ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

HAEMORRHOIDS AND THEIR MANAGEMENT

A guide for patients

Haemorrhoids are enlarged blood vessels around the anus (back passage). They can cause bleeding and itchiness, and sometimes are very painful.

The word haemorrhoid comes from the Greek haim for blood and rhoos for stream (hence, bleeding). Haemorrhoids are also known as piles.

There are two types of haemorrhoids: internal and external.

Internal haemorrhoids are inside the back passage where the rectum joins the anus. They are covered by the mucous lining of the rectum. Internal haemorrhoids are enlargements of the normal cushions of blood vessels. They may be aggravated by constipation and straining.

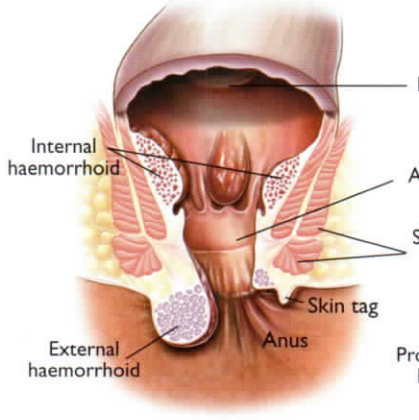
When internal haemorrhoids enlarge, they may come down through the back passage, usually at the time of a bowel motion. This is called prolapse. Occasionally these prolapsed haemorrhoids may remain outside all the time.

Prolapsed internal haemorrhoids may discharge mucus, causing a wet sensation in the under clothes. They are rarely painful unless complicated by thrombosis (clotting) or strangulation (swelling and squeezing of the haemorrhoid, causing impaired blood supply).

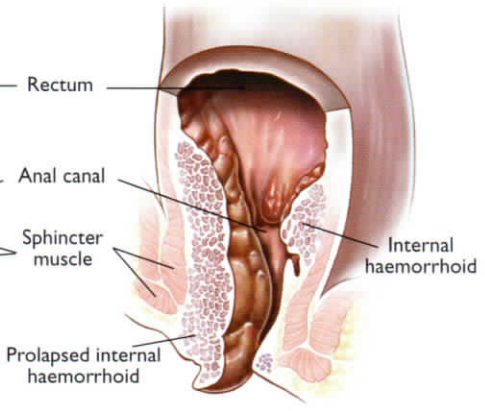
External haemorrhoids are on the outside of the back passage and are covered by skin. These are often enlarged due to stretching of the anal skin, as may occur during childbirth or straining.

External haemorrhoids often cause itchiness and discomfort, and may become very painful when a clot forms in blood vessels under the skin. These are called thrombosed external haemorrhoids.

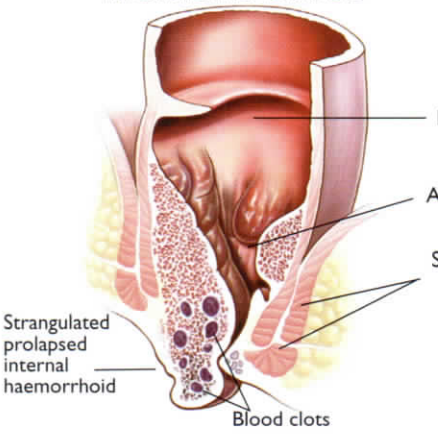
INTERNAL AND EXTERNAL HAEMORRHOIDS



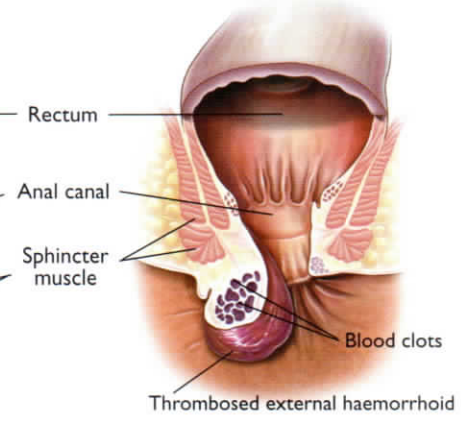
PROLAPSED INTERNAL HAEMORRHOID



STRANGULATED PROLAPSED INTERNAL HAEMORRHOID



THROMBOSED EXTERNAL HAEMORRHOID



Other flaps of skin called skin tags may also be present around the outside of the anus.

These are remnants of stretched or swollen skin that do not bleed but may itch. Skin tags are more of a nuisance than a health concern.

Haemorrhoids occur equally in men and women. About half the population in Australia and New Zealand has had at least one problem with a haemorrhoid by age 50.

TALK TO YOUR SURGEON

The aim of this pamphlet is to provide you with general information. It is not a substitute for advice from your surgeon and does not contain all known facts about haemorrhoids. If you are not sure about the benefits, risks and limitations of treatment, ask your surgeon. Read this pamphlet carefully. Technical terms are used that may require further explanation by your surgeon. Write down any questions that you want to ask. Your surgeon will be pleased to answer them. Seek the opinion of another surgeon if you are uncertain about the advice you are given. Use this pamphlet only in consultation with your surgeon.

Consent form: If you decide to have surgical treatment, your surgeon will ask you to sign a consent form. Before signing, read it carefully. If you have any questions about it, ask your surgeon.

Your Surgeon

IMPORTANT: FILL IN ALL DETAILS ON THE STICKER BELOW

DEAR SURGEON: When you discuss this pamphlet with your patient, remove this sticker, and put it on the patient's medical history or card. This will remind you and the patient that this pamphlet has been provided. Some surgeons ask the patient to sign the sticker to confirm receipt of the pamphlet.

TREATMENT INFORMATION PAMPHLET

PROCEDURE:.....

PATIENT'S NAME:.....

DOCTOR'S NAME:.....

EDITION NUMBER:.....DATE: (day).....(month).....(year).....

Edition number: 3

SIGNS, SYMPTOMS AND DIAGNOSIS

Internal haemorrhoids

These are rarely painful. Often the first sign of internal haemorrhoids is a small amount of bright red blood at the time of a bowel motion. The blood may either be on the toilet paper or in the toilet bowl.

When you have symptoms, examine the toilet bowl after having a bowel motion, before flushing.

Whenever you notice bleeding from the back passage or blood in the stool, it is important to have a thorough examination and diagnosis. Bleeding may be a symptom of another disorder unrelated to haemorrhoids.

Your surgeon will examine the back-passage area by spreading the buttocks and inspecting the anus. A gloved, lubricated finger is inserted into the anal canal to examine the anus and rectum. This is to check for other lumps or causes of your symptoms.

A small tube with a light and air-pumping device (endoscope) will be passed through the back passage into the rectum so that the surgeon can look inside the bowel to confirm the diagnosis and check whether other problems may exist. (If further endoscopy is required, the RACS patient education pamphlet *Endoscopy of the Colon or Gastrointestinal Tract* may be helpful.)

External haemorrhoids

The first symptom of external haemorrhoids is usually the awareness of a lump around the anus with an associated itch. Thrombosed external haemorrhoids can be very painful.

CAUSES OF HAEMORRHOIDS

Factors that contribute to the development of haemorrhoids include:

- a Western diet that is typically high in processed food and low in fibre and bulk, resulting in constipation (hard stool)
- straining to pass a motion due to constipation
- pregnancy and childbirth
- chronic coughing
- vomiting
- obesity
- lifting heavy weights incorrectly
- age.

Principles of Treatment

Your surgeon will discuss treatment options with you. The type of treatment depends on the severity and frequency of the signs and symptoms, the size of the haemorrhoids, and whether they are external or internal.

The most effective form of treatment is prevention. Your surgeon can advise you on simple lifestyle changes to help prevent haemorrhoids from getting worse, including the following.

