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# UPDATE ON COMMON ANORECTAL DISORDERS IN HIV MEDICINE

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**Update on Common Anorectal Disorders in HIV Medicine**
**[video transcript]**

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- [Host] Welcome to Physicians' Research Network. I'm Jim Braun, the course director of the monthly meetings of PRN in New York City. Since our beginning in 1990, PRN has been committed to enhancing the skills of our members in the diagnosis, management, and prevention of HIV disease as well as its co-infections and complications. We hope this recording of Stephen Goldstone's presentation, Update on Common Anorectal Disorders in HIV Medicine, will be helpful to you in your daily practice, and invite you to join us in New York City for our live meetings in the future. PRN is a not-for-profit organization dedicated to peer support and education for physicians, nurse practitioners, and physician assistants. The membership is open to all interested clinicians nationwide at our website, prn.org. And now allow me to introduce Steve Goldstone, Assistant Clinical Professor of Surgery at the Icahn School of Medicine at Mount Sinai in New York City.
- [Stephen] Hi, good evening, everybody.

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All right, so the prevalence of anorectal disease is very high. Most patients won't complain of a problem because they're embarrassed or they're afraid, and most physicians no longer do a rectal exam. Can I just ask for a show of hands, don't be embarrassed, we won't take away your dinner. How many people routinely do rectal exams? Wow, it's about six times the amount of what we usually see. And everyone's uncomfortable in the room. You, with your finger poised, and them waiting for the exam. So it's tough. I think the most important part is clearly the history.

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Presenting complaints. Pain, when did they have the pain? Is the pain with the bowel movement, is it before the bowel movement, is it after the bowel movement? What's the character of the pain? Can they pinpoint it? And bleeding is very important. Is it just on the toilet paper, which is something very different than if it's dripping in the bowl or streaking the stool. Do they have a discharge? Are they soiling their underwear? What are their bowel movements like? Have they ever been treated for something? And prior complaints are important, like what other diseases do they have? For instance, psoriasis on the elbows may very well have an anal component to it that's causing them problems. You know, being on immune modulator therapy for systemic lupus or something like that. Have they had a colonoscopy? What about STIs? What about HIV? And then the sexual history. Do they have anal sex? Is it protected? Do they have rimming, fingers, toys? Are they monogamous, or Chelsea monogamy, which dates back to a medical student many years ago who came to my office and I, they learned in my class how to take a sexual history, and he said to me,
"Dr. Goldstone, I don't understand it. I asked him if he was in a monogamous relationship. He said yes. Whenever he and his partner have three-ways, they're always together." So we term that now Chelsea monogamy. Whenever it's a crowd, as long as you're there with your partner, it's okay, all right?

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So what's the diagnosis? Anyone? Yes? No? This is a normal asshole, okay? These are not hemorrhoids. This is just normal puckering of the skin from the external sphincter tightening because the patient is afraid I'm about to stick a finger in there or a scope or something else. So this is normal external.

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So you have an external sphincter, which is voluntary control. The internal sphincter, which is involuntarily controlled, and here's the dentate line, where we used to think of the squamocolumnar junction right there. So the exam is critical. You need a well-lighted space, because you have to look at the perianal skin.

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I like them in the knee-chest position. You have them just bend over the table. Some people like a lateral decubitus position. The nice thing about bending over is that you get a better view. With a decubitus position, you get in farther. You want to have a non sterile glove, and I really like having a good anesthetic lubricant. You can use lidocaine. This happens to be tetracaine. Because if someone is tender, it's the most important time to examine them, because you wanna know, is there an abscess in there? What's going on? You don't wanna just empirically treat them for a hemorrhoid. You don't really know what's going on. So when someone comes in tender, it's so important you examine them. So if you put in an anesthetic in there and wait a few minutes, they'll numb up and it's a much easier exam to do. And I think it's very important they have draping, privacy, and an assistant present.

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So external inspection by spreading the buttocks. And when you spread the buttocks, it's very important. Look for pigment changes, ulcerations or lesions, and then use your finger around the perianal skin, because especially if people are hairy, you may not see something, but you may feel it, and then move the hair away and take a good look. Feel for tenderness, nodules, induration.

