

Chart #: \_\_\_\_\_

Name: \_\_\_\_\_

I have read this brochure regarding colorectal examinations and am familiar with its contents.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date:

### The Colorectal Examination

This informational brochure has been prepared to acquaint you with the conduct and nature of your initial colorectal examination. We are doing this in order to provide you with the required listing of potential although extremely rare, complications.

A colorectal examination is concerned with the examination of the colon and the rectum and its relationship to your total body in general. While other areas of the body such as the head, neck, chest, etc. may impact on colorectal conditions the colorectal examination generally does not go into detail in those other areas. Where examination of these areas is considered important, it may be advisable to refer you to an appropriate specialist. In most patients, whenever possible, the stool is checked for blood. A chemical test is used which can detect minute quantities, which are otherwise invisible.

In general the specific type of examination would depend on the nature of your symptoms as well as your age and other factors. Those with rectal pain will generally be subjected to a more limited examination in an effort to avoid further discomfort. Since rectal pain almost always arises from the lower 1 or 2 inches of the rectum, this limited examination is likely to reveal its cause.

Rectal examination begins with a visual inspection of the tissues around the anus. Your doctor may obtain a photograph of this region if it is felt to assist in the permanent recording of information or to assist in his subsequent discussions with you. These regions, as well as the interior of the rectum, are next palpated with the examiner's index finger.

An anoscope, a short, narrow, hollow instrument is inserted. This enables visualization of the lower rectum and anus and is particularly valuable in the evaluation of hemorrhoids, fissures and fistulas. A rigid proctoscope or sigmoidoscope is next inserted to enable examination of the lower rectum, including the "blind spot," an area of the rectum, which is easily overlooked with the newer flexible instruments.

When it is indicated, in addition to an examination of the lower rectum, a flexible sigmoidoscopy is performed. This generally involves cleansing the rectum and colon with 1 or 2 Fleet enemas. Each enema is held in place for approximately five minutes and then expelled.

A flexible instrument is then inserted into the rectum and guided up the colon. It is generally passed for approximately 2 feet. A sensation of a desire to defecate is often felt during this portion of the examination. This is generally a false sensation due to the presence of the examining instrument within the rectum. An actual bowel movement during the examination is most unusual. In addition abdominal pain may be felt. If this becomes intense please inform the examiner, as there is no need nor desire to cause pain. The limiting factors in passage of this instrument are the adequacy of the cleansing of the colon and the presence of pain during the procedure. If the examination is painful it is halted. This examination is usually completed within 25 minutes.

These procedures are all commonly done with a minimal risk of complications. In our hands, we have never had a serious complication in examining a normal colon. However, the literature does contain reports documenting such accidents. Rarely complications have occurred in the evaluation or treatment of patients with diseased colons. The two most important complications are bleeding and perforation. Minor bleeding occurs occasionally and usually of no concern. Rarely there can be heavy bleeding, which could require hospitalization, transfusion or operation. Aspirin or other blood thinning agents such as Coumadin, Persantin or dipyrimadole can predispose to bleeding. If you are taking any of these products, please be certain to bring it to our attention.

The most feared complication is perforation of the colon. As mentioned previously, this has never occurred to us in patients with normal colons. However, there are some disease states that could predispose to this complication. A perforation of the colon requires hospitalization. In some cases treatment with antibiotics alone is sufficient. However, in most cases operation is necessary. Occasional a temporary colostomy or ileostomy is required. Deaths, although rare, have been reported to occur when the colon has been perforated.

Biopsies are occasionally performed. Biopsy of the skin around the anus is usually performed by injecting a small amount of local anesthetic and then removing a small disc of skin and underlying tissue. This procedure is performed when there are

abnormalities in the skin of the anal region in which it is anticipated that the biopsy would provide information regarding its cause and treatment. A biopsy itself does not mean that the physician suspects a malignancy. Aside from the initial pain of the injection of the anesthetic, the remainder of the procedure should be painless. Rarely bleeding can occur after this type of procedure. If heavy or continuous bleeding occurs, we should be called promptly.

The rectum or colon can be biopsied by removing tiny samples of tissue with specially designed forceps. This is generally a painless procedure and requires no anesthetic since there are no nerve endings, which are sensitive to cutting of tissue. The risk of bleeding described previously also applies to biopsies in this area.

Further tests, which can be ordered, include testing the stool for blood, stool cultures and parasite studies, blood counts, chemistry screening profiles in which multiple tests are performed on a single specimen of blood, or other blood tests. Colonoscopy is advised when it is felt that the colon further upstream should be examined.

Most procedures, which your doctor may consider to offer you, will be discussed with you following completion of the examination. There are occasional circumstances where it is advantageous to proceed with the indicated procedure directly without waiting for a subsequent discussion. First a polyp seen on sigmoidoscopy often is best managed by excising it promptly. It is often correct to do this at this time because the polyp may not be readily identifiable at a subsequent examination. The next such circumstance is that of a biopsy which is described earlier in this brochure. The risks entailed are detailed above in the discussion on complications of flexible sigmoidoscopy. Most other procedures, which are recommended, will be discussed with you following the initial examination.

After your doctor has completed his examination, he will meet with you and whomever else you desire to discuss his findings and his recommendations for further evaluation or treatment.

As specialists, the focus of our examination is on the colon and the rectum. Our examination is not intended to be a comprehensive history and physical examination. When that type of examination is

indicated we usually refer you to your internist or to one we recommend.

If there are any questions regarding the initial examination or anything else please discuss it with your doctor or another member of the staff.

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