Rectal examinations in elderly subjects: attitudes of patients and doctors

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Abstract

Objective: to determine the attitudes of older patients and hospital doctors to rectal examinations.

Design: a structured interview and audit of case notes.

Setting: departments of medicine for the elderly in two NHS hospitals.

Subjects: 178 mentally alert patients and 76 hospital doctors in general and geriatric medicine.

Results: some patients would feel embarrassed (13%), offended (2%), reluctant (11%) or neutral (73%) if asked to undergo a rectal examination (PR). Most (76%) thought a PR examination was important and 92% would give permission if a doctor asked. Of 200 case notes audited, only 38 patients had a PR documented. Of the hospital doctors interviewed 3 said they would routinely do a PR examination. Some doctors lacked confidence in detecting a rectal mass (33%) or abnormal prostate (41%). Thirty (39%) of doctors thought elderly patients were offended by PR examinations and 65% that there was not sufficient training in this procedure.

Conclusion: most older patients do not find PR examinations disagreeable and regard it as an important examination. Despite this, few doctors routinely perform this procedure and some feel unable to detect abnormalities. The importance of PR examinations and adequate training needs to be addressed.

Keywords: elderly subjects, rectal examination

Introduction

Medical students and junior doctors are taught that digital examination of the rectum (PR) should be part of any general physical examination. This simple procedure may be omitted for a number of reasons, including objection by the patients—who may find the procedure disagreeable—and extra trouble for the doctor, who may also find it unpleasant [1]. Rectal examination is especially important in the older patient in whom pathology is more common [2].

The attitudes of older people to this procedure have not previously been established. Patients’ and doctors’ attitudes may influence whether the procedure is performed as part of the routine physical examination.

Subjects and methods

The study was approved by two district ethics committees. Two hundred case notes of patients (median age 82 years, 121 females) admitted to acute geriatric wards in two NHS trust hospitals were audited using a standardized proforma.

Case notes

Of the 200 case notes audited, only 38 patients (20 female) had a PR examination documented. Consistency of stool was not documented in 21 patients. Of the 18 male patients, eight had no description of the prostate gland. Most of the PR examinations (27/38)
Table 1. Frequency that various grades of doctor performed rectal examinations (PR) when examining patients on admission

<table>
<thead>
<tr>
<th>Grade of doctor</th>
<th>No. of examinations</th>
<th>Total</th>
<th>With PRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>House officer</td>
<td>32</td>
<td>161</td>
<td>13</td>
</tr>
<tr>
<td>Senior house officer</td>
<td>161</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>Senior registrar/registrar</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

χ² = 18.36, P < 0.0001

had positive results, including rectal mass (two), impacted faeces (14), abnormal prostate (five), rectal prolapse (two), blood (three) and third-degree haemorrhoids (one). In all of these cases, the findings in rectal examination influenced (use of enemas or laxatives, sigmoidoscopy or referral to the urologist or general surgeon). Information from the nursing staff revealed that 10 patients were faecally incontinent but only two of these had a PR examination, whilst in 34 patients with urinary incontinence only four had a PR examination. Registrars were most likely to perform a PR if they had clerked the patient initially (Table 1; χ² = 18.4, P < 0.0001).

Sixty-one patients were taking laxatives: fybogel (three), senna (23), codanthromer (14) and lactulose (21). Only 22 patients who were prescribed laxatives had a PR documented in the case notes.

Patient questionnaire

Thirty (17%) of the patients questioned had had a PR examination and six could not recall a doctor asking permission to do this examination. Only one third recalled a doctor explaining the reason for the need for this examination.

None of the patients had refused permission for a rectal examination. Most (76%), thought that the examination was important, 20% were not sure and only 4% did not think it was important. Fourteen patients who were not sure if the examination was important thought it could be under certain circumstances.

Although 23 (13%) would feel embarrassed, 19 (11%) reluctant, three (2%) offended, four (2%) upset, the majority 129 (73%) would feel neutral if a doctor asked to examine the back passage. Most patients (92%) said that they would give permission for a rectal examination if a doctor asked. Only seven would refuse and seven were not sure what response they would give. Some patients who felt reluctant or embarrassed would give permission if a doctor requested it.

The majority of patients (84%) had no preference whether a PR examination was carried out by a female or a male doctor. More female patients expressed a preference for a female doctor than male patients for a male doctor to perform a rectal examination (23/116 versus 3/62, χ² = 5.67, P < 0.02).

Doctors’ attitudes to PR examinations

The hospital doctors who were interviewed included 48 males and 28 females (Figure 1). Most (53) were UK graduates. Only three said they would routinely do a PR examination in every patient they examined (one consultant and two house officers).

Some doctors (33%) did not feel confident in their ability to detect a rectal mass whilst some (41%) did not feel confident in their ability to detect an abnormal prostate gland. Two-thirds believed they had insufficient training in rectal examinations. Most (79%) felt comfortable in performing PR examinations, however, 30 (39%) thought that elderly patients were offended by a PR examination.

The equipment for PR examinations, disposable gloves, lubricating jelly and gauze were readily available on all the acute geriatric wards in this study.

Discussion

Digital examination of the rectum is an important part of a physical examination but especially so in the older patient, in whom pathology is more common. Inspection alone may reveal rectal prolapse, prolapsed internal haemorrhoids, pruritus ani, perianal haematomas, external orifices of a fistula in ano or a sentinel tag of a fissure, ulcers and peri-anal abscesses and carcinoma of the anus [4]. Many patients over the age

![Figure 1. Clinical conditions for which junior doctors would request permission from an elderly patient to perform a rectal examination.](http://ageing.oxfordjournals.org/DownloadedFrom/..)
Surgical cure at presentation. In North America, where male cancers [19]. The average age at diagnosis in men in England and Wales accounting for 11.5% of all patients.