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And then I always do an anal cytology, which is the top picture. You use a moistened Dacron swab with tap water. You spread the anal opening with your index finger and thumb of your non-dominant hand, and then you move the Dacron swab in and out. You have to jiggle it. You move it in and out for a couple of inches, and rotate it. You wanna get in all the folds and pick up the cells. You have to be a little rough, because you need to get the cells off. And then you put it immediately into a liquid-based cytology, whatever your lab wants. And then I think it's very important, and especially in MSM who, and especially if they have pain, get from your lab, your commercial lab or your hospital, a NAATs kit for gonorrhea and chlamydia. It's extremely sensitive. Wet the swab, stick it in. You just move it in and out very quickly. Break it off in the transform media. Because if you're just doing urines for gonorrhea and chlamydia, you're missing about a third of the infections.

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Okay, then we insert a gloved, lubricated finger. Anesthetic if they're tender. You go all the way up to the prostate in a man or a shelf in a woman. Feel both lobes. And then it's, and go circumferential. Then pull back to where the sphincter muscles grab your finger. This is the anal canal, and this is very important that you do a 360 degree sweep here, because this is where you'll feel like anal nodules, anal cancers, warts, fissures. And then I say don't do a stool guaiac, because if you've done a good pap smear, it better be guaiac-positive, you know, because you've been moving that swab in and out. So that's the whole deal here.

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I think a well-lighted anoscope. This a Welch Allyn on the bottom that you can buy, and look inside if they have a complaint. The other one is a simple scope that you need an external light source.

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So here we have a normal view. The white is the squamocolumnar junction. Here, squamous cells. The dentate line is way back here with the crypts. Squamous cells grow right up over the colonic mucosae. Here you can see it's sort of like the squamous cells falling apart there. You can see the colon through it.

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So, common pathology, hemorrhoids. 50% of all Americans have hemorrhoids. The peak age is 45 to 65. Hemorrhoids are totally normal. You need them to cushion your bowel movements. And there are two kinds of components. There's the internal component, which is here, and it does not sense pain. Then you have the external hemorrhoid here, which can have pain, and these large internal hemorrhoids can become so large that they actually prolapse out with a bowel movement, and they're typically three bundles. Right, anterior and posterior, and left lateral.

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Internal hemorrhoids, the symptoms are painless bleeding and prolapse. If they have pain, it's usually not an internal hemorrhoid. And we grade them one to four. Three comes out with a bowel movement, four you can't push in. They're often nontender, nonpalpable. If you put your finger in, you can sometimes feel some ridges in there. That's usually, they're soft, they're hemorrhoids. You don't see it unless they're, it's a grade four or they're straining in your office, like you ask them to bear down and they may come out. It's a weakness of the connective tissue. With age and stress, you get engorgement of the veins. And pushing to have a bowel movement is sort of like a tourniquet, where you're basically valsalving and forcing blood into the hemorrhoids and that's why they come out. So straining is a big reason why they develop and why they prolapse.

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So here you see a patient where we're sort of spreading the anal opening a little bit, and we're asking the patient to bear down, and you can see this internal hemorrhoid peeking out. And so this is a grade three hemorrhoid. And this is mucosa that you're seeing, the pink. And this is what it looks like through an anoscope, and you can see these nice crypts here, which are similar here, and here's the bulging vein, which is the hemorrhoid right there.

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Okay, so these are grade four hemorrhoids that they're out all the time. The one on your left is just, you know, prolapsing mucosa, and it's out, and the issue with that is it's gonna be staining his underwear or her underwear all the time. It's gonna discharge mucous and this is exudate, the white on it right here. Here's the skin out here. And this one is more dangerous. This is a grade four prolapsing hemorrhoid, which is ischemic, because the sphincter muscles are basically acting like a tourniquet, so you're getting a venous ischemia here, and this is very tender, and the patient's in a lot of pain, and this is something we have to treat immediately.

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Okay, external hemorrhoids are dilated veins that may or may not be connected to the internal hemorrhoid and they're covered in skin. And their symptoms are swelling, pain, bleeding, if you irritate

them, and itch. The itch, while it's the most common symptom ascribed to hemorrhoids, it's often not because of hemorrhoids, rarely. They ulcerate and they thrombose. Tags are usually not hemorrhoids, and I'm gonna show you some of them in a minute. They're often just a reactive process to a fissure where the skin swells, becomes inflamed, but it's not a true hemorrhoid. And sometimes patients want them removed for cosmetic reasons, because of sex or photographs, I don't know, that they want those things removed, okay?

