PROCTALGIA FUGAX

BY

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If a disease has no name, references to its symptoms are necessarily difficult to trace. This no doubt explains the ignorance of Wallis (1909), Pybus (1910, unpublished: see Pybus, 1946), Douthwaite (1928), and Thaysen (1935) in earlier writings. To Thaysen goes the credit of fathering, though somewhat apologetically, the term "proctalgia fugax" and of giving an excellent description of the malady. In fact, half a century earlier Myrtle (1883), of Harrogate, wrote a limited description of this subject in a paper dealing with various anal discomforts. He writes of an affection which "is purely neurotic in its nature and very fitful in its attacks, coming on at long intervals and when the subject of it is apparently in the best of form: he will go to bed perfectly well and awake at any hour with a gnawing grinding pain in the sphincter." He suggests that the nocturnal onset is due to the bedclothes having been displaced and chilling having occurred. Clearly with the importance of cold in mind, he says that another provocative is sitting on a cold seat and that local heat is the outstanding remedy. He quotes the case of a patient who in his worst attack entered a first-class railway carriage and got prompt relief from sitting on "the hot tin." British Railways inform me that the hot tin was a long metal foot-warmer filled with hot water. It was provided for first-class passengers and would on demand be refilled at intermediate stations.

It is safe to assume that many other references must exist in the older literature and will emerge if interest in the condition increases.

Definition.—Proctalgia fugax may be defined as pain, seemingly arising in the rectum, recurring at irregular intervals and being unrelated to organic disease.

Characteristics

The characteristics formulated by Thaysen include the essential points which meet agreement with subsequent writers. They are:

1. Unaccountable occurrence at very irregular intervals in the day or night in a patient in perfect health.

2. Spontaneous disappearance without leaving any ill effects except passing lassitude. Attacks are not followed by disturbances of intestinal function.

3. Localization of pain in the rectal region above the anus, always in the same place with the same patient but varying somewhat in different sufferers.

4. Pain of varying severity: it may even lead to fainting.

5. Short duration—that is, only a few minutes—only one of the patients having had it for 10 minutes. The duration of the attacks seems to be constant in each patient.

6. The type of pain is described as gnawing, aching, cramp-like, or stabbing. It is often associated with a tight sensation in the epigastrium or precordium which makes the patients gasp for breath and gives them the impression of being gravely ill. It is neither preceded nor followed by tenesmus, nor by flatus or paraesthesia in the rectum or anal region, and it is very seldom of a radiating character.

Proctalgia fugax is not uncommon, but it appears to be so until one puts a leading question to patients irrespective of the complaint for which they seek advice (Douthwaite, 1956; Ibrahim, 1961). The fact that the pain is so infrequent and transient, and is not followed by any other distress, leads to its being forgotten. These factors to some extent give a false view of sex incidence. Nearly all writers claim that it is much commoner in males than in females, but in my present series, on which this paper is based, there were 21 male and 27 female sufferers. In an earlier series, when I relied on spontaneous complaint of pain, I had no female case recorded. Women are so used to pain in the sacral region that they are inclined to attribute it to some disturbance of the reproductive organs and to make light of it, especially as proctalgia is so short-lived.

The complaint very rarely occurs before puberty. It lessens in severity after the age of 60 and usually disappears by the age of 70. I have not met a familial influence, but this has been reported by Ibrahim (1961) and Pybus (1946).

In my 21 male cases the attacks have usually occurred in the night, either within two hours of falling asleep or within a few minutes of coitus. Among the 27 women, only seven recorded nocturnal pain. Abrahams (1935) noted that it was commoner in males than in females and that the attacks generally occurred in the early hours of the morning.

Provocatives in descending order of importance are straining ineffectively at stool, sudden explosive bowel action, ejaculation (especially if repeated within an hour), prolonged sitting on a hard seat, and mental fatigue. In females sexual activity is not a provocative. In the male it receives comment from Douthwaite (1928), Blyth (1935), "Biologist" (1952)—who among others refers to occasional associated priapism—and Ewing (1953).

Relief from the pain, which is wellnigh unbearable, is sought by walking about, by intense heat to the sacral area, by distension of the rectum with air from an enema syringe, and by firm upward pressure on the anus. The last is the simplest and appears to be the most effective manœuvre provided that it be maintained until the pain has completely subsided (J. A. Ryle, personal communication).

Pybus (1946), Bett (1952), Hughes (1952), and Ewing (1953) believe that the taking of food or even drink will bring relief. As I have met patients whose attacks have occurred during meals (Douthwaite, 1956) I find the suggestion difficult to accept.

The inhalation of 12 minims (0.7 ml.) of chloroform (MacLennan, 1917) will arrest the attack. Amyl nitrite has no effect.

Physical Signs

As many of the patients are doctors, we have the advantage of their self-performed digital examination. This is not an easy exercise, but it is thus possible to explore for a short way beyond the internal sphincter. In nearly all reported cases no spasm of the anus is encountered, and in fact nothing abnormal in the nature of obstruction is found. An exception to this was the patient in whom spasm of the anal sphincters was encountered in association with a contracted and tender iliac colon (Douthwaite, 1928). In fact, the association with colon spasm was fortuitous. The sphincteric spasm was occasioned by nervousness at the examination. Rectal exploration in later attacks, carried out by the patient himself, revealed no resistance to the passage of the finger.

