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Sze-Lin Peng

New Zealand Doctor
Rata Aotearoa

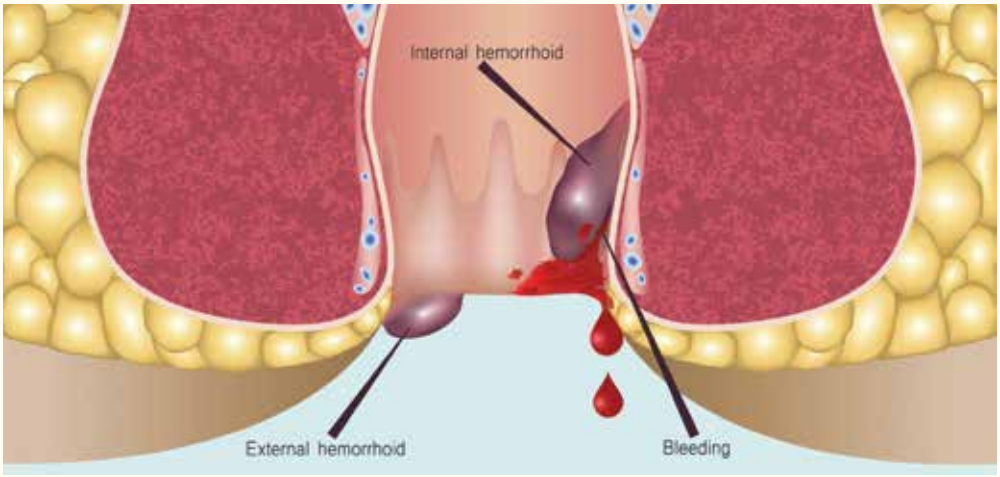
Choice of treatment for haemorrhoids is highly dependent on symptoms

CLINICAL UPDATE

Haemorrhoids are very common in patients presenting to general practice and can significantly impact on quality of life. This article summarises the treatment of haemorrhoids after careful history and accurate examination have been performed

▶**Sze-Lin Peng**

Sze-Lin Peng is a colorectal and general surgeon at Counties Manukau DHB



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This article pertains to *internal haemorrhoids*, which are proximal to the dentate line and have visceral innervation. They are extremely common in the general population. At Counties Manukau DHB in 2015/16, presumed haemorrhoids accounted for over 90 per cent of referrals to the outpatient colorectal service (own data).

External haemorrhoids is a term commonly used to describe conditions such as perianal haematoma or skin tags, and treatment for these is *not* the same as described here.

Treatment summary

- Patients older than 45 should be offered colonic exoneration, especially for persistent symptoms or anaemia.
- Most patients with intermittent bleeding from minor, grade 1–2 haemorrhoids respond to dietary and lifestyle management.
- It may be acceptable for patients who require anticoagulation to have ongoing, intermittent, minor bleeding, provided serious pathology is excluded, as treatment risks and benefits need to be carefully balanced.
- Patients with bleeding, prolapsing haemorrhoidal disease often need definitive EH, although some may be suitable for consideration of either the stapled technique or HAL-RAR.
- Post-operative recovery following haemorrhoid surgery is often very painful, and patients need reassurance; delayed bleeding at one to two weeks after surgery is common.
- Useful medications to help post-operative recovery usually include simple analgesia, laxatives, metronidazole, lignocaine gel, and topical glyceryl trinitrate or diltiazem.

Serious conditions such as malignancy and inflammatory bowel disease should always be considered, as they may present with similar symptoms, and can also coexist. All patients with per rectal bleeding over the age of 45–50 should have formal colonic exoneration by either colonoscopy or CT colonography. The risk of malignancy in this age group is approximately 1–3 per cent, with an incidence of polyps of about 15 per cent.[1,2]

Further, any re-presenting patient with increasing symptoms, regardless of age, should be carefully considered for formal colorectal exoneration, and referral to a specialist may assist with that. Importantly, colorectal cancer in patients under the age of 50 is predominantly left sided, so digital rectal examination at initial review is crucial.

What are haemorrhoids?

Haemorrhoidal columns, also known as "anal cushions", are normal anatomic clusters of vascular and connective tissue, smooth muscle and overlying mucosa that exist in the left lateral, right anterior and right posterior anal canal (the classic four, seven and 11-o'clock positions). They serve in providing continence but become pathological when engorged and, subsequently, symptomatic.

Haemorrhoids are clinically classified as follows:

Grade 1 – haemorrhoids do not prolapse
Grade 2 – prolapse with straining
Grade 3 – require manual reduction to reduce prolapse
Grade 4 – are irreducible.

The common symptom of internal haemorrhoids is *painless* outlet rectal bleeding. Patients typically describe bright red blood (often causing them concern) and often hear the blood dripping into the toilet bowl. If they have any prolapsing disease, they may complain of perianal discomfort or an ache/heaviness, pruritis ani (from mucous soiling) and/or faecal incontinence.

Treatment of haemorrhoids is highly dependent on symptoms and needs to be carefully balanced with the patient's comorbidities. There are two groups of patients with symptomatic haemorrhoids that should be discussed.

