RECTAL EXAMINATION

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Learning objectives

What you should know

- What is the Rectal Touch
- What is explored through the Rectal Touch
- What materials are needed to perform a Rectal Touch
- Positions in which the examination is performed
- Rectal Touch technique
- What clinical signs can be found at the inspection of the anus and perianal region
- What is being looked for when examining the rectal ampoule
- What is being done to examine the organs in the vicinity of the rectal ampoule
- What is on the explorer’s glove

What you should do

- Collect the necessary materials
- Explain to the patient the procedure and why it is needed / useful
- Explain to the patient the position of the examination
- Perform the Rectal Touch
- Describe what you saw during the examination

Definition

The Rectal Touch is the procedure that explores the perianal region, anal canal, rectal ampoule, and adjacent organs. The rectal touch is a variation of single-finger palpation, but in this work is also included the inspection of the anal region. The Rectal touch is the main screening work for prostate cancer and rectal cancer.

Instructions

- In all cases where the anamnesis and the rest of the objective examinations point to an anal, rectal or perineal pathology
  o Rectal bleeding
- Constipation or alternating intestinal transit - especially when they have recently appeared
- Elimination of pus in the perianal region
- Pain in the perianal region
- Rectal tenesmus
- Anal incontinence
- Intestinal occlusion or other forms of acute abdomen
- Upper digestive haemorrhage
- When the anamnesis suggests a disease of the prostate or other surrounding organs
  - Nocturia, pollakiuria, dysuria
  - Rectal tenesmus

- For screening purposes
  - Mainly the touch must be applied to all patients over 40 years of age
  - Rectal cancer
  - Prostate cancer

**Contraindications**

There are no contraindications to the procedure. However, the rectal touch will be avoided when it can be painful:
- Prostatitis, prostatic abscess
- Anal fissure with spastic contracture of the anal sphincter

**Elements of anatomy and physiology**

- The rectum has 2 portions: anal canal and rectal ampoule:
  - A boundary between these is the pectinate line (at the top of the Morgagni columns);
  - In the submucosa of the anal canal there are hemorrhoid venous plexuses (upper and lower) from which hemorrhoids develop;
  - On the side of the rectum and inferior of the anal lift muscles are the fat from the ischiorectal fossils (right and
The anal canal and the lower third of the rectal ampoule (6-8 cm from the anocutaneous edge) are accessible to touch exploration.

- Ratio of anal canal to lower rectal ampoule:
  - In the posterior there are: the sacrum and the coccyges;
  - In the anterior there are: prostate and seminal vesicles - in the male, vagina and cervix - in the female, Douglas sack (recto-vesicle recess in male and recto-uterine in female);
  - On the side there is the ischiorectal fossa

**Figure 2.** Rectal ratios in male (A) and female (B)

### Necessary materials
- Non-sterile gloves
- Ointment (Vaseline, ultrasound gel)
- A compress (to remove the ointment after the touch)

### Preparing the patient
- Begins with explaining the procedure and its necessity and utility
  - It is good to have the procedure done in a private setting, not in the salon along with other patients
  - Often the patient has anxiety and prejudice on this examination (fear of pain, shame)
  - Ensure the patient that the procedure is not painful, even if it is unpleasant
    - Keep a professional attitude
    - Ensure the patient that the procedure is done with respect for his / her privacy; With the exception of comatose or altered (untreatable) patients, do not make rectal vision in the salon, in front of other patients
- Explain the patient's position during the examination
  - Knee-chest position
    - Is the most convenient position for the examiner
  - In lateral decubitus, with the knees as tight as possible to the chest
    - Is suitable for patients who cannot sit in the genipectoral position (obese, important ascites, heart failure, gonarthrosis or coxarthrosis etc.)
  - On the gynecological exam table
    - Usually when symptomatology suggests a condition that could be solved on the spot
    - For example in a patient with hemorrhoidal thrombosis, examination may be continued with local anesthesia thrombectomy

A.  
B.  
C.  

**Figure 3.** Patient position for the rectal examination: A. Knee-chest position; B. In lateral decubitus; C. On the gynecological table

**The technique of the Rectal Touch**
- Confirm (if applicable) the identity of the patient; introduction of the practitioner performing the procedure (if applicable)
- He will be explained the procedure, the purpose and utility, the position in which he will have to sit
- Preparation of the necessary materials, positioning of the patient (see above), dressing of gloves; applying the ointment to the exploration finger; a gauze compress is left in the left hand.
- The patient's buttocks are removed; the patient is required to contract and relax the sphincter; Stretch the fold of the anus (progressively when the patient relaxes the sphincter) and

