BMJ 2016;355:i4931 doi: 10.1136/bmj.i4931 (Published 4 November 2016)

PRACTICE

10-MINUTE CONSULTATION

Anal itching

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A 39 year old lorry driver describes three months of an itchy bottom. He has tried to improve his hygiene and showers several times a day. It has now become embarrassing in public. He is otherwise well, his bowel habit is unchanged, and he has had no rectal bleeding and no history of bowel problems.

Itching in the perianal area—pruritus ani—causes discomfort with an uncontrollable desire to scratch. Patients may be embarrassed to talk about it. Data on prevalence and aetiology are scarce because most patients do not consult a doctor.[1] It is estimated that 5% of the population are affected by anal itching at some point in life, more commonly men, and predominantly when they are in the fourth to sixth decade of life.[2] Itching may be short lived or chronic and can be caused by local factors or systemic disease (box 1). More commonly, it is idiopathic and no cause is identified.[3 4]

What you should cover

History

Ask about:

- *Onset and duration of itch*—causes and relieving factors. Itching is often worse at night or after a bowel movement.
- *Bowel habit*—Consistency and frequency of motions, and any faecal leakage. Looser, more frequent stools and leaking can exacerbate itching. Blood in stools, a change in bowel habit, or weight loss can indicate malignant pathology.
- *Precipitating factors*—Consider laundry detergent. Nylon and other synthetic fabrics retain moisture and can irritate the skin.[3] Soaps and detergents for washing the perianal area can perpetuate itch. Alcohol based cleansers and wet wipes can cause irritation or allergic contact dermatitis.[4]
- *Food habits*—Diet, food intolerance, or allergies can cause loose stools.
- *Medical history*—diabetes, thyroid disorders, and liver disease, which cause generalised pruritus. Review dermatological history. Stress, anxiety, or depression can influence symptoms.
- *Drugs*—Sometimes, corticosteroid creams and ointments used to treat haemorrhoids (especially those containing benzocaine) act as allergens.[5]
- *Travel to regions where sanitation might be poor*—consider intestinal nematode infection [6] and pinworm, particularly in children, and in countries with a temperate climate.[7] Pinworm itch commonly occurs at night. Fingernails harbour eggs, which facilitates spread.
- *Sexually transmitted* infections—Human papillomavirus.[8]

Examination

Offer a chaperone. Consider general dermatological inspection before focusing on the perianal region.

Inspection

In the perianal area look for:

Erythema, scales, plaques, or excoriation marks suggesting dermatological conditions such as contact dermatitis

Skin tags, warts (fig 3⇓), or any pathology that might make passage of faeces difficult

Nodularity and scarring, which are signs of hypertrophic skin denoting chronic disease

Syphilitic chancres mimic anal fissures in appearance. Chancres are predominantly associated with itch rather than pain

Tinea cruris (fungal groin infection) characterised by well defined, irregularly shaped erythematous plaques

Evidence of faecal leakage

Lice infestation in pubic hair

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This is part of a series of occasional articles on common problems in primary care. The *BMJ* welcomes contributions from GPs.

What you need to know

- Ask about frequent stools and leaking because faeces are a known irritant of the perianal skin
- A symptom diary can help to identify foods, allergens, or washing practices associated with symptoms, but most commonly no cause is found
- Avoid triggers and consider a short course of topical steroids for acute pruritis

Box 1: Possible causes of pruritus ani (idiopathic if no cause is identified)

Colorectal

Chronic diarrhoea, chronic constipation, haemorrhoids (fig 1⇓), fissures, fistulas, colorectal and anal cancers (including anal intraepithelial neoplasia), rectal prolapse, anal creases, anal warts

Dermatological

Dermatitis, psoriasis, Bowen's disease, lichen planus, lichen sclerosus (fig 2⇓)

Infections—condyloma accuminata, HIV, candida, gonorrhoea, threadworm, tinea cruris

Bacterial—*Corynebacterium minutissimum;* squamous cell carcinoma, Paget's disease, hidradenitis suppurativa, perianal Crohn's disease

Systemic

Diabetes mellitus, thyroid disease, vitamin disorders, uraemia, polycythemia vera, liver disease (hyperbilirubinaemia), psychological

Palpation

Perform a digital rectal examination and consider proctoscopy. Note sphincter function.

What you should do

Most patients have idiopathic itching and can be managed in primary care – these patients are likely to have no easily identifiable cause in their history and a normal physical examination. The following tips are based on expert opinion and our current practice.

