impaction

Focused Hx

- Is This Really Constipation？
  - How many stools are there per day？
  - What is the consistency of the stool？
- Is the Constipation Acute or Chronic？
  - When did the Constipation start？
  - How long have you been Constipated？ Is this an individual episode or is it chronic？
  - At what age did the Constipation first begin？
- If the Constipation Is Acute, What Condition Should Consider？
  - Have you been ill recently？ Have you had a fever？
  - Do you have any chronic health problems？

Focused Hx (continued)

- If the Constipation Is Chronic or Recurrent, What Should I Consider？
  - What do you usually eat in a day？
  - How many glasses of liquid do you drink each day？
  - What are your usual bowel habits？
  - How active are you？
  - What medications are you taking？
  - Do you use laxatives？ How often do you take laxatives？ How long have you used laxatives？
- How Can I Further Narrow the Cause？
  - What does your stool iook like？Is the stool size large or small What is the general shap of the stool (e.g.,small, round, ribbonlike)？
  - Is the stool formed or liquid？
  - Have you had Constipation alternate with periods of diarrhea？

Focused Hx

- What Else Do I Need to Consider？
  - Do you have the urge to defecate？
  - Do you have any urinary tract symptoms？
  - Do you have any nausea or vomiting？
  - Is there any pain with defecate？
  - Is there any bleeding with defection？ How much？
  - What color are your Stools？ Are the stools very dark colored or black？
- If This Is a child, Is There Anything Else I Need to Consider？
  - Is there fecal soiling of underpant？
  - Is there crying with defecation？
  - If an infant: Is there a history of delayed passage of meconium stool？
  - Has the child begun to drink milk？
  - Has the child recently started toilet training？
  - Does the child have urinary frequency？
- Is There a Family History or Genetic Predisposition？
  - Is There a Family History of constipation or IBS？

Focused PE

- Perform Abdominal Examination
- Perform Digital Rectal Examination
- Perform a Focused Neurological Examination

Lab and diagnos tic studies

- Fecal Occult Blood Test(FOBT)
- Fecal Immunochemical Test(FIT)
- Complete Blood Cell Count
- Serum Electrolytes
- Serum Thyroid-Stimulating Hormone
- Urinalysis
- Anoscopy
- Flexible Sigmoidoscopy and Colonoscopy
- Barium Enema
- Colon Transit Studies

Common Problems of the Abdomen and Gastrointestinal System - II

rectal pain & itching

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Rectal Pain, Itching, and Bleeding*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Pain			
Anal fissure	Cutting or tearing pain during defecation and gnawing, throbbing discomfort afterward	Early fissures appear as superficial erosions; more advanced lesions are linear or elliptical breaks in skin; long-standing fissures are deep and indurated; internal fissures are seen when anal sphincter relaxes as examining finger is withdrawn; sentinel tag may be visible at anal verge	Anoscopy
Perirectal abscess	Swelling, throbbing, continuous progressive pain	Erythema and swelling in perirectal area; pain may preclude examination	Anoscopy

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Rectal Pain, Itching, and Bleeding*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Proctalgia fugax	Sudden, severe, transient pain in rectum often occurring at night; may be accompanied by sweating, pallor, tachycardia; may occur as 1 episode/yr or in waves of 3-4 times/wk	Normal rectal examination	Diagnosed by clinical history and negative physical examination
Proctitis/ proctocolitis	Anorectal pain; mucopurulent discharge, tenesmus, constipation with proctitis; also diarrhea, abdominal pain, and fever with proctocolitis; history of and intercourse, immunocompromised	Purulent discharge, inflamed mucopurulent rectal mucosa	Cultures, molecular testing, Gram stain, serology for syphilis; stool examination, stool O & P

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Rectal Pain, Itching, and Bleeding*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Pilonidal disease	Pain in sacrum, superior to rectum; history of sedentary occupation	Erythema, swelling over sacrum, which can be fluctuant	None
Perianal streptococcal cellulitis	History of GABHS, local itching, pain	Erythema, proctitis, blood-streaked stools	Culture of perianal area
Sexual abuse	History of abuse, perianal pain, itching	Large irregular and fissures, bruising, rectal tone decreased, warts, presence of semen	Serology for syphilis; culture (gonorrhea, T. vaginalis, herpes); molecular testing, (herpes, chlamydia, gonorrhea)

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Rectal Pain, Itching, and Bleeding*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Itching			
Pruritus ani	Discomfort and itching exacerbated by friction; history of poor anal hyginene or overcleansing	Mild erythema and excoriation over perirectal skin; in later stages: red, raw, oozing, pale lichenified perirectal skin	
Pinworms	Itching, expecially at night	Visualize white-yellow worms 8-13 mm in length at night with flashlight	Scotch tape test positive for eggs

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Rectal Pain, Itching, and Bleeding*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Bleeding			
Hemorrhoids	Bright red rectal bleeding with defecation or blood on stool; burning or itching; straining at stool; prolonged sitting; pregnancy and childbirth	External hemorrhoids: bluish, skin-covered lumps; internal hemorrhoids: may be visible when patient bears down	FOBT or FIT
Condyloma acuminata	Few symptoms with small lesions; bleeding, discharge, itching, and pain with large lesions	Pink or white warty lesions with papilliform surface; may extend into and cancal	Serology to distinguish from condyloma lata caused by syphilis
Cancer of rectum, anus	Feeling of lump; usually painless; may or may not bleed; may have family history of polyposis	Polyp, internal or external masss, ulcers, verrucous growths	Anoscopy, flexible sigmoidoscopy, solonoscopy

