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2022
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AUGUST 26–28, 2022  JW MARRIOTT HOTEL INDIANAPOLIS, INDIANA
Register online: meetings.gi.org
Participating in the Webinar

All attendees will be muted and will remain in Listen Only Mode.

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2022 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2023 for this activity.
If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement. THESE ANSWERS WILL BE REVIEWED.

ACG Virtual Grand Rounds
Join us for upcoming Virtual Grand Rounds!

ACG International Virtual Grand Rounds – June 25, 2022
Biologics in IBD: Different Perspectives
Vineet Ahuja, MD, DM, MNAMS
Stephen B. Hanauer, MD, MACG
Mahesh K. Goenka, MD, FACG
Govind K. Makharia, MD, DM, DNB
Samir A. Shah, MD, FACG
Rakesh Kochhar, MBBS, MD (PGI), FRCP (London), EULAR
Ajit Sood, MD, DM
June 25, 2022 at 8:00-9:15 PM Indian Standard Time

Week 26 – June 30, 2022
Geriatrics and Gastrointestinal Disorders: Is Age Only a Number?
Bharati Kochar, MD, MS
June 23, 2022 at Noon Eastern and 8PM Eastern!

Visit gi.org/ACGVGR to Register
Disclosures

**Arnold Wald, MD, MACG**
HealthiVibe: Scientific Advisory Board
No relevant relationships indicated

**Adil E. Bharucha, MD**
Cairn Diagnostics: In-Kind Donation for Research
GI Supply, Inc.: Consultant
Medical Insights Group: Consultant
Medspira: Patents, Royalties
Medtronic: Patent
Minnesota Medical Technologies: Research Grant, Patents, Royalties

*All of the relevant financial relationships listed for these individuals have been mitigated*

ACG Clinical Guidelines: Management of Benign Anorectal Disorders

Arnold Wald, MD
University of Wisconsin School of Medicine and Public Health
Division of Gastroenterology and Hepatology
Methodology

Scientific Evidence was assessed using the process of Grading of Recommendations, Assessment, Development and Evaluation (GRADE system)

If evidence was not appropriate for GRADE, expert consensus were used to develop key concept statements*

*Each key concept or recommendation was assessed by the 6 authors based upon a 5-point Likert Scale (5=strongly agree; 1=strongly disagree)

Consensus > 24 of max of 30

Definition of Recommendations

Strong: authors agree that benefits outweigh negatives or the results of no action

Conditional: some uncertainty remains about the balance of benefits and potential harms
Quality of Evidence-Definitions

**Moderate**: moderate confidence in the estimate of effect although future studies would be likely to impact our confidence level.

**Low**: Further studies would likely have an important effect on our confidence.

**Very Low**: Very little confidence and the true effect is likely to be substantially different from the current estimate.

Defecation Disorders

**Key Concepts**

1. **Symptoms suggestive of DD** include excessive straining during defecation, sense of anorectal blockage during defecation, use of manual maneuvers to facilitate evacuation and a sense of incomplete evacuation after defecation.
2. **Digital rectal examination is strongly recommended as part of the assessment to identify structural abnormalities** (ie, anal fissures, hemorrhoids, fecal impaction, descending perineum syndrome or anorectal cancer) and **assess anal sphincter function**.
3. DD may result from inadequate rectal propulsive forces and/or impaired relaxation or paradoxical contraction of the external anal sphincter and/or puborectalis muscle.
4. **Both Anorectal manometry (ARM) and balloon expulsion are required to diagnose DD**.
5. Important initial approaches include normalizing of stool form, advice on toileting position and behavior.
Defecation Disorders

6. **Biofeedback** should involve 4-6 sessions with well-trained therapists aimed at normalizing rectoanal coordination, ensuring good rectal pressure on strain, sensory retraining and balloon expulsion retraining.

7. **Baseline ARM and balloon expulsion is useful to predict the outcome and guide biofeedback therapy.**

8. Defecography (MR or barium) may be indicated in patients with DD who fail conservative therapy and biofeedback.

9. The decision to treat a structural abnormality with surgery should be based on overall clinical assessment including symptoms, ancillary testing and psychological assessment where appropriate.

10. **Most patients with structural abnormalities do not need surgical therapy** given the high prevalence of these findings in asymptomatic patients, the low-level evidence for efficacy and the moderate risks of surgery.

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Defecation Disorders

11. Patients with DD should be carefully counseled on benefits vs risk before any surgery for DD, as often potential risks outweigh potential benefits.

12. **Selection of patients for rectocele repair should depend on symptoms.** Size and degree of non-emptying of the rectocele and/or vaginal bulge or prolapse in conjunction with defecatory symptoms are a stronger indication than for symptoms alone.

13. **Evidence to support use of botulinum toxin in patients with DD is poor;** in addition, results are short-lived and the procedure is unlikely to be a practical long-term solution.
Defecation Disorders

**Treatment recommendations**

1. Instrumental anorectal biofeedback therapy should be used to manage symptoms of DD. (Strong recommendation/minimal risk of harm/moderate quality of evidence)

2. Full-thickness rectal prolapse often requires surgical treatment with abdominal rectopexy or in selected cases, a perineal procedure. (Conditional recommendation/moderate risk of harm/very low quality of evidence)

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Proctalgia Syndromes

**Key Concepts – Proctalgia Fugax**

1. The clinical history and a normal digital rectal examination alone is sufficient to diagnose PF.
2. The presence of prolapsed hemorrhoids, chronic anal fissure or other anorectal pathology does not invalidate the diagnosis of PF
3. The preferred approach to patients with PF is an explanation of the disorder and reassurance
4. Given the brevity of episodes of PF, there is no evidence to support treatment intervention or to prevent attacks
Proctalgia Syndromes

Key Concepts – Chronic Proctalgia

1. The duration rather than the frequency of proctalgia episodes is used to diagnose chronic proctalgia.
2. The presence of levator tenderness and absence of other potential causes are sufficient for the diagnosis of levator syndrome.
3. The absence of levator tenderness in a patient with chronic proctalgia defines idiopathic chronic proctalgia syndrome.
4. Anorectal manometry and BET should be formed in patients with levator syndrome to identify patients who are eligible for biofeedback therapy.

