Unusual presentation of more common disease/injury

Obstructive perianal lesion in a 75-year-old man

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A 75-year-old man presented with a fungating peri-anal mass which appeared malignant at presentation and required a defunctioning colostomy due to abdominal distension. Multiple biopsies were negative for malignancy and CT/MRI scans showed no malignant mass. A provisional diagnosis of prolapsed haemorrhoids was made and the mass was treated with sugar and charcoal dressings. There was a dramatic resolution of the mass with this treatment and the patient was discharged 1 month post-admission. The patient then underwent an elective haemorrhoidectomy by which time the mass had decreased to a perianal skin tag. The only clues in this case were the acute presentation of the mass, the fact that the mass had appeared post-defecation and that the patient had been diagnosed with haemorrhoids 2 years previously on colonoscopy. This case highlights the importance of evaluating all investigations and considering all differential diagnoses before embarking on definitive management.

BACKGROUND

Fungating perianal masses are most commonly due to advanced malignancy. They often present with large bowel obstruction and require surgery – either curative or palliative. It is unusual for haemorrhoids to cause significant abdominal distension or present as large fungating masses. However, in the absence of histological or radiological confirmation of malignancy, the possibility of haemorrhoids has to be evaluated. This case highlights the need for structured management planning before embarking on definitive management strategies.

CASE PRESENTATION

A 75-year-old man presented with a 6 day history of a perianal mass and inability to defecate due to pain. This mass had appeared post-defecation and gradually increased in size. Before this episode his bowels had been functioning normally and he exhibited no signs or symptoms of gastrointestinal disease. Apart from hypertension and hypercholesterolaemia he had no significant medical comorbidities, and his only previous surgical attendance had been an outpatient appointment 4 years previously with large third degree haemorrhoids, which were treated conservatively.

On examination, he was in significant discomfort with a painful ulcerated lesion arising from the anal canal (figure 1). This lesion was fungating with necrotic areas and obvious superadded infection. His abdomen was tender, distended and tympanic.

Examination under anaesthetic was undertaken and biopsies of the mass obtained. A defunctioning colostomy was performed and CT scan of the chest, abdomen and pelvis along with MRI scan of the pelvis were requested.

INVESTIGATIONS

In total three sets of biopsies over the initial 2 weeks after presentation all yielded only benign histological

appearances. The CT scan was normal, and MRI showed only a peri-rectal soft-tissue mass with distended veins.

Figure 1 Lesion at presentation.

DIFFERENTIAL DIAGNOSIS

The initial appearances of the perianal mass were strongly suggestive of a malignancy – either a primary anal cancer, or rectal prolapse with malignant change.

When multiple histology samples yielded benign results and CT/MRI scans did not identify a malignant focus, prolapsed haemorrhoids were diagnosed.

TREATMENT

The patient was treated with sugar and charcoal dressings.

OUTCOME AND FOLLOW-UP

The mass decreased dramatically in size and the patient was discharged 1 month following admission.

The patient returned for an elective examination under anesthesia (EUA) and haemorrhoidectomy 2 months later when only a very small skin tag and remnant haemorrhoid remained, which was excised with diathermy (figure 2).

DISCUSSION

While haemorrhoids can prolapse and thrombose, the degree of tissue necrosis and fungation seen in this case

are rare. Similarly, it is very unusual for haemorrhoids to cause such a large mass that a defunctioning colostomy is warranted. The clues in this case were the multiple negative biopsies and normal imaging, coupled with the previous history of haemorrhoids and the fact that the mass appeared directly after defecation.

The authors have not discovered any previous case reports of haemorrhoids presenting with large bowel obstruction.

Learning points

- ▶ All differential diagnoses should be considered before planning definitive management.
- ▶ If investigations do not support the obvious diagnoses, alternatives should be considered.
- ▶ Unusual presentation of benign diseases can mimic advanced malignancy.

Competing interests None.

Patient consent Obtained.

Figure 2 Lesion after treatment with sugar and charcoal dressings.

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