Management of Haemorrhoids

Link to guidelines: [http://www.enhertsccg.nhs.uk/](http://www.enhertsccg.nhs.uk/)

Severity grading
Haemorrhoids are graded into 4 groups by the Goligher classification defined by their degree of prolapse

- **First degree**
  - Classified as: Bleed but do not prolapse

- **Second degree**
  - Classified as: Prolapse but reduce spontaneously

- **Third degree**
  - Classified as: Prolapse but reduced manually

- **Fourth degree**
  - Classified as: Permanently prolapsed and irreducible

Presentation with Haemorrhoids

History, examination and investigation

Differential diagnosis

Thrombosed haemorrhoids

**RED FLAGS**
- If any suspicion of cancer refer on to 2 week wait pathway
- For management of thrombosed piles see separate box

Refer on 2ww pathway if Red Flags present

**Conservative management**

- Refer to secondary care if conservative treatment has failed and symptoms are severe

**Rubber band ligation**

**Stapled haemorrhoidopexy/haemorrhoidal artery ligation**

**Surgical haemorrhoidectomy/stapled haemorrhoidopexy**

**Surgical haemorrhoidectomy/stapled haemorrhoidopexy**

Refer to secondary care if conservative treatment has failed and symptoms are severe
**Presentation with Haemorrhoids**

Haemorrhoids are a common condition affecting a third of the general population. Peak incidence of haemorrhoids is between ages 45 to 65 years. Symptomatic haemorrhoids increase in prevalence in women during pregnancy and postpartum periods, but subsequently resolve. Most haemorrhoids can be treated in primary care with dietary advice and avoidance of straining, and do not benefit from surgical intervention.

**Symptoms**

- A person may be asymptomatic.
- Bright-red, painless rectal bleeding with defecation is the most common symptom. It may be streaks on the toilet paper or blood dripping into the toilet. Blood may coat stools but is not mixed in.
- Anal itching and irritation may result from chronic mucus discharge irritating the perianal skin.
- A feeling of rectal fullness, discomfort or of incomplete evacuation on bowel movements may be present if prolapse occurs with straining.
- Prolapsed haemorrhoids may present with a history of a lump at the anal verge.
- Soiling due to mucous discharge or impaired continence may also be experienced.
- Pain is rarely felt with internal haemorrhoids unless the haemorrhoid prolapses and becomes strangulated.
- Strangulated haemorrhoids may thrombose which is intensely painful.
- External haemorrhoids do not usually cause symptoms unless thrombosis occurs causing acute severe pain and a visible/palpable perianal lump.
History, examination and investigation

History alone does not provide a diagnosis of haemorrhoids. Physical examination including digital rectal examination and proctoscopy is a minimum requirement to confirm suspected diagnosis of haemorrhoids and to exclude other anorectal pathology. All cases of haemorrhoids should be investigated for anaemia and other red flag signs and symptoms. If positive, these cases should be referred on appropriately under the two week wait criteria.

Signs on examination

External examination
- Non-prolapsed internal haemorrhoids are not evident on external examination and are difficult to feel on digital rectal examination.
- Local perineal irritation may be seen if chronic mucous discharge is present.
- Asking the patient to strain may allow haemorrhoids to become visible at the anal verge. They appear as bluish, bulging vessels covered by mucosa.
- Thrombosed haemorrhoids are seen as purple, swollen, acutely tender perianal lumps.

Digital rectal examination
- It is essential to carry out digital rectal examination even though internal haemorrhoids will not be palpable. Other pathology needs to be excluded.