Proctalgia Syndromes

Treatment Recommendations – Chronic Proctalgia

1. Recommend biofeedback to teach pelvic floor muscle reconditioning for levator syndrome with abnormal anorectal manometry. (Strong recommendation/very low quality of evidence)
2. Suggest electrogalvanic stimulation may be attempted to manage levator syndrome with abnormal anorectal manometry if biofeedback is not available. (Conditional recommendation/very low quality of evidence)
3. There is no evidence to support the use of Botox or digital massage in chronic proctalgia (Consensus)
Anal Fissures

Key Concepts

1. Chronic anal fissures are defined as lasting more than 8-12 weeks and are characterized by edema and fibrosis.

2. Chronic anal fissures persist as nonhealing ulcers by anal sphincter spasm and consequent ischemia. Treatment is directed towards softening of stool and reducing spasm to improve perfusion to the area.

Anal Fissures

Treatment Recommendations

1. Recommend local application of a calcium channel blocker (CCB) as the initial medical treatment. (Strong recommendation/low quality of evidence)

2. Recommend lateral internal sphincterotomy (LIS) is the surgical treatment of choice for chronic anal fissures that do not respond to nonsurgical measures (Strong recommendation/high quality of evidence)

3. Suggest that botulinum toxin A injections may be attempted in patients in whom CCB fails or as an alternative option to CCB. (Conditional recommendation/low quality of evidence)
Hemorrhoids

Key Concepts

1. The cardinal signs of internal hemorrhoids are painless bleeding and intermittent protrusion. The diagnosis generally requires exclusion of other conditions that can produce similar symptoms.

2. Internal hemorrhoids are assigned a functional grade based on their history: First degree do not prolapse; second degree prolapse but spontaneously reduce; third degree prolapse and required manual reduction; fourth degree prolapse and cannot be reduced.

3. External hemorrhoids may become thrombosed by developing a clot in a vein under the squamous epithelium of the anal verge.

Hemorrhoids

Treatment Recommendations

1. Dietary modification consisting of adequate fluid and fiber intake and counseling to minimize straining at defecation should be first line therapy for symptomatic hemorrhoids. (Strong recommendation/moderate quality of evidence)

2. Patients with acutely thrombosed hemorrhoids may benefit from either surgical excision or incision and evacuation of the clot. (Strong recommendation/low quality of evidence)

3. Symptomatic grade 1 and 2 internal hemorrhoids that fail medical therapy can be effectively treated with office-based procedures such as rubber band ligation. Alternatives include infrared coagulation, sclerotherapy and bipolar coagulation. (Strong recommendations/moderate quality of evidence for grade 2; no evidence for grade 1)

4. We suggest that Doppler-guided procedures such as hemorrhoidal artery ligations have similar outcomes to hemorrhoidectomy for symptomatic grade 3 hemorrhoids. (Conditional recommendation/very low quality of evidence)
Fecal Incontinence

Key Concept: Definition

FI is the involuntary loss of solid or liquid feces, including staining of the underwear.

Key Concepts: Diagnosis

1. The clinical assessment should identify conditions that predispose to FI and gauge symptom severity by asking patients about the type, frequency and amount of leakage and the presence of urgency to defecate. **Severity predicts the need for consultation with a clinician.**

2. Diagnostic tests provide useful functional and structural information that can guide treatment. There is no single test that can be considered as the gold standard (MRI). Functional (anorectal manometry, balloon evacuation testing, sensory evaluation and imaging (endoanal ultrasound and MRI) are complementary.

Fecal Incontinence

Key Concepts: Treatment

1. **Conservative measures (education, preventing diarrhea and pelvic floor exercises are safe, inexpensive and often effective.**

2. For some invasive procedures (eg, SphinKeeper), safety and efficacy data are insufficient.
Fecal Incontinence

Treatment Recommendations – Strong

1. **We recommend antidiarrheal drugs** (e.g., loperamide, diphenoxylate with atropine, bile salt binding agents, anticholinergic agents and clonidine) **when FI is accompanied by diarrhea** (low quality of evidence)

2. Patients with FI who do not respond to conservative measures should undergo biofeedback (i.e. pelvic floor rehabilitative techniques with visual or auditory feedback) (Moderate quality of evidence)

3. We recommend sacral nerve stimulation for moderate to severe FI which has failed conservative measures, biofeedback and other low cost, low risk techniques (low quality of evidence).

Fecal Incontinence

Treatment Recommendations – Conditional

1. **Anal plugs, vaginal balloons and other devices** to impede defecation should be considered in selected patients who do not respond to conservative measures and biofeedback (very low quality of evidence)

2. **Injecting bulking agents** such as dextranomer sodium may be considered in selected patients, patients with FI who do not respond to conservative measures or biofeedback (low quality of evidence)

3. We suggest anal sphincteroplasty for acute injuries to the anal sphincters (low quality of evidence)

4. We suggest offering an **end stoma** in patients with severe FI who have not responded to other treatments (low quality of evidence)
Questions and Answers

Arnold Wald, MD, MACG

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