

## Haemorrhoids: Management update and a word of caution

### Introduction

There are three cushions present in the normal anal canal, which contribute to 15-20% anal closure pressure and are important for both flatus and faecal continence. Haemorrhoids, more commonly called piles, occur when these vascular cushions become congested and swollen, and when the condition becomes severe, they can prolapse out of the anal canal. (Fig.1) It is a very common condition but its exact aetiology is poorly understood. Chronic straining, pregnancy and prolonged sitting or squatting are thought to be some of the precipitating factors.



**Fig. 1** Haemorrhoids (Grade III)

### Diagnosis

The patient with haemorrhoids classically presents with painless fresh per rectal bleeding at time of defaecation. Typically, there is fresh blood stain on the toilet paper or fresh blood in the toilet bowl with normal stools or stools with blood on the surface only. The amount of blood passed is usually small, but occasionally large amount of blood can occur if a haemorrhoidal vein is ruptured. Perianal discomfort and itchiness are common. However, haemorrhoids are normally NOT painful unless they have prolapsed and become strangulated and/or thrombosed. (Fig.2)



**Fig. 2** Strangulated haemorrhoids

Inspection of the external anal region might be normal, but often there are excessive redundant skin or skin tags at the perianal area. Prolapsed haemorrhoids are easily recognized and usually reducible with finger. Proctoscopy will show the classical appearance of haemorrhoids being the dark venous mucosal swellings which bulge into the the protoscope as it is slowly withdrawn.

### Different diagnosis

It could have serious consequences if other perianal and anal conditions are mistaken to be haemorrhoids, especially anal and rectal cancers. Therefore, it is paramount that these similar conditions are to be excluded before starting to treat the case as haemorrhoids.

Anal fissure also presents with fresh PR bleeding, but classically there is intense anal pain, during and soon after passage of a hard stool. Proctoscopy will reveal the split anal mucosa typically at 6 o'clock.

Perianal haematoma mimicks thrombosed haemorrhoids. However, it usually presents as a single small tender darkish lump which is not reducible, whereas thrombosed haemorrhoids are larger and usually multiple.

Protruding anal or rectal polyps can sometimes be mistaken as prolapsed haemorrhoids. Careful examination should reveal a stalk and a more pinkish colour of the lump, as opposed to the darkish colour of a prolapsed haemorrhoid.

In perianal abscess there is a painful perianal swelling with erythematous skin. Presence of an external opening with slight discharge would indicate perianal fistula. (Fig. 3)

A careful digital rectal examination is paramount as it would exclude anal and lower rectal cancers. (Fig.4) In the older patients, even haemorrhoids are present, it is important to exclude colorectal cancers by doing a sigmoidoscopy or a full colonoscopy in a patient presenting with PR bleeding, as haemorrhoids can co-exist with colorectal cancers.



Fig. 3 Anal fistula

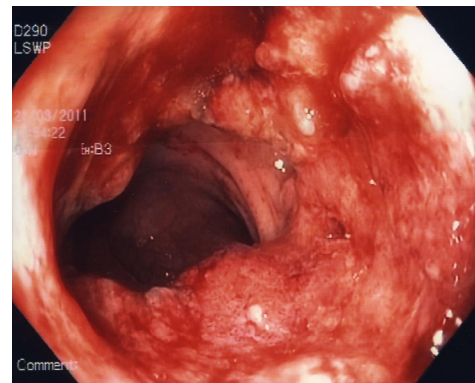


Fig. 4 Rectal cancer

## Management

When a case of haemorrhoids is suspected after taking the history, then a careful examination is important. External examination of the perianal region may reveal skin tags and external components of haemorrhoids. On digital rectal examination (DRE), prolapsed haemorrhoids once reduced are not palpable. Any palpable lumps should alert one to the possibility of anal rectal polyps or even carcinoma. Proctoscopy is paramount and would reveal the classical appearance of the internal haemorrhoids and their positions. In older patients and in patients with abnormal DRE, rigid sigmoidoscopy should be performed. If not available, then a flexible sigmoidoscopy or a full colonoscopy should be arranged.

