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PEARLS FROM THE PROS

Digital Rectal Examination: An Invaluable Clinical Tool

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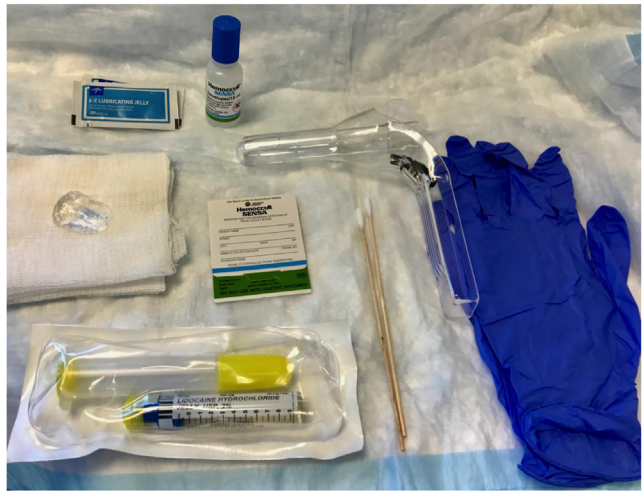

Figure. Digital rectal examination set up including latex free gloves, lubricating and lidocaine gel, gauze swab, occult blood testing kit and q tip and a lighted proctoscope.

Dyssynergic defecation, fecal incontinence, and other anorectal disorders affect one third of the population. Together with history, digital rectal examination (DRE) can provide invaluable diagnostic information using proper technique and set up (Figure), but there is lack of knowledge and training on performing DRE.

DRE consists of 4 basic steps (Table); (1) **Inspection** of the perianal skin for skin excoriation, tags, anal fissure, prolapsed rectum, stool staining, scars or hemorrhoids; (2) **Assessment** of anocutaneous reflex; (3) **Digital palpation**; (4) **Maneuvers** to assess anorectal function, including assessment of resting and squeeze sphincter tone, tenderness or stricture and push effort evaluation. Normal response consists of abdominal muscle contraction and anal sphincter and puborectalis relaxation. Dyssynergia is suspected if 2 or more are present; (i) unable to contract abdominal muscles, (ii) unable to relax anal sphincter/puborectalis, (iii) paradoxical contraction of anal sphincter/puborectalis, or (iv) absence of perineal descent.

The sensitivity and specificity of DRE for identifying dyssynergia are 75% and 87%, respectively. Likewise, there was good specificity and sensitivity for resting and squeeze pressure assessment in fecal incontinence. Although trainees lack skills for DRE, coaching improves performance.

DRE is a useful, bedside, clinical tool that can reveal significant findings leading to appropriate management plan and should be performed after providing detailed information to patient.

Table. Components of the Digital Rectal Examination Technique, Expected Findings, and Grading of Responses

Exam component	Technique	Findings & grading of response(s)
I. Inspection of the anus	Place patient in the left lateral position with hips flexed to 90°. Inspect perineum under good light	Skin excoriation, skin tags, anal fissure, scars or external hemorrhoids, gaping anus, prolapsed hemorrhoids or rectum, and condyloma
II. Testing the anocutaneous reflex	Stroke the skin around the anus in a centripetal fashion (towards anus), in all 4 quadrants, by using a stick with a cotton bud	Normal: Brisk contraction of the perianal skin, the anoderm, and the external anal sphincter Impaired: No response with the soft cotton bud, but anal contractile response seen with the opposite (wooden) end Absent: No response with either end
III. Digital palpation	Slowly advance a lubricated and gloved index finger into the rectum and feel the mucosa and surrounding muscle, bone, uterus, prostate and pelvic structures	Tenderness, mass, stricture, or stool and the consistency of the stool (BSFS). Examine prostate for nodules, mass, tenderness Evaluate for retroverted uterus, rectocele
IV. Maneuvers to assess anorectal function and dysfunction		
Resting tone	Assess strength of resting sphincter tone	Normal, weak (decreased) or increased
Squeeze tone	Ask the patient to squeeze and hold as long as possible (up to 30 s)	Normal, weak (decreased) or increased
Push	Place one hand over the patients' abdomen along with the finger in the rectum, and ask the patient to push	(i) Abdominal push effort: Normal, weak (decreased), excessive (ii) Anal relaxation: Normal, impaired, paradoxical contraction (iii) Puborectalis relaxation: Normal, impaired, paradoxical contraction (iv) Perineal descent: Normal, excessive, absent (v) Rectal mucosal intussusception/ prolapse: Presence or absence
Anorectal pain assessment	Palpate levator ani muscle in all 4 quadrants	Evaluate tenderness over the levator ani muscle. If present, grade intensity on a scale of 0–10.

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BSFS, Bristol Stool Form Scale.

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