Use of a Rectal Hook for Perirectal Abscess Drainage

Thomas A. Johnson, Jr, MD
St. Louis, Missouri

Drainage of various types of perirectal abscesses can be facilitated by the use of a rectal hook, allowing many of these infections to be easily handled in the outpatient setting.

Several types of abscesses, including ischiorectal and pelvirectal abscesses, although usually originating at the crypts of Morgagni, cannot be drained adequately by this technique. Differential diagnosis of anal pain is considered.

Pyogenic infections of the anal canal usually begin in the crypts of Morgagni lying at the pectinate line. These crypts are lined by mucous membranes and extend with their glandular tissue into the submucous tissues.

Cryptitis may lead to an intersphincteric abscess which then usually leads to a perianal abscess. It can also extend through both sphincter muscles into the ischiorectal space becoming an ischiorectal abscess, or extend upward into the pelvirectal space to form a pelvirectal abscess.

Diagnostic Considerations

Diagnosis of these rectal abscesses is usually prompted by rectal pain. Occasionally the cryptitis will lead to only an intersphincteric abscess, a pyogenic abscess located between the internal and external rectal sphincters. However, usually this promptly becomes a perianal abscess by burrowing in the intersphincteric plane down to the anal margin. Even though the pain of the intersphincteric abscess can be severe, the diagnosis can possibly be overlooked since no rectal fissure is present.[1] By the time the infection has progressed to a perianal abscess the diagnosis is usually easier; however, even at that stage it can be misdiagnosed as an external hemorrhoid thrombosis.[1]

Internal hemorrhoids, of course, are painless but must be considered, as well as abscess, external hemorrhoids, rectal fissure, carcinoma of the anal canal, anal Crohn disease involvement, and anal fistula.

If the site of the abscess cannot be visualized on inspection, or signs of systemic toxicity are present, a deep pelvirectal or ischiorectal abscess (Figure 1) may be present and in-hospital drainage would be indicated. Hemorrhoids, fissure, and carcinoma can be diagnosed by anoscopy which can sometimes be made less painful for the patient by lubricating the anus with lidocaine jelly before insertion of the anoscope. Rectal fissures are usually midposterior and occasionally midanterior. If elsewhere, suspect anal Crohn disease, or in the very unusual patient, an anal syphilitic ulcer.

Drainage by Rectal Hook

The drainage of anal cryptitis may be accomplished simply by cleansing

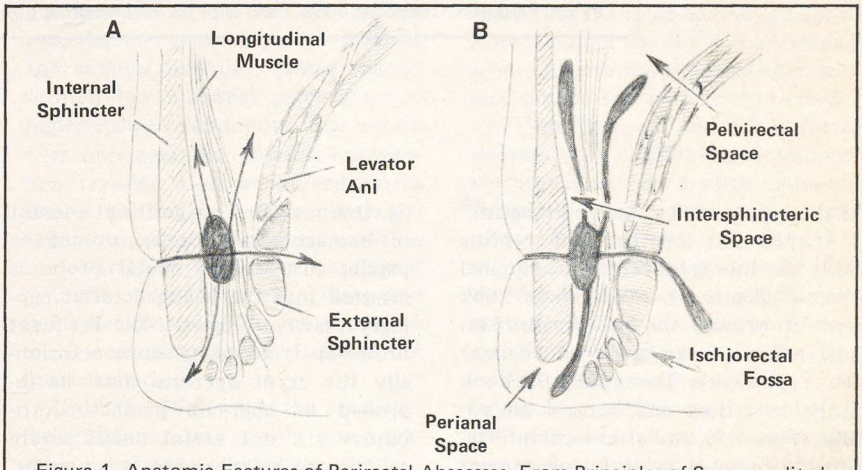

Figure 1. Anatomic Features of Perirectal Abscesses. From Principles of Surgery edited by SI Schwartz. Copyright 1974. Used with permission of McGraw-Hill Book Company.

From the Department of Family Practice, St. John's Mercy Medical Center, St. Louis, Missouri. Requests for reprints should be addressed to Dr. Thomas A. Johnson, Jr., Department of Family Practice, St. John's Mercy Medical Center, St. Louis, MO 63141.

