

*When piles become*  
more than just a nuisance

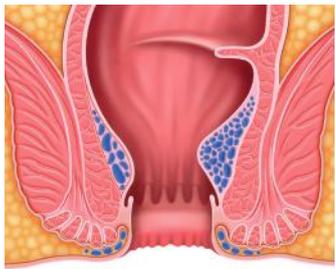
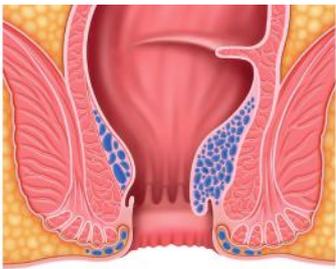
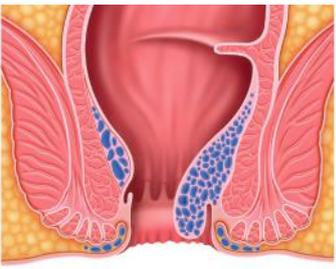
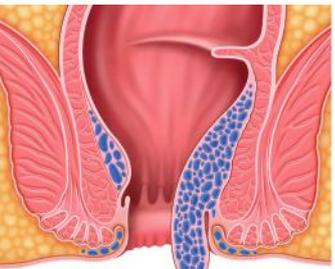


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# When piles become more than just a nuisance

Piles are classified as either internal or external, based on where they develop. Internal piles are generally painless as there are less nerves in the anal canal. External piles can become painful when swollen (or thrombosed). When internal piles progress and start to prolapse (or “hang out”), they can be graded on a scale from I to IV, which guides effective treatment.<sup>1,2</sup>

Grade I	Grade II	Grade III	Grade IV
			
Degrees I	Degrees II	Degrees III	Degrees IV
The pile bleeds and may push into the anal canal, but is not prolapsed.	The pile prolapses when passing stool but retracts back by itself.	The pile prolapses when passing stool, but does not retract by itself, it needs to be pushed back manually.	The pile is permanently prolapsed and cannot be pushed back.

Adapted from Agbo SP, 2011<sup>2</sup>

## What are my treatment options?

When your doctor decides on the best therapy for your piles, he will most probably choose the least invasive treatment considering your age, how severe your symptoms are and any other conditions you may suffer from. The below table gives an overview of the some of the treatment options available for piles:<sup>3</sup>

Treatment	Grade I	Grade II	Grade III	Grade IV	Acute thrombosis and strangulation
Dietary and lifestyle modification	X	X	X	X	X (after acute event)
<b>Office procedures</b>					
Rubber and ligation	X	X	X		
Sclerotherapy	X	X			
Infrared coagulation	X	X			
<b>Operating-room procedures</b>					
Haemorrhoidectomy			X	X	X (emergent)
Stapled haemorrhoidopexy			X	X	
Doppler-guided haemorrhoid artery ligation		X	X		

Source: Sun Z, Migaly J, 2016<sup>3</sup>

# What dietary & lifestyle changes should I make?

For all grades of piles, it is important to make the following dietary and lifestyle changes to help reduce the recurrence of piles.<sup>1</sup>



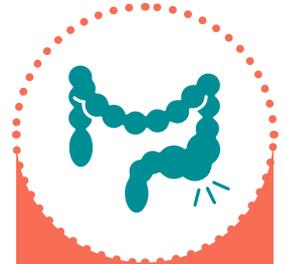
Follow a high-fiber diet (25 to 35 g per day), or use fiber supplementation.



Increase your water intake.



Take warm water (sitz) baths.

