Home and office treatment of symptomatic

haemorrhoids

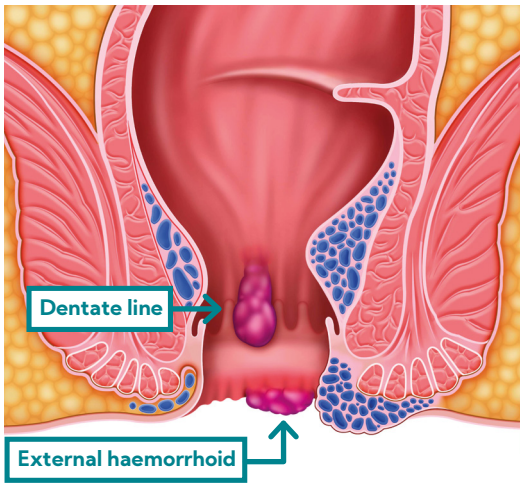
Bleday R, Breen E. UpToDate 2022; [cited 10 March 2022]; Available from: www.uptodate.com.

Introduction

- Haemorrhoids are collections of submucosal, fibrovasular, arteriovenous sinusoids that are part of the normal anorectum[1]
- Symptoms include painless rectal bleeding during defaecation with or without prolapse (most common), anal pruritis or pain, and a lump at the anal verge from thrombosis or strangulation[1]
- Most patients with low-grade internal haemorrhoids will experience relief with home-based conservative treatment or office-based procedures[1]
- Surgery is indicated for low-grade haemorrhoids that are refractory to conservative treatment, high-grade haemorrhoids and complicated haemorrhoids[1]

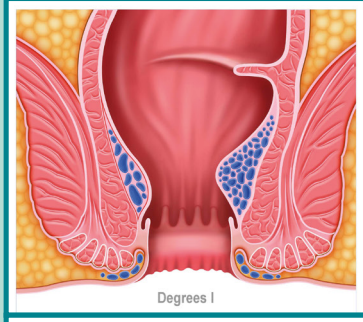
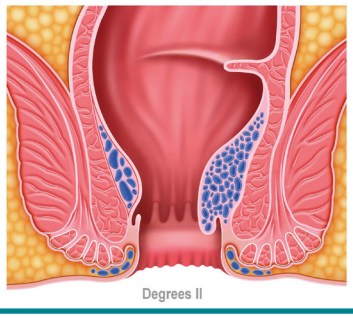
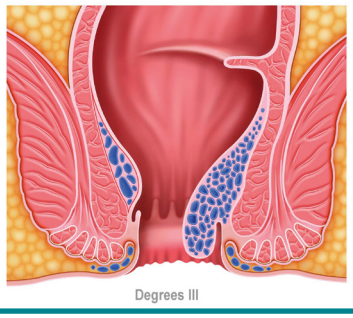
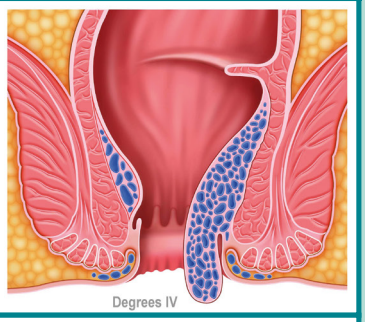
Classification of haemorrhoids

- Haemorrhoids can be internal, external or mixed, depending on their relationship to the dentate line[1]



- **Internal haemorrhoids** originate from above the dentate line and are less sensitive to pain due to visceral innervation – amenable to office-based procedures with minimal or no anaesthesia[1]
- **External haemorrhoids** originate from below the dentate line and are sensitive to pain due to somatic innervation – anaesthesia is necessary if treated surgically[1]
- **Mixed internal and external haemorrhoids** straddle the dentate line and are treated as external haemorrhoids[1]

- Internal haemorrhoids are further subclassified into 4 grades depending on the degree of prolapse:[1]

Grade I	Grade II	Grade III	Grade IV
			
Haemorrhoid bulges into anal canal without prolapse[1]	Haemorrhoid prolapses with straining but reduces spontaneously[1]	Haemorrhoid prolapses beyond dentate line with straining and reduces by manual pressure[1]	Prolapsed, non-reducible haemorrhoid with chronic inflammatory changes[1]