- Controlling constipation and keeping weight within the healthy range can help prevent haemorrhoids or reduce their severity.
- Eat an adequate amount of fibre. Adopt a low-fat, high-fibre diet that includes fruit, vegetables, high-fibre bread and cereals.
- Have an adequate fluid intake, which is at least two litres of water every day.
- Use a bulk stool softener or a fibre supplement, such as psyllium or methylcellulose. Several brands containing these plant-based preparations are available from pharmacies.

All these factors increase the bulk of the stool and soften it. This reduces the need to strain during a bowel motion and reduces the pressure on haemorrhoids.

If straining is eliminated, haemorrhoids are less likely to develop and protrude from the anus.

NON-SURGICAL TREATMENT

Smaller haemorrhoids can often be treated without surgery. Measures to reduce symptoms include the following:

- Have a salt bath two or three times per day for about 10 minutes. This is best done after a bowel motion and helps to reduce pain and swelling. Add a tablespoon of salt to just enough water to cover the pelvic region.
- Ice packs may reduce swelling.
- Apply a soothing haemorrhoidal cream, wipes, or suppositories (bullet-shaped tablets inserted into the anus) to reduce the size of the haemorrhoids and relieve symptoms of pain and itching.

THE DECISION TO HAVE SURGERY

The decision whether to have your haemorrhoids surgically treated should only be made after discussion with your surgeon. The decision is always yours and should not be made in a rush.

Make a decision only when you are satisfied with the information you have received and believe you have been well informed.

For most people, surgical treatment of haemorrhoids is an elective procedure; that is, surgery may be effective in improving health and well-being, but is not a life-saving or urgent procedure.

Most surgical treatments for haemorrhoids can be performed in the surgeon's office without anaesthetic.

GIVING YOUR FULL HEALTH RECORD

Your surgeon will ask you about any previous health problems. Some may interfere with surgery, anaesthesia and care after surgery.

Your surgeon needs to know your medical history to help plan the best possible treatment. Tell your surgeon if you have a history of:

- an allergy or bad reaction to antibiotics, anaesthetic drugs, or any other medicines
- recent or long-term illness, or previous surgery
- psychological distress or psychiatric illness.

Give your surgeon a list of all medications or herbal remedies you are taking or have taken recently. This includes aspirin, cough medicines, hormone replacement therapies, the contraceptive pill and warfarin.

ANAESTHESIA

Excision of small haemorrhoids may be done with or without a local anaesthetic. More complex cases may be performed under general anaesthesia or regional anaesthesia (spinal or epidural block).

If you have ever had a reaction to an anaesthetic drug, tell your surgeon. Modern anaesthesia is safe with few risks. However, a few people may have serious reactions to anaesthetic drugs.

The anaesthetist can explain more about the best anaesthetic in your case and the associated benefits and risks.

Some surgical treatments do not require any anaesthetic.

COST OF TREATMENT

Your surgeon can advise about public health insurance, private health insurance and out-of-pocket costs. You may want to ask for an estimate that lists the costs. This includes medical fees for your surgeon, anaesthetist, hospital fees, pathology costs and related items. This is best done at the first consultation with your surgeon. If you are not sure, ask for further advice. As the actual procedure may differ slightly from the proposed procedure, the final account may vary from the estimate. It is best to discuss costs before treatment rather than afterwards.

Surgical Treatment of Haemorrhoids

Haemorrhoids may be treated by one of the following surgical methods, which are considered to be minor procedures. These methods are used to shrink, destroy or remove the haemorrhoids.

Injection sclerotherapy: This treatment is most effective for small internal haemorrhoids that bleed. A chemical "sclerosant" is injected under the lining of the rectum, causing the blood vessels in the haemorrhoids to shrink and shrivel.

This is performed in the surgeon's office, without local anaesthetic, using a tube and light (anoscope) to see inside the anus. The procedure takes a few minutes. It is not painful because no pain receptors are in internal haemorrhoids.