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So this is a thrombosed hemorrhoid here. You can see the bulging clot right in this hemorrhoid here. It's tender. And then this is a thrombosed hemorrhoid where the pressure has gotten so great, it was obviously extremely tender, that they've gotten a little necrosis of the skin from the pressure, it became ischemic, and the clot has eroded through. They don't embolize from these hemorrhoids. They're not gonna get a PE from the hemorrhoid, and they won't hemorrhage, because this clot is adherent to the vessel wall. You can't get it out. So what it does is it's just that it keeps weeping blood all the time. So that's a thrombosed hemorrhoid that's eroded through.

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So the treatment, most hemorrhoids respond to conservative therapy. The most common treatments that we do are sitz baths. Soaking in warm water will reduce the swelling and reduce any pain. Bulk agents like any fiber, psyllium husk-basked fiber. You can buy psyllium husk, you can buy Metamucil, Citrucel, Cons, or whatever it is. The key with the fiber is that you have to drink a lot of water, because the fiber works by absorbing water or other liquids. So if you just take the fiber and don't increase the fluid intake, it can be like passing straw, and it can make them even more constipated. I like to give them something like docusate sodium, because it pulls water into the stool, or Miralax. Miralax is a wonderful, wonderful stool softener. And then reduce internal hemorrhoids. Push them in if you see that mucosa. External hemorrhoids, don't push them in. If what you're seeing is swollen skin, you don't wanna push it in. It doesn't belong inside. A topical steroid medication with or without an anesthetic really helps. If they have swelling on the outside, you give them something they put on their finger and rub right on the point that's swollen. If it's inside, if it's an internal hemorrhoid that you've reduced, a topical cream isn't going to work. You wanna give them the suppository or a cream they can put up their anus so that it'll dissolve, and giving them a suppository for something on the outside also isn't gonna work. So you need to know, is it internal or external? And then choose your medication accordingly. And external hemorrhoids, we no longer do the I&D to get the clot out. We actually remove the hemorrhoid if it needs to be removed.

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So I'm not a spokesman for Analpram or Peranex. These are just two preparations I had in the office. Both of them have hydrocortisone with anesthetics. One has pramoxine, one has lidocaine. They're all good. If it's on the outside, squeeze it on your finger, and rub it on the spot. If it's on the inside, put the nozzle in, and squeeze out the amount you need.

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So what's the diagnosis here? Anal fissure, okay? So this is your test question. Here it is, this is right at the opening. It's an acute tear. You can see it there. It's bleeding. There's granulation tissue at the base. I got a look at it with, by putting anesthetic in. Then you see this big knobby thing on the inside coming up right here. I'll show it to you better in a minute. So this is a fissure.

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It's a tear in the anal derm from trauma, a bowel movement in heterosexual people, a hard bowel movement, but in many MSM, they're not too tight to begin with because they've had anal sex. So it's often sexual trauma, or it can be from wiping too much. Don't forget infectious causes, syphilis, herpes, HPV and TB we used to see more in the early HIV epidemic and including HIV, which it was usually, I've just seen, I've seen one in the last couple years with a viral load of like a couple million. He went on antiretrovirals, and his fissure healed. So we used to see them a lot in the early HIV epidemic. And colitis, it's painless in Crohn's, not in ulcerative colitis. They often will have a visible tear, and they may have increased sphincter pressure from spasm, especially if they're heterosexual. Symptoms are pain with bowel movements and blood streaking the stool, or sometimes on the toilet paper. They're often posterior and single in about 90% of cases. If you start seeing multiple fissures, think of trauma or something else going on.

