Case reports

Oral clonidine for proctalgia fugax

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SUMMARY A report is made of the successful use of oral clonidine for proctalgia fugax by the author on himself. The author, a 30 year old otherwise healthy man, has been having attacks of proctalgia fugax for several years. He had hitherto left the condition untreated. Last year, in a severe attack, he tried oral clonidine 150 µg twice a day and found it to be dramatically effective. He was completely relieved in three days and tapered off the drug thereafter. A further attack of proctalgia fugax after a month was again treated successfully with oral clonidine. The presumed aetiology of proctalgia fugax is discussed and the possible mechanism of action of clonidine in this condition is outlined. Further trials of clonidine appear to be worthwhile for this condition which has been described as incurable.

Proctalgia fugax is characterised by severe cramp like pain in the anorectal region. The pain occurs at irregular intervals and is not associated with any organic disease. Pain often occurs in bed at night, during straining at stool, or during coitus. It usually lasts a few minutes, but may often last longer. The pain may be unbearably severe and is notoriously unresponsive to treatment. The condition is said to affect anxious persons and has been claimed to be more common among young doctors. Proctalgia fugax has been described as incurable, but harmless and it gradually resolves itself.^{1,2} While it lasts, however, it is extremely agonising.

Numerous treatments have been tried for proctalgia fugax without success. This paper reports the efficacy of oral clonidine in this condition, the first report of its kind.

Case report

The author, a 30 year old otherwise healthy man, has had proctalgia fugax for several years, with one to three episodes per year. The episodes usually last for a few days, but sometimes up to two weeks. The episodes were not associated with a change in bowel habit. There were no obvious predisposing factors. The author has, however, had three episodes during three consecutive years during, or shortly before, his

university examinations when he was obviously under some mental stress.

The attacks usually occurred abruptly, without any premonitory symptoms, frequently starting in the late evening or early night. During a typical attack the author had intense colicky pain in the anorectal region, associated with a desire to pass faeces, or flatus. There were no abdominal cramps, flatulence or altered bowel movements during an episode. Each attack would last for about 15 minutes to a few hours, the pain gradually increasing in intensity and then subsiding slowly. Though usually spasmodic, the pain was sometimes throbbing in nature, synchronous with the heart rate. The author has had several attacks of gastroenteritis caused by bacterial, as well as protozoal pathogens in the past which had all been successfully treated. None of the episodes of proctalgia fugax was related to the attacks of gastroenteritis.

Although it was at times quite distressing, the author had not taken any treatment for proctalgia fugax earlier.

The author was investigated during one of the episodes. Proctoscopy, sigmoidoscopy and colonoscopy were normal. Microscopic and bacteriological stool examination was normal.

Last year, the author had an episode just after he had got engaged. He left it untreated as usual for a few days, but it showed no signs of abating. As he did not want to be distressed by the pain during that particular time, he decided to treat it. All the treatments described for this condition appeared to

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be equally uninspiring. He decided to try treatment with clonidine. Clonidine appeared worth trying because of its analgesic, sedative, sympathoinhibitory and antispastic properties.³ He took clonidine in a dose of 150 µg twice a day orally. There was dramatic relief from the very first dose and he was completely relieved by the third day. He observed mild parotid discomfort and mild sedation as side effects, but they did not impair his routine. After the third day he tapered off the drug, to avoid a rebound phenomenon, by taking 75 µg twice a day for two more days and 75 µg once a day for a further two days.

A month after this, by which time he had been married, the author developed another episode of proctalgia fugax which was quite severe. He was reluctant to try clonidine this time because of its known adverse effect on potency.

After two days of severe pain, however, he changed his mind. He took clonidine again, being cautious, however, to avoid its effect on potency as far as possible. He took 150 µg in the morning and 75 µg in the early evening for two days. There was significant relief with this treatment, with no adverse effect. For the next two days he took 150 µg of clonidine twice a day. Complete relief was obtained with this and so he tapered off the drug as earlier.

Discussion

The exact cause of proctalgia fugax is as yet undetermined. It is possibly caused by spasm of the levator ani muscle, more specifically the pubo-coccygeus muscle.¹² Spasm of the rectal smooth muscle, the internal anal sphincter and the external anal sphincter have also been suggested.⁴

It has been thought that proctalgia fugax might be a variant of irritable bowel syndrome.⁵ This view, although plausible, has not been accepted universally.⁶ It has recently been suggested that proctalgia fugax could be a vascular disease, something like a rectal equivalent of migraine.⁷ There is as yet no consensus of opinion about its aetiology.

Treatments for proctalgia fugax are many and include analgesics, tranquillisers, quinine, muscle relaxants, amyl nitrite, sitz baths, biofeedback, yoga, and acupuncture. An elegant description of the condition and its treatments has recently been made by Wright,⁴ who also reported the efficacy of inhaled salbutamol in relieving the pain in proctalgia fugax. Diltiazem has also been reported to be effective in relieving proctalgia.⁷

Clonidine is an α_2 adrenoceptor agonist which possesses several useful therapeutic properties. It acts directly on α_2 receptors and produces an

inhibitory response by either inhibiting the post-synaptic neurone directly or by inhibiting the release of neurotransmitter from the presynaptic neurone. α_2 receptors have been located on sympathetic as well as parasympathetic nerve terminals in the gastrointestinal tract.^{8,9} Stimulation of these receptors by clonidine can be expected to produce relaxation of the rectal smooth muscle (effect on parasympathetic neurones) and relaxation of internal anal sphincter (effect on sympathetic neurones). Clonidine also has an antispastic effect³ which might possibly inhibit the spasm of levator ani and external anal sphincter. In addition to these actions, the central sedative and analgesic actions of clonidine would also be very useful in producing relief. Thus, clonidine appears to be almost tailor-made for treating proctalgia fugax.

Inhaled salbutamol, although reported to be rapidly effective, is likely to have some drawbacks in this condition. It would have to be absorbed in sufficient amounts to produce a systemic effect and adverse effects are likely to be significant at such doses. Besides, prescribing an aerosol inhaler of salbutamol to a patient who is likely to use it for only a few days in a year is likely to be wasteful.

Oral clonidine appears to be an effective and safe treatment for proctalgia fugax. The author strongly recommends further trial of this drug in this distressing condition.

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