DIFFERENTIAL DIAGNOSIS OF *Common Causes of Rectal Pain, Itching, and Bleeding*			
CONDITION	**HISTORY**	**PHYSICAL FINDINGS**	**DIAGNOSTIC STUDIES**
Ingestion of maternal blood	Newborn	Hematemesis	APT test
Allergic colitis	Infant 0-6 mo, milk formula or breastfed mother who has intake of milk	Blood-streaked stools	None
Necrotizing Enterocolitis	Preterm, newborn infant	Ileus, abdominal distention, gastrointestinal bleeding, bilious vomiting	Immediate referal
Meckel's diverticulitis	Preschool child, painless gastrointestinal bleeding	Black or maroon stools	referral
Intussusception	Colicky abdominal pain, vomiting, currant jelly stools	Sausage-shaped mass may be felt in abdomen	Refer
Junvenile polyps	Painless bleeding with stool, ages 2-5 yr	None	Colonoscopy

Rectal pain

- Tenesmus
  - A painful sphincter contraction that may caused by anorectal infection
- Rectal pain may caused by tear, infection, or hemorrhoid or parasite or by hypersensitivity to substances in the environment.
- Pain with defecation is characteristics of anal fissures. The pain may be so severe that the patient may avoid defecation.
- Anorectal pain that begins gradually and becomes excruciating over a few days may indicate infection.
- A localized tender area may indicate an abscess.

Bleeding

- Bleeding from hemorrhoid occurs after defecation and is noted on the toilet paper.
- Bleeding with fissures occurs with defecation and is accompanied by pain.
- Carcinomas and polyps can bleed intermittently.
- Blood that is black and tarry and has an aroma is from the upper GI and is called melena.
- A loose stool that has blood that is bright red and mixed with mucus may indicate chronic ulcerative colitis.

Itching

- Itching is common with both hemorrhoids and fissures.
- Intensive itching is a hallmark of pruritus ani, which occurs from hypersensitivity caused by irritating soap, lubricant, fragrance, or dyes present in toilet paper.
- Itching at night can be caused by pinworms.

Classification of internal hemorrhoids

grade	description	symptoms
1	Do not prolapse	Minimal bleeding or discomfort
2	Prolapse with straining, reduced spontaneously	Bleeding, aching, pruritus when prolapse
3	Prolapse with straining, requires manual reduction	Bleeding, aching, pruritus when prolapse
4	Cannot be reduced, or manual reduction ineffective.	Bleeding, aching, pruritus when prolapse

Focused Hx

- Might This Condition Require Immediate Hospitalization or Referral？
  - Are you receiving anticoagulation therapy？
  - Do you have a bleeding disorder？
  - Is the patient an infant？
  - Do you have HIV/AIDS？
  - Are you on chemotherapy？
  - Is there purulent discharge？

Focused Hx (continued)

- Could This Be Caused by Sexual Practices？
  - How many Sexual partners do you have？
  - Do your Sexual practices include anal intercourse？
  - Do you insert any objects into your rectum？
- Could This Be the Result of Sexual Abuse？
  - Have you had unwanted sexual contact. If a child: You might ask, “Has anyone touched your private parts？”
  - Do you think the child has been abused？

Focused Hx (continued)

- What Do the Presenting Symptoms Tell Me？
  - Have you had any bleeding？ How much bleeding has there been？ When does it bleed？ Describe the color of the bleed.
  - If a child; How old is this patient？
  - Have you had pain？ When does it occur？ Describe the pain？
  - Specifically, do you have pain on defecation？
  - Have you had itching？ When does it itch？
  - Can you feel a lump？
  - Have you had any stains on your underwear ? Describe the stains(e.g.,blood, stool, pus).
  - Have you had diarrhea？
  - Have you been constipated？

Focused Hx (continued)

- Do Risk Factors Point to a Likely Condition？
  - Do you strain to have a bowel movement？
  - How often do you move your bowel？
  - How often do you experience constipation？ Are your stools hard and dry？
  - What is your occupation？ Does it require sitting for long periods？
  - Describe your personal hygiene practices？
  - For women: Determine the number of pregnancies and childbirth history.
  - Do you have HIV/AIDS or are you on chemotherapy？
  - Do you have diabetes？
  - Note patient,s gender.
  - Do you have a family history of familial adenomatous polyposis(FAP), hereditary nonpolyposis colon cancer, or Gardner,s syndrome？

Focused PE

- Obtain Vital Signs
- Inspect the perirectal Area
- Perform a Digital Rectal Examination
- Perform Anoscopy

Lab and diagnos tic studies

- Fecal Occult Blood Testing(FOBT)
- Fecal Immunochemical Test(FIT)
- Flexible Sigmoidoscopy/ Colonoscopy
- Gram Stain Rectal Discgarge
- Cultures for Infectious Organisms
- Herpesvirus Antigen Detection Test
- Molecular Testing for Infectious Organisms
- Serology for Syphilist
- Alum-precipitated Toxoid Test
- Technetium 99m Scan
- Microscopy Examination of Stool
- Stoolfor Ova and Parasites
- Scotch Tape Test

Q&A