What Are Hemorrhoids?

Hemorrhoids are cushions of tissue composed of blood vessels and smooth muscle. Hemorrhoids may aid in the process of having a bowel movement. Everyone has hemorrhoids. Many people do not have symptoms from them. Treatment is indicated only when symptoms occur.

When the smooth muscle within the hemorrhoids breaks down, the hemorrhoids can be exposed to the sheer forces in the anal canal. This may result in bright red bleeding, prolapse of hemorrhoids out the anus, discomfort and pruritus (itching). It is important to know that there may be other explanations for anorectal itching and these symptoms may persist after surgical removal of the hemorrhoids.

It is also important to know that symptoms attributed to hemorrhoids may be caused by other benign anorectal diseases, as well as benign or malignant tumors. Depending on your presentation, your doctor may suggest that you undergo a colonoscopy to further investigate this.

Symptoms of bleeding and prolapse are typical of internal hemorrhoids. External hemorrhoids (those at the level of the anal opening) can swell or form blood clots within them and cause pain. Many people have a combination of internal and external hemorrhoids.

AT THE TIME OF YOUR VISIT

When the colorectal specialist sees you, you will be asked several questions with respect to your history. An examination of your anal canal and rectum will likely be conducted during your visit, unless this causes too much discomfort. The exam itself usually causes little discomfort and usually much less than the patient anticipates. Visualization of the outer anal skin is followed by a digital/rectal examination performed with a well lubricated gloved finger. An anoscopy exam is next which involves inserting a small tube to better view the anal canal and lower rectum. This may be followed by a proctosigmoidoscopy, which involves placing a lighted scope into the rectum and lowermost colon. If you have acute pain from hemorrhoidal thrombosis (blood clot) or if you have pain from a cause other than hemorrhoids, part of the examination may be deleted to limit the amount of discomfort that you experience.
TREATMENT OPTIONS

1) Fiber Supplements and Fluids:
You may be asked to take a fiber supplement, which is usually first-line therapy for hemorrhoids. Fiber supplements include Metamucil, Citrucel Fiber Con, and Benefiber. These are bulk laxatives, which is a bit of a misnomer. These agents may resolve constipation, but are also given to some patients with diarrhea to bulk up the stools. Many patients are under the false impression that they are going to have more frequent bowel movements when taking bulk laxatives. Fiber supplements may give bulky bowel movements that are easy to pass and require less straining. Bulking agents may be beneficial even in those patients who have no problems with their bowel movements. It is important to take fiber supplements with plenty of water and/or other fluids. Drinking plenty of water helps avoid constipation that may worsen symptoms from hemorrhoids. In addition, patients with hemorrhoids should avoid straining and spending too much time on the toilet. This is not the place to get reading done.

Depending on your symptoms, in addition to bulking agents you may be asked to do warm tub or sitz baths for discomfort. Warm water works quite well and no additives are necessary.

2) Hemorrhoidal Banding
Should your symptoms persist despite adequate fiber supplementation and if your hemorrhoids are only internal, you may be a candidate for hemorrhoidal banding. This is an office procedure, which involves placing the internal hemorrhoid within the barrel of an instrument, which then places a rubber band over the hemorrhoid. The rubber band strangulates the hemorrhoidal tissue that then sloughs in 48-72 hours, leaving a raw surface which gradually heals.

There are several important points to know regarding rubber band ligation. The first is that it is only for internal hemorrhoids. Internal hemorrhoids lack pain fibers and therefore, the procedure is tolerated very well in this situation. External hemorrhoids cannot be banded, as they are richly innervated with pain fibers. This is a procedure performed in the office and usually causes little or no pain. Most people do not require pain medication, though sometimes one may feel an urge to strain and have a bowel movement. You are advised not to strain excessively. Banding does not remove all the hemorrhoids. It is a procedure that, short of surgery, may remove enough hemorrhoidal tissue to relieve hemorrhoidal symptoms. It does not remove the volume of hemorrhoidal tissue that surgery removes. Success rates for hemorrhoidal banding in the literature varies between 65% and 85%. In many patients the procedure may need to be repeated and often with a successful result. About 10% of patients fail bulking agents and banding and they may then be candidates for surgery.
The complications associated with rubber band ligation include: bleeding, pain, blood clot in a corresponding external hemorrhoid, and rarely infection. You may have some mild bleeding after banding which would not be unusual. Should you develop persistent bleeding, especially about one week after the banding procedure, you should call the office immediately.

You may have some minor discomfort that lasts up to 72 hours. You should call the office if this discomfort lasts more than 72 hours or the pain is unbearable. There are rare case reports of patients developing severe infections after hemorrhoidal banding. You should call the office if you notice a fever greater than 100.5, unbearable anal pain, or inability to urinate.

You should make an appointment for an office visit, usually four to five weeks after the banding procedure, for further evaluation. If at that time your symptoms have resolved, then your doctor will likely recommend bulking agents alone. If your symptoms persist, then you will be considered for either repeat hemorrhoidal banding or surgery.