Advise patients to

• avoid scratching and mechanical irritation such as use of toilet paper[9]

• clean by washing with plain water after defecation and dry by dabbing with cotton swabs or soft towels or use soap substitutes such as an emollient

• avoid excessive wiping or rubbing and the use of alcohol based disinfectants, cosmetic preparations containing fragrances, and wet wipes. Where available, sitz baths and bidets are useful.[10] Recommend loose cotton undergarments that absorb sweat

• Patient forums suggest short finger nails to reduce the risk of inadvertent trauma[3]

• A cotton wool plug could prevent soft faeces leaking from the anus on exercise

Consider a patient led symptom diary to record relation to diet. Firming up of the stool by reduction in fibre intake can prevent passive leakage. Foods such as coffee (caffeinated and decaffeinated), chocolate, citrus fruits, cola, and calcium (dairy) have been implicated as precipitants.[11] Avoidance of these might improve symptoms, but evidence is inconclusive.[12 13]

A short course of topical steroids such as 1% hydrocortisone ointment can be offered for up to two weeks for acute pruritus, if fungal infection is unlikely. Evidence for its efficacy in perianal itch is limited,[14] but it is well documented as a treatment for dermatitis.

Other treatments, including topical capsaicin (0.006%) cream,[15] tricyclic antidepressants,[16] and local methylene blue injections,[17] are recommended only under specialist supervision.

Red flags include a history of weight loss, change in bowel habit, or palpable mass on digital rectal examination. These warrant referral to a colorectal surgeon.

In patients with longstanding itch and suggestive findings on examination, consider the following investigations:

- Patch testing to identify allergens in generalised itching
- Skin scrapings for microscopy and culture to identify fungal infection
- Skin biopsies to exclude conditions such as anal intraepithelial neoplasia
- Selective flexible sigmoidoscopy to exclude inflammatory bowel disease and neoplasms

If pinworm infection is suspected offer formal diagnosis.

When in doubt of the diagnosis offer treatment according to local guidelines and offer a review in two weeks. Consider specialist referral if symptoms fail to settle.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following interests: None.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Education into practice

- What simple tips do you use to help patients to relieve symptoms of perianal itch? What could you add or alter about giving that advice?
- If you prescribe steroid cream for anal itching, do you describe when to stop the cream?
- In most patients with symptoms of itching no readily identifiable cause is found. How can you best explain this to a patient?

How patients were involved in the creation of this article

A patient with pruritis ani reviewed the article and recommended expanding the section on conservative management, in particular modifying the diet.

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Accepted: 13 07 2016

Figures

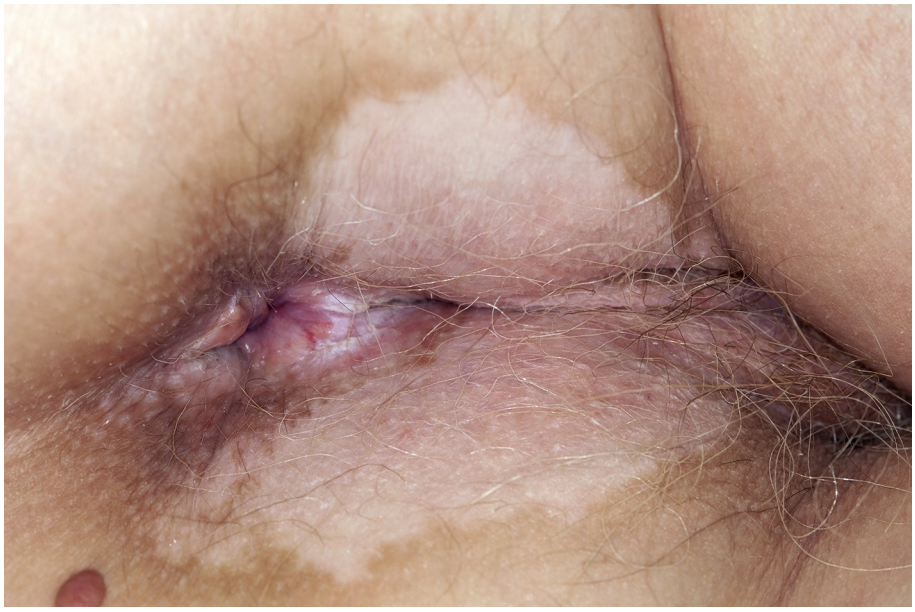

Fig 1 Close-up of a thrombosed (clotted) haemorrhoid (pile) projecting from the anus

[Image: P Marazzi/Science Photo Library]

