

# *Primary Care of Anally Receptive Men*

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The practice of anal intercourse among pairs of male partners involves both insertive anal intercourse (IAI) and receptive anal intercourse (RAI); individuals may participate in either or both activities. Many nurse practitioners do not possess adequate knowledge to counsel their patients on this subject or to treat the common health care problems that may be associated with it. The purpose of this column is to provide information about the care of men who practice anal intercourse so that nurse practitioners may continue to provide comprehensive and nonjudgmental care to all individuals. Because of the history of stigma and discrimination against the gay community, many men who practice IAI and RAI with other men may choose not to identify themselves as gay or homosexual. Although this discussion is of anal intercourse among men, women may practice receptive anal intercourse and have specific health care needs related to it as well.

## **Sexual Issues**

The rectum is a vulnerable area in terms of sexually transmitted diseases (STDs), and information about safer sex is important for the sexually active individual. The first and most effective means of primary prevention of STDs is the barrier method, practiced by use of condoms during intercourse. The most common material is latex, although polyurethane condoms are becoming more readily available for the latex-allergic population. Sheepskin condoms should be avoided because they may be porous enough to allow viruses to be transmitted through the condom. Dental dams made of latex may also be used; users must remember which side of the barrier is “up.” Common household products such as plastic wrap are also used, but there is a risk for contamination by changing sides as well as the threat of choking on the product if swallowed or

aspirated. (The plastic wrap products labeled “microwavable” are porous and should not be used sexually.)

Before applying condoms, one should inspect both the package and the condom itself to make sure there has been no accidental perforation. Applying condoms all the way up to the base of the penis is important so they do not fall off during intercourse. Lubricants should be used with condoms to prevent breakage and reduce friction; these must be water based, because oil-based lubricants may change the chemical nature of the latex in the condom and facilitate breakage. The products made specifically for this purpose are widely available in pharmacies and will say that they are water based on the label, as this need is widely recognized by the manufacturers. The ubiquitous petroleum jelly (Vaseline) and vegetable shortening (Crisco), which both have histories of use as sexual lubricants, are oil based and can be damaging to latex.

Oral-genital contact (fellatio) has potential risk of transmission of STDs and should be negotiable between partners. Even if the insertive partner does not ejaculate, the sexual lubricating fluid, commonly called “pre-cum,” produced in the prostate gland, is known to contain HIV. The organisms of gonorrhea, syphilis, and herpes, when present in the urethra, may also be transmitted to partners without ejaculation, so we cannot tell patients that this activity is completely safe, only that it is made safer when a barrier method is used.

Steps taken to reduce the risk of physical trauma during sex also reduce the risk of infection and injury. “Fisting” is anal penetration by the partner’s fingers, hand, or wrist. Fingers and hands should be rendered least capable of causing trauma by well-trimmed fin-

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gernails and the removal of jewelry (especially rings, but also bracelets). It is advisable to use latex (or polyurethane) gloves and water-based lubrication for manual insertion.

Oral-anal intercourse, commonly referred to as “rimming” or “around the world,” may not be a likely means of transmitting HIV but carries a risk of transmission of hepatitis A virus, intestinal bacterial agents (salmonella, shingle, campylobacter), and parasitic agents (*Entameba histolytica*, *Giardia lamblia*, or supposedly nonpathogenic protozoan organisms, which may cause symptoms nevertheless, especially in the HIV-positive individual).

Sexual aids or toys, often including penis models referred to as *dildoes*, may act as vectors for infectious agents that may cling to the objects and be transmitted to the partner or next user. Careful washing, including soaking objects in bleach solutions, is recommended. Extra care is taken by using condoms over the insertive objects. This creates an extra barrier to infection (when changed between users and when the objects are carefully washed between users) and may also help to reinforce the condom habit among participants.

## **History and Physical Examination**

### **History**

It is important to ask the patient if he has any anal symptoms, including pain, pruritis, masses, discharges, loss of bowel continence, or anything else of concern. Inquiry about sexual practices should be frank and accepting, using the term *receptive anal intercourse*. Slang terms may need to be used if the patient is unfamiliar with this term. The patient should be encouraged to expand on any related complaints and symptoms; concerns and questions should be taken seriously and pursued.

### **Physical Examination**

It is best not to begin the physical examination at the anorectal area to allow sufficient time for the patient to gain trust. If lying down, the patient should be in a supine position and draped. The patient is then asked to turn to the lateral position. The rectal exam may also

be performed with the patient standing against the exam table and the practitioner seated behind him. The palpation for inguinal and femoral nodes should be considered the beginning of the anal exam.

