

CLINICAL VIGNETTE

Anal Skin Tags Mistaken for Hemorrhoids in Early Crohn's Disease

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A previously healthy 17-year-old female presented to gastroenterology for “hemorrhoids.” She first noticed a mass about three months prior accompanied by tenesmus, diarrhea, and occasional blood in the stool. She was assumed to have external hemorrhoids by pediatricians, urgent care, and emergency medicine and treated with stool softeners. Despite adequate compliance, the masses tripled in size by the time she saw gastroenterology, and she reported nocturnal diarrhea, rectal bleeding, rectal pain, and weight loss of 4.5 kg. She denied fever, nausea, vomiting, constipation, arthritis, joint pain, genital lesions, oral ulcers, sexual activity, or notable family history.

Physical exam revealed a confluence of nontender, pedunculated, perianal pink papules, each measuring 5 to 10 mm each without visible fissures. Digital rectal examination was negative for palpable masses in the anal canal. Laboratory evaluation showed a microcytic anemia (Hgb 9.7 g/dL, MCV 75.2 fL), elevated inflammatory markers (CRP 12.9 mg/dL; ESR 104 mm/hr), and elevated fecal calprotectin (>3000 ug/g). Upper endoscopy demonstrated edematous duodenum and scalloping of duodenal folds, and colonoscopy revealed chronic colitis with ulceration and small non-necrotizing granuloma in the transverse colon to the rectum, confirming the diagnosis of Crohn's disease (CD). Magnetic resonance enterography demonstrated skip lesions in the jejunum and terminal ileum descending to the sigmoid colon as well as perirectal fistula. The patient was subsequently started on biologic therapy with gradual reduction of the perianal tissue.

Hemorrhoids are one of the most common diagnoses for pediatric patients referred for perianal masses given their high prevalence in the general population.¹ However, the history along with the physical examination should distinguish hemorrhoids from other entities. Hemorrhoids are rare in pediatrics and arise predominantly from constipation or portal hypertension.² In adults, the likelihood of developing hemorrhoids increases with older age. The pathogenesis may be due to deterioration of connective tissue anchoring hemorrhoids, hypertrophy or increased tone of the internal anal sphincter, abnormal distension of arteriovenous anastomoses, and arteriovenous congestion and stasis from tissues draining into the superior and inferior hemorrhoidal veins.³ External hemorrhoids appear pink and glistening, and are occasionally

tender. First line treatment involves increased fiber intake, increased water intake, warm water baths, and stool softeners, which reduces bleeding by about half.^{4,5}

In our patient, findings and history were more consistent with CD perianal skin tags. In general, skin tags are overgrowths of skin arising from recurrent irritation. They are common in pediatrics and are associated with constipation or obesity, though can also develop from healing hemorrhoids and fissures. Compared to hemorrhoids, skin tags are more likely to be skin colored, less likely to be painful or pruritic, and less frequently cause bleeding with bowel movements.⁶ There are also differences between skin tags that are not associated with CD compared to those that are. Skin tags arising from healed fissures or hemorrhoids are usually edematous, hard, and painful, with a red or blue color. Alternatively, the hypertrophic skin tags associated with CD are often described as “elephant ears,” as they are raised, smooth, painless masses with a soft and compressible consistency and flesh coloration.⁷ They may also be accompanied by other perianal findings of CD, including fissures, abscesses, strictures, and fistulas.⁸ Given that skin tags may be the first and only sign of CD for months to years, careful visual inspection and palpation are necessary to avoid delayed diagnosis and late complications.⁹

Several elements of this patient's presentation were inconsistent with a diagnosis of hemorrhoids and merited re-evaluation. First, her perianal mass was associated with Bristol Stool Scale type 5 and 6 for a series of months. While hemorrhoids may be exacerbated by diarrhea, they are much more commonly found in the setting of constipation. Second, the size of the mass increased despite her regular stooling patterns and compliance with bowel regimen. This was particularly notable given the rate of growth. Lastly, symptoms including nocturnal stooling and unintentional weight loss were present, which are much more suggestive of a systemic illness rather than an isolated case of refractory hemorrhoids. Taken altogether, these symptoms prompted further investigation.

The spectrum of perianal conditions should extend beyond hemorrhoids, and a high index of suspicion for other possible diagnoses should be maintained if the history and physical examination are not consistent with the natural course of hemorrhoidal disease. There should be a low threshold for

primary care physicians to refer for subspecialty evaluation for any perianal conditions associated with a suspicious clinical history, constitutional symptoms, or change in bowel pattern. Early referral and recognition of a pediatric perianal patient with CD may ensure faster diagnosis and treatment along with prevention of the serious complications of CD including fistula, stricture, perforation, and medically refractory disease.

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