Celebrating Pride!

Canada Pride 2024 in Vancouver takes place from 26 July to 4 August. Pride marks a time of celebration, advocacy, and reflection for the LGBTQIA2S+ community. Vancouver's Pride parade is on 4 August 2024.

My colleagues and I at the Pacific Centre for Reproductive Medicine have marched in every Pride parade since 2016. I have also had my children alongside me in the parade since they were babies—it's a great event for kids, as Pacific Street turns into a collective rainbow bash of positive vibes, water guns, and music. One year, my son had the honor of being interviewed by the drag queens hosting the television coverage. My son was bursting with pride when they announced to the crowd that his mom was their fertility doctor! After that encounter, my kids assumed that my office was basically an all-day dance party.

Beyond the parties, Pride is more than symbolism and pageantry. As physicians, we have a unique responsibility to foster inclusivity by providing equitable health care for all individuals, regardless of sexual orientation or gender identity. While British Columbia boasts progressive values, it's essential to acknowledge the persistent health disparities faced by those who identify as LGBTQIA2S+. Research tells us that members of this community experience higher rates of certain mental and physical health issues compared with their cisgender, heterosexual counterparts.[1] Discrimination, stigma, and lack of access to affirming health care services are some of the contributors to this disparity.

Pride marks a time of celebration, advocacy, and reflection for the LGBTQIA2S+ community.

Pride can be an opportunity for health care providers to reflect on our role in these disparities. LGBTQIA2S+ individuals face an ongoing struggle for rights and equality. This is an opportunity to re-examine and re-affirm our commitment to providing compassionate and culturally competent care to all patients.

There are many ways to improve how we deliver inclusive health care. Each of us knows our own unique patient populations and strives to evolve to meet their needs. One aspect of affirming medical care might include continuing education, such as keeping up with the latest guidelines or educating team members on inclusive language. We can display visible symbols of support, such as Pride flags, so that patients know our facilities are safe spaces where they can express their identities without fear of judgment or discrimination. Egale Canada (formerly Equality for Gays And Lesbians Everywhere; https://egale.ca) and Trans Care BC (www.transcarebc.ca) are two resources I've found helpful, but there are many others. Please comment online or email the *BCMJ* if you have resources or advice to share.

In Vancouver and across BC, we are fortunate to have a vibrant and active LGBTQIA2S+ community that provides support and resources to its members. Health care providers can find ways to stay actively engaged, seeking input and feedback to assess how our services are meeting the community's needs. Pride season is a powerful reminder that together we can build an inclusive, compassionate, and equitable health care system. Happy Pride! ■

—Caitlin Dunne, MD, FRCSC

Reference

1. Jakubiec BAE, Pang C, Seida K. Healthcare access experiences and needs among LBQ women, trans, and nonbinary people in Canada: A research report. Egale Canada. 2023. Accessed 14 May 2024. https://egale.ca/wp-content/uploads/2023/10/EN-Action-Through-Connection-Report_Final.pdf.

Vancouver Pride parade, 2023.

Pain in the butt

Anorectal complaints can be a "pain in the butt" for both patients and physicians. Many patients believe hemorrhoids are to blame for problems "down there," such as bleeding, pain, irritation, itchiness, swelling, or protrusion. This perception, along with feeling embarrassed when discussing anorectal complaints and anxious about the eventual examination, can be a barrier to seeking help. At times, patients can be so convinced of a self-diagnosis of hemorrhoids that they relabel the term *rectal bleeding* as "hemorrhoids acting up." When I ask "Have you had any rectal bleeding?" a common response is "Oh, no . . . no, doc . . . just hemorrhoids, you know . . . I've had them all my life."

"The very first step towards success in any occupation is to become interested in it."[1]
The problem is that many anorectal pathologies can have overlapping symptoms. Therefore, one should always keep an open mind when taking history and an open eye when performing physical examination, as part of a stepwise approach in managing patients with anorectal complaints. "I would start by taking a full history and performing a complete physical examination." I am sure most of us used this blurb when answering questions for the Royal College of Physicians and Surgeons of Canada oral exam; it gave us the sought-after checkmark on the scoring sheet and should do the same in real life!

"Listen to your patient, he is telling you the diagnosis."[1]
It has been said that surgeons are not always the most thorough history takers. When it comes to assessing patients with anorectal symptoms, asking the right questions and looking for patterns are fundamental. Most of the time, I have a very good idea of what the diagnosis will be by the end of history taking. For example, sharp, razor-like pain, starting with bowel movements and lasting up to a couple hours after, with associated blood on toilet paper or coating the stool, all preceded by recent episodes of constipation, has a diagnosis of anal fissure written all over it. Experiencing discomfort (not sharp pain), with perianal "swelling" after bowel movements, bright-red blood on toilet paper or dripping into the toilet bowl, mucus discharge, and having to "push things back" at the end point to prolapsing hemorrhoids or possibly rectal prolapse. And last, a nonhealing wound with persistent discharge after incision and drainage of a perianal abscess usually suggests the diagnosis of anal fistula.

Just as patients blame everything on hemorrhoids, I treat everything with fibre (well, not exactly, but at least as a starting point in many cases).

