Corridor Consult

Hemorrhoids: Modern Remedies for an Ancient Disease

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Introduction

A patient arrives at your office with a chief complaint of hemorrhoids. Is it really hemorrhoids, or is it something else? How are hemorrhoids best treated? And when should you send the patient to see a surgeon?

Hemorrhoids have plagued humankind since ancient times and might have even influenced world history. The emperor of France, Napoleon Bonaparte, suffered from hemorrhoidal disease. On the day of the decisive battle at Waterloo, Napoleon was in pain because of a severe case of thrombosed hemorrhoids, which impaired his battlefield conduct.[1] Today hemorrhoids remain the most common anorectal disorder and are frequently seen in primary care clinics, emergency wards, gastroenterology units, and surgical clinics.[1–4] More than half of all people will at some point develop symptomatic hemorrhoids. However, half of those seeking care for hemorrhoids may in fact have another disorder, such as fissure, anal abrasion or irritation, or a skin tag.

Table 1. Hemorrhoidal symptoms

Internal	External
Prolapse and mucus discharge	Burning
Bleeding	Pain (if thrombosed)
Discomfort	Difficulty with hygiene
Difficulty with hygiene	Itching
Itching	

Pathophysiology and Presentation

Hemorrhoids are vascular cushions in the lower rectum and anus. The role of hemorrhoids is not entirely clear, but it has been proposed that they contribute to sensation and continence. There are two types of hemorrhoids: internal and external. Internal hemorrhoids are inside the anal canal and are covered by anal mucosa. In most patients, one can identify three columns of hemorrhoids, two on the right and one on the left. However, several variations exist, and some patients have more than three bundles. External hemorrhoids occupy the inferior aspect of the anal canal and are covered by anoderm and skin. External hemorrhoids can be present in one or more quadrants or can be circumferential.

The exact cause of hemorrhoids is unknown. Several contributing factors have been implicated, including the upright posture of humans, aging, pregnancy, heredity, constipation or chronic diarrhea, and spending excessive periods of time on the toilet (ie, reading, straining).

Patients often complain, "Doc, I have hemorrhoids," equating any anorectal symptoms with hemorrhoidal disease, including bleeding, lumps, masses, and pain. It is important to keep in mind that although hemorrhoids are common, the differential diagnoses for anorectal disorders include dermatologic diseases such as pruritus ani, abscess and fistula, fissure, sexually transmitted diseases, warts, HIV, atypical infections such as tuberculosis, inflammatory ulcers such as Crohn's disease, and malignancy. The symptoms of internal and external hemorrhoids are summarized in Table 1. Although severe anal pain is often attributed to hemorrhoids, they are rarely the cause. In the absence of visible, thrombosed external hemorrhoids (blood clot and swelling), severe pain is frequently secondary to anal fissure, not an internal hemorrhoid. Table 2 presents other causes of severe anal pain.

Evaluation and Management

The medical history should include the duration and nature of the symptoms, bowel habits, comorbid conditions, prior abdominal or anal surgeries, medications including nonsteroidal anti-inflammatory drugs (NSAIDS) and anticoagulants, prior endoscopic examination, and family history of gastrointestinal disorders. The physical examination should include visual inspection of


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Table 2. Possible causes of severe anal pain
Thrombosed external hemorrhoids
Anal fissure
Anal abscess
Acute herpetic ulceration or other sexually transmitted diseases
Crohn's ulceration and inflammation
Anal, rectal, or pelvic cancer
Lymphoma or leukemia

the anal region, digital examination, and anoscopy. Patients younger than age 50 years should undergo a flexible sigmoidoscopy, especially if bleeding is a presenting complaint. Colonoscopy is recommended for patients older than age 50 years, patients of any age with bleeding and anemia, those with persistent bleeding despite medical therapy, select patients with significant family history of colorectal malignancy, and patients with other symptoms such as abdominal pain and bloating and diarrhea.

Contrary to popular belief, not all hemorrhoids require treatment. Treatment should be reserved for symptomatic hemorrhoids only. It is important to reassure patients that hemorrhoids are part of normal anatomy and to dispel myths such as "if they are left alone, they will turn into cancer" or "hemorrhoids are blocking my anus." Treatment is not based on hemorrhoid size or aesthetic appearance.

The cornerstone of conservative management is avoidance of constipation and hard stool. Dietary modification with an emphasis on increasing fiber consumption is crucial. The diet of the average American contains 10-15 grams per day. For treatment of hemorrhoids, the recommendation is 30-35 grams of daily fiber. Dietary sources include beans, fruits, vegetables, and whole grains. Dried figs, prunes, blackberries, boysenberries, raspberries, pears, chickpeas, kidney and pinto beans, lentils, brown rice, and oat bran cereals have a high fiber content. Numerous fiber supplements are available (Table 3). Most fiber products are bulking agents that soften the stool by absorbing water. Psyllium is a natural source of pure fiber, sold in powder form from the husks of seeds from the psyllium plant. Patients who are unable to tolerate psyllium-based products because of excessive gas or bloating can try FiberCon or Benefiber. Patients should be advised to increase fiber supplementation gradually and in conjunction with adequate fluid intake (six to eight glasses of a noncaffeinated beverage daily) and increase in daily activity so as to avoid constipation. To promote patients' compliance with fiber supplementation, it is important to explain the other health benefits of fiber, such as decreasing the incidence of colon cancer and diverticular disease, controlling blood cholesterol levels, improving control of diabetes, and aiding in weight control.