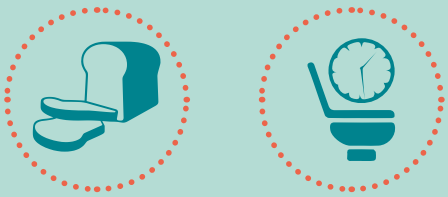
Conservative treatment for all patients

- Most patients with new-onset symptomatic haemorrhoids can be treated conservatively for as long as needed with dietary/lifestyle modification, and topical or oral medications to relieve symptoms[1]

Treatment approach by symptoms	
Irritation or pruritis[1]	• Analgesic creams, hydrocortisone suppositories, warm sitz baths
Bleeding[1]	• Dietary modification and external creams • Office-based procedures or surgery if bleeding persists
Thrombosis[1]	• Conservative treatment is usually sufficient as clot usually resorbs and pain lessens within a few days
Prolapse[1]	• As grade worsens there is a greater benefit of office-based procedures or surgery

Dietary and lifestyle modification

- Increased fibre intake improves symptoms of bleeding, mild prolapse, irritation and pruritis[1]
- Patients should ingest 20–30 g of insoluble fibre per day either through diet or supplements, and increase water intake to 1.5 to 2 litres a day[1]
- Patients should be advised to refrain from straining or lingering on the toilet, to exercise, avoid medications that cause constipation or diarrhoea and to limit their intake of fatty foods and alcohol[1]



Medications for symptomatic relief

- Hydrocortisone–lidocaine combinations are effective for relieving acute pain and topical steroids may relieve associated pruritis and shrink the haemorrhoids[1]
- Venoactive agents or phlebotonics improve venous tone and may reduce bleeding, as well as other symptoms such as pruritis[1]
- Antispasmodic agents, e.g., nitroglycerin, reduce anal sphincter spasm and associated pain[1]
- Warm sitz baths 2–3 times a day reduce inflammation and oedema and relax anal sphincter tone[1]

CPD Questionnaire

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TITLE:		HPCSA REG. NO.:	
FULL NAME:		NON-HPCSA REG. NO.:	
E-MAIL:		SPECIALITY:	
TELEPHONE:		REGION:	

For each question, choose the correct answer(s). Please note that there may be more than one correct answer for each question. Once completed, please email your questionnaire to: ronel@lepetta.co.za.

1. Choose the correct answer. Haemorrhoids are:
- ☐ a. Submucosal
- ☐ b. A collection of arteriovenous sinusoids
- ☐ c. Part of the normal anorectum
- ☐ d. All of the above

2. Which is the most common symptom of haemorrhoids?
- ☐ a. Anal pruritis
- ☐ b. Pain
- ☐ c. Painless rectal bleeding with or without prolapse
- ☐ d. Lump at the anal verge

3. Which treatment is most successful for new onset low-grade haemorrhoids?
- ☐ a. Haemorrhoidectomy
- ☐ b. Conservative treatment
- ☐ c. Rubber band ligation
- ☐ d. Sclerotherapy

4. Surgery is indicated for:
- ☐ a. Low-grade haemorrhoids that are refractory to conservative treatment
- ☐ b. High-grade haemorrhoids
- ☐ c. Complicated haemorrhoids
- ☐ d. All of the above

5. Choose the correct answer. Internal haemorrhoids:
- ☐ a. Straddle the dentate line
- ☐ b. Are below the dentate line
- ☐ c. Are above the dentate line
- ☐ d. None of the above

6. Choose the correct answer. External haemorrhoids are:
- ☐ a. Below the dentate line
- ☐ b. Innervated by somatic nerves
- ☐ c. Painful
- ☐ d. Require anaesthesia when surgery is performed

7. Which one is subclassified into 4 subgroups?
- ☐ a. Internal haemorrhoids
- ☐ b. External haemorrhoids
- ☐ c. Mixed haemorrhoids
- ☐ d. All of the above

8. Which one of the following describes a grade III internal haemorrhoid?
- ☐ a. Bulges into anal canal, no prolapse
- ☐ b. Prolapses with straining but reduces spontaneously
- ☐ c. Prolapses with straining and reduces manually
- ☐ d. Prolapsed and non-reducible

9. Which of the following conservative treatments are recommended for patients with new-onset symptomatic haemorrhoids?
- ☐ a. Diet/lifestyle modification
- ☐ b. Topical medication
- ☐ c. Oral medication
- ☐ d. All of the above