An interesting observation (Douthwaite, 1956) made by 10 doctor patients was that in an attack the only abnormality noticed on rectal examination was a tense tender band to one or other side of the rectum, a structure which they interpreted as being the levator ani.

Wallis (1909) asserted that the cause lay in submucous pockets leading up from Morgagni's crypts and that surgery would cure. It seems likely he was following a lone trail.

It is especially important to mention Bolen (1943) because his findings have, as it were, been revived by Ibrahim (1961), who appears to accept his explanation. Bolen, writing on "spasmodic rectal pain," quoted the case of a 60-year-old man who had suffered from bouts of pain for four years and claimed that in an attack slight rigidity of the muscles of the rectum could be felt and that the mucosa of the anal canal felt hot as if the seat of inflammation. The prostate was enlarged and the sigmoidoscopic appearances were a red swollen mucosa with prominent vessels. Pressure with the tip of the instrument at the central point of the levator caused spasm. Difficulty was encountered in negotiating the recto-sigmoid junction and gas escaped as soon as the corner had been passed. He had 12 cases in all—10 males and 2 females. All the men had prostatic hypertrophy and both women had pelvic inflammation (unspecified). In my view the age of onset and the associated abnormalities make it doubtful whether he was describing proctalgia fugax. In any event, for a pain which seldom lasts more than 10 minutes what a felicitous combination of time, place, and opportunity must have arisen to allow of sigmoidoscopy.

Origin of Pain

Although nearly all the authorities I have quoted have regarded the rectum as the source of the pain, a contrary view has been expressed by Smith (1935) and in "Any Questions?" (*Brit. med. J.*, 1952), the former having noted tenderness of the levator ani in an attack. The latter authority had no doubt after a similar examination that the pain was due to spasm of the pelvic floor muscles. I expressed a similar view (Douthwaite, 1956) and still hold it.

In favour of cramp of striped muscle are the relief by perineal pressure, the description of a cramplike pain, the failure to obtain relief from amyl nitrite, the complete lack of disturbance of bowel action, the absence of sphincteric spasm, and the tenderness felt to one or other side of the rectum. Furthermore, the common exciting factors of straining at stool and ejaculation, and the occasional association with priapism, favour this view. If the tender area palpated is the pubococcygeus muscle (third and fourth sacral nerves), the link can be explained in that the centres controlling the tonic action of the transversus perinei, bulbocavernosus and ischiocavernosus lie in the grey matter of sacral segments 3 and 4, as also are those regulating their clonic action in the act of ejaculation (Bing, 1921).

Treatment

For a symptom so capricious in its appearance no treatment for lasting relief suggests itself. If it is due to muscle cramp a nightly dose of quinine might help. I doubt if any sufferer is sufficiently incommoded to justify division of the muscle. The weakening of the pelvic floor might be serious, though no anxiety in respect of the original function of the pubococcygeus is likely to be experienced.

Summary and Conclusion

A review of the literature on proctalgia fugax over the past 85 years is presented. The relationship between the symptoms, signs, provocatives, and relieving measures is discussed. The personal observations relate to 48 cases seen between 1930 and 1960.

Proctalgia fugax is a pain which does not arise in the rectum but is occasioned by segmental cramp of the pubococcygeus muscle. It is harmless, unpleasant, and incurable.

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"Inevitably, the birth-control movement was pioneered by women, medical and lay, rather than men; and was conducted as a crusade partly to rescue wives from male selfishness, partly to rescue lower-class families from the ignorance and unhappiness perpetuated among them by the prejudices of their betters. Equally inevitably, the clinic seemed the only feasible means of bringing people in need, on terms they could afford, in touch with doctors willing to serve them. . . . There have been great changes in the characteristics of people using the Family Planning clinics; in the terms on which they receive services; in the clinics' relations with the health authorities; and in the climate of medical and lay opinion in which they operate. Modes of thought and work which were natural in the 1930s linger on, however, in the altered circumstances of the 1960s. Clinic patients are still 'patients.' Though income limits have been dropped, the older (and still not wholly inappropriate) charitable approach is evident in the very low fees still charged by many clinics, and in the nomenclature remaining in vogue in some clinics. North Kensington and Chester now operate 'marriage welfare centres,' Islington a 'family planning centre,' and Manchester a 'family planning clinic.' But Plymouth still has a 'mothers' advice centre' and Edinburgh a 'mothers' welfare clinic,' while Liverpool employs (1960) a 'secretary almoner' and states in its official reports that 'this clinic exists to promote happy and healthy family life by giving advice to married couples who cannot afford the fee of a specialist.' The clinics in most places still utterly depend on voluntary workers, whose ethic often disposes them to look askance at the suggestion that they might attain greater efficiency in serving the public by a greater use of paid secretarial and administrative staffs. The clinics' clientele remains almost wholly feminine and the cap remains the method of choice. The clinics' medical corps remains feminine, as are the voluntary workers and the bulk of branch committee members. Organizationally, F.P.A. retains the constitution and structure designed in days when its branches, clinics, doctors, and voluntary workers were five or six times fewer than now." (*Family Planning and Family Planning Clinics To-day*, a survey by the F.P.A. Working Party, May, 1962, under the chairmanship of Professor F. Lafitte, professor of social policy and administration, Birmingham University.)