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Acute Anus (Gallese's Desease)

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1. Summary (Aim)

The author points out that some urgent pathological situations concerning the anal region require timely therapeutic interventions, similarly to what commonly happens for cases of "acute abdomen": these conditions, of clear emergence, are such not because they can represent a risk for life, but for the very strong physical discomfort caused to the affected patient, with rapid and important repercussions also on the psychic aspects, since these are "unbearable" conditions, with maximum impact, in a very short time, on the quality of life. This pathological condition is called "acute anus" and the author attributes the authorship of it ("Gallese's desease"). The various possible forms of acute anus are described and catalogued, with the basic principles necessary for inclusion in this pathological context.

The treatment is completed with only brief references to the diagnostic modalities and therapeutic possibilities, which go beyond the eminently academic aim (identification of the disease) and less clinical of this work.

2. Introduction and Methods

In surgery there are various, so-called "acute" events which, due to the intense symptomatic impact and the serious compromise of the patient's local and general conditions, if not addressed in emergency mode, lead to serious consequences quoad vitam et quoad valetudinem for the patient himself. What is chronic, without neglecting its objective and subjective importance, is not urgent and, therefore, "not acute" and not endangering anything immediately, allows you to reflect on the symptoms, ponder the diagnosis, plan with relative tranquillity the better therapy, with the possibility of modifying it and modulating it over time. The acute state is not! It does not leave much time for reflection and can confront situations never seen before and require interventions that have never been done before, to solve completely new and unknown emerging problems. An old teacher of mine said that the "real Surgeon" is so in the urgency ... in the daily mode "all surgeons are good". The best known "acute" surgical condition is undoubtedly the one that involves the abdominal region subjected to violent and sudden by peritonitic, occlusive, strangulative, ischemic, haemorrhagic, traumatic causes. Less known, but fairly frequent, is the surgical emergency for the scrotal content (didymus, epididymis, appendix of Morgagni) than for infectious, traumatic and ischemic/congestive phenomena, especially from "twisting" of peduncles, although not representing an emerging problem for life, it can cause irreparable damage with permanent disabling results, involving the physical, sexual and psychic sphere. Practically unknown, probably due to underestimation by those who have never had to deal with it directly, the problem of anal urgency which, instead, depending on "social" diseases, afflicting over 50% of the adult population, is much more frequent than what you can imagine and which provoke a symptomatology so intense as to totally upset and in a very short time, the life of any person who is affected. The great Roman orator Cicero (3 Jan 106 BC - 7 Dec 43 BC), to signal his intense suffering due to a violent acute anal crisis, wrote *"ferenda non videtur"*, that is "they do not present themselves as bearable things", probably referring , naively, to "haemorrhoids", a notably imprecise and excessively simplistic term, even nowadays, to indicate, too generically and most of the time quite wrongly, one of the many possible situations of anal acuity.

We are faced with the so-called "Acute Anus", disease or syndrome, not catalogued under this denomination, coined ex novo for this occasion, although, who writes, given the over forty years of procto-perineological experience, he used it frequently and always, to describe concisely, but clearly, a lot of conditions that can fall within the context of a truly urgent situation. In the treatment

there is no pretension to carry out a scholastic clarification of the diagnostic and therapeutic aspects of the individual pathological conditions involved, but only to frame and catalogue them within a broader and more complex pathological entity that can lead, through an observation to wide visual angle, with more "logical" and more in-depth reasoning, to improvement in the theoretical and practical approach to these problems.

The author warns the opportunity to systematize the topic, based on his knowledge, fixing some fixed points and clarifying controversial aspects, which represents the purpose of this work. The author believes, perhaps pretentiously, but for intellectual right, to have to attribute to himself the authorship of the name "Acute Anus", adding, in brackets "Gallese's disease".

3. Discussion

In surgical pathology, there are emergency situations, sometimes well known, other times less so:

- Definition of Acute Abdomen

acute pathological situation that requires acute diagnosis and acute therapy, by an acute mind, to save a man

- Definition of Acute Scrotum

Acute pathology> acute diagnosis> acute intervention by an acute mind, to save a ... testicle

- Definition of Acute Anus (Ed)

critical condition which, for various triggering causes and pathological expressions, leads to a state of intense anal pain, only rarely life-threatening, but which, more often, causes high acute deterioration of the quality of life, heavily conditioning both physical conditions and mental of the affected individual which cannot be endure it for long, without a spontaneous resolutive event, drug treatment or urgent surgical intervention. All to save the anus. (Anal rescue and anal repair)