As when treating any condition in medicine, it is helpful to have a list of the most common causes for various anorectal complaints. For example, when seeing a patient with anorectal pain, I usually have the following three at the top of my differential diagnosis: anal fissure, perianal abscess, and thrombosed external hemorrhoids. Of course, a fungating anorectal cancer or Levator syndrome can also cause anorectal pain, but they are not as common. Nevertheless, the next step—a physical examination—is key in confirming the diagnosis and ruling out other ominous pathology.

"The whole art of medicine is in observation . . . but to educate the eye to see . . . and the finger to feel takes time."[1]
As you reach the end of history taking, you are itching to move on to examine the patient so you can confirm what you have postulated as the most likely diagnosis. This is your moment to shine. The feeling is akin to the moment you are being "pimped" as a surgical resident in the operating room by the attending surgeon and you answer every question correctly. A gratifying sense of accomplishment confirming you know your stuff and have gained the trust of your attending; yes, believe it or not, there can be moments of gratification when managing patients with pain in the butt and beyond.

"One finger in the throat and one in the rectum makes a good diagnostician."[1]
Ignore the throat part (unless the patient has dysphagia, and if so, make sure to change your gloves or at least examine the throat first!). In addition to visual inspection, digital rectal examination (DRE) must be performed on any patient with anorectal complaints; this is where telehealth has no place. And don't be shy; you do not want to miss a distal anorectal mass just because you didn't want to cause the patient more discomfort. This is an unpleasant exam, and the patient is going to be uncomfortable regardless, so you might as well make the most of it. A missed diagnosis of anorectal cancer, waiting on the specialist triage list for months because of a negative DRE, is what we really hope to avoid. One exception where DRE may be deferred is when the history is consistent with and you see an obvious anal fissure on exam. Regardless, bring the patient back for re-examination, including DRE, once symptoms have improved after a short trial of treatment.

"There is no more difficult art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language."[1]
Be as descriptive as you can when

documenting anorectal symptoms and pathology. You do not have to commit to a diagnosis, but, if using diagnostic terminology, make sure it represents your impressions correctly. For example, fecal incontinence is a common complaint, especially in our aging population. It is important to clarify the nature, frequency, circumstances, and impact on quality of life. Often what patients or physicians perceive as fecal incontinence is in fact new onset urgency, staining secondary to poor hygiene as a result of hemorrhoids or skin tags, or mucus discharge related to anorectal tissue prolapse. Speaking of anorectal prolapse, the term *rectal prolapse* in both general and colorectal surgery usually refers to full thickness rectal prolapse. Once you see a full thickness prolapse (in a patient or on Google Images), you will appreciate the difference between hemorrhoidal and full thickness rectal prolapse. The treatments for these two entities are very different, with the latter almost always surgical and the former mostly non-operative. Last, when localizing anal pathology, use terminology such as posterior/anterior and left/right (or variations of these) in relation to the side of the patient. This way you don't have to worry about mixing up the clockface, as this can change depending on the position the patient is examined in (as a commonly accepted rule, the clockface should refer to a patient in lithotomy, with 12 o'clock anterior and 3 o'clock left of the patient).

"The good physician treats the disease; the great physician treats the patient who has the disease."[1]

After diagnosis comes the grand finale, putting it all together. Symptoms, signs, and expectations should all be considered to prescribe an effective, patient-tailored treatment regimen. Not all hemorrhoids or skin tags need to be treated or removed if they are not the root cause of the problem or if the risks outweigh the benefits. Additionally, if you plan to refer the patient to a surgeon, initiate treatment regardless. Considering the current health care constraints and wait times, it may be months until they see the surgeon. Having some knowledge of first-line treatment options and encouraging patients to follow the recommended treatment in the meantime will help the surgeon determine whether more invasive or advanced treatment is necessary at the time of surgical consultation.

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"One of the first duties of the physician is to educate the masses not to take medicine."[1]

Almost everyone with the presumed diagnosis of hemorrhoidal disease uses or is told to use hemorrhoid creams. These products usually contain a combination of various ingredients, including steroids. Although they can sometimes improve symptoms (probably more by placebo effect than anything else), there is no robust evidence for their use. I tend to stay away from these products, especially for prolonged use, as they can cause skin irritation and sensitization, which can make things worse. The key is to address the underlying triggers that led to the disease.

Last, keep in mind that many anorectal symptoms improve with simple dietary and lifestyle modifications. Just as patients blame everything on hemorrhoids, I treat everything with fibre (well, not exactly, but at least as a starting point in many cases). Whether complaints are secondary to symptomatic hemorrhoids, fissure, irregular bowel habits, defecatory dysfunction, or fecal incontinence, ensuring adequate fibre and fluid intake (at least 25–35 g of fibre and 6–8 glasses of water a day) can often improve, if not resolve, symptoms.

"Medicine is a science of uncertainty and an art of probability."[1]

Finally, one should have a low threshold to refer patients with rectal bleeding for endoscopic evaluation. With the increase in incidence of early onset colorectal cancer, we should always keep more ominous causes such as colorectal neoplasms in mind when managing such patients. This, of course, should be put in the context of clinical presentation and patient risk factors. ■

—Sepehr Khorasani, MD, MSc, FRCSC

Reference

1. Life in the fastlane. Oslerisms. Accessed 12 June 2024. https://litfl.com/eponymictionary/oslerisms.