6.10 Hemorrhoids (Piles)

Presentation

Patients with external hemorrhoids generally complain of a painful purple lump covered with anal skin. It may have been precipitated by straining during defecation, heavy lifting, or pregnancy, but in most cases there was no definite preceding event. The external hemorrhoidal swelling is caused by thrombosis of the vein and is very tender to palpation and usually does not bleed unless there is erosion of the overlying skin.

Patients with internal hemorrhoids usually seek help because of painless (or nearly painless) bright red bleeding at the time of defecation. Patients usually notice intermittant spotting on toilet tissue or episodic streaking of stool with blood. A prolapsed internal hemorrhoid appears as a protrusion of painless, moist red mass covered with rectal mucose at the anal verge. Prolapsed internal hemorrhoids may become strangulated and thrombosed, and thus painful. Itching is not a common symptom of hemorrhoids

What to do:

- If the problem is rectal bleeding, it should be approached as any other gastrointestinal bleeding. The amount of bleeding should be quantified with orthostatic vital signs and a hematocrit; the rectum should then be examined with an anoscope. For non-threatening rectal bleeding from hemorrhoids, the initial management should include a high fiber diet, stool softeners and bulk laxatives, and the patient should be instructed to spend less time sitting on the commode. Prolapsed or strangulated hemorrhoids warrant surgical consultation and possible hospital admission. All patients with rectal hemorrhage should be referred for a thorough gastroenterologic evaluation which might include proctosigmoidoscopy, barium enema or colonoscopy. Young patients in whom hemorrhoids are the obvious source of bleeding may not require more than a digital rectal examination and anoscopy.
- If the problem is pain, the rectum should be examined using a topical anesthetic (lidocaine jelly) as a lubricant. First look for thrombosed external hemorrhoids and prolapsed internal hemorrhoids. Have the patient perform a Valsalva maneuver as you provide traction on the skin of the buttocks, to evert the anus. Examine the posterior mucosa for anal fissures. After the topical anesthesia has taken effect, complete the digital rectal exam, looking for internal hemorrhoids and evidence of rectal abscesses or other masses.
- If topical mucosal anesthetic does not give enough relief to permit examination, follow with subcutaneous injection of 10mL of 1% lidocaine with epinephrine or bupivacaine for extended pain relief.
- If topical anesthetics on the rectal mucosa help control the pain, provide for more of the same, perhaps also with some added corticosteroid for anti-inflammatory effect (Anusol-HC cream). Suppositories are convenient, but may not deliver the medication to where it is needed, so prescribe cream or foam (Proctofoam-HC, applied externally rather than internally).
- Instruct the patient to treat lesser pain and itching with witch hazel compresses, Tucks, and ice packs followed by warm sitz baths. Prevent constipation by using bulk laxatives (bran, psyllium) and stool softeners

(docusate 50mg qd) and arrange follow up. Inform the patient that hemorrhoids may recur and require surgical removal.

- Small ulcerated external hemorrhoids usually do not require any treatment for hemostasis. Bulk laxatives and gentle cleansing are generally all that is required.
- If a thrombosed external hemorrhoid is still moderately to severely painful after topical anesthesia, apply an ice pack for 15 minutes and then inject around it with a local anesthetic to allow for examination and excision. The thrombus may be enucleated via an elliptical incision over the anal mucosa. Locular clots can be broken up by inserting a straight hemostat into the wound, and spreading the tips, thereby allowing the clots to be expressed. Pain relief from this simple surgical technique can be dramatic, but excision is not effective unless the entire thrombosed lesion is completely removed. Apply a compression dressing and tape the buttocks together for 12 hours to minimize bleeding. The patient can then begin the non-surgical treatment described above. Schedule a follow up examination in 2 days. Narcotics may be prescribed for a day, but should be switched to NSAIDs as soon as the risk of bleeding is less so they do not cause constipation.

What not to do:

- Do not labor to reduce prolapsed hemorrhoids unless they are part of a large rectal prolapse with some strangulation. Everything may prolapse again when the patient stands or strains.
- Do not traumatize the patient with your examination.
- Do not miss infectious and neoplastic processes which can resemble or coexist with hemorrhoids.
- Do not excise a thrombosed hemorrhoid when the patient has a bleeding abmormality, is taking an anticoagulant or daily aspirin, or has increased portal venous pressure.

Discussion

The pathogenesis of hemorrhoids is multifactorial. Predisposing factors include heredity, portal hypertension, straining to defecate, and pregnancy. Internal hemorrhoids are classified into four groups. First-degree internal hemorrhoids do not protrude, cannot be palpated by digital examination, and require anoscopy for diagnosis. Second-degree hemorrhoids protrude with defecation, but reduce spontaneously. Third-degree hemorrhoids protrude and require manual reduction. Fourth-degree hemorrhoids are irreducibly prolapsed. Elastic banding techniques can be 80-90% curative for second, third and fourth degree internal hemorrhoids, but can increase prolapse of first-degree hemorrhoids. Patients with bleeding diatheses, prolapse or both internal and external hemorrhoids are best treated by surgical resection. The diagnosis of "hemorrhoids" may cover a variety of minor ailments of the anus, which may or may not be related to the hemorrhoidal veins. The ED approach consists of ruling out immediately life-threatening problems, and then providing the patient with symptomatic relief and appropriate referral.