- Acute anus catalogued according to pathogenetic modalities

1 - **Traumatic**

Faecal (acute constipation)

Chemical (diarrhoea, food abuse, incongruous topical drug)

Thermal (contact or introduction of high or low temperature medical devices)

Iatrogenic (diagnostic or therapeutic medical manoeuvres)

Foreign bodies

Other trauma (multi-fragmentary pelvis fractures, impalements, blast injuries, blade or gunshot wounds)

2 - **Circulatory**

Ischemic (strangulation> ulcer and necrosis)

Congestive / Thrombotic (congestion, distension, hyper-inflow, obstructed outflow, microcirculation dysfunction)

Haemorrhagic

3 - **Hypertonicity (muscle tension)**

Continuous spasm of the sphincter

Recurrent sphincter spasm

4 - **Phlogistic-Suppurative**

Dermatitis

Proctitis

Abscess

5 - **Neuropathic** (rare, for acute central or peripheral pudendal nerve neuralgia> usually chronic)

6 - **Complex**

Hypertonicity/Thrombosis/Necrosis

Thrombosis/Abscess (infected thrombus)

Thrombosis/Phlogosis (inflammatory mediators extend the process)

Trauma/Haemorrhage

Trauma/Hypertension of sphincter (reactive hypertonicity)

7 - **Perforations**

For all the causes mentioned above with all the possible consequences mentioned above (haemorrhage, abscess, etc)

- Diagnostic and therapeutic aspects of the acute anus

As stated, it is not the purpose of this work to deepen the treatment of diagnostic or therapeutic possibilities, of which, therefore, only the general principles will be stated.

The conditions of Acute Anus, generally present with characteristic symptoms for each and with macroscopically and well recognizable aspects; so a quick and well-conducted anamnesis (which must always be compatible with the prostration state of the patient) and an expert eye, in most cases lead to an immediate and clear diagnosis, with the possibility of taking equally immediate therapeutic measures.

Most frequent aspects of Acute Anus

Anal thrombosis: it is often ignorantly defined as "hemorrhoidal thrombosis or inflamed external haemorrhoids, thrombosed haemorrhoids, prolapsed haemorrhoids, etc.", when the innocent haemorrhoids, except rare cases, have little or nothing to do with thrombosis which interest, the more often than not, the skin of the anal margin or the skin tags remaining from previous and recurrent congestive episodes, linked to periods of reactive sphincter hypertonicity (from psycho-physical stress or secondary to other anal pathologies).

Sphincter hypertonicity, with the consequent alterations of the blood flow and decompensation of the local microcirculation, represents a frequent but not unique cause of anal thrombosis which can also follow intense and prolonged physical efforts, persistent coughing, thermal or chemical damage, traumatism faecal, sexual and iatrogenic or any other condition capable of modifying the

anal circulatory system.

The anamnesis, which could also guide the diagnosis by phone, will report a hard little ball in fast growth with early involvement of the entire anal circumference and intense continuous pain (even at night), quickly worsening, not linked to defecation.

The objective examination is usually decisive for the diagnostic confirmation: will be observed the showy thrombosed purple nodule, with retained clot (or multiple mini-clots), sometimes spontaneously expelled (totally or partially) and the massive circumferential edema of the anal skin due to the release, by the thrombus, of the chemical mediators of inflammation (Cytokines, prostaglandins, leukotrienes, histamine, etc. - "cascade of inflammation") that involve the entire anal zone.

In hyperacute cases the immediate outpatient incision (with or without local anaesthesia), with evacuation of the thrombus, represents the solution of choice, allowing an instant improvement in pain and allowing to undertake a subsequent drug therapy, specify the diagnosis causal with planning of the appropriate exams to establish an elective surgical treatment.

Sphincteric strangulation: already considered in the genesis of anal thrombosis, the sphincter hypertonicity, continuous or accessional, represents the primus movens of many anal pathologies (see ASS-SSA or Gallese's Anal Sphincter Syndrome) such as fissure or Proctalgia Fugax, with the character of acute, chronic or recurrence. In some cases the sphincter hypertonicity, in a vicious circle pain> contracture> pain can become spastic and create a zone of elevated (and prolonged) pressure in the anal canal: within this zone any tissue, from the anal skin, to the hemorrhoidal plexuses , to a prolapse wedged in the sphincter, to a descending polyp, can undergo ischemic damage with ulceration or necrosis. The acute sphincterotomy, associated, if needed with necrosis excision, is often indispensable, but, in fortunate cases, an immediate mechanical dilatation (even with a simple finger), may interrupt the vicious circle that supports the pathological condition, with pain relief for the patient and precious time for other diagnostic and therapeutic possibilities.