Some bleeding may occur for a few days after the procedure, but this usually ceases. The injection procedure may have to be repeated if bleeding persists.

Rubberband ligation: This treatment is most effective for large internal haemorrhoids that bleed and prolapse. Rubberband ligation involves grasping and holding the haemorrhoid with a special instrument (or using a suction device) and simultaneously placing a rubberband around the base of the haemorrhoid.

This is performed in the surgeon's office without local anaesthetic, using a tube and light (anoscope) to see inside the anus. This procedure may need to be repeated several weeks later if bleeding and prolapse persist.

Surgical excision (haemorrhoidectomy): This is most effective for large internal haemorrhoids that prolapse and are associated with large external haemorrhoids and skin tags. Haemorrhoidectomy involves surgical removal of the internal haemorrhoid, the external haemorrhoid and associated skin. Excision may be performed with scalpel, scissors, diathermy or another form of surgical coagulation. The subsequent wound is either left open to heal or is sutured closed.

The procedure is performed in a hospital or day-surgery facility. It often requires a general anaesthetic and a short stay in hospital. As external haemorrhoids and skin tags are covered by skin, the operation can cause significant postoperative pain for two to four weeks. This can be managed with pain relief medication.

Thrombosed external haemorrhoids are most effectively treated by surgical excision (haemorrhoidectomy). This may be performed under local anaesthetic either in the surgeon's office, hospital or day surgery facility. Simple cutting of the thrombosed external haemorrhoid and removal of the clot may relieve pain in the short-term, but this form of treatment is not always definitive.

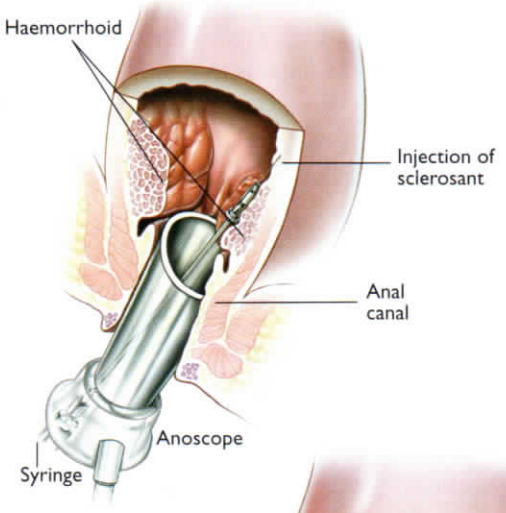
Stapled haemorrhoidectomy: This is effective for prolapsing internal haemorrhoids and fleshy external haemorrhoids. It is a relatively new technique, and surgeons are still evaluating its effectiveness.

Treatment involves insertion of a disposable circular stapler into the rectum through the anus. The stapler simultaneously cuts out a cylinder of the lining of the rectum (rectal mucosa) and joins the remaining circles of tissue together with a ring of titanium staples.

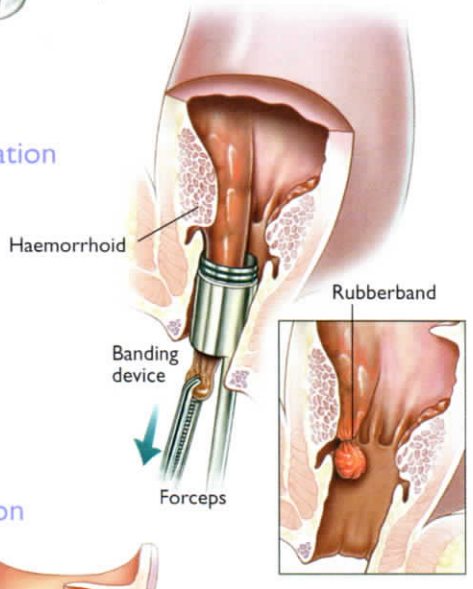
This is effective in treating internal and external haemorrhoids by cutting off the blood supply to the blood vessels of the haemorrhoidal tissue. As the tissue removed is in the rectum (which has few pain receptors) with no external wound, the procedure is less painful than surgical excision. Skin tags may need to be removed simultaneously by surgical excision.