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So here is the fissure triad that we see. Here's the fissure, then here's that knobby thing that you're seeing right here. That's called the hypertrophic papillae, which is basically a huge callous from all the chronic inflammation, and there are a couple little ones here and here from basically chronic constipation. You know, you get these callouses. And then on the outside, you see this, what we call sentinel pile or tag. This is not an external hemorrhoid, which is one of your choices on the exam. This is related to the fissure. It's swelling from the acute tear, just proximal to it, just on the inside at the verge. And what happens is this'll be swollen and they'll have a lot of tenderness, and they'll come in and say,
"I have a swollen, tender hemorrhoid." And it may be tender if you push on it, because you're actually pushing on the fissure just on the other side of it. This is not the problem. The problem is the fissure, okay. They do not have an external hemorrhoid, they have a fissure. Is that clear? Yes? Good.

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So 70% of acute fissures resolve in less than six weeks. If it takes longer than six weeks, it's called a chronic fissure. 20 to 30% of chronic fissures will heal. They often have these heaped edges, the hypertrophic papillae, and the tag, the triad. They may be hyperkeratotic. In men, MSM, like I said, often don't have increased tone. Treatment is the same for everything. Bulk agents, fluids, docusate sodium, pain management. Now, I don't like to give narcotics, because narcotics are constipating. So I like to use a topical, like one of the ones I showed you, either lidocaine or hydrocortisone with lidocaine, or pramoxine. You tell them to put it on their finger, move their finger right into the spot that hurts, keep their finger there for 10 to 15 seconds, and then that'll really help numb it up before a bowel movement or after. Joe, what do you like to use, Calmol?
- [Joe] Calmol-4.
- [Stephen] Calmol-4, Joe loves. Joe's the colorectal surgeon that works with me. You've seen him here. And Jonathan's a PA who works with me. So they really know anorectal disease. So that's all they see.

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Anyway, so other agents, nitroglycerin. 0.2% were the original studies. It reduces the resting sphincter pressure and increases blood flow, and it heals fissures. 41% healed in six weeks, 88% by 12 weeks, but over 50% get headache. The reason that I use it at times is because it is available now commercially as Rectiv, but 0.4%, so some insurance companies will cover it when they won't cover diltiazem or

nifedipine, which I love them, the calcium channel blockers. They're just as effective as the nitroglycerin, but they have to be compounded. Like New London and Bigelow and a lot of the pharmacies, you know, the smaller pharmacies will compound it, but it may not be covered by their pharmacy. And less headache is the main thing. And Botox, 30 international units. Joe is a pro at Botox. They do it with sedation in the office. It's really wonderful, because it gives a little to the fissure. There's some left over, and that's why I look so good, because then he does my forehead and everything else, okay? Soiling can be a side effect. 75% healed by six months, but 55% recurred. The deal with a fissure is it may never fill in, but it's epithelialized.

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And here's a picture of a fissure that's fully healed. But you still have that divot there, and you may still palpate it, but it is not an acute fissure, and it's no longer symptomatic. Stop the treatment. I've had a patient that's been nifedipine ointment for like three years, just because, well, this is him. This is what you see there. But he doesn't have pain, and it's never gonna fill in, okay? So once they're done with their symptoms, you can stop the topicals. They may recur if the same inciting thing happens over, rough sex or hard bowel movements or wiping too much.

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Anyone know what the diagnosis is here? What?
(audience member speaks indistinctly)
I can't hear you.
- [Audience Member] Atrophy?
- No, abscess. See the shiny skin, it's red? This is a big abscess.

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So the presenting symptoms are pain, pain, pain, and more pain. Skin can be tense, red, warm, tender. They may have drainage or a pointing, like you see at the bottom. It's rarely a cellulitis. If you see this, they need to see a surgeon, or you can drain it yourself or needle it. This is not something that heals with antibiotics. It's rarely a cellulitis. It's often coming from deep crypt. Sometimes we have to get a CAT scan or an MRI if we're not sure, or we explore it. Adequate antibiotics. You cover a colonic bacteria. I've seen a couple of GC abscesses. Sometimes it's from the skin with MRSA. If you drain it, local anesthetic.

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Make a small incision. You may have to go deeper or change the incision. Joe does a nice cruciate incision. I make a Jewish star. No, just kidding.
(audience laughs)
You know, if it's loculated, sometimes you break it up, but we're getting away from that. We clean it out, put a little wick in there for hemostasis. And anywhere from five to, I've seen as high as 15% will go on to become a fistula. It's not because you did anything wrong, it's because the channel from the intra-anal canal that started it feeds, stays open. Fistula-in-ano is a connection from the internal canal, usually from one of those crypts to the outside. You can see them with Crohn's disease. And the symptoms are leakage or discharge. Sometimes itch, because it's chronically inflamed, and pain. And it's often intermittent, like they'll complain of pain and swelling down there, and then they'll get a sudden, it'll burst, almost, and they'll get a little fluid, it may be bloody or a little purulent, and then they feel great until it happens again, and that's a fistula.