Potentially resectable carcinomas may be missed. Examinations performed, two revealed a rectal mass. Although complications of constipation include idiopathic megacolon [9] and faecal incontinence.

Faecal incontinence and the indignity it causes an older person can always be avoided if managed correctly. In one study [10] of long-stay geriatric wards, there was a 45% incidence of faecal incontinence. In a more recent study [11] 26% of older people on geriatric wards were doubly incontinent. In our study 5% (10) of the patients were faecally incontinent but only two had undergone a PR examination.

Faecal incontinence may arise from underlying disease of the colon or rectum or anal sphincter, neurogenic change and faecal impaction [12]. Faecal impaction may cause urinary incontinence due to retention with overflow or with loss of bladder capacity. In this study only four of the 34 patients with urinary incontinence had undergone a PR examination. Faecal impaction may also cause an acute confusional state and abdominal pain [13]. Only three of 21 patients with acute confusion had a PR examination whilst six of 13 patients with abdominal pain had had a PR examination.

Colorectal cancer is the second most common cancer in the UK, with between 25 000 and 28 000 new cases each year [2, 14]. The incidence begins to rise appreciably after the age of 40, when it rises in each decade by a factor of 2 until it reaches a peak between the ages of 75 and 85 [15]. Since most patients will present in the sixth and seventh decades, colorectal cancer represents an important problem in old age [16, 17]. About 55% of colorectal carcinomas involve the rectum and 35-50% can be diagnosed by digital examination [18]. In our study of the 38 PR examinations performed, two revealed a rectal mass and these were referred to the surgeon. Although symptoms may have led to a PR being performed, potentially resectable carcinomas may be missed because of failure to do PR examinations in older patients.

Prostate cancer is the third most common cancer in men in England and Wales accounting for 11.5% of all male cancers [19]. The average age at diagnosis in England and Wales is 73 years and most are beyond surgical cure at presentation. In North America, where routine health checks including regular rectal examinations have been commonplace, the average age at diagnosis is 66 years with up to half of cancers being confined to the prostate and therefore potentially curable by radical prostatectomy. Combining prostate-specific antigen measurements with rectal examinations increases the positive predictive value from 32 to 49% [20]. Of the five abnormal prostate glands documented in the medical notes in our study, three had advanced prostatic carcinoma and were treated with endocrine therapy. There was a failure to mention the prostate gland in eight of the 18 PR examinations done on male patients.

Few junior doctors routinely do PR examinations on elderly patients. House officers are more likely to perform a PR examination than senior house officers. This might suggest that they leave medical school with the knowledge that PR examinations are important, but as they advance they are less enthusiastic about performing this simple procedure. Another explanation may be that the examination is delegated to the most junior member of the team. It is of concern that 49 (65%) doctors interviewed did not feel they had sufficient training in PR examinations and several did not feel confident in detecting a rectal mass 25 (33%) or abnormal prostate gland 31 (41%). There may be many reasons for failure to perform a PR examination. Junior doctors with increasing pressure on their time may defer a PR examination on admission, intending to do it at a later date but unfortunately never finding the time to do it or simply forgetting. If senior doctors overlook the fact that their elderly patient has not had a PR examination then their trainees may take this as tacit agreement that such an examination is not expected. Another factor may be lack of confidence by doctors in their ability to detect an abnormality on PR examination: many may feel that there is no point to subjecting their patient to such an examination since they may not be able to detect an abnormality even if one were to be present. Some doctors may not do PR examinations because they find it an unpleasant procedure. There was no lack of the basic equipment needed for doing a rectal examination on any of the acute geriatric wards in this study.

On some geriatric wards, nurses routinely perform PR examinations to check for faecal impaction. However, nurses are not trained to detect rectal or prostatic masses, so the responsibility for an initial rectal examination should remain with the doctor.

The finding that 30 (40%) of junior doctors believe that elderly patients are offended by rectal examinations is interesting, as we found that only a few (2%) patients feel this way. Are doctors projecting their own feelings about this examination onto their elderly patients? Younger doctors may regard the thought of a PR examination on themselves as something that is offensive and an invasion of privacy. Some older patients are pre-occupied by their bowels, having lived through an era where regular and frequent bowel actions were thought to be important for a healthy life.
R. Morgan et al.

Hence they may be less reluctant than people of other ages to undergo this examination. Perhaps older patients may accept a PR examination as a consequence of greater awareness of an increased risk of colorectal disease.

Although there is no evidence that rectal examinations have any value as a screening procedure in the adult population as a whole, in the elderly patient (in whom pathology is not only more common but who may have an atypical clinical presentation) rectal examinations are important. Early detection of an abnormality might avoid unnecessary investigations and a more appropriate management.

In conclusion, hospital doctors are not performing PR examinations as often as they should. The importance of this simple examination needs to be reinforced in undergraduate and postgraduate education.

Key points
- Few hospital doctors routinely perform rectal examinations on older patients.
- Two-thirds of hospital doctors felt inadequately trained in this procedure.
- Some doctors lack confidence in detecting abnormalities on rectal examination.
- Over one-third of doctors thought elderly patients were offended by rectal examinations.
- Most older patients would give permission for a rectal examination.
- Most older patients do not find rectal examinations disagreeable and regard it as an important examination.

References

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