The procedure is performed under general anaesthesia in a hospital or day-surgery facility. The patient is usually discharged the following day.

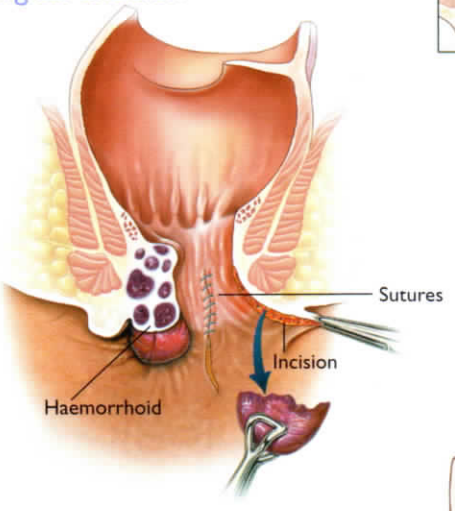
Injection sclerotherapy



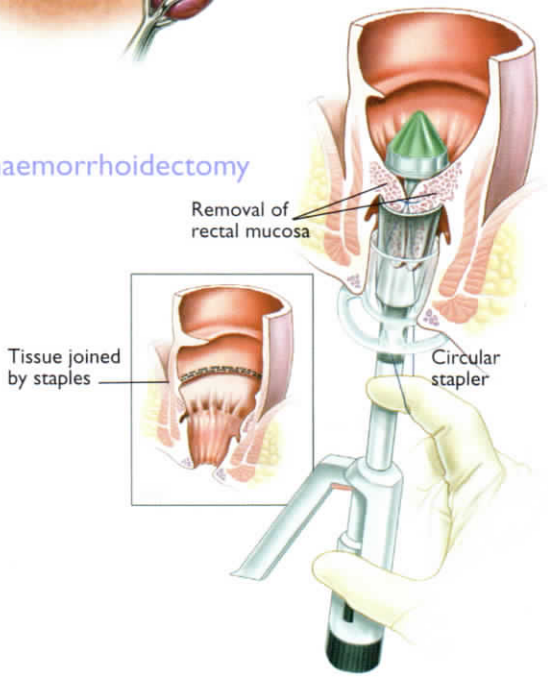
Rubberband ligation



Surgical excision



Stapled haemorrhoidectomy



■ Injection sclerotherapy – This is relatively painless, but a dull ache may be noticed afterwards. You can resume normal activity and diet immediately after the procedure. A follow-up visit may not be necessary.

■ Rubberband ligation – This may cause mild ache. Rest with your feet elevated. Use a stool softener immediately after the procedure. Mild bleeding may occur for a few days after treatment and when the haemorrhoid falls off, about five to 10 days after surgery. If bleeding occurs you may need to wear a pad. Suitable pads are panty liners, available from a pharmacy. Provided there is no pain, normal activity may be resumed a day or two after treatment. The surgeon will want to review you two weeks or so after treatment.

■ Surgical excision – After surgical excision, the hospital stay will be two to three days. Pain can last for four weeks and requires painkiller. Bleeding from the anus is common and may persist for a few days. It may be necessary to wear a pad for about a week as discharge from the healing wound can occur. No sutures need to be removed because they will dissolve. For three to four days after haemorrhoidectomy, continue to use a laxative or bulking agent to ensure that your bowels open. It is best to have a bowel motion before leaving hospital.

