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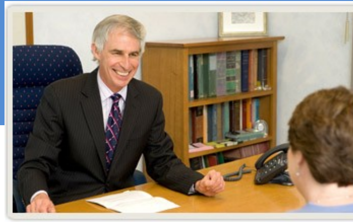

Haemorrhoids

1. DEFINITION

Haemorrhoids are enlarged veins within the anal canal. The term is derived from two Greek words indicating "blood vessels".

2. ANATOMY

The normal anatomy of the anal canal includes small venous "cushions", lying within the anal columns immediately above the Dentate line, 3 to 4cm from the anal verge. These cushions form part of the fine continence mechanism.

Enlargement of the veins leads to haemorrhoids. These should be regarded more as an extension of "normality", rather than a disease entity.

3. PATHOLOGY

Classified into first, second and third degree according to the size and extent of prolapse from the anal verge. Prolapsed, thrombosed, strangulated haemorrhoids represent "complicated" haemorrhoids and present clinically with severe pain.

4. AETIOLOGY

Multifactorial, including genetics, age, past pregnancies and irregularity of bowel function.

5. MANAGEMENT OF HAEMORRHOIDS

This indicates confirmation of the diagnosis and treatment. In the event of bleeding two principles apply:
1. Exclude a more proximal cause for the bleeding, eg. polyps, inflammatory bowel disease or malignancy. A colonoscopy may be required.
2. Perform the least possible medical intervention, as haemorrhoids are not regarded as a disease process.
The diagnosis is confirmed by clinical examination plus/minus proctoscopy.

6. TREATMENT

CONSERVATIVE THERAPY

Directed to regulation of the bowel pattern and topical applications.

INJECTION SCLEROTHERAPY

An Out-patient procedure often performed simultaneously with a colonoscopy. The intention is to reduce bleeding and prolapse of the haemorrhoids. The treatment is safe, essentially painless, and effective, but certainly not curative.

HAEMORRHOIDS (CONT.)

RUBBER BAND LIGATION

Effective in minor prolapse. Often performed at a colonoscopy. The banding is performed above the Dentate line, (i.e. the level of sensation), and is therefore associated only with transient discomfort.

HAEMORRHOIDECTOMY

Reserved for large, third degree haemorrhoids. A “definitive” yet “limited” surgical procedure is performed with two intentions: to resolve the problem in the longterm and secondly to minimise the post-operative recovery period. Nevertheless, the recovery requires two to three days in hospital and seven to nine days away from work. A “stapled” haemorrhoidectomy may be feasible in cases of lesser prolapse.

Dr Currer has a personal experience in over 2000 haemorrhoidectomies during a twenty-three year period, and in appropriate cases will discuss the surgery, pre-operative precautions and the post-operative course in full.

7. SUMMARY

Haemorrhoids are extension of the normal anatomy of the anal canal. The treatment should be “minimalist” in approach. A colonoscopy may be required in the event of bleeding to exclude significant colorectal disease.