Gently spread the buttocks and inspect for external hemorrhoids or anal warts. Signs of perianal excoriation or infestation with candida or tinea will appear as annular erythema at the anal opening. Fissures may or may not be seen at first; pain on initial palpation may be a sign of their presence (Bernstein, 1997). If the patient has too much pain to complete the internal anal examination, he should be referred to a proctologist for the examination to be done under anesthesia.

The anoscopic exam can reveal the ulcers of primary syphilis, internal anal warts, and the discharges associated with gonorrhea and chlamydia, which may be cultured through the anoscope. The anoscope is a clear plastic instrument consisting of a graduated cone and a central plunger. The instrument is gently inserted into the anus, the plunger is removed, and the slow removal of the cone allows the intra-anal mucosa to be seen by the examiner. Discomfort can be minimized by (a) lubricating the instrument with plain warm water (lubrication products can interfere with culture specimens); (b) moving it slowly, especially at initial insertion; (c) explaining to the patient what you are doing as you proceed; and (d) being generally sensitive to his situation, similarly to when using the gynecological speculum.

If the anoscope is tolerated, the digital examination can begin, with a water-based lubricant applied to the gloved finger. Allow the patient to see that the hand is gloved and tell him that a lubricant is being applied. The internal digital examination should begin with the 360-degree sweep of the anal canal to evaluate for masses or tenderness. Anal sphincter tone should be noted. The prostate should be palpated for tenderness and softness. In men past age 45, the prostate should be palpated for enlargement or masses as well, which may be benign or malignant; referral to proctology should be made, if present.

### **Health Issues**

Several health problems may be associated with the practice of RAI, although none are exclusive to the practice. The throwaway term “gay bowel syndrome”

should not be used as an excuse to not investigate specific complaints that can almost always be diagnosed and treated (Modesto & Gottesman, 1994). The following summary is not meant to be a comprehensive discussion of the specific conditions but rather a discussion of their association with the anal examination.

## Hygiene

Many patients may need some education about care of the anal area of the body (in that social norms make discussion of this subject uncomfortable). Patients should keep the bowels regular by consuming fiber in the diet and drinking plenty of water. The best hygiene measures include regular bathing, cleansing with mild soap and water, and keeping the area dry. Soaps and bathroom tissues with colors and scents should be avoided because the chemicals in these products may be irritating to the mucosa or skin. Applying a mild astringent periodically may help prevent hemorrhoids. Some people may practice anal douching for hygiene. Although widely practiced (but not often discussed), this practice is controversial in that forcing fluid into the anal canal may actually push infectious agents into the mucosa and encourage infectivity, including with HIV.

## Hemorrhoids

Hemorrhoids may be external or internal, relative to the dentate line. There are many factors that may lead to hemorrhoids, including posture, prolonged sitting, and constipation. Symptoms may include bright red bleeding (as opposed to melena), pain, and palpable protrusions. (Itching is a common rectal symptom, but it is not associated specifically with hemorrhoids.) Hemorrhoids may be classified by the amount of prolapse. First-degree hemorrhoids are ones that bulge and bleed at the time of bowel movement; second-degree hemorrhoids prolapse at the time of bowel movement and spontaneously return to normal position; third-degree hemorrhoids may prolapse at any time and require digital manipulation to be restored to normal position; fourth-degree hemorrhoids are permanently prolapsed (Mazier, 1994). For intermittent hemorrhoids, the triple treatment of (a) fiber in the

form of a psyllium product, (b) sitz baths, and (c) astringents or hydrocortisone cream for painful perianal bulging is frequently adequate.

## Itching

Perianal itching is often referred to as *Pruritis ani*, and people may tolerate it for long periods due to stigma. Common treatable causes may include ringworm; *candida albicans* (an increased risk in the HIV-infected population); acidic dietary components, such as caffeine, tomatoes, or citrus; stress; chronic scratching due to anxiety; and, most alarmingly, anal neoplasm (Mazier, 1994). Most cases of *Pruritis ani* have no known cause; itching may be due to chronic moistness of the area, leading to skin excoriation. Causes of chronic moistness may include poor poststool hygiene, bowel leakage caused by oily foods or new dietary fat substitutes, or topical products applied by patients to combat the itching. In these cases, keeping the area very dry with talcum powder or zinc oxide may treat the symptom.

## Fissures

A fissure is a crack or cut in the lining of the anal canal at the area of the sphincter. The symptom is intense pain, which increases with pressure, such as with the passing of hard stool. Fissures are caused by trauma to the sphincter, as occurs with passing hard stool during constipation, or during RAI with inadequate lubrication. Other serious sources of perianal pain must be considered during evaluation, such as carcinoma, Crohn's disease, or perianal abscesses (Mazier, 1994).

The treatment of fissures includes the prevention of further trauma by treating constipation and the use of sufficient lubrication during intercourse. Nurse practitioners should counsel their patients to avoid the habit of resisting the urge to evacuate stool (Mazier, 1994). Softening of the fissure can be accomplished with sitz or Jacuzzi baths. A barrier over the fissure, using zinc oxide cream, helps healing as well. Low potency nitroglycerine ointment is currently being tried and appears to be effective (D. Wlodarczyk, M.D., personal communication).

## Gonorrhea

As recently as the 1970s, the anorectal site was not generally recognized as a possible site for gonococcal infection, but it is now known to be so. The majority of individuals infected at this site may be asymptomatic. When symptoms do occur, they may include tenesmus, pruritis, and/or a mucoid or bloody rectal discharge (Modesto & Gottesman, 1994). Identification of the gram-negative diplococcus on gram stain or a culture of the discharge on Thayer-Martin medium reveals the diagnosis (Bernstein, 1997). Treatment should follow current guidelines. Although rarely seen anymore in the developed countries, later stage untreated gonorrhea may present with symptoms of perihepatitis, meningitis, endocarditis, pericarditis, and/or arthritis.

## Chlamydia

This is the most common STD in the United States, presenting anally with pain, tenesmus, and mild proctitis, or as lymphogranuloma venereum (LGV), with painful anal and perianal ulcers and inguinal adenopathy (Bernstein, 1997). Although more often symptomatic in women than in men as well as more common in heterosexual than in gay men, chlamydia is rising in incidence among anally receptive men. Symptoms of proctitis usually occur within 10 days of infection, but as with gonorrhea, in the anal site, asymptomatic infection is possible. The presenting symptoms are very similar to those of gonorrhea but typically result in less purulent discharge; the two infections can occur simultaneously. Untreated, chlamydia infection is associated with the development of abscesses, fistulae, and/or strictures.

## Syphilis

The clinical presentation of syphilis can be extremely variable, and the rapid plasma reagin (RPR) serologic test remains the standard for diagnosis. Primary syphilis, within about 6 weeks of exposure, is usually characterized by the ulcerative-appearing lesion called the *chancre*. The genital chancre often appears on skin, but the chancre associated with RAI may mimic the appearance of a fissure or may be on

the internal mucosa. In these locations, the usually painless chancre may cause pain due to stretching during the passage of stool or due to superinfection by bacteria or herpes virus. Direct microscopic examination by darkfield examination, often unavailable in clinical sites not specifically dedicated to STDs, is a valuable diagnostic tool. Obtaining a serum RPR must be done for all perianal ulcerative lesions. Treatment of syphilis should follow current guidelines.

## Herpes Virus

Herpes virus Type 2 is responsible for almost all anorectal herpes outbreaks. After initial infection, the viral invasion of neurons accounts for the recurrence of herpes outbreaks at the same site, which may (and often does) occur repeatedly over a long period of time. Initial infection typically manifests as a vesicular outbreak about 4 to 21 days after infection and lasts 7 to 10 days. The vesicles evolve into an open, moist, circumscribed ulcer that may be extremely painful. The outbreak may be accompanied by inguinal adenopathy. The fluid discharge from the vesicular lesion is highly infectious, although the infected individual may also shed virus when asymptomatic. Diagnosis is made by viral culture, which should be done for confirmation even in the case of the "typical" herpes lesion. Management of acute outbreak includes analgesics, sitz baths, stool softeners (when at the anal sphincter), and, of course, the use of acyclovir. In cases nonresponsive to acyclovir, resistance to the drug, although still rare, should be considered.

## Anal Warts

*Condylomata acuminata*, the wart caused by human papilloma virus (HPV), a sexually transmitted, double-stranded DNA virus, is commonly found in the perianal area and within the anal canal. The virus is present in both the warty tissue and in normal-appearing superficial epithelial tissue (Luchtefeld, 1994). It tends to occur in individuals who have had RAI with partners infected on the genitals, but actual intercourse may not be necessary; transmission may occur with digital contact, close frottage, or other contact. Another diagnostic possibility is *Condylomata lata*, the typically flatter warts associated with secondary syphilis (these are a

rare presentation compared to HPV). An RPR should always be part of the workup of anal warts.

Anal warts are usually distinctive in appearance and easy to recognize on inspection. They are typically cauliflower-like and quite variable in size and number; smaller ones may look papular. Although the warts are almost always painless unless superinfected, patients may have palpated the warts themselves and complain of "hemorrhoids" (Mazier, 1994).