- **Figure 4.** Inspection of the perianal region
the anal region is observed; look for:
- Uncomplicated hemorrhoids - soft, depressed, painless
  - The number and layout of packages are recorded
- Thrombosis hemorrhoids - more firm, underpressed, painful
- The sentinel polyp usually located at the posterior coma, which accompanies the anal fissure
- Anal fissure - most commonly situated in the posterior
- Sciatic abdominal abscess - swelling accompanied by pain, erythema and (sometimes) local heat in one of the ischiorectal fossa
- Perianal fistula - fistulous hole (sometimes surrounded by a small cutaneous protrusion) where the pus gets eliminated
- Note: To pinpoint the location of an anal or perianal lesion, compare the anal ring with a clock dial; Reference is made to the patient in genic-pectoral position: 12 o'clock corresponds to the posterior anal commissure, 6 o'clock corresponds to the posterior anal commissure

A.  
B.  
C.  

**Figure 5.** Inspection of the perianal region: A. Uncomplicated hemorrhoids; B. Anal fissure; C. Perianal fistula

- The patient is required to mimic a defecation effort: We can notice:
  - Internal hemorrhoids proccidenti
  - A rectal prolapse or a rectal mucosa prolapse:
    - In mucosal rectal prolapse there are concentric folds
    - In the rectal mucosal prolapse the folds are radia

**Figure 6.** Prolapse of the rectal mucosa
The exploratory index is applied to the anal orifice and the indices are inserted gently through the anal canal; The patient's reaction is observed:

- Introducing the index is unpleasant but not painful
- A disproportionate reaction (pain) can be caused either by patient anxiety or by an anal fissure
- In some patients with anal fissure the sphincter is spastic and does not allow the index to be inserted or the index insertion is very painful; In this situation it is forbidden to make the touch and the anoscopy will be done under sedation

- The anterior and the posterior commissure are fought; Pain at this level may be due to an anal fissure

- The patient is invited to tighten and relax the anus several times to appreciate the sphincter tonicity
  - It is low in multipurpose women or in patients who have had pelvic surgery with shamed nerve damage
  - Low sphincter tone in a patient with feces incontinence shows a sphincter lesion
  - The sphincter may be spastic in chronic constipation, peri-rectal suppuration or inflammatory processes of neighborhood

- Insert the finger up to the rectal ampoule; its content is appreciated:
  - The rectal ampoule may be empty
  - Fecal matter is soft and can be mobilized, surrounded by the finger
  - Rectal polyps are small-sized, vegetative tumors implanted in the wall
The rectal tumor is hard, vegetative or ulcer-vegetative; is fixed, with a portion that implants in the rectum wall.

- Slide your finger on the wall of the rectal ampoule (anterior, lateral and posterior)
- The walls of the ampoule, possibly tumors, and the surrounding organs are appreciated
  - A rectal polyp is a small tumor (a few centimeters) with a wide or narrow base of implantation in the rectal wall
  - Polyps sessile - with a wide base of implantation
  - Pedunculated polyps - with narrow implantation that hangs in the rectal ampoule lumen

![Image of palpation methods]

**Figure 10.** A Palpating a pedunculated polyp. B. Palpating a sessile polyp

- A rectal tumor could be:
  - Vegetative – protruding in the rectal ampoule lumen;
  - Infiltrative – the rectal wall is tough;
  - Ulcerative – as a defect (missing) in the rectal wall;
  - In fact, rectal tumors are actually mixed between these three types: ulcerative-vegetative, ulcerative-infiltrative, etc.;
  - The vicious tumor is friable, soft consistency

![Image of rectal tumor]

**Figure 11.** A. Palpation of a rectal tumor. B. Ulcerative rectal carcinoma (opened resected rectum)

- The palpation is done on the anterior side to the prostate for man, cervix for women
• Touching the prostate:
  o Normal: circa 3 cm, protruding circa 1 cm in the rectal ampoule, having two lateral lobes with a smooth surface, homogeneous consistency, parenchymal (approximately the consistency of a tennis ball / comparable to the tenacious eminence of the hand when the finger opposition is made on the finger 5), with a median channel between the two lobes

  ![Figure 12. Transrectal prostate examination](image)

  o Benign hyperplasia: increase in volume - global or predominantly of a lobe, with the removal of the median channel but of normal consistency
  o Nodular prostate (neoplasm, chronic prostatitis): one or more nodules with a modified consistency (tough); the number, location, nodule size is noted
  o Acute prostatitis: hypertrophied, but very painful prostate; the pain requires the examination to be interrupted