There are other methods besides hemorrhoidal banding that address internal hemorrhoids. They include injection therapy, cryosurgery, infrared coagulation, and arterial ligation. These other methods of treatment resolve internal hemorrhoids through a mechanism similar to banding and are rarely performed in this office.

3) Conventional Surgery
Surgical hemorrhoidectomy involves the removal of external and internal hemorrhoids. If you present with severe perianal pain from a thrombosed external hemorrhoid (clot), then you may undergo excision of this hemorrhoid in the office under local anesthetic. If you present with symptoms related to hemorrhoids that do not respond to bulking agents or banding, or if you are not a candidate for banding, then surgical hemorrhoidectomy may be an option. This technique involves removing all external and internal hemorrhoids, or at least those that appear to be the source for your symptoms, in the operating room. This is usually done in the outpatient setting.
4) Procedure for Prolapse and Hemorrhoids (Stapled Hemorrhoidopexy)

Another operation for some patients with hemorrhoids is the stapled hemorrhoidopexy. This procedure repositions hemorrhoids to their anatomic position by excising and stapling the lining of the lower rectum. At the same time, the blood supply to the hemorrhoids is interrupted while staples fix the hemorrhoids to the end of the rectum above the anal canal. This is all accomplished with a circular stapler. The procedure does not remove all of the outside hemorrhoids and has been likened to an anorectal “facelift”. Many studies have demonstrated less pain and quicker recovery time compared to conventional hemorrhoid surgery, probably because there are no wounds outside the anus where pain fibers are plentiful.

WHAT TO EXPECT WITH SURGERY

You may be asked to stop taking any blood-thinning medication for at least a week prior to surgery. This may include medications like aspirin and Motrin. If you are taking a medication to prevent blood from clotting (coumadin, warfarin, plavix, others), please let your doctor know.

You may be asked to take two Fleet's enemas, either the night before or the morning of your surgery. Upon arrival, a receptionist and other ambulatory surgical facility staff, including nurses and anesthesiologists, will greet you. The anesthesiologist will discuss anesthetic options with you, which will include a general or spinal anesthetic. At some point you will be greeted by your colorectal surgeon, who will answer any remaining questions that you may have. The operation usually takes 30 to 60 minutes, after which you will be taken to the recovery room where you likely will be discharged within two hours. You will receive discharge instructions that should be read carefully and in their entirety. If you do not receive these instructions, notify the recovery nurse prior to being discharged.
RISKS AND COMPLICATIONS OF SURGERY

1) Pain
You may have pain and/or urgency after surgery. You will receive a prescription for a narcotic (usually Vicodin or Darvocet N-100) specifically for pain. You should not drive, drink alcohol, perform strenuous exercises or make important decisions (like signing important papers) while taking this medication. You should not use a hot stove or equipment that may cause injury, or be responsible for the care of children. Some of the side effects include itching, shortness of breath, and constipation. For other side effects refer to a Physicians Desk Reference. Do not take on an empty stomach, since it may cause nausea. Avoid constipation by watching your diet and following other measures outlined below. You may also be given another pain medication referred to as a nonsteroidal anti-inflammatory drug or NSAID (e.g. Advil, Motrin, toradol, etc.). This medication is not a narcotic. It may be taken in addition to the prescribed narcotic pain medication. However, other NSAID medications and aspirin should not be taken at the same time without your physician's advice (that is, either Motrin or aspirin but not both).

2) Inability to urinate (urinary retention)
You may have difficulty urinating after this surgery. It can be a result of pain and/or pain medication. Sitting in a warm tub may be helpful in resolving this problem. If your bladder is full and you are uncomfortable and not able to urinate, you should call our office.

3) Constipation
This complication can be caused by pain or by pain medication. See below.

4) Bleeding
This complication can be immediate or delayed. In rare circumstances (less than 1 percent), hemorrhage (bleeding) shortly after surgery may require a return visit to the operating room to control. Another form of hemorrhage occurs seven to fourteen days after surgery and is probably a result of a suture eroding through the banded hemorrhoidal tissue. This may require a return to the hospital or operating room for control. Bleeding complications are very rare. Almost all patients have some degree of bleeding after this surgery, small in amount and of no concern. If your bleeding is of large volume or dramatic, then you should call our office or go to the emergency room immediately.

5) Infection
Infection is a rare complication after surgery. Despite the location of the wounds, infection requiring aggressive or operative intervention is very rare. A very rare form of potentially fatal sepsis resulting in gangrene of the tissues of the anus, rectum, and tissues around the rectum has been described after standard and stapled hemorrhoidectomies, as well as after banding.

6) Anal Skin Tags
You should not expect to have a smooth anal skin surface after your surgery. As a result of the healing process, you may develop bumpy skin tags, which if particularly troublesome, can be removed under local anesthesia.

