Body System: Gastrointestinal		
Session Topic: Hemorrhoids and Anal Fissure		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Physicians should be able to formulate an appropriate treatment plan for chronic anal fissures based on the therapies and evidence available. • Physicians should be able to educate patients about the benefits of fiber in the diet for improving symptoms of hemorrhoids. • Physicians should be able to assess their training needs and knowledge of surgical procedures used to treat chronic anal fissures and hemorrhoids. • Physicians should be able to compare and contrast the risks and benefits of stapled hemorrhoidectomy compared with conventional excisional surgery. • Physicians should have an in-depth knowledge of recommendations for	1. Review the anatomical classifications and characteristics of hemorrhoids and anal fissures. 2. Identify the preferred diagnostic approach for hemorrhoids and anal fissures. 3. Discuss prevention methods for hemorrhoids and anal fissures. 4. Review medications and modalities for the treatment of hemorrhoids and fissures.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

colonic evaluation in patients with hemorrhoids.		

ACGME Core Competencies Addressed (select all that apply)			
X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- [insert bullet related to session topic]
- [insert bullet related to session topic]

Needs Assessment

Current estimates of the prevalence of symptomatic hemorrhoid disease in the United States range from 10-23 million people (4.4%-12.8%).[1,2] Hemorrhoids affect about 1 in 20 Americans, however, about half of adults older than 50 have hemorrhoids.[3]

Anal fissure is one of the most common and painful proctologic diseases. Its treatment has long been discussed and several different therapeutic options have been proposed.[4]

Practice Gaps

CME outcomes data from American Academy of Family Physicians (AAFP) FP Audio™ Edition #449: *Hemorrhoids and Intestinal Gas*, suggest that physicians have knowledge and practice gaps with regards to counseling patients on effective hemorrhoid management; and hemorrhoid treatment strategies.[5]

While most patients are prescribed topical treatments for anal fissure, many prescriptions are never filled.[6] We suspect that many of these prescriptions were never filled because compounded

preparations are not available in all pharmacies, and because many patients find their high cost unaffordable and not covered by their insurance benefit.[6]

Common anorectal conditions, such as hemorrhoids and anal fissures, are frequently misdiagnosed or incorrectly treated.[7,8] It is not uncommon for patients and physicians to assume that most anal problems are caused by "hemorrhoids" leads to an error in diagnosis, incorrect management strategies, worsening of disease-related symptoms, development of new symptoms such as contact dermatitis, and delay in accurate diagnosis and resolution of symptoms.[8]

Physicians sometime give a diagnosis of hemorrhoids without pursuing higher-risk diagnoses, thus leading to a process-of-care failure.[9] The failure to obtain a family history, or to order appropriate diagnostic or laboratory tests, can often lead to missed or delayed colorectal cancer diagnoses.

Physicians may improve their care of patients with [insert topic] by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[1,10]

- Fiber supplementation should be recommended to decrease symptoms in all patients with hemorrhoids.
- Excision of thrombosed external hemorrhoids provides more rapid pain relief than conservative treatment.
- Rubber band ligation causes less postoperative pain and fewer complications than stapled hemorrhoidopexy and excisional hemorrhoidectomy, and is the surgical treatment of choice for grades 1 and 2 hemorrhoids.
- Excisional hemorrhoidectomy has a lower risk of recurrence than stapled hemorrhoidopexy.
- Stapled hemorrhoidopexy causes less postoperative pain, pruritus, and fecal urgency than excisional hemorrhoidectomy.
- Topical diltiazem (obtained from a compounding pharmacy) can be used to decrease postoperative pain after excisional hemorrhoidectomy.
- Topical steroids, antibacterial soap, and topical capsaicin 0.006% cream are effective for the treatment of idiopathic pruritus ani.
- OnabotulinumtoxinA (Botox) injected into the internal anal sphincter, topical nitroglycerin, and topical calcium channel blockers are treatment options for anal fissures.
- No single treatment for anogenital warts has demonstrated superiority over any other treatment.
- For the treatment of grade III hemorrhoids, excisional hemorrhoidectomy has higher remission rates but increased pain and complication rates compared with rubber band ligation.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may

result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Hemorrhoids[1]
- Evaluation and Management of Common Anorectal Conditions[10]
- FamilyDoctor.org. Hemorrhoids | Overview (patient education)[11]

References

1. Mounsey AL, Halladay J, Sadiq TS. Hemorrhoids. *American family physician.* 2011;84(2):204-210.
2. Ganz RA. PERSPECTIVES IN CLINICAL GASTROENTEROLOGY AND HEPATOLOGY. *Clinical Gastroenterology and Hepatology.* 2013;11(6):593-603.
3. National Institute of Diabetes and Digestive and Kidney Diseases. Definition & Facts of Hemorrhoids. 2017;
4. Altomare DF, Binda GA, Canuti S, Landolfi V, Trompetto M, Villani RD. The management of patients with primary chronic anal fissure: a position paper. *Techniques in Coloproctology.* 2011;15(2):135-141.
5. FP Audio #449 CME Outcomes Report. Leawood KS: AAFP; 2016.
6. Mapel DW, Schum M, Von Worley A. The epidemiology and treatment of anal fissures in a population-based cohort. *BMC gastroenterology.* 2014;14:129-129.
7. Clark SJ. Benign anal disease. *JAAPA : official journal of the American Academy of Physician Assistants.* 2016;29(11):23-29.
8. Chang J, McLemore E, Tejirian T. Anal Health Care Basics. *The Permanente journal.* 2016;20(4):74-80.
9. Weingart SN, Stoffel EM, Chung DC, et al. Delayed Workup of Rectal Bleeding in Adult Primary Care: Examining Process-of-Care Failures. *Joint Commission journal on quality and patient safety / Joint Commission Resources.* 2017;43(1):32-40.
10. Fargo MV, Latimer KM. Evaluation and management of common anorectal conditions. *American family physician.* 2012;85(6):624-630.
11. FamilyDoctor.org. Hemorrhoids | Overview. 2014;