A. B. C.  

  ![Figure 13. A. Benign prostatic hypertrophy  B. Prostate nodule (cancer?)  C. Acute prostatitis](image)

  o Anterior, above the prostate / cervix, The rectum is in contact with the perineum of the Douglas bag; Transrectal palpation may reveal:
Pain (“the Douglas cry”) – is the sign of an inflammatory process at this level (generalized peritonitis, pelvic abscess)

The presence of tumor formations:
- Sigmoid tumor developed on a long sigma, "fallen" in Douglas
- Peritoneal metastasis (peritoneal carcinomatosis) - Blumer sign (or sign of the bag of nuts)

**Figure 14.** A. Abscess in the bottom of the Douglas bag B. Metastases in the Douglas bag (peritoneal carcinomatosis)

- Posterior, the sacrum is touched
  - Sometimes tumors may develop in the presacral space (cystitis, teratomas, sacral meningocoele, sacrum cord), which can be detected by palpation through the posterior rectal wall

- Lateral:
  - A lateral-rectal abscess (sechiorectal abscess, pelvic-subperitoneal abscess - located above the anal elevators and under the pelvic peritoneum)
  - Intense pain at the touch, palpation of the side wall - should be interpreted in relation to the other clinical signs
  - Rectal wall bulging - in fact hard to notice due to the pain that intrarectal palpation produces to the patient

**Figure 15.** Palpation of a tumor in the presacrum space. B Aces under the pelvis peritoneum (left) and ischiorectal recess abscess (right); the examination reveals the intense pain, rarely the intraluminal bombardment of the abscess
• Patients with constipation, difficult / painful defecation can test the function of the pelvic floor requiring the patient to perform a defecation effort and try to push the examiner's finger
  o The normal anal sphincter and the pubertal rectal muscle relax and the perineum drops 1-3.5 cm
  o If the sphincter and puborectal muscle remain tense and / or if the perineum does not come down is probably a pelvic floor disinfection which makes the act of defecation difficult
• Retract your finger and examine the glove
  o Fecal matter: normal
  o Melenic chair: superior digestive bleeding
  o Blood: a pathological process with rectal bleeding(neoplasm, polyp, ulcer-hemorrhagic rectocolitis, etc.)
  o Blood in a patient with an acute abdomen dominated by shock: entero-mesenteric heart attack
  o Pus: perianal abscess in the rectum
  o Mucus: probably a vicious tumor
• Wipe the grease traces - it is not unimportant: the patient should be treated with respect
• Removing gloves; washing the hands
• Note what was found in the patient's sheet, referral note, etc., indications (PSA / endorectal ultrasound / colonoscopy / medication, etc.).

Incidents and accidents
• Pain:
  o Anal fissure - anoscopy under sedation
  o Hemorrhoidal thrombosis - usually itching can occur, inspection and palpation quickly clarify the diagnosis
  o An acute prostatitis: intense pain at the palpation of the prostate; An examination is not necessary
  o Ischiorectal recess abscess: pain upon palpation of the lateral wall of the rectal ampoule
• Patient non-cooperation:
  o The patient is entitled to refuse the examination; his refusal is recorded in the observation sheet
## Assessment / Self-Assessment Form

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<thead>
<tr>
<th>Stage / Criterion</th>
<th>Correct</th>
<th>Incorrect</th>
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<tbody>
<tr>
<td>Identify the patient; introduce oneself</td>
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<td>Explain the procedure</td>
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<td>Collect the necessary materials</td>
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<td>Choose / explain the patient's position</td>
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<td>Put on the gloves; lubricant</td>
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<td>Inspection of the anal region – follow up:</td>
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<td>The presence of hemorrhoids</td>
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<td>The presence of an anal fissure</td>
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<td>The presence of a fistula or a perianal abscess</td>
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<td>Polyps that pierce through the anus</td>
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<td>Rectal prolapse</td>
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<td>Introduce the index</td>
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<td>Appreciates the tone of the anal sphincter</td>
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<td>Exploration of the rectal ampoule – look for:</td>
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<td>Content</td>
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<td>The walls of the rectal ampoule</td>
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<td>Exploration of the prostate – look for:</td>
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<td>Size</td>
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<td>Shape, prostate symmetry</td>
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<td>The presence of the median groove</td>
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<td>Consistency (homogeneous / inherent; Parenchymal / modified areas, etc.)</td>
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<td>Examination of the glove – look for:</td>
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<td>Fecal matter</td>
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<td>Mucus</td>
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<td>Wipe the ointment</td>
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<tr>
<td>Record the examination and interpretation</td>
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