

Approach to Patients with Hemorrhoids at Our Tertiary Care Centre

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Abstract

Haemorrhoids is considered to be one of the most common surgical condition nowadays. Its prevalence is 4.4% i.e. 10 million world population. The purpose of this study is to observe outcomes of various procedures and conservative management in patients respective to their grades of haemorrhoids. In our setup we used dietary and lifestyle modification, Medications (Topical/Systemic) stapled haemorrhoidopexy, Milligan Morgan Hemorrhoidectomy.

Keywords: Haemorrhoids, Treatment, Outcomes, Complications.

Introduction

Haima (bleed) + Rhoos (Flowering) are the greek words for origin of word Haemorrhoids which means bleeding from flowered like structure. 'Pila' is the word of origin for Piles in latin vocabulary⁽¹⁾. Haemorrhoids are normal Vascular tissue within the submucosa located in anal canal⁽²⁾. Displacement or enlargement of anal cushions results to development of haemorrhoids. Anal Cushions normally resides in left lateral, right anterolateral, right posterolateral and are aggregation of blood vessels (arterioles, venules), smooth muscles and elastic connective tissue in submucosa⁽³⁾. Many people have features of piles on proctoscopy but may or may not have symptoms so exact prevalence of haemorrhoids is difficult to evaluate. Sometimes patient with portal hypertension develop per rectal bleeding but that is due to rectal varices and not to be confused with haemorrhoids (4). They can be mucosal or vascular. Vascular type is seen in young whereas mucosal in old age people.

Present concept is weakening of Park's ligament which is lower end of external sphincter. Basically, there are 2 types- 1) Internal- Above dentate line, covered with mucous membrane. 2) External- below dentate line, covered with skin. Other way of classification is 1) Primary- located at 3,7,11'0 clock position related to branches of superior hemorrhoidal vessel which divides into 2 branches on right and 1 on left side. 2) Secondary- one which occurs between primary sites.

Grades of haemorrhoids- Grade 1- Piles bleed but doesn't come out. Grade 2- Piles that prolapse during defecation but returns back on its own. Grade 3- Piles that prolapse on defecation and can be replaced back manually. Grade 4- Piles that are permanently prolapse. Specific considerations like acutely thrombosed or strangulated internal haemorrhoids, acutely thrombosed external piles, Pregnancy induced piles, various underlying liver disorders like portal hypertension and cirrhosis, patients on various anticoagulants and antiplatelets medications.

Modes of treatment used are- 1) Dietary and Lifestyle modifications which includes high fibrediet, increase oral fluid intake, and also avoid constipation and cough, Warm Sits bath with anal region dipped in water for 20 minutes, 2-3 times a day 2) Medical Management includes topical application to reduce pain, oedema, itching. Oral Antibiotics, Laxatives, NSAIDs are also used. 3) Stapled Haemorrhoidopexy (Antonio Longo)-

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circumferential excision of mucosa and submucosa 4 cm above dentate line using circular Haemorrhoidal stapler passed per anally (MIPH- Minimally Invasive procedure for haemorrhoids) which is less painful, less blood loss, faster recovery, short hospital stay and equally efficacious. Ring formed as a result of staplers restores the downward displaced tissue back to its place and thus both anatomical and functional integrity is maintained.⁽⁵⁾ But it need advanced surgical skill experience, costlier, may cause full thickness excision of rectal wall, may injure anal sphincter and improper purstring can cause incomplete doughnut leading to severe haemorrhage and it is contraindicated in associated anorectal diseases like fissure, fistula in ano.

4) Milligan Morgan Open Hemorrhoidectomy which involves ligation and excision of piles and anal mucosa and skin is left open to heal by second intention. Some RCTs and meta-analyses stated that this method is best for patients with recurrent symptoms of grade 3 and 4 Hemorrhoids⁽⁶⁾. It is also recommended in patients with mixed grades of hemorrhoids and for patients in whom other treatments failed.⁽⁷⁾⁽⁸⁾

Perianal pain while defecation, muscular or sphincter injury, per rectal bleeding, recurrence, bleeding or painful anal fissure, faecal incontinence can occur as post operative complications.

Materials and Method

The study is prospective study conducted at Dhiraj general Hospital of 100 patients of haemorrhoids fitting into this study requirements according to inclusion and exclusion criteria.

Inclusion Criteria:

1. Patients above 16 years of age of either sex.
2. Suffering from any Grade of Haemorrhoids.
3. Fit for Anesthesia if planned for Surgical Intervention.
4. Patients available for follow up

Exclusion Criteria:

1. Cases with active Per anal wound infection.
2. Mentally ill patients/any cognitive impairment.

Observation and Results

	Grade 1	Grade 2	Grade 3	Grade 4	Specific considerations
M1	Yes	Yes	Yes	Yes	Yes
M2	Yes	Yes			
M3		Yes	Yes	Yes	
M4		Yes	Yes	Yes	Yes

M1- Dietary and lifestyle modifications, M2- Medical Management, M3- Stapled Haemorrhoidopexy, M4- Milligan Morgan Hemorrhoidectomy



Figure 1: Showing prolapsed hemorrhoids



Figure 2: Showing hemorrhoidal stapler used for stapler haemorrhoidopexy

Conclusion

1. Dietary and lifestyle modification is necessary and helpful for all grades and specific considerations.
2. Medical management is useful for only Grade 1 and 2
3. Stapler and Milligan Morgan both are useful in Grade 2,3,4.
4. Only Milligan Morgan Hemorrhoidectomy is useful in Specific considerations.

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