Behavioral modification, such as avoidance of prolonged sitting on the toilet, reading while defecating, and excessive straining can alleviate some of the symptoms. Sitz baths (warm water, ten minutes, twice a day, no additives in the water) are helpful to patients with anal itching, aching, or burning and those with thrombosed hemorrhoids.[5] Numerous over-the-counter creams and products are available, but most are ineffective or provide little relief. Many patients will benefit from zinc oxide cream or Calmoseptine, which is available over the counter, applied as needed once or twice a day inside and outside the anus. Short courses of hydrocortisone 1%/pramoxine hydrochloride 1% (local anesthetic) cream or 25-mg hydrocortisone suppositories once or twice a day can be helpful.

Patients with bleeding and prolapsing internal hemorrhoids refractory to conservative treatment can undergo ablation. Several office-based procedures are available, including injection sclerotherapy, infrared coagulation, and rubber-band ligation. All procedures accomplish shrinkage and scarring of the internal hemorrhoids. Rubber-band ligation has been the most effective of these modalities. Patients should refrain from taking NSAIDS or anticoagulation for one week prior to and one week after rubber-band ligation to minimize the risk of bleeding. At the initial office visit, it is preferable to ligate one hemorrhoid; if the procedure is well tolerated, the patient can undergo multiple ligations at subsequent visits. The procedure should be relatively painless as long as the internal hemorrhoid is ligated above the dentate line. If the patient experiences sharp or severe pain when the bundle is grasped, then a different hemorrhoid should be tried; if pain persists, the procedure should be abandoned. It is our practice to ligate the hemorrhoid that looks most inflamed or irritated at time of the visit. Some patients have a vasovagal reaction immediately after the proce-

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Table 3. Fiber products		
Type of fiber	**Trade name**	**Fiber content**
Psyllium	Metamucil	3.4 g/teaspoon 0.5 g/capsule
	Konsyl	6.0 g/teaspoon 0.5 g/capsule
Methylcellulose	Citrucel	2 g/teaspoon 0.5 g/caplet
Calcium polycarbophil	FiberCon	0.5 g/caplet
Guar gum	Benefiber	3 g/tablespoon 1 g/tablet 0.5 g/caplet

dure, so care must be taken to gradually get the patient off the procedure table. Patients are instructed to take Tylenol and use sitz baths as needed for the dull ache after ligation that usually lasts for 24 to 48 hours. Although ligation is a safe procedure, severe bleeding and sepsis have been reported to result in some patients. Patients should seek immediate care if any of the following symptoms develop: fever, chills, abdominal or pelvic pain, continuous rectal bleeding, purulent anal drainage, and urinary retention. The rubber band can fall off soon after the procedure or up to three weeks later. Patients can usually return to work or normal daily activities after the procedure. They are usually seen back in the office three to four weeks later.

Surgical intervention for hemorrhoids is less frequently undertaken today than in the past.

When Should the Patient See a Surgeon?

Most of the time, hemorrhoidal disease will respond to conservative measures as long as the patient complies with the prescribed regimen. Surgical intervention for hemorrhoids is less frequently undertaken today than in the past.

Surgery can be considered in patients with incarcerated and gangrenous hemorrhoids (a rare condition), acutely thrombosed external hemorrhoids, or recurrent or chronic symptomatic external hemorrhoids; in those in whom conservative management, rubber-band ligation, or both failed; and in those who have heavy bleeding with anemia. Surgery can be considered also for some patients taking anticoagulants over the long term who have bleeding hemorrhoids refractory to medical therapy. Surgery in this latter group can relieve the problem with one intervention, alleviating the need to disrupt anticoagulation multiple times for several sessions of rubber-band ligation.

Conclusion

Hemorrhoids are common, affecting millions of Americans. It is important to distinguish this disease from other anorectal diseases. Avoidance of constipation is key in treating hemorrhoids. Most patients can be effectively treated with fiber supplementation and local ointments. Surgical intervention is now less frequently undertaken than in the past but can be considered for patients with acute complications of hemorrhoidal disease or those in whom conservative treatment has failed. ❖

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Suggested Reading

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Suffering

People have a hard time letting go of their suffering.
Out of a fear of the unknown, they prefer suffering that is familiar.

— Thick Nhat Hanh, b 1926, Vietnamese activist, writer and Buddhist monk