

# PRESENTATION AND MANAGEMENT OUTCOME OF SYMPTOMATIC HAEMORRHOIDS

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## ABSTRACT

**Background:** Haemorrhoids is one of the most common anorectal condition, which involved human beings both in ancient and recent times. **Objective:** The study was conducted to describe clinical profile and management outcome of symptomatic haemorrhoids. **Patients and methods:** A total of 405 patients of symptomatic haemorrhoids were included from outdoor and indoor department. Conservatively managed patients of grade I were 150 while for others open haemorrhoidectomy was performed. This descriptive study was planned to assess the outcome at week one and six and complications for one year. **Result:** Our results showed that majority of the patients has multiple symptoms. 75% of the conservatively managed patients of grade I were cured. Among grade II, 80% responded to treatment within one week, whereas, 88% of grade III responded in one week, 81% of grade IV responded in 1<sup>st</sup> week. It was noted that up to 10% of grade II, 26% of grade III and 38% of grade IV had complications. **Conclusion:** It is concluded that majority of the patients present with multiple symptoms, however, carefully categorized and subsequently managed patients has good outcome and minimum complications. All surgeons should tailor the treatment of haemorrhoids based on understanding of the indication and complications associated with the procedure.

**Key words:** Haemorrhoid, clinical features, management.

## INTRODUCTION

Haemorrhoids is one of the most common anorectal conditions.<sup>1</sup> It has involved human beings in ancient times and might have even influenced world history.<sup>2</sup> It is common in both developing and developed countries. Exact incidence is difficult to determine because many people are reluctant to seek medical advice due to various personal, cultural and socioeconomic reasons.<sup>3</sup> Estimate of the proportion of the U.K population affected ranges from 2.4%-4.4%<sup>5</sup> while more than fifteen million people are affected in USA each year.<sup>4,5</sup>

Haemorrhoids are vascular cushions and due to constant straining during the passage of hard faecal stool which deranges the muscles connective tissue support ultimately results into prolapse.<sup>6</sup> According to Golighar Classification System, it is graded as:

Grade I: haemorrhoid non prolapsing, Grade II: haemorrhoid prolapse on straining but reduced spontaneously, Grade III: haemorrhoid required

manual reduction, Grade IV: haemorrhoid non reducible. The management of haemorrhoids depend upon grade of the haemorrhoids which includes conservative and surgical, with chances of recurrence and other complications. The objective of our study was to describe, the clinical profiles and management outcome of symptomatic haemorrhoids.

## PATIENTS AND METHODS

All the patients having symptomatic haemorrhoids were included in this descriptive study. All the patients having DM, hypertension and any other chronic condition were excluded. The outcome was assessed at 1<sup>st</sup> week and 6<sup>th</sup> week and good outcome was labelled when symptoms were subsided at 1<sup>st</sup> and 6<sup>th</sup> week. Post operative complications were noted such as recurrence, bleeding, pain and tenosus.

Detailed history of age, sex, mode of presentation, past history of any intervention, detailed examination (digital/proctoscopy) was carried out. 200 cases with first degree haemorrhoid were managed conservatively. They were advised to avoid constipation and hard stools. Dietary modifications with instruction of use of fibres. Sitz bath (warm water 10 minutes twice a day), no additive in water, avoids anal itching, aching and burning. Local ointments (zinc oxide, calomoseptine or steroids) were also prescribed. Fifty cases of grade I who did not responded to conservative treatment were

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admitted and operated upon. The majority (200) of our patients belonged to grade II, 34 belonged to grade III whereas, 21 to grade IV haemorrhoids.

All patients of grade II and above were thoroughly prepared for operation. Among patients above 40 years of age colonoscopy and sigmoidoscopy were also performed to find out any colonic disease above the haemorrhoids.

All patients were given preoperative antibiotics prophylaxis. Open haemorrhoidectomy (Milligan and Morgan) was performed under spinal anaesthesia. Operating time was 20-25 minutes. After surgery packing was done and pack was removed after one day when they were advised sitz bath and oral laxatives. All patients were followed up after every week for 6 weeks. Next 6 months they were examined monthly and after that every two months up to one year.

## RESULTS

Majority of the patients has more than one symptoms such as, bleeding (84%), constipation (54.6%), self reduction (50.9%), prolapse (34.5%), burning (9.8%) and itching (5.4%).

Among the 200 cases of grade I haemorrhoids, 150 improved while 50 did not responded to conservative treatment and were further managed according to grade II/III haemorrhoids.

Out of 200 cases of grade II, 120 were male and 80 % had very good outcome in first week, 15% improved in next 2-6 week time while 4 % patients of second degree haemorrhoids, complained of itching burning without any visible residual recurrence on proctoscopy when performed post operatively, 10% of the patients developed recurrence of the disease for which their detailed history, examination, proctoscopy and colonoscopy was carried out and complete cure occurred after re-do surgical intervention. In third degree haemorrhoid 26 were male, 88.2% got tremendous immediate relief in their symptoms in first week, 8.8% improved in next 2-6 weeks. Only 2.9% patients were not satisfied even after 6 weeks of constant monitoring but clinically and endoscopically they did not have any pathology, however, their tenosus was not subsiding.