Anal Abscess: not always acute, but sometimes with tumultuous evolution, with continuous growing pain, fast-growing swelling, dystrophic alterations of the anal and perianal skin, compromise of general conditions with septic fever (shiver, sweating, hypotension and other general symptoms) up to real septic shock.

The diagnosis does not present any problems and, in urgency, does not require the execution of a Transanal Ultrasonography (with 360° probe) or CT and/or MRI (examinations to be postponed, appropriately, to the subacute phase).

If the abscess does not appear spontaneously fistulized, but "mature" (floating) for the incision, the ancient and always valid rule of "ubi pus, ibi evacua" applies: a scalpel tap, even in first aid room and without anaesthesia, preferably large enough, allowing the drainage of the abscess cable, relieves the patient's suffering, reduces the intensity of the septic condition, allows to continue the therapeutic diagnostic process in "armed waiting", in view of the study and treatment of the residual anal fistula as usual.

Anal Haemorrhage: Acute haemorrhagic anus is not frequent, although, often, patients ask for urgent visits for the fear of little defecatory blood loss, limited to the expulsive phase and not prolonged, absolutely not dangerous (but that should not be underestimated) linked to a lot of anal and rectal pathologies (fissure, haemorrhoidal disease, prolapse, proctitis, polyps, cancer, diverticula, etc.). Cases with true bleeding condition (always for the above reasons) are not frequent and not necessarily linked to other symptoms such as pain or swelling, but capable of causing fast cardio-circulatory impairment (hypotension, sweating, pallor, malaise, air hunger, tachycardia, feeling of imminent death), easily confirmed by the common urgent examinations of the case (ECG, CBC, blood gas analysis) able to highlight the drop in values of haemoglobin and saturation of O2.

If the causal conditions are not already known, the diagnosis must be clarified urgently, with rectal inspection and exploration and proctoscopy; in these cases, the diagnosis is not always easy and the patient's agitation, which is easily transmitted to family members and health personnel, is not beneficial: at times it is necessary to resort, in urgency, with constant resuscitation support (even during transfusions and assisted breathing) to endoscopic or radiographic (CT) instrumental examinations and in extreme cases (really emergency) to exploratory interventions, so heroic as dangerous.

On the other hand, in favourable cases, even a simple elastic ligation of a bleeding little internal haemorrhoid can solve a dramatic situation with minimal efforts, maximum results and a very good satisfaction for the proctologist.

In lucky cases, a compression by anal plug (Foley catheter) and contemporary medical therapy, reasoned, but at "decided" doses (tranexamic acid, MPFF, corticosteroids, etc.) can lead the patient from an emergency and life-threatening condition, to a subacute stage that allows, without anxiety, other diagnostic and therapeutic choices.

Of course, the extreme variability and complexity of the multiple situations that can occur, do not allow to define univocal and programmable criteria neither in the diagnostic field, let alone therapeutic, representing, in any case, the acute anus, a difficult emergency condition management also by an "Acute Surgeon".

In the subacute phase, on the other hand, in most cases, although, clearly, not in all, it is possible to apply "generic" therapeutic schemes, which are simple to maintain, during the diagnostic process and in anticipation of the possible or needed surgical interventions.

One of the simplest, most effective and risk-free protocols is rep-

resented by the scheme below:

1- Micronized Purified Flavonoid Fraction - MPFF

cps 500 mg 1 cps x 2/day (1, 2 or more months)

Aim - microcirculation optimization > reduction of edema, congestion and mucous permeability)

2 - Sucralfate (as SOS - Sucralfate Ointment with Soothing Herbs)

local applications h24/24 (1, 2 or more months)

Aim - barrier effect > control of irritative stimuli and reduction of severity of inflammation lesions, with

reduction of traumatism due to the transit of the stool and the chemical action of the stool itself

reduction of the microbial load in direct contact with the rectal and anal wall

reduction of wall permeability

4. Conclusions

The explanatory and proactive purpose of this work appears to have been achieved. The disease "Acute Anus" (Gallese's disease) has been systematized, defined and "named". Its various expressions have been catalogued starting from the pathogenetic mechanisms. The essential concepts of urgent diagnostic impact and the need for immediacy of therapy were highlighted, with foreseeable surgical difficulties in an emergency; the insights on these aspects, beyond the main purpose of the work, are to be postponed to future times.

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