If you have not had a bowel motion by the third day after surgery, a mild enema may be given. A warm salts bath or shower taken after each bowel motion, or when you are in pain, may reduce discomfort and spasm of the anal area. Try to avoid using toilet paper in the two days or so following haemorrhoidectomy; this is when salt baths are especially useful. If it is not possible to wash the area after the bowels open, then moist cotton wool or baby wipes should be used gently to clean the anus. Dry cotton wool can be used in a gentle, patting action to dry the area. Within a few weeks, most patients have returned to normal daily activities. The surgeon will review you about two to three weeks after surgery. Often this is the only follow-up necessary.

■ Stapled haemorrhoidectomy – There may be slight bleeding following surgery. Pain usually lasts for one to two weeks. Most people return to normal activities in one to two weeks.

■ General advice – After any of these surgical procedures, arrange to have a friend or relative to take you home. After a general anaesthetic, do not drive, operate heavy machinery, drink alcohol or make important decisions within the next 24 hours, and sometimes longer if your recovery is slow. Pain usually settles quickly when a pain reliever containing codeine or paracetamol is taken. Should the pain persist, contact your surgeon. Successful treatment does not ensure against the recurrence of haemorrhoids. If you adopt a healthy low-fat high-fibre eating plan, exercise regularly and drink adequate volumes of fluid, the risk is minimal that haemorrhoids will return.

RISKS OF SURGERY

Rubber band ligation, injection sclerotherapy, haemorrhoidectomy and stapled haemorrhoidectomy are generally safe procedures, but do have some risks.

Despite the highest standards of surgery, complications can occur. It is not usual for a surgeon to outline every possible complication of a procedure. However, it is important that you have enough information about possible complications to fully weigh up the benefits, risks and limitations of surgery. If you have concerns about complications, discuss them with your surgeon. It may help to write a list of issues and questions to ask your surgeon.

The following possible complications are listed to inform you, not to alarm you. There may be other possible complications and side effects that are not listed.

General risks of surgery

- Wound infection may require treatment with antibiotics and can delay healing.
- A chest infection may develop after general anaesthesia.
- Sore throat, caused by the breathing tube used during general anaesthesia, can last for a few days.

Risks of injection sclerotherapy

- Occasionally, pain from an injection or bleeding from the puncture site.
- Rarely, urinary tract infection.
- Impotence in the male has been reported following damage to nerves near the prostate gland, but this is very rare.
- Rarely, the sclerosant causes an inflammatory response, with pain and fever.

Risks of rubberband ligation

- Any pain is usually mild, lasting for an hour or two. In some patients, pain can be severe. For some cases, the surgeon may need to remove the rubberband, and this can require a general anaesthetic.
- About 10 days after treatment, when the haemorrhoid separates from the anal canal, a small artery at the line of separation may start to bleed. Rarely, this bleeding may be severe, requiring admission to hospital and a blood transfusion.
- Rarely, pelvic infection; this can be life threatening and requires immediate treatment.

Risks of surgical excision

- Uncommonly, retention of urine.
- Rarely, sepsis (infection of the blood) may develop and lead to bleeding into the rectum about 10 days after surgery. This condition can be life threatening and requires immediate treatment.
- Anal fissure (anal ulcer) is a rare complication that may result from failure of one of the haemorrhoidectomy wounds to heal. Usually the wound heals well, provided the stools are kept soft.
- New skin tags may form after a haemorrhoidectomy. They are rarely painful but may occasionally bleed. More commonly, they make cleaning the anus difficult and may itch.

Risks of stapled haemorrhoidectomy

The risks for this procedure are similar to surgical excision. In addition:

- The technique may be more prone to causing bleeding after surgery.
- Pain as a consequence of the technique may be a long-term problem.

REPORT TO YOUR SURGEON

Tell your surgeon at once if you have any of these unexpected side effects:

- severe pain
- difficulty in urinating
- severe unexpected rectal bleeding, or passing of blood clots
- fever greater than 38°C or chills
- a general feeling of being unwell
- weakness or dizziness
- persistence of haemorrhoidal symptoms
- any other concerns you may have about the surgery.

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