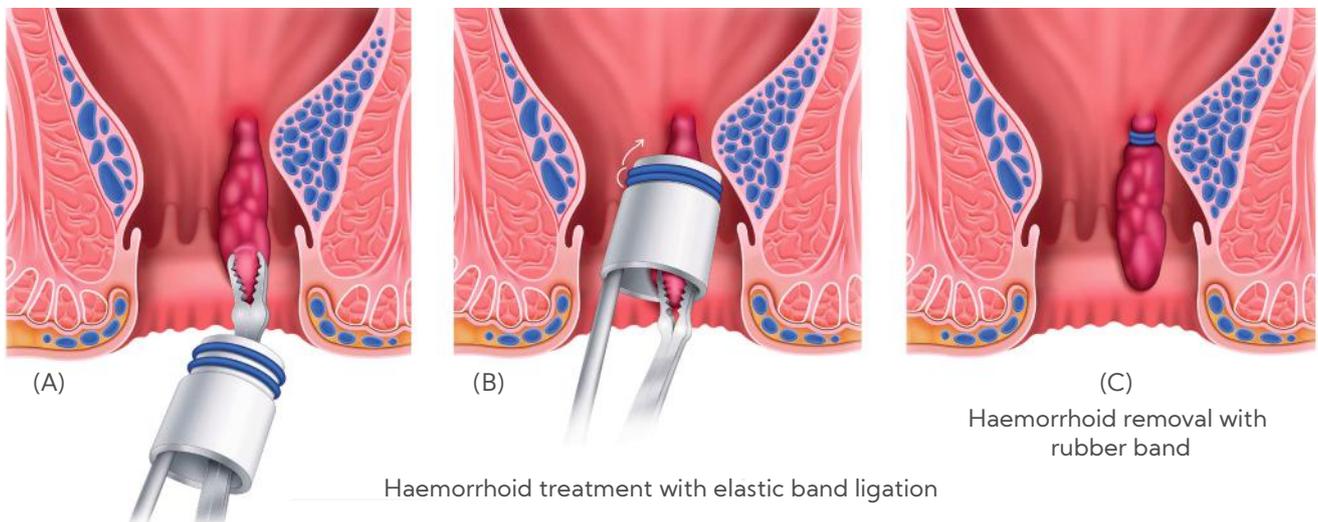


Try using stool softeners.

## Using topical treatment

There are several topical treatments available to treat the symptoms of piles, and the ideal treatment would aim to reduce the inflammation, decrease disease symptoms, return you to your normal daily activities and minimize the impact on quality of life.<sup>4</sup>

## Procedures done in the doctor's rooms explained



- Rubber Band Ligation uses a device that allows a rubber band to be applied to each haemorrhoid via a proctoscope. This band constricts the blood supply, the pile receives no oxygen and falls off approximately 1–2 weeks later.<sup>5</sup>
- Sclerotherapy is a procedure where the doctor uses an anoscope to locate the pile. The skin below/above the pile is then injected with a sclerosant material — typically a solution including phenol in vegetable oil — which causes the tissue to harden. The redundant tissue attaches to the anal canal, and eventually gets destroyed.<sup>3</sup>
- Infrared coagulation is the direct application of infrared waves to the base of the pile, causing the pile tissue to die and the pile to ultimately fall off.<sup>5</sup>

# Surgical procedures explained

1

**Haemorrhoidectomy** is the surgical removal of piles and is perhaps one of the oldest operations ever performed. There are 2 basic ways this is performed, open excision or closed haemorrhoidectomy.<sup>5</sup>

2

**Stapled haemorrhoidopexy** – In this procedure the doctor uses a circular stapling device to cut out a doughnut-shaped piece of the tissue above and around the pile, and the skin is then stapled back, effectively lifting the pile back.<sup>1,5</sup>

3

**Haemorrhoidal artery ligation** – The doctor uses a modified proctoscope that is fitted with a Doppler probe to accurately find the superficial arteries feeding the pile. These arteries are then bound to reduce the blood engorgement whilst also allowing the tissue to be pulled up to prevent prolapse.<sup>1,5</sup>



**References:** 1. Mott T, Latimer K, Edwards C. Hemorrhoids: Diagnosis and Treatment Options. Am Fam Physician. 2018;97(3):172-179. 2. Agbo SP. Surgical Management of Hemorrhoids. J Surg Tech Case Rep. 2011;3(2): 68-75. 3. Sun Z, Migaly J. Review of Hemorrhoid Disease: Presentation and Management. Clin Colon Rectal Surg 2016;29:22-29. 4. Abramowitz, L. The Diagnosis and Management of Haemorrhoidal Disease from a Global Perspective. Aliment Pharmacol Ther. May 2010;31(1):1-58 5. Brown SR. Haemorrhoids: an update on management. Ther Adv Chronic Dis. 2017;8(10):141-147.