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Treatment is surgical, again, it's not gonna get better with antibiotics or I&Ding it. They can be multiple, and sometimes, if too much of the sphincter's involved, we may not wanna do surgery on it. So these are just some different pictures of the external and internal openings. Often you don't see the internal opening, so here is just heaped-up skin. So this person had been treated for condyloma, but in reality, you look at it very carefully, and just on the back side of it was a hole, and that was the internal opening. Here's a more classic external opening. Here's an internal opening which is just a deep crypt with a, you can see the hole there. Here's one that's just granulation tissue on the inside, you know, like red, beefy stuff that's oozing. Sometimes we see pus coming out, sometimes we don't. And this is just one to totally take away your appetite.

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This is, when we're about to do surgery, we've passed a probe from the external opening to the internal opening. And this patient is asleep, so don't worry, okay? And then we open it up and clean it out.

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So, anyone know the diagnosis?
(audience member mumbles)
It's a pilonidal, okay? You can see the hair actually coming right out of the deep crypt right here. I love this picture.

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They're chronic inflammation. They're not hair growing out. The hair is loose, it works its way into the deep crypts and gets inflamed and the crypts get larger. They're midline fold, you don't see them before puberty. And they may go away by the time someone's in their 50s. They can have skin flora if it's an abscess, staph epi, staph aureus. And they're often chronic, they can drain, become abscessed. We try not to operate on them. Shaving is superior to depilatory agents, but we use depilatory agents. We pull the hair out. Antibiotics only if necessary, and sometimes surgery. And it's very interesting. I often thought it was like a buttock hair that works its way in. But someone did a study, and they found that it's hair often from the head, from the back, from the cat. You know, it's just hair that works its way in between the cracks, and the poor cat, I don't know.
(audience laughs)

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Okay, what's the diagnosis? Anybody? What? This is perianal dermatitis with a lot of hyperkeratosis. Here in the middle of the crack, it's all red.

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So anal pruritus, in one series, about 50% of people complained of an anal itch at some point. It's anything that irritates the skin. Discharge from a fistula, prolapsing hemorrhoids, seepage, chemical irritants, topical creams, or stuff in the feces, cathartics, infection. But the main thing is it's a dermatitis from over-wiping. If they have eczema somewhere, they're gonna get it down here. If they have psoriasis somewhere, they'll get it here. If they have atopic dermatitis, they'll get it there. And the biggest problem is that they wipe too much. And then the wipe, they itch, so they wipe, it gets more inflamed, they itch more, so they wipe more, okay?

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Oh, here are some pictures. Here's the one I showed you. This is very hyperkeratotic. Here's another one. It's not fungal. If you think it's fungal, look in their groin. If they don't have fungal infection there, they're probably not gonna have it here. And then this one, the person was being treated for a fissure, because what was he doing? He was coating his finger in toilet paper after a bowel movement sticking his finger up there, hooking it, and pulling it out to remove any feces that were left, and he was basically digging a hole here in this hyperkeratotic skin. Okay, so they often will have bleeding. It's usually just on the toilet paper.

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The minute they tell you there's blood on the toilet paper, this is it. So let me tell you how I treat this, just so that you know. We used to do all kinds of crazy diet things. The first thing is to look to see if they have skin infections, skin problems elsewhere, okay? If they do, that's something that's important to treat. The key is no wiping, and then they look at me in horror. After they're done moving their bowels, get off the toilet directly into the shower, or maybe if they're lucky, they have one of those Japanese Toto toilets, which are a godsend for these patients. You bend over in the shower. Let the water run down. With your fingers, gently massage the area. No soap, soap's very irritating and drying. Pat it dry with their 5,000 thread count amazing Egyptian towels, and pat it dry and that's it, no rubbing.

