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UNITING SCIENCE AND COMPASSION

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Hemorrhoids

We all have internal hemorrhoid cushions from birth. Internal hemorrhoids are small "cushions" in the low rectum filled with blood vessels. These three cushions fill with blood when we are not having bowel movements, swelling the cushions and creating a "seal" inside the low rectum. Some experts report that 15% of our ability to control our bowels and differentiate whether we need to pass gas or stool is determined by healthy hemorrhoid cushions. Unfortunately, as we age, our hemorrhoids began to sag and droop in response to constant use, long times on the toilet, pregnancy in women, and effects of gravity.

Medical management of internal hemorrhoids is designed to minimize irritation and blood engorgement of the area. It works in early hemorrhoids by soothing the region. No medical therapy exists that "shrinks" hemorrhoids or resuspends these back to their proper internal location. Surgical therapy can removes excess stretched internal hemorrhoid tissue and suspends the remaining cushions back to their normal location inside the low rectum.

External hemorrhoids generally develop over our lifetime. Blood vessels under the skin around the outside of the anus can swell with heavy lifting, pregnancy, excessive time up on the toilet, and just because it is a bad day. This stretches the skin outside of the anus. Usually the blood vessel swelling resolves after a few days or weeks, but the stretched skin may remain stretched out, and become skin tags around the anus. A person with external hemorrhoids can feel the skin tags when touching around the outside of the anus. Hemorrhoids in this region will not shrink in response to medical therapy, although medicines can soothe the region. These can create difficulty cleaning after bowel movements and become inflamed and irritated intermittently.

Medical Management

1. Avoid constipation with stool softeners and a high fiber program
2. Limit time on toilet
3. Treat the region with topical medications (creams, foams, suppositories) for limited periods of time.

Office Procedures

Banding (rubber bands)

1. Banding can be done to treat Internal Hemorrhoids Grade I, II, and III, but not to treat external hemorrhoids. It is done in the office during a 15 minute appointment.
2. Office alternatives to banding include Sclerotherapy injection and Infrared coagulation ("laser"). Studies show that none of these three alternatives is clearly superior to the other. We choose to use banding in this office.
3. We can band one hemorrhoid group in the office every 4-6 weeks – most people will require three or more treatment sessions.
4. Banding usually causes significantly less pain than surgery, but usually several treatments are required.
5. Rarely people can have severe pain, infection, severe bleeding, or develop external hemorrhoids after banding.

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Operative Treatment

Hemorrhoidectomy

1. Used for Grade III and IV internal hemorrhoids with external hemorrhoids
2. Hemorrhoidectomy is surgical removal of the internal hemorrhoid cushions and external hemorrhoid tags with fixation of internal tissue.
3. Although it is very painful and a tough recovery, almost all patients are very pleased with the results.
4. Long term recurrence rates of some hemorrhoid tissue in 5%.
5. Up to 25% of patients will have early troubles while recovering from surgery, including constipation, difficulty passing bowel movements, excessive pain, difficulty urinating, and rarely severe infection or severe bleeding.

Hemorrhoidopexy (stapled hemorrhoid surgery, PPH)

1. Used for severe Grade II hemorrhoids and Grade III hemorrhoids. External hemorrhoids are not well treated by hemorrhoidopexy, so we will usually due an external hemorrhoid excision at the same surgery (this can increase pain with recovery).
2. Hemorrhoidopexy is removal of a majority of the internal hemorrhoid cushions with fixation of internal tissue in the low rectum.
3. This procedure doesn't work very well for the external hemorrhoid tags, so these are usually removed with additional surgical excision, if necessary.
4. Somewhat less painful than hemorrhoidectomy, but higher long term recurrence rates of 10-14%.
5. Up to 20% of patients will have early troubles while recovering from surgery, including constipation, difficulty passing bowel movements, excessive pain, difficulty urinating, and rarely severe infection or severe bleeding.

Doppler Guided Hemorrhoid Surgery (THD, Non-cutting hemorrhoid surgery)

1. Used for severe Grade II hemorrhoids, Grade III and early Grade IV hemorrhoids. Many external hemorrhoids are treated by this, but not all. Some will require an additional external hemorrhoid excision (this can increase pain with recovery).
2. Doppler Guided Hemorrhoid Surgery involves using a doppler ultrasound probe to identify 6-8 artery/vein bundles in the low rectum that supply the hemorrhoid region; each of these is tied off, limiting blood flow to the hemorrhoid region. In a second step in the operation, additional stitches are placed in 6 locations to suspend and fixate drooping hemorrhoid tissue into the low rectum.
3. Controls bleeding in 90% of patients
4. Somewhat less painful than hemorrhoidectomy, but higher long term recurrence rates between 10-15%. Lower risk of severe bleeding than the other two methods because no cutting is done.

Studies are in progress comparing the three methods with long term follow-up.