Modern Treatment
TREATMENT OF HAEMORRHOIDS (100):

Haemorrhoids have been treated by various methods depending upon their stage. Haemorrhoids currently benefit from wide therapeutic possibilities ranging from the standard hygiene and dietary rules to surgery, including medicines and instrumental treatment such as sclerosing, elastic ligatures, and controlled freezing.

These different methods have their indications and their limitations. The treatment of haemorrhoids envisaged only after the patient has been carefully interrogated and examined so as to rule out other affections of the anal region like fissure, suppuration, venereal diseases, and tumours etc.

The treatment of haemorrhoids can be divided into four parts according to their degree and the local conditions:

1. Palliative treatment
2. Injection treatment
3. Parasurgical treatment
PALLIATIVE TREATMENT (101) :

Palliative treatment consists of ingeniously providing sufficient comfort to permit postponement of the application of the curative measures. No treatment is required for the symptomatic haemorrhoids. Palliative measures may include avoiding heavy labour, administration of medicinal agents such as enteral oil, wet packs after defaecation and the control of the diarrhoea or other abnormal functions of the bowel. This treatment is indicated mainly for the early degree of haemorrhoids and haemorrhoids complicated by thrombosis and infection.

SYSTEMIC TREATMENT (102) :

Vasculotroches of the flavinoid type (Daflone) perceptibly improve congestive attacks provided they are administered in high doses. They are specially useful in women during catamenia or during contraception with estrogen progestrones. Proteolytic and even antiinflammatory enzymes are indispensible in the case of oedema particularly in the oedematous thrombosis and strangulation.

For grade I of haemorrhoids constipation should be treated with a diet rich in fibre (Addition of bran) mucilage, paraffin oil. The
bowel also can be regulated by Esapgul husk and if necessary a small dose of senna alkaloids at night.

LOCAL MEDICAL TREATMENT :

Ointments and suppositories contain often in combinations, drugs acting on infection, congestion, oedema and pain. The antiseptic effect of neomycin and collargal is useful when cryptitis is associated with haemorrhoids.

Inflammatory phenomenon are combated with halorunoidase and antiinflammatory agents. In case of infection antiseptic lotion like aqueous mercury perchlorate (1:2000) is much helpful. The products containing heparin are used when there are phenomenon of thrombosis. Local anaesthetics improve the comfort of the patients, but they have the inconvenience of sometimes triggering allergic reactions. These drug treatments are basically intended for moderate haemorrhoidal attacks.

In this way facts clear that prolapsed and thrombosed internal haemorrhoids particularly treated on palliative and antiseptic lines when perfectly clean then a decision can be made as to what further treatment is to be continued, if needed.
Radio-therapy in antiinflammatory doses has been particularly used for its analgesic effect on thrombosing and oedematous prolapse. Its effectiveness is known but apart from the precautions necessary for any eradication, it necessitates several trips of the radio-therapist room which are less easily accepted than the ingestion of some antiinflammatory capsules.

**INJECTION TREATMENT**: (SECLEROSING INJECTIONS) (103) (104) (105).

These consist of submucous injections of an irritating substance which creates a tissue reaction evolving towards sclerosis. The sclerosis has a double objective:

1. To occlude veinous lakes and fix the mucosa at deep levels. The technique must be correct. The injection is given through an anoscope at the subhaemorrhoidal level. It should not be very deep in the mucosa, as it would cause sharp pain, not too near the surface as it would strip off the mucosa, thus creating a fish bladder evaluating towards sloughing.
1. 5% solution of quinine and urea hydrochloride in water
2. 7% alcohol
3. 5% Sodium morrhuate in benzyle alcohol was tried by Bobsen
4. The common agent is Albright's solution or 5% phenol in almod oil. This method was probably first used in United State by Blackwood Mitchel of Clinton.

The solution is injected into in each pile pedicle in the submucosal space by a special syringe at the level of the ano-rectal ring. For a large haemorrhoid 10 ml may be injected. All the three primary haemorrhoids may be injected in one sitting.

Four to six injections of 3 to 5 ccs are distributed around the periphery (avoiding the prostrate zone in the males) would be necessary for the complete treatment, each injection being administered at an interval of at least a week. Though usually very early tolerated they can nevertheless give rise to side effects and rarely to accidents.

In the hours following an injection of quinine urea the patient may experience a sensation of lypothimic dyscomfort which resolves spontaneously. To minimise this dyscomfort, some dilute quinine-urea during the initial injections should be injected.
INDICATIONS:

This treatment is suitable for the I and II degree of haemorrhoids. This form of treatment must not be employed for the III degree haemorrhoids. This treatment can be used for bleeding in associated piles.

CONTRAINICATIONS:

This therapy is contra indicated in presence of proctitis and during or soon after an attack of thrombosed and prolapsed piles. In the presence of a chronic fissure or a fistula is an indication for the surgical treatment. This treatment is not favoured for bleeding internal haemorrhoids during pregnancy unless antianaemic measures prove inadequate and definitely to avoid in the presence of uncontrolled diabetes mellitus.

COMPLICATIONS OF INJECTION THERAPY (106) (107) (108):

1. Tenesmus

2. The pain some times in the right hypochondrium due to entry of sclerozant into the portal venous system.
3. Injection ulcer will occur if the proper solution is not used and the injection is not administered in the correct plane.

4. Mucosal sloughing may occur if an intramucosal injection is administered or too big dose is given. It is usually accompanied by haemorrhage

5. Submucus abcess (occasionally)

6. Stricture of the anus

7. Oleogrannulomma formation

8. Recurrences

PARASURGICAL METHODS (109) (110) (114) (115) :

Barron Band Ligation : This method is introduced by 'Blasdell' (1958) and popularized by 'Barron' (1963). The principle is very simple. The haemorrhoidal mass is encircled with elastic, the contraction of which causes eschemia and then necrosis of haemorrhoid. The elastic (rubber) is inserted through an anoscope with a special apparatus. Each haemorrhoid is grasped at its base by the grasping forceps. It is important that the point selected for the application of the forceps atleast 6 mm above the
dentate line. When the bands are seen in position and banding instrument have been released and removed.

This therapy has been asserted with encouraging results by some workers.

INDICATIONS:

Rubber band ligatures are indicated in the case of grade I and grade II degree haemorrhoids, which are too large to respond successfully to injections and also tried when other treatments have failed or do not seem to have reasonable results.

CONTRAINDICATIONS:

1. In any dysenteric infection  
2. Chron's disease or colitis  
3. Anal fissure  
4. Fistula in ano

COMPLICATIONS:

1. Haemorrhage on sloughing are rare but possible  
2. Severe pain can result if the bands have been applied too
low in the anal canal or if too many piles have been banded at one time.

3. Seldomly thrombosis of an external haemorrhoids may happen.

In the hours that follow the patient could experience dyscomfort due to the presence of ligatured haemorrhoids which would feel like a foreign body.

COAGULATION OF HAEMORRHOIDS WITH INFRA RED RAYