Why is it SO important to include a rectal examination in every physical examination you do? 
Well, aside from being the exam “highlight”, there are numerous practical reasons as well. Many conditions affect the “hind end” of dogs but manifest with zero to only subtle clinical signs making it harder for owners to realize there is a problem until the condition is quite advanced.

What are the common clinical signs seen with perianal/perineal abnormalities? 
Scooting, excessive licking at the anus and perineum, straining, tenesmus, constipation.

What other signs can be seen that aren’t always specific to perianal/perineal abnormalities?
Polyuria polydipsia as a consequence of hypercalcemia, stranguria, urinary obstruction

Anal Sac Tumors
Most common tumor type is anal sac adenocarcinoma. This tumor is often small enough it is not visible and only detected as a firm, pea size nodule in the anal sac on rectal examination. Hypercalcemia is a common lab abnormality and frequently results in PU/PD. Anal sac adenocarcinomas have a high metastatic rate (46-96%) to the pelvic and sublumbar lymph nodes. Lymph node involvement may be detected on rectal palpation (these dogs often have difficulty defecating or tend to pass, small, flattened stools), abdominal radiographs (deviation of the colon ventrally), and abdominal ultrasound.

The treatment of choice for anal sac adenocarcinoma is surgical removal of the tumor via anal sacculectomy. If nodal involvement is present, abdominal exploratory to excise the abnormal lymph nodes is recommended to decrease the tumor burden (improve or resolve the hypercalcemia) and to alleviate the physical obstruction of the pelvic canal. Adjunctive therapy with radiation and/or chemotherapy can also be beneficial as local recurrence (29-45%) and metastasis is common. Recurrence of hypercalcemia with either local recurrence or metastasis is seen 35-50% of patients. Radiation and chemotherapy as primary treatments can also be considered, however, results are more variable.

Negative prognostic indicators for anal sac adenocarcinoma include:

- Increasing primary tumor size
- Presence of lymph node metastasis
- Presence of distant metastasis
- Advanced clinical stage
- Nonpursuit of surgery
- Treatment with chemotherapy alone
- Benign neglect
Median survival time varies with treatment(s) utilized, however, up to 544 days has been reported. Anal sac neoplasia is much less common in cats but when seen tends to be more locally aggressive and it is typical to have ulceration and fistulas.

**Perianal Tumors--Benign adenomas**
Tend to be slow growing, non-painful, well circumscribed, movable, and can be single or multiple. Dogs with perianal adenomas are frequently asymptomatic. It is helpful to obtain FNA and cytology of these to rule out other more aggressive tumors. Treatment of choice is local excision and narrow margins are often adequate. It is also advised to neuter the dog to remove any androgen influence. Prognosis is good.

**Perianal Tumors--Adenocarcinoma**
Tend to be firm, rapidly growing mass(es) fixed to deeper tissues, often with an ulcerated surface. These dogs do show clinical signs of tenesmus, discomfort, obstipation, and can experience PU/PD resulting from hypercalcemia. Abdominal and thoracic radiographs and abdominal ultrasound are important diagnostics for staging. Metastasis tends to occur later in the course of the disease (only about 15% had metastasis at the time of diagnosis). Treatment of choice is surgical excision and castration (however these tumors are not testosterone dependent). Enlarged lymph nodes should also be removed if possible. Adjunctive radiation therapy is commonly recommended for incomplete or very narrow excision and when lymph node metastasis is documented.

Negative prognostic indicators:
- Metastasis at time of diagnosis
- Tumor size > 5cm

Median survival times for masses <5cm is 2 years. Median survival time for masses with lymph node or distant metastasis is 7mo.

The efficacy of adjunctive chemotherapy or radiation therapy is undefined.

**Surgical considerations for anal sacculectomy or perianal mass removal:**
- Wide surgical margins are difficult to obtain due to location.
- Portions of the anal sphincter muscle may need to be removed--up to 50% of the sphincter muscle can be disrupted and result in only transient incontinence. Always discuss the possibility of incontinence with your owner.
- This is a clean/contaminated surgery. Digital removal of stool and anal purse string can be helpful in minimizing contamination.
- Protect the pudendal artery, vein and nerve
- Close dead space and close without tension to minimize dehiscence of site.

**Perineal Hernias**
Perineal hernias are most common in intact male dogs but can occur in any dog and in cats as well. Weakness or atrophy of the muscles of the pelvic diaphragm allow the rectum, pelvic fat,
prostate, urinary bladder, etc. to herniate into the perineal region resulting in a soft, often fluctuant swelling in the perineum. Proposed underlying causes include:

- Rectal abnormalities that cause excessive straining (rectal diverticulum, rectal deviation)
  
  Is this the chicken or the egg??
- Hormonal influences
  
  Affect of testosterone on the prostate
  
  Older male dogs may produce more estrogen
- Gender anatomic differences (stronger pelvic diaphragm in females)
- Prostatic disease
- Neurogenic atrophy

Diagnosis is made primarily on rectal palpation. This is typically a non-emergent condition, however, if the urinary bladder is retroflexed and trapped in the hernia, urinary obstruction results which can be life threatening. Obstruction can be addressed by cystocentesis, passage of a urinary catheter, and ideally manual reduction of the bladder back into the abdomen. 

Surgical repair traditionally involves reinforcing the pelvic diaphragm via elevation of the internal obturator muscle. The obturator is elevated and sutured to the external anal sphincter, coccygeus and levator ani to reestablish the muscular “wall” that supports the rectum. 

Alternative repairs utilize the semitendinosus m. transposition, superficial gluteal m. transposition, or polypropylene mesh. 

Adjunctive procedures that can be done include vasopexy to help keep the urinary bladder in a more cranial-intraabdominal position, cystopexy, and colopexy (utilized when there is significant rectal deviation or sacculation). Castration at the time of repair is strongly recommended! 

Prognosis following repair is good, especially if any underlying factors are also addressed.

Surgical considerations for perineal hernias

- Clean contaminated surgery--drape out the anus by sewing in the medial portion of the skin incision
- Know your anatomy--it is essential that the muscles be identified
- Protect the pudendal artery, vein and nerve
- Protect the sciatic nerve--it is possible to entrap it if the sacrotuberous ligament is incorporated into the repair.
- Epidural as part of the analgesia plan can help with postoperative straining.

Referral tips for Perianal/Perineal conditions:

- If hypercalcemia is noted on routine blood work, do a rectal exam to rule in/out anal sac tumor or perianal tumor. (other differentials for hypercalcemia include primary hyperparathyroidism, lymphosarcoma, renal failure, etc.)
• If owner expresses concerns about scooting, straining to defecate, changes in appearance of stool, **do a rectal exam** to assess this area
• If anal sacs feel full/firm--express them, if not expressible or there is a mass effect, be suspicious of an anal sac tumor and recommend FNA/cytology
• If perianal masses are noted--recommend FNA cytology to differentiate between adenoma and adenocarcinoma--recommend castration
• If soft, poopy appearance on one or both sides of the anus, **do a rectal exam** to assess for laxity and presence of hernia.
• If perineal hernia is suspected/diagnosed and dog is having difficulty urinating--alleviate urinary obstruction and/or send as an emergency case

**Always do a rectal exam as part of your physical exam!!**

**References available upon request**