## Treatment

**Conservative.** Most cases of early haemorrhoids can be managed by conservative measures. These consist of increasing fibre in diet or prescribing fibre supplement, such as Metamucil or Normacol. Local application of ointment, such as Anusol and Faktu, helps to ease perianal discomfort. Ultraproct suppositories are useful especially in cases of prolapsed haemorrhoids with pain, but should not be routinely given for simple haemorrhoids as it contains steroid. If haemorrhoids are frequently prolapsing, oral Daflon might help to reduce the venous congestion. It is particularly useful in cases of strangulated haemorrhoids that have been reduced.

**Interventional procedures.** If symptoms persist despite the conservative treatment, injection sclerotherapy with phenol in almond oil is effective for early haemorrhoids. For larger haemorrhoids and those with early prolapse, rubber band ligation when correctly performed is highly effective. Haemorrhoidal artery ligation is also effective in selected cases. All these procedures can be done in the clinic setting.

**Surgery.** If the haemorrhoids are large, prolapsing and not responding to conservative treatment or clinic procedures, then haemorrhoidectomy is indicated.

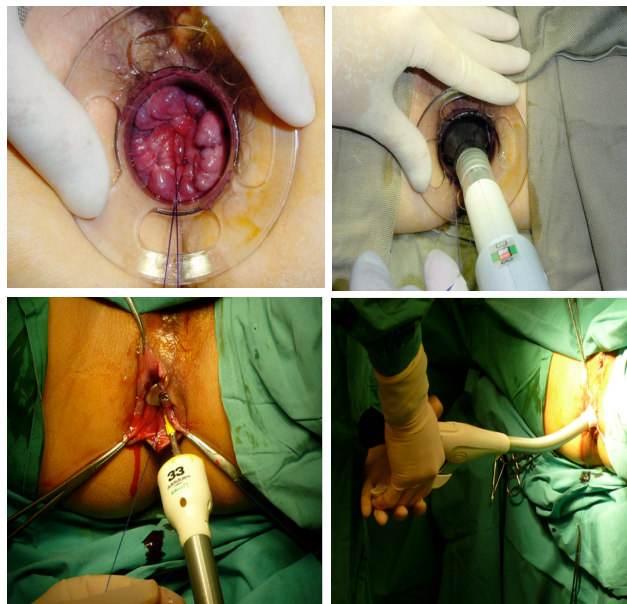
The traditional Milligan-Morgan haemorrhoidectomy is highly effective with small recurrent rate. However, the perianal wounds are quite painful (Fig. 5) and require good daily cleaning care. Excision with bipolar scissors or ultrasonic scalpel has been shown to be less painful and has less bleeding during operation <sup>1</sup>.



**Fig. 5** Wounds after traditional haemorrhoidectomy

## Stapled haemorrhoidopexy

Recently, excision of the haemorrhoid cushions by means of a circular stapler (stapled haemorrhoidopexy) (Fig.6) has been popular. Advantages of this stapled haemorrhoidopexy include minimal post-operative pain, reduced operative bleeding and virtually no external wound <sup>2,3</sup>. It is suitable for Grade II and III haemorrhoids. But it does not deal with the irreducible components of the haemorrhoids such as those seen in Grade IV condition. Recurrent rate is also higher especially for Grade IV haemorrhoids. Cases of serious bleeding and sepsis have been reported. Longer term results are still pending.



**Fig. 6** Stapled haemorrhoidopexy

## References

1. Chung CC, Ha JP, Tai YP et al. Double-blind, randomized trial comparing Harmonic Scalpel hemorrhoidectomy, bipolar scissors hemorrhoidectomy and scissors excision:ligation technique. *Dis Colon Rectum*. 2002 Jun;45(6):789-94
2. Gerjy R, Derwinger K, Lindhoff-Larson A, Nyström PO. Long-term results of stapled haemorrhoidopexy in a prospective single centre study of 153 patients with 1 to 6 years follow-up. *Colorectal Dis*. 2011 Nov 5
3. Panarese A, Pironi D, Venlettuoli M et al. Stapled and conventional Milligan-Morgan haemorrhoidectomy: different solution for different targets. *Int J Colorectal Dis*. 2011 Nov 4.