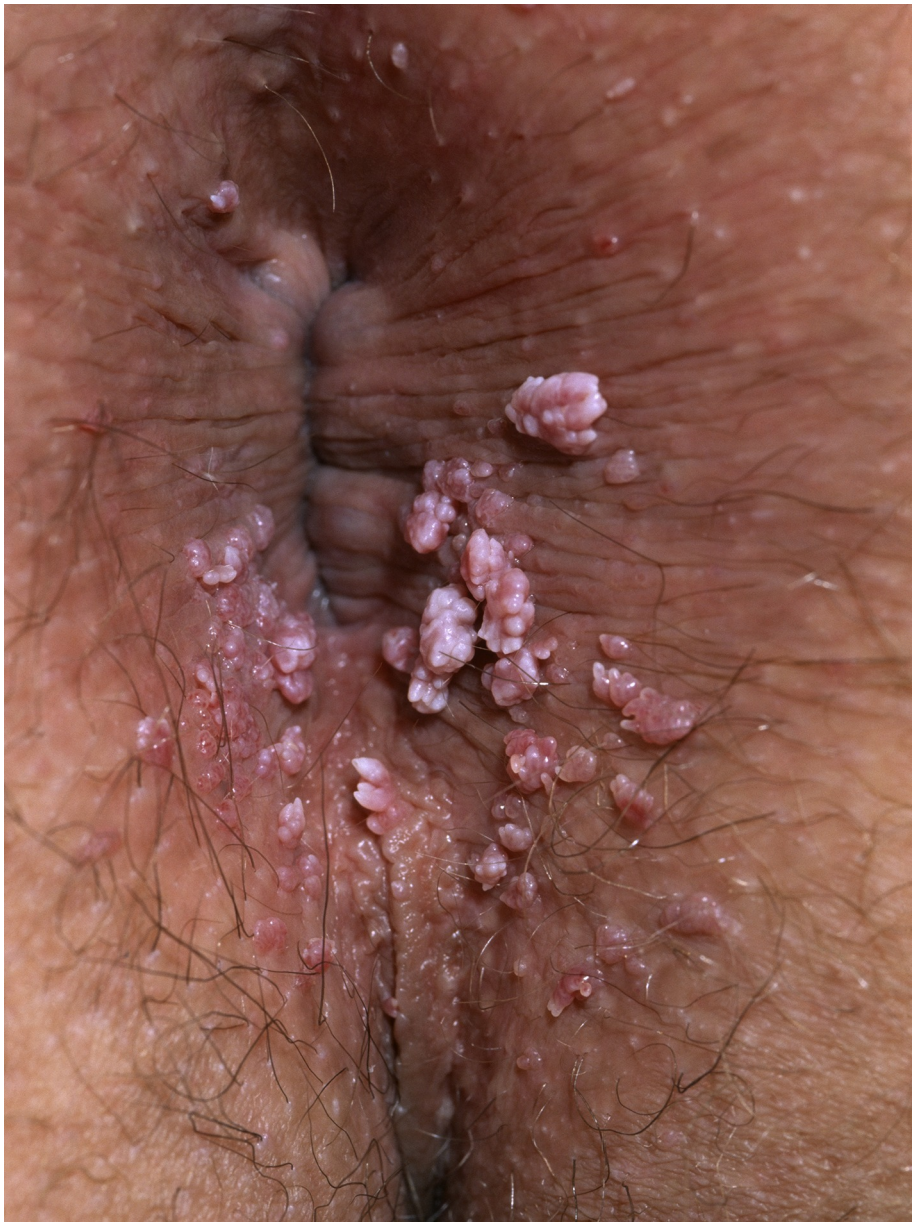

Fig 2 Lichen sclerosis around the anus

[Image: P Marazzi/Science Photo Library]

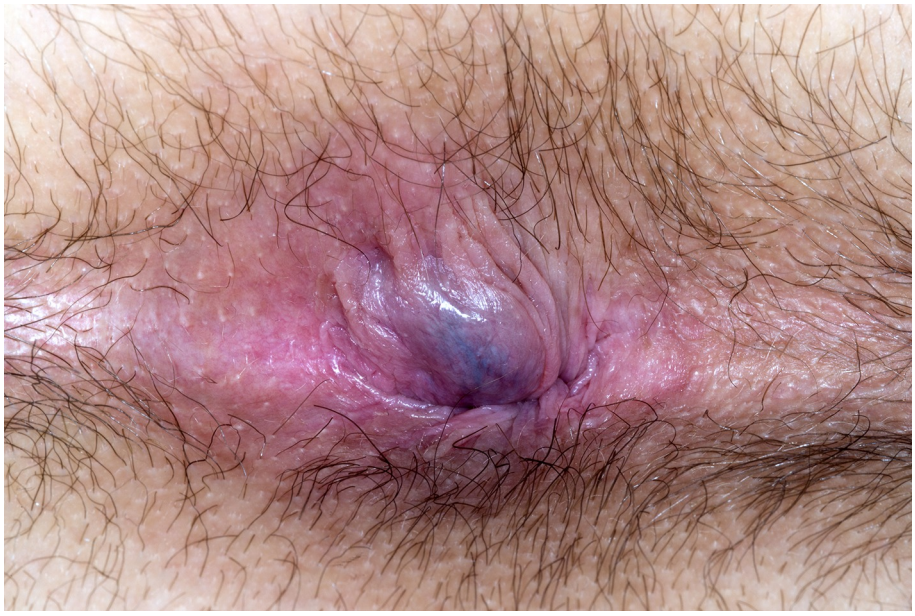

Fig 3 Anal warts

[Image: P Marazzi/Science Photo Library]