Bedfordshire and Hertfordshire Priorities Forum guidance

Subject: Management of Haemorrhoids
Number: 58
Date of decision: December 2010
Date of review: December 2013

Haemorrhoids or piles are a common condition affecting a third of the general population. Age distribution demonstrates a peak incidence between 45 and 65 years. Symptomatic haemorrhoids also increase in prevalence in women during pregnancy and postpartum. Most of the haemorrhoids can be treated in primary care with dietary advice and avoidance of straining, and do not benefit from surgical intervention. In the year 2009/2010, 368 inpatient procedures were carried out in NHS Hertfordshire for haemorrhoids which results in total PbR cost of £309,096 (Source: HIDAS/HES). Among these were 128 spells of haemorrhoidectomy (HRG cost £598-2351 per spell), 46 spells of stapled haemorrhoidectomy (HRG cost £746-1090 per spell), 121 spells of rubber band ligation (HRG cost £550-2438 per spell) and 32 injection sclerotherapy HRG cost (£550-979 per spell). However, these procedures do not include endoscopic investigation and treatment of haemorrhoids.

Symptomatic haemorrhoids form a large part of colorectal surgeons’ workload both from the perspective of diagnosis and excluding more serious disease as well as for treatment. This guidance will help the clinicians in the management of haemorrhoids.

History alone does not provide the diagnosis so that physical examination including digital rectal examination with proctoscopy is a minimum requirement to confirm suspected diagnosis of haemorrhoids and to exclude other anorectal pathology. Haemorrhoids are graded into 4 degrees by Goligher classification which is by the degree of prolapse.

- First degree haemorrhoids: bleed but do not prolapse
- Second degree haemorrhoids: prolapse but reduce spontaneously
- Third degree haemorrhoids: prolapse but reduced manually
- Fourth degree haemorrhoids: permanently prolapsed and irreducible

In addition, there is acutely thrombosed haemorrhoid which needs a different mode of management.

All cases of hemorrhoids should be investigated for anaemia and if positive should be investigated appropriately.

**Guidance**

**First line treatments**

For first and second degree haemorrhoids, dietary management consisting of adequate fluid and fiber intake (>25g per day) is first line of treatment. This conservative management is recommended by published guidelines and a systematic review of randomized controlled trials.

For first and second degree haemorrhoids which failed to improve with conservative treatment and for 3rd degree haemorrhoids, rubber band ligation is recommended as first-line. A single haemorrhoid or multiple haemorrhoids may be ligated with rubber bands per session. Since sepsis with pelvic cellulitis is a rare but severe complication, this technique should probably be avoided in immunodeficiency states.
The priority forum encourages that non-operative procedures be performed as a day case under colorectal surgery.

For patients refractory to the non-operative procedures, or fourth degree haemorrhoids, or patients with combined internal and external hemorrhoids, excisional haemorrhoidectomy \(^9,11-14\) is recommended.

For small thrombotic haemorrhoids, it is recommended to treat at home for 10-14 days using ice packs, stool softeners and analgesia rather than surgical excision \(^2,3\). Emergency surgery may be needed in severe cases to remove the engorged haemorrhoid or to debride necrotic tissue.

**Second line treatments**

Injection sclerotherapy is a second line alternative to rubber band ligation in first and second degree haemorrhoids which failed to improve with conservative treatment and for 3\(^{rd}\) degree haemorrhoids. Randomised controlled trials found rubber band ligation is more effective than injection sclerotherapy \(^3,15-18\).

NICE recommended PPH01 and PPH03 Staplers as an option \(^19\) for third degree haemorrhoids which need surgical intervention \(^11-14,20-25\). Staplers are contraindicated in extremely painful haemorrhoids including acutely thrombosed external haemorrhoids.

**Clinical Pathway Diagram for Management of Haemorrhoids**

![Clinical Pathway Diagram](attachment:image.png)
References:

18. Hibberts F, Schizas A. Assessment and treatment of patients with haemorrhoids. Nurs Stand. 2010 Jan 6-12;24(18):51-6, 60; quiz 58.


The Human Rights Act has been considered in the formation of this policy statement.