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Then I give them a topical anti-inflammatory, often with an anesthetic, because it'll immediately stop the itch. And I'm telling you, if they do this, their itch will be gone within a week, generally. And if they're at work and they can't get in the shower, then, and they don't wanna quit their job, then I tell them to use Tucks, but they're only allowed two wipes. One gently up, one gently down, throw it away. I'd rather that they stain their underwear than wipe the hell out of their skin, and no baby wipes. There's a reason a kid screams when you diaper them, because the preservatives in a lot of these wipes cause tremendous irritation. That's what we do. Oh, certain lubricants for sex, stay away from. And the big one are the silicone-based lubes, why? Because they don't come off, and patients will scrub and scrub and scrub trying to get the lube off. So if they're happy having the lube there, then silicone's great. If they're not, then use something else.

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So here's someone that we treated for atopic dermatitis with a steroid cream. Came back six weeks later and it didn't get any better. Anyone know what this is?
(audience member mumbles)
Cancer. Have a very low threshold to biopsy. If they, you don't wanna just give them a cream and say, "Have a nice life, I'll see you in eight to 10 years." If you're treating a dermatitis, see them again in six weeks. If you're treating hemorrhoids or pain, see them again. Make sure it goes away. Don't just rely on them to call you, because it can be a cancer.

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Infectious, acute herpes on the left. All those superficial ulcerations, incredible pain. On the right, it's just a secondary recurrence where you get it much more localized with the blisters and pain. This you're never gonna get the diagnosis because, but what does it look like to you?
(audience member mumbles)

What? Warts? No, it looks like cancer. You know, it's indurated, it's hard, it's red, it's disgusting. I've seen this and I immediately think cancer. Biopsy, it's just chronic inflammation and acute inflammation.

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This is herpes pyoderma vegetans. We see it in very poorly controlled HIV, transplant patients, et cetera. The culture may be negative. You may see it when you do a biopsy of it because you think it's cancer, and they'll call you up and tell you, gee, it looks just like herpes, you know, or they'll stain it for herpes. And the treatment here is, we have to put them on very high dose medication, like three grams a day of Valtrex is what we try to use. And they may be on suppressive therapy, but it's just not enough, or they're taking it sporadically. So it's really a problem, and oftentimes, it'll go away, but it takes a long time and a lot of high-dose treatment here.

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This is molluscum, which you'll see often, okay? You can curette it, you can desiccate it, you can use imiquimod. People are using all different treatments. But it's that central umbilication, and it often'll look like a zit, you know, like a little folliculitis, and with a red border around it. The way you know it's not is you can't pop it, okay? And you gotta see them repeatedly, because they'll often come back. So this is what we see all the time.

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This is what is never diagnosed. This is proctitis, and I urge you, anyone who comes in with pain in their ass, stick the swab up there, and this is proctitis. Beefy, red, you may see pus, you may see ulceration, and it can be herpes, but the number one thing this is in Chelsea now is LGV, okay? Please, it can be syphilis. What I do is I give them my cocktail, which is a shot of ceftriaxone, 21 days of doxy, 100 milligrams BID, and Valtrex, one gram, BID for 10 days. Send off all the tests, and if the chlamydia NAAT comes back negative, I call them up and say stop the doxy, okay? But if I see a fissure, I'll check for syphilis, but I won't empirically treat. You know, if there's an explanation, a thrombosed hemorrhoid, I don't treat. If I see proctitis, then I empirically treat. This is one of the questions on the pretest, okay? I empirically treat if I see proctitis. I don't empirically treat, I won't empirically treat for syphilis if I see a fissure, because the RPR comes back so quickly. Here you see a rip-roaring proctitis with a big ulcer. You may not see the big ulcer. You may just see proctitis. The ulcer may not have formed yet.

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But here is an LGV ulcer with a lot of proctitis, and this is one week after this. So the ulcer develops, okay? And then here is two months later, you still see this ulcer healing and his symptoms are better, but this is LGV.

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Here's a syphilitic chancre. We biopsied it and on high power with a syphilis stain,

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you can see all the red spirochetes. And here you can see them invading the wall of the capillaries, okay? So this is syphilis.