Several topical treatments for anal warts are available, including the caustic agents podophyllin, trichloroacetic acid, liquid nitrogen, and the drug 5-FU. A recent treatment is imiquimod 5% cream (Aldara), a member of a new class of anti-HPV drugs called *immune response modifiers*, which is available by prescription and may be applied by the patient at home. Surgical excision is done by proctologists, and laser excision is now available. This should be done under surgical conditions only, due to the possibility of aerosolization of virus during the procedure. Health care providers inexperienced with the techniques of office anal wart treatment should receive instruction with an experienced clinician before trying independently to treat these warts. Research is currently being done to look at a vaccination against HPV with an autologous vaccine.

In anorectal carcinomas as well as in cervical carcinomas, the DNA of the HPV has been known to become integrated into the chromosomes of the malignant cells. Therefore, there is reason to believe the transmission of this virus plays a part in the etiology of these malignancies. In sexually receptive individuals, anal Pap smear or anoscopy may prove effective as screening for anorectal carcinoma; studies are currently ongoing.

### Malignant Diseases

The relationship between HIV and the development of anal neoplastic diseases has been documented (Palefsky, 1995; Palefsky et al., 1998). The combination of HIV-induced immunodeficiency plus HPV infection appears to be more frequently associated with anal carcinoma in men than is the case of HIV and cervical carcinoma in women (Palefsky et al., 1998). There is concern that as the prevention and treatment of opportunistic infection improves and patients sur-

vive longer, anal neoplasia may become more common among HIV-infected anally receptive men (Palefsky, 1998). Physical trauma to the anal tissue, associated with RAI, may also play a role in the development of these neoplasias. Most studies in this area have focused on anal intraepithelial neoplasia (AIN), also referred to as *carcinoma in situ* or, more ominously, as *preinvasive cancer*. Smoking appears to be an additional risk factor for AIN (Northfelt, 1994; Palefsky, Shiboski, & Moss, 1994).

Early detection of these lesions may lead to more timely and therefore more successful treatment. It has been recommended that persons at risk be screened with anal Pap smear and anoscopy with anal biomicroscopy (colposcopy) at 3- to 6-month intervals and that patients with AIN be referred to an oncologist for treatment. In addition, patients with abnormal anal symptoms such as pain, discharge, or bleeding should be screened for neoplasia as well (Northfelt, 1994). However, these screening guidelines are not yet universally in effect among clinicians.

### HIV

The most dramatic and potentially life-threatening problem associated with anal intercourse is that it is a very high-risk activity for the transmission of HIV. Recent research has used statistical modeling to attempt to determine the relative risk of HIV transmission per sexual encounter. Although these techniques are complex and limited, the findings are consistent with current estimates of risk. Unprotected anal sex is still considered the riskiest activity, with a risk of infection per encounter of around 1 in 120. In protected anal sex, the risk is still about 1 in 1,000, probably due to undetected condom failure (San Francisco Department of Public Health, 1999). These numbers reveal that *safer sex* is indeed a relative term, but if patients are going to be sexually active, counseling regarding barrier methods continues to be important.

### References

- Bernstein, M. (1997, April). Benign anorectal disease in HIV-positive patients. *Resident & Staff Physician*.
- Luchtefeld, M. A. (1994). Perianal condylomata acuminata. *Surgical Clinics of North America*, 74(6), 1327-1337.

- Mazier, P. W. (1994). Hemorrhoids, fissures, and pruritis ani. *Surgical Clinics of North America*, 74(6), 1277-1293.
- Modesto, V. L., & Gottesman, L. (1994). Sexually transmitted diseases and anal manifestations of AIDS. *Surgical Clinics of North America*, 74(6), 1433-1464.
- Northfelt, D. W. (1994). Cervical and anal neoplasia and HPV infections in persons with HIV infection. *Oncology*, 8(1), 33-40.
- Palefsky, J. M. (1998). Human papillomavirus infection and anogenital neoplasia in human immunodeficiency virus-positive men and women. *Journal of the National Cancer Institute Monograph*, 23, 15-20.
- Palefsky, J. (1995). Human papilloma virus-associated malignancies in HIV-positive men and women. *Current Opinion in Oncology*, 7(5), 437-441.
- Palefsky, J. M, Holly, E. A., Ralston, M. L., Jay, N., Berry, J. M., & Darragh, T. M. (1998). High incidence of anal high-grade squamous intra-epithelial lesions among HIV-positive and HIV-negative homosexual and bisexual men. *AIDS*, 12(5), 495-503.
- Palefsky, J. M., Shiboski, M., & Moss, A. (1994). Risk factors for anal human papillomavirus infection and anal cytologic abnormalities in HIV-positive and HIV-negative homosexual men. *Journal of Acquired Immune Deficiency Syndrome*, 7(6), 599-606.
- San Francisco Department of Public Health. (1999, August 13).