Classification
Haemorrhoids can be classified as internal or external relating to their position of origin either above or below the dentate line. Haemorrhoids are graded into 4 groups by the Goligher classification defined by their degree of prolapse.
- 1st degree haemorrhoids: Bleed but do not prolapse
- 2nd degree haemorrhoids: Prolapse but reduce spontaneously
- 3rd degree haemorrhoids: Prolapse but reduced manually
- 4th degree haemorrhoids: Permanently prolapsed and irreducible
Differential diagnosis

- Anal carcinoma
- Colorectal cancer
- Inflammatory bowel disease: Crohn's disease, ulcerative colitis
- Rectal prolapse
- Adenomatous polyps
- Anal fissure
- Condylomata acuminata (genital warts)
- Anorectal abscess
- Anal fistula

Other causes of pruritus ani - e.g., threadworms, contact dermatitis
**Thrombosed haemorrhoids**

Thrombosed haemorrhoids are extremely painful.
- Consider admission for those presenting early, as some advocate excision under local anaesthetic. Incision and drainage of the clot relieves pain but the thrombosis often recurs and there may be persistent bleeding.
- Conservative treatment includes analgesia, ice packs and stool softeners. A topical calcium antagonist may help to relieve pain.

If managed conservatively, symptoms usually settle within 10-14 days.
Conservative management

For first, second, and third degree haemorrhoids, dietary management consisting of adequate fluid and fibre intake remains the treatment of choice. In addition bulk forming laxatives, non-opioid analgesia and topical haemorrhoid preparations can be prescribed for symptomatic relief.

Pain and symptom relief

- Simple analgesia - for example, paracetamol. Avoid constipating codeine analgesia.
- Topical therapies:
  - Anaesthetic preparations may alleviate pain, burning, and itching. They should be used for only a few days, as they may cause sensitisation of the anal skin.
  - Topical corticosteroids may reduce inflammation and pain. Local infection must be excluded before use and they should only be used for up to seven days, as prolonged use may lead to skin atrophy, contact dermatitis and skin sensitisation.
  - Good perianal hygiene may be helpful in providing symptomatic relief and preventing perineal dermatitis. Moistened towelettes or baby wipes can be used to clean the perianal area. The area should then be patted dry.
  - Straining at stool should be avoided as it can make symptoms worse.
Refer to secondary care if conservative treatment has failed and symptoms are severe

As a non-priority condition, haemorrhoidectomy will only be commissioned if conservative treatment has failed and one of the following three criteria is present:

1. Haemorrhoids are recurrent;
2. Haemorrhoids are causing persistent bleeding;
3. Haemorrhoids cannot be reduced
**Stapled haemorrhoidopexy/ haemorrhoidal artery ligation**

For 3rd degree haemorrhoids where conservative management has failed, either rubber band ligation or haemorrhoidectomy/ haemorrhoidal artery ligation could be used as first line interventions.

For haemorrhoids refractive to rubber band ligation, stapled haemorrhoidectomy is recommended by NICE in place of traditional surgical haemorrhoidectomy. Models of device evaluated in the evidence review on stapled haemorrhoidopexy were the HCS33 (PPH01 model) and CDH33 model. Stapled haemorrhoidopexy was found to be as effective as conventional haemorrhoidectomy when used appropriately and offered immediate benefits in terms of postoperative pain. In addition, taking into account the requirements for postoperative pain management and other support during inpatient stay and after discharge, stapled haemorrhoidopexy was thought to potentially lead to modest cost savings.
Rubber band ligation

For 1st & 2nd degree haemorrhoids refractive to conservative management with diet, rubber band ligation remains the intervention of choice and is more efficacious than injection sclerotherapy. Rubber band ligation offers economic advantages as a day case procedure and patients recover quicker when used appropriately.
Rubber band ligation

For 3rd degree haemorrhoids where conservative management has failed, either rubber band ligation or haemorrhoidectomy/haemorrhoidal artery ligation could be used as first line interventions.
Stapled haemorrhoidopexy/ haemorrhoidal artery ligation

For 4th degree haemorrhoids, haemorrhoidectomy or haemorrhoidopexy should be the first line intervention.

Stapled haemorrhoidopexy is considered appropriate for people with fourth-degree haemorrhoids for whom residual external prolapse or skin tags would not be a concern. Alternate treatment for fourth degree haemorrhoids remains traditional surgical haemorrhoidectomy/stapled haemorrhoidopexy.