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Okay, 30-year-old heterosexual man, severe itching for four months, he can't sleep, he had a biopsy from a colon and rectal surgeon, and it looks like possible cancer, and that's what he was told, and came to see me, freaked out that he has anal cancer, because that's what he was told. His girlfriend had cervical CIN2 a few years prior, and he was totally freaked out, and he's heterosexual.

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This is not cancer, okay? Anal cytology was ASCUS. No high-risk HPV in there. Culture was moderate growth of staph aureus and group B strep. What next? We biopsied it here and there where it was more indurated and ulcerated, and it's psoriasis, okay? No HPV in it.

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Before we got cultures back, we treated him with topical in it, and then we added Augmentin when the cultures came back and Mupirocin and sent him to a dermatologist for psoriasis,

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and this is what he looked like four weeks later. So, and he was 75% improved. The dermatologist I sent him to put him on imiquimod because of the path report. I immediately called up the dermatologist and said stop it, stop it, this isn't HPV.

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And five months later, he's got a little ulceration, still has a little psoriasis, 90% improved.

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All right, this is the opposite. Perianal dermatitis, I was sure it was from the itch, all the excoriation. Six weeks later comes back, he's no better. I biopsy it. This is high-grade dysplasia. Treated him with Veregen, which is a Sinecatechin, a green tea extract which I like for HIV positive patients. It works better than imiquimod. And this is him four months after treatment where he's fully resolved, okay? If you use the Veregen, it makes it much worse at first. First time I used it, I thought I gave the patient gangrene of the asshole. You know, it was big, black eschar, and I was so glad he couldn't see what it looked like. I really thought it was a problem. I teased it away, and there was beautiful, pink granulation tissue under it. And eventually, the eschar separated and it was healthy skin. So be prepared.

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Here's something, everything you see is not a condyloma. Here this is a patient who had been treated for a year for condyloma. We biopsy it, the diagnosis was condyloma. I said it's not condyloma. They tested for HPV, there's no HPV in it. They amend the report to just hyperkeratosis, okay? So please, if you're treating someone for a long time for condyloma, biopsy it, because oftentimes they'll get hyperkeratosis afterwards.

00:40:03
This is a hypertrophic papilla. It looks like a wart, it's not.

00:40:08
Summary, ask the questions, patients don't volunteer. Do a digital anorectal exam. Soften the stool, use the appropriate creams. STD testing, especially if pain, fissure, and pus, but don't treat empirically

unless you see proctitis. Low threshold for biopsy. Don't treat them endlessly. If they're not better after six weeks, another question on the pretest, send them to the surgeon. Follow up to be sure symptoms resolved.

00:40:37
I just want to show you this patient quickly. It came from Callen-Lorde. It was treated perfectly, okay? Guy complained of pain and bleeding after fisting. He has a lot of sex.

00:40:51
We found out afterward from the Callen-Lorde chart that he had been treated appropriately for high-grade dysplasia recently. He had told me he hadn't been treated for 10 years. In 2015, he had AIN1 with one biopsy, that was the last time.

00:41:09
At Callen-Lorde he was negative for GC and chlamydia. I didn't know that. But they thought he had a fistula and a fissure.

00:41:16
Here you see the skin here, that's a swollen tag with an external hole.

00:41:22
Internally he was in a lot of pain. I could barely look. But then you have this fissure in there.
It looks like a big cut from fisting right here with granulation tissue. He didn't heal up, you know, for six weeks at Callen-Lorde, so they sent him to us. I, of course, I didn't have the STD testing.

00:41:42
I put him on doxycycline and stool softeners. Chlamydia NAAT returned negative.

00:41:50
He came back a month later and I biopsied him. Actually, I couldn't biopsy him, Joe biopsied him the next day, because I thought he may have like an abscess in there or something that was causing it. Then we had to sedate him.

00:42:06
We biopsied him, and here is normal skin with the red arrow and the black arrow is the transition to the cancer that he had. Here you see it. And here where the green arrow is, he's got invasion of the vessels.

00:42:22
And again, more invasion, and he has invasion in the liver. This did not develop, he was totally treated properly at Callen-Lorde for anorectal disease. This has been going on for a while.

00:42:38
It's just that patients often ascribe things to like fisting or whatever, but in reality, he had this cancer growing for a while. So please don't forget to see them back,

00:42:50

and I think that's my last slide.
(audience applauds)
Thank you.  [Video End]