Among 4<sup>th</sup> degree, 14 were male, 81 % patients improved in the first week, 10% showed

improvement of their initial symptoms' in 2-6 weeks, 5% patients developed recurrent mass, visible even after surgical intervention. They were reinvestigated to find out the underlying pathology which was treated. Their symptoms subsided on medication but they recurred when medication was stopped. Outcome and postoperative complications of patients are shown in table I.

**Table I: Treatment outcome among patients of grade II, III and IV haemorrhoids.**

Haemorrhoids grades	Patients (total)	Good Outcome			Post-Operative Complications			
		1st week	2 <sup>nd</sup> -6 <sup>th</sup> week	>6 weeks	Recurrence in 1 year	Tenosus	Bleeding	Pain
Grade II	200	160(80%)	30(15%)	8(4%)	20(10%)	17 (8.5%)	18(9%)	20(10%)
Grade III	34	30 (88%)	3(8.8%)	1(2.9%)	8(23.5%)	5(14%)	9(26%)	5(14%)
Grade IV	21	17 (81%)	2(10%)	1(5%)	7(33%)	8(38%)	8(38%)	4(19%)
<b>Total</b>	<b>255</b>	<b>207(81%)</b>	<b>35(13.7%)</b>	<b>10(3.9%)</b>	<b>35 (13.7%)</b>	<b>30 (11.7%)</b>	<b>35(13.7%)</b>	<b>29(11.3%)</b>

## DISCUSSION

Haemorrhoids are physiologic and represent a part of anal sphincter system however non physiologic enlargement and displacement of this anorectal plexus together with symptoms must be considered a disease.<sup>6</sup> It is quite common in all age groups but the predominant age group was between 45 to 65 years. In our study the ratio between male and female was 1.6:1 whereas, age range was 20-60 year as it was reported in another study.<sup>7</sup>

They all presented with multiple symptoms including bleeding, prolapse, constipation, and discharge with itching. First degree haemorrhoid which are managed conservatively and respond to stool softener and do not experience any change in their routine and lifestyle and usually get good results without any serious complications.<sup>8</sup> Patients should be advised to increase fibre supplementation gradually in conjunction with adequate fluid intake of a non-caffeinated beverage daily and increase daily activity to avoid constipation, behavioural modification such as avoidance of prolonged sitting on toilet, reading while defecation and excessive straining.<sup>2</sup> Similarly second degree haemorrhoids are more common than third degree haemorrhoids whereas Bernarl J et al reported second degree haemorrhoid in 51.43 % and third degree haemorrhoids 29.83% respectively.<sup>9</sup> While in our case 2<sup>nd</sup> degree were 78.4%, 3<sup>rd</sup> degrees 13.3% and 4<sup>th</sup> degree, 8.3%.

According to Ali U et al, 90% patients presented with

bleeding per rectum, while 80% of the patients had prolapse, 10% of them had burning while 55 % complained of itching. Majority (80%) patients had constipation. Self-reduction of mass out of anal verge was noted in 60 %.<sup>10</sup> While our study showed bleeding 84%, constipation 59.6%, prolapse in 34.5% of patients.

In third and 4<sup>th</sup> degree haemorrhoids there are many chances of the engorgement of the distended vessel and during acute swelling of these vessels blood may pool and consequently clot and thus pain and bleeding may lead to an emergency medical care. Symptoms may last up to 4 weeks. Surgeons hesitate to perform a haemorrhoidectomy due to risk of delayed bleeding, anal stenosis but surgical treatment can be a good choice of appropriate presentation of mucosal wall and an adequate skin bridge are guaranteed to minimise the predictable complications.<sup>10,11</sup>

Based on a recent study which reported that surgical excision was the most effective for treating early symptoms than drug therapy, early surgical exercise is now considered to be helpful for treating severely thrombosed external haemorrhoids.<sup>12</sup> Still advanced and additional studies are required in the future for analysing long term haemorrhoid recurrence.<sup>13,14</sup> According to several studies surgical intervention still carries a good reputation with a risk of recurrence where an additional surgery was required.<sup>15,16</sup>

The haemorrhoidectomy is the most fundamental treatment method and has been used for long period. It is a good method to estimate the pathophysiological factor of haemorrhoids but has the disadvantage of having an approximately 10% post-operative complications.<sup>17</sup> In our study 11.7% of patients suffered from tenosus which was higher than the frequency reported in another study.<sup>18</sup> The conventional haemorrhoidectomy is accepted as a gold standard treatment by most surgeons however, it is important to combine appropriate number, width, height of haemorrhoids to excise by considering the flexibility of the anus and avoid excision of anal epithelial layer because excision of haemorrhoid to prevent recurrence may lead to a complication such as anal stricture or secondary bleeding.<sup>19</sup> There is always a possibility of revascularization and recurrence of the symptoms of haemorrhoids but this procedure can be repeated at any time.<sup>20</sup> In

a study which was done after one year of surgery, recurrence including rebleeding was observed in 13.7 % cases which was higher than other studies conducted in this respect.<sup>21-25</sup> The cause of persistent anal pain remains uncertain.<sup>26</sup> While Cheetham et al blamed the presence of retained smooth muscle in the doughnut to the persistent pain.<sup>27</sup>

## CONCLUSION

It is concluded that majority of the patients present with multiple symptoms and carefully categorized and subsequently managed patients has good outcome and minimum complications. Surgeons should tailor the treatment of haemorrhoids based on the indication and complications associated with the procedure.

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