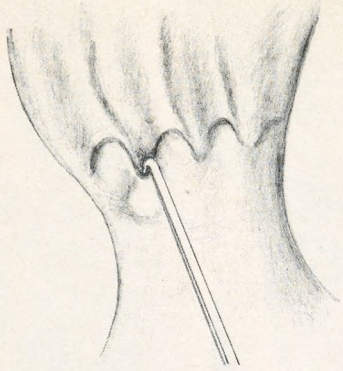

Figure 2. Retracting the Anal Papilla. From Surgery of the Ambulatory Patient edited by LK Ferguson. Copyright 1966. Used with permission of JB Lippincott Company.

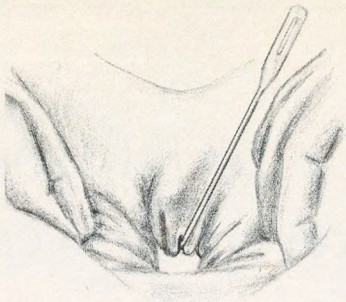

Figure 4. Probing the rectal papillary cavity. From Surgery of the Ambulatory Patient edited by LK Ferguson. Copyright 1966. Used with permission of JB Lippincott Company.

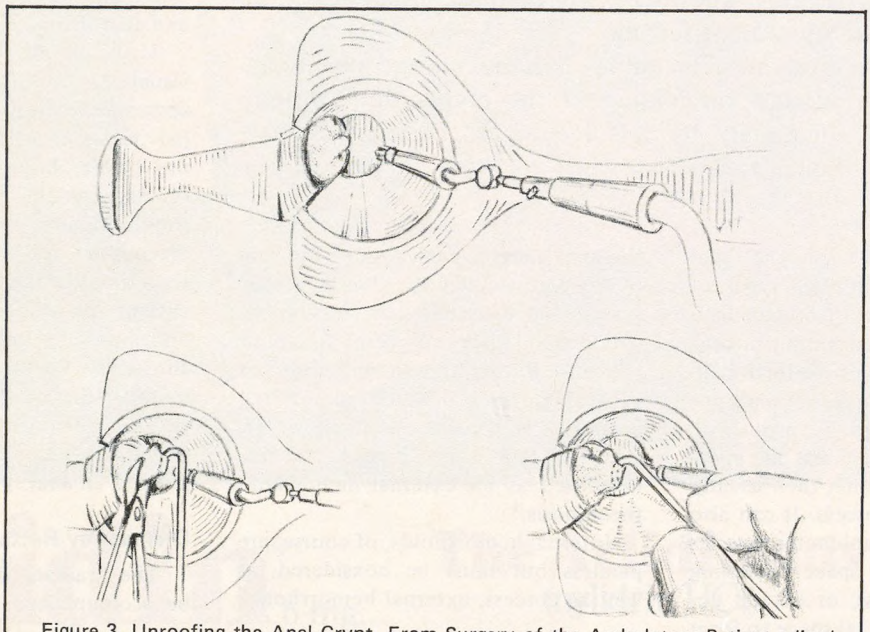

Figure 3. Unroofing the Anal Crypt. From Surgery of the Ambulatory Patient edited by LK Ferguson. Copyright 1966. Used with permission of JB Lippincott Company.

of the crypts with saline or sitzbaths.[2]

If these fail, then the anal cryptitis leads to intersphincteric or perianal abscess (Figure 1), and a rectal hook with or without the aid of a Brinkerhoff anoscope can probe and enlarge the crypt cavity. Then, using the hook probe to retract and control the papilla (Figure 2), and after local infiltration of the papilla with one percent lidocaine, unroof the crypt with tissue scissors allowing easy drainage (Figure 3). One may find a significant amount of drainage even before excision of the papilla just as the rectal probe is inserted into the enlarged rectal papillary cavity (Figure 4). Frequent follow-up is necessary since occasionally the crypt aperture must be reprobed to maintain patency. Antibiotics are not useful unless severe cellulitis or massive abscess is present, and a massive abscess would require in-hospital drainage.[3]

Acknowledgement

The author appreciates the drawing reproductions by Mrs. F. C. McLaren.

References

1. Sabiston DC, Jr (ed): Davis Christopher Textbook of Surgery, ed 10. Philadelphia, WB Saunders, 1972

2. Ferguson LK (ed): Surgery of the Ambulatory Patient, ed 4. Philadelphia, JB Lippincott, 1966

3. Cerda JJ, Fazio VW, Muldoon JP, et al: Tracing and treating the causes of rectal pain. Patient Care 10:40, 1976