Patients with painless outlet bleeding

Symptomatic haemorrhoids, especially those in grades 1–2, are usually self-limiting and often respond well to non-invasive treatment: increasing fluid and soluble fibre intake, regular exercise, avoiding straining (can be with constipation or diarrhoea) and spending less time on the toilet.

A meta-analysis of seven randomised trials showed that fibre supplementation (7–20g per day; note that one teaspoon of psyllium husk only contains about 6g of fibre) decreased bleeding symptoms by 50 per cent, but had little effect on prolapse, pain and itching from haemorrhoids.[3] There is no evidence to support the use of popular over-the-counter topical corticosteroids, although many patients report subjective improvement.[4]

Surgical treatments should be reserved for patients who report regular bleeding, especially with anaemia.

Rubber band ligation – is the most common office-based procedure used to treat grade 1–2 haemorrhoids. It can be an option for some patients with grade 3 haemorrhoids who may want to avoid formal surgery. A small silicone band is placed through a proctoscope well above (about 1cm) the dentate line along the superior aspect of the symptomatic haemorrhoidal columns.

The bands are *not* placed around the haemorrhoids themselves as normally that would include tissue of the anal transition zone, which is sensate and causes significant pain. Topical anaesthetic, such as 10 per cent lignocaine spray, applied before the banding can be useful. Some patients cannot tolerate banding in the clinic and require either sedation or a general anaesthetic.

Potential complications include discomfort (often a deep lower abdominal ache) for up to a week, tenesmus, delayed bleeding at one to two weeks, urinary retention and, very rarely, perianal sepsis.

Results are generally very good with up to 90 per cent resolution of symptoms. Even if repeated treatments are required, banding is very cost effective with low impact on quality of life.[5]

Patients on anticoagulation – can pose a clinical challenge in terms of treatment decision. The indication for anticoagulation, the risk of significant bleeding from haemorrhoids, and treatment complications should be carefully balanced. It may be acceptable for these patients to experience minor bleeding without anaemia.

The risk of rebleeding after any haemorrhoid treatment is at one to two weeks after the procedure, and often anticoagulation is only stopped in the days prior to treatment. A 2009 paper found that most patients can safely receive banding while on anticoagulation and that anticoagulation should only be stopped afterwards to reduce the risk of significant rebleeding.[6]

Patients with outlet bleeding with prolapse

Surgical options are usually reserved for grade 3–4 haemorrhoids. The procedures described below are commonly performed under general or spinal anaesthesia.

Excisional haemorrhoidectomy (EH) – is still the "gold standard" technique. Various methods have been described, ranging from sutured versus not (ie, closed Ferguson versus open Milligan–Morgan) and standard diathermy versus energy devices (eg, LigaSure and Harmonic). The common principle is excision of the prolapsing haemorrhoid with or without associated skin tags.

Most patients report significant post-operative pain for the first one to two weeks. There is usually significant swelling during this time, and patients should be reassured that this will improve in four to six weeks. It is common for the presence of some fibrin or wound exudate to be present for weeks. Any sutures used may dangle out in this time and are absorbable.

Oral and topical metronidazole have been shown to reduce pain following haemorrhoidectomy, although patient intolerance to the oral route is common.[7] Topical glyceryl trinitrate 0.2 per cent or diltiazem 2 per cent, with or without lignocaine gel, have also been shown to reduce post-haemorrhoidectomy pain.[8,9]

After pain, a common post-operative course is delayed bleeding, which occurs one to two weeks after surgery. This is likely due to the granulating wound being traumatised by straining or defaecation. Fresh outlet bleeding during defaecation for a few days is normal, but any massive bleeding may require hospital admission. Return to theatre for control of post-surgical bleeding is uncommon.

Infections are rare and usually characterised by obvious cellulitis, fever and severe pain not responding to analgesia.

Stapled haemorrhoidectomy – is performed using a specific circular stapling device that excises a ring of haemorrhoidal tissue and results in a circular staple line at the anorectal junction. This involves meticulous surgical technique as serious complications include severe pain, bleeding and rectovaginal fistula (vaginal tissue inadvertently incorporated into the stapling device).

Patients typically describe bright red blood…and often hear the blood dripping into the toilet bowl

In expert hands, stapled haemorrhoidectomy is associated with less pain than EH. However, a separate excision may still be required for associated skin tags. Multiple meta-analyses have shown that stapled haemorrhoidectomy has higher rates of recurrence than EH.[4]

Haemorrhoidal artery ligation with recto-anal repair (HAL-RAR) – is a newer technique that does not involve excision of haemorrhoidal tissue or skin tags. A specially designed doppler probe inserted into the anal canal locates arterial signals from haemorrhoidal vessels. The detected vessel is ligated, and a synchronous suture ligation is performed on the haemorrhoidal column.

A randomised study in 2016 showed a trend towards reduced recurrence compared with rubber band ligation at one year, but increased costs should be considered.[10] Three randomised trials comparing HAL-RAR to EH present varying results.[4] The only significant advantage appears to be reduced post-operative pain, which may be an important factor for patients who wish to return to work earlier.

Acute haemorrhoid crisis – is rare and will appear as beefy red, ulcerated or necrotic haemorrhoids on examination. This occurs when internal haemorrhoids prolapse and become irreducible. Affected patients usually require hospital admission for analgesia, and occasionally acute surgery is performed in the presence of sepsis or severe necrosis. ■

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