10. Which treatment can be recommended for patients with irritation or pruritis?
- ☐ a. Analgesic creams
- ☐ b. Hydrocortisone suppositories
- ☐ c. Warm sitz baths
- ☐ d. Any of the above

11. What is the correct treatment for an external thrombosed haemorrhoid more than 3 days old?

- ☐ a. Conservative treatment
- ☐ b. Refer for surgery
- ☐ c. Office based removal of the clot
- ☐ d. Rubber band ligation

12. What quantity of insoluble fibre should patients with haemorrhoids ingest daily?

- ☐ a. 5-10 g
- ☐ b. 10-20 g
- ☐ c. 20-30 g
- ☐ d. 100 g

13. What lifestyle advice is recommended for patients with haemorrhoids?

- ☐ a. Avoid lingering and straining on the toilet
- ☐ b. Exercise regularly
- ☐ c. Avoid medicines that cause constipation or diarrhoea
- ☐ d. All of the above

14. In addition to increasing fibre intake, how much water should patients aim to drink daily?

- ☐ a. 2 litres
- ☐ b. 3 litres
- ☐ c. 5 litres
- ☐ d. 8 litres

15. What is the effect of hydrocortisone-lidocaine combination creams/ointments on haemorrhoids?

- ☐ a. Relieve pain
- ☐ b. Relieve pruritis
- ☐ c. May shrink the haemorrhoid
- ☐ d. All of the above

16. What is the mechanism of action of venoactive agents?

- ☐ a. Reduce bleeding
- ☐ b. Improve venous tone
- ☐ c. Relax the anal sphincter
- ☐ d. a and b

17. Which one of the following treatments relaxes the anal sphincter?

- ☐ a. Phlebotonics
- ☐ b. Nitroglycerin
- ☐ c. Lidocaine
- ☐ d. Witch hazel

18. When is specialist referral required for treatment of haemorrhoids?

- ☐ a. Symptomatic low-grade (I or II) internal haemorrhoids refractory to 6-8 weeks of medical treatment
- ☐ b. Symptomatic high-grade (III or IV) internal haemorrhoids
- ☐ c. Thrombosed haemorrhoids <3 days old (symptoms usually begin to subside after 3 days)
- ☐ d. All of the above

19. Which of the following are commonly used office-based procedures?

- ☐ a. Rubber band ligation
- ☐ b. Sclerotherapy
- ☐ c. Infrared coagulation
- ☐ d. All of the above

20. When is rubber band ligation preferred?

- ☐ a. Healthy patients with internal haemorrhoids refractory to conservative treatment
- ☐ b. Patients on anticoagulants
- ☐ c. Patients who are immunocompromised
- ☐ d. Patients with portal hypertension

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Reasons to refer to a specialist

- Symptomatic low-grade (I or II) internal haemorrhoids refractory to 6–8 weeks of medical treatment.[1]
- Symptomatic high-grade (III or IV) internal haemorrhoids.[1]
- Thrombosed haemorrhoids, with the exception of subacute (older than three days) thrombosed external haemorrhoids, which can be managed expectantly with resolution of symptoms expected in 7 to 10 days.[1]
- Patients ≥ 40 years old with rectal bleeding should be referred for colonoscopy.
- Patients with haemorrhoids and one of the following conditions should be referred for colonoscopy regardless of age: anaemia, bleeding, concomitant change in bowel patterns, personal history of colorectal polyps, family history of inflammatory bowel disease or colorectal cancer in a first-degree relative, or other suspected pathologic pelvic changes that could contribute to the patient's symptoms.[1]

Office-based procedures for symptomatic haemorrhoids

- Recommended for patients with symptomatic grade I, II, or III internal haemorrhoids refractory to conservative treatment[1]
- Common procedures include rubber band ligation, sclerotherapy, infrared coagulation of internal haemorrhoids, and excision of thrombosed external haemorrhoids[1]
- Rubber band ligation is preferred for healthy patients with grade I, II, or III internal haemorrhoids, whereas sclerotherapy is preferred for patients who are on anticoagulants, are immunocompromised or have portal hypertension[1]
- Acutely thrombosed external haemorrhoids can be excised if patient presents within the first 3 days of symptoms[1]
- Grade IV internal haemorrhoids require definitive surgical treatment[1]

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