

Bright red blood on the toilet paper

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Occasional bright red rectal bleeding is common and may not require any therapy once a sinister cause has been excluded. Here, Dr Brown outlines his approach to per rectal bleeding.

Remember

- It is useful to distinguish outlet bleeding (bright red rectal bleeding seen on the toilet paper or in the bowl) from altered bleeding (dark blood, and/or mixed in with stool), as the latter suggests a non-anal and probably more serious cause.
- Intermittent minor bright rectal bleeding is common, and usually due to benign anal pathology such as haemorrhoids or anal fissure (Figure 1).
- Important but less common causes include cancer, large polyps, inflammatory bowel disease and radiation proctitis.
- Risk factors for sinister causes of rectal bleeding include age above 40 years, dark or heavy bleeding, change in bowel habit, abdominal pain, anaemia and a family history of bowel cancer.

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- Haemorrhoids are common (arguably universal); they are due to congestion of anal vasculature associated with constipation and straining.
- Painful defaecation suggests an anal fissure – a split in the anal lining associated with painful spasm of the internal anal sphincter. Fissures can become chronic.
- Irritable bowel syndrome is not a cause of rectal bleeding.
- Bloody diarrhoea is the hallmark of inflammatory bowel disease or infectious colitis and requires prompt referral.
- Acute heavy bleeding (usually caused by diverticular disease, less commonly by cancer, arteriovenous malformations or Crohn's disease) requires urgent referral for specialist hospital care.

Assessment

- Clarify the colour of the blood (bright or dark) and the relationship to stool (mixed in or on the paper) to help differentiate outlet from altered bleeding.
- Check for risk factors (age above 40 years, change in bowel habit, abdominal pain, family history of bowel cancer, anaemia).
- Anal inspection and digital rectal examination is essential for every patient: inspect for a fissure, haemorrhoids or anal cancer, and feel for rectal polyps or cancer; tenderness suggests a fissure.
- If feasible, rigid sigmoidoscopy at the initial consultation is often sufficient for patients less than 40 years old with 'simple' outlet bleeding, provided a cause is found and responds to therapy.

Management

- Persistent bleeding needs investigation even in young patients. Simple anal conditions can be treated with confidence if a more proximal lesion has been excluded.
- In patients less than 40 years old without risk factors, sigmoidoscopy



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Figure 1. Haemorrhoids are the commonest cause of blood on the toilet paper (seen at proctoscopy).

(ideally, but not necessarily, flexible) is usually adequate for outlet bleeding.

- Colonoscopy should be considered in patients with altered bleeding, those over 40 years old, if any of the other risk factors are noted, or where bleeding is persistent. Virtual colonoscopy is not yet suitable for routine use in this setting.
- Barium enema and sigmoidoscopy should be used only if colonoscopy is not readily available.
- Occasional bright rectal bleeding may not require any therapy once a sinister cause has been excluded, if this is acceptable to the patient.
- Simple therapies such as bulking/softening agents and topical anal therapy (e.g. Proctosedyl) may help if haemorrhoids or anal fissure are thought to be the cause.
- Persistent anal fissures may also respond to 0.2% glyceryl trinitrate ointment (Rectogesic) – not 2% because of invariably severe headaches.
- Persistent symptoms, even when thought to be due to a benign cause, should be referred for specialist evaluation.

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DECLARATION OF INTEREST: None.

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