# *PRURITUS ANI*

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## INTRODUCTION

Pruritus ani is one of the most controversial problem of proctology and lots of questions are still open: is it a disease or a symptom? Why men are more often affected than women? Which is the relation with depression or psychological disorders?
Anal pruritus, an intense chronic itching affecting the perianal skin, is a common condition. Anal pruritus is estimated to affect up to 5% of the population, with a male to female ratio 4:1.
Perianal skin is vulnerable towards different kind of noxae patogenae. The patient eases the itch by scratching the perineum, which produces short lived relief. Continued scratching causes damaging excoriations, which may bleed. A vicious circle of itching and scratching develops which is difficult to break and induces a state of nervous exhaustion.

## AETIOLOGY

Pruritus ani have a benign aetiology, but in most of cases the aetiology is unknown, such as we can define pruritus ani as idiopathic.
Nearly 100 different causes for pruritus ani have been reported. The majority of co-existing conditions are anorectal, predominantly haemorroids and fissures, faecal contamination and anal cancer. Dermatological conditions are usually not restricted to the perianal area, but the morphology of perianal skin lesions may be typical for the disease elsewhere.
Foods have been implicated in idiopathic pruritus ani such as caffeinated drinks, alcohol, milk products, peanuts, spices, citrus, grapes, tomato and chocolate. Some researches have claimed diminution of itch within 14 days if these were avoided.
Although occurring in the minority, the importance of bacterial, fungal and sexually transmitted infections should non to be underestimated.
Some parasites should be considered in the aetiology of pruritus ani above all in children (Enterobius vermicularis).
The use of some topical products (topical steroids, soaps, shower gel, creams, talc, perfumed toilet paper, baby wipes and latex condom) and some orally ingested medications (laxatives, colchicines, quinidines, peppermint oil, antibiotics) can occur itch by a sensibilization of perianal skin.
Systemic diseases can lead to pruritus ani and most commonly diabetes mellitus, liver disease, leukemia, lymphoma, renal failure, iron-deficiency and hyperthyroidism.
Anxiety, stress and certain personality traits may contribute to arise the itch, in fact pruritus ani may be the first manifestation of depression or psychological disturbances.

## DIAGNOSIS

It is important to take a direct history in order to identify readily treatable causes and exclude or diagnose serious pathology. Patients have to consider any relevant history that should cover the onset and time of the symptoms, significant medical conditions, other skin complaints, bowel habit, drug history, dietary history, family history of inflammatory bowel disease, dermatoses, diabetes or bowel cancer, sexual habits, psychological disturbances and social history.
The examination of the patient should not be limited to the anoderm, but it has to include examination of external genitalia, perianal area, mucous membranes, nails, scalp, beard, chest, axillae and groin looking for dermatoses, lice, scabies, drug eruptions and secondary syphilis.
The next step is the digital examination followed by the use of a lubricated proctoscope.

For last but not least, colonscopy must be always considered if there is a doubt of some colorectal pathology.

**THERAPY**

Any underlying cause identified need to be appropriately treated. Dermatological conditions should be treated by an appropriate specialist; infections should be treated by an adequate antibiotics therapy; anorectal conditions should be treated surgically, when it is necessary.
It is important to educate the patient about the recurring, benign nature of this irritating condition and to ensure adherence to the following simple, yet essential, measures to eliminate irritants and resolve symptoms (tab.1).

**Tab. 1 Guidelines for patients with pruritus ani**

- Keep the anal area clean by washing after defecation
- Avoid medicated soaps which may cause sensitisation
- Dry the anal area by gentle dabbing
- Use only specifically prescribed ointments
- Avoid acrylic and nylon underwear
- Mantain a regular bowel habit
- Avoid higlhly seasoned and spiced foods
- Wear cotton gloves at night to reduce the damage from subconscious scratching

Mild-to-moderate symptoms can be treated with a weak topical steroid such as 1% hydrocortisone after washing and can be combined with antibacterials or antifunginals.
Once symptoms regress, application can be reduced while substituting with a barrier cream. Patients should be informed of side effects and the need to limit treatment duration.
Severe symptoms and skin changes require stronger topical steroids, but for a definite period of time.
At any stage, if the response is poor, one must reconsider the diagnosis.
Unfortunately, a significant percentage of patients remains very difficult to treat and represents an important clinical challenge. Attempts to treat refractory pruritus ani include perianal injection of anaesthetic agents, surgical disruption of the sensory nerve supply to the perianal area, have had significant side effects.
In the last years several authors have considered the use of topical capsaicin in a 0,006% preparation for the treatment of intractable pruritus ani.
Anal tattooing should be considered in those who have failed other treatment measures. The technique involves several intradermal and subcutaneous injections of methylene blue.

## Bibliography

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