7) Fecal Incontinence (leaking stool)
It is possible that, as a result of this surgery, anal sensation could be impaired or the anal-sphincter muscles may be injured, which could result in leaking gas, stool or both. The incidence of this complication is about five percent.
8) **Anal Stenosis**

Hemorrhoidectomy may result in narrowing of the anal canal. This is a very rare complication, the incidence of which is quoted as 3% and is may be less.

9) **Recurrence**

A well-performed hemorrhoidectomy rarely results in recurrence. The incident of this complication is probably about five percent. After the stapled hemorrhoidopexy procedure, the incidence of recurrence may be higher and some patients may require further procedures or surgeries at a later date.

10) **Fistula** (connection between anus and vagina)

This is a rare complication of stapled hemorrhoidectomy.

11) **Rectal Perforation**

This is a rare complication of stapled hemorrhoidectomy.

**DISCHARGE INSTRUCTIONS AFTER SURGERY**

1) **Diet**

There is no special diet required. You will be encouraged to eat a well balanced diet. Since constipation can be a problem after any operation, your diet should include adequate water intake. Proper diet combined with moderate activity, such as light walking, should help restore normal bowel function. Avoid constipation. It is unlikely that the wounds will become infected or disrupted as a result of having a bowel movement. Though some pain may be experienced initially after bowel movements, you will be given a prescription for pain medication.

2) **Pain Medication**

see 1) Pain above under Risks and Complications

3) **Bulking Agents**

You may be asked to take Metamucil, Citrucel, Fibercon, Benefiber, or some other fiber supplement. Although these are referred to as bulk laxatives, they are not laxatives in a true sense. In fact, people with diarrhea are often prescribed bulking agents in order to control diarrhea. In those people who have constipation, fiber supplements provide soft, bulky bowel movements that are beneficial in people taking narcotic pain medication. Furthermore, bulking agents provide a natural expansion of the anal canal.

4) **Stool Softener**

You may be prescribed a stool softener like Colace. This medication is designed to offset the constipating effects of narcotic pain medication. It should be taken at the recommended dose. If you have problems with diarrhea, you should call our office. You may be asked to stop taking this medication.

There are other options to treat constipation including Miralax and Milk of Magnesia. If the above regimen to include bulking agents, stool softeners, and plenty of water does not resolve the problem, call our office and we will discuss these options with you.
5) **Warm tub or sitz baths**

After your operation, it may be best to remove the dressing at about 6pm or sooner if you have a bowel movement. Then take a warm bath for 15-20 minutes. We will ask you to sit in a warm tub or sitz bath several times a day. Most people prefer to do this four or five times a day. The frequency is more important than the duration. It is better to sit in a warm tub for 15-20 minutes four times a day, than to sit for one hour, once or twice a day. This will keep your wounds clean and provide you with some comfort.

6) **Fluids**

We will ask you to drink plenty of water. You should drink six to eight glasses of water a day unless otherwise instructed by your primary physician. This is a very important step in preventing constipation after this type of surgery, particularly when taking pain medication. It will also keep you adequately hydrated.

7) **Constipation**

The following are options to avoid constipation. You may try whichever option appears most comfortable for you.

Take a fiber supplement (Metamucil, Citrucel, Fibercon, Benefiber are examples) starting the evening after surgery. You should take one tablespoon in 8 ounces of water or orange juice with dinner and with breakfast. In addition, take a stool softener like Colace 100mg by mouth twice a day. If you do not have a bowel movement within 4-5 days after surgery, you should call our office. We may recommend another medication to assist you with this (for example, Milk of Magnesia, Miralax, or an enema). It is very important not to go four, five or six days after surgery without a bowel movement if this is not your routine. This can lead to fecal impaction in the rectum that, under the worst of circumstances, may require a trip to the operating room to remove.

8) **Activity**

Have someone stay with you tonight. Restrict your activities and rest for 24 hours. Resume light to normal activity tomorrow. This would include walking or climbing stairs. Jogging or running, bicycle riding and other exertional activities should be avoided until your post-op visit, at which time you will be given further instructions. You should not drive a car if you are taking narcotic pain medication.

9) **Other Instructions**

We should be notified of any problems seemingly related to your operation. Some specific ones are:

- Temperature greater than 100.5 F
- Pain not controlled by pain medication.
- Excessive bleeding. Some bleeding and discharge from the anal area is expected and normal. This should not alarm you. However, if you are soaking pads every few hours, please call the office.
- Unable to urinate or the feeling of not being able to empty your bladder completely. It may be helpful to urinate in a warm bath or shower.
- Continued drainage 3 weeks after surgery.
- Anal tags are fleshy swellings which may appear days, weeks, or months after your surgery. These are not recurrent hemorrhoids but rather swelling of the skin. The skin around the anal area will not be smooth and is not cause for alarm.
If any additional problems arise concerning your operation or you need reassurance, please call our office and ask to speak with one of the office nurses.

If you have any questions, please feel free to contact our office at (734) 712-8150.

10) Helpful Websites and References
   
b) www.omni.ac.uk/browse/mesh/D006484.html
c) www.hemorrhoidsinplainenglish.com
d) www.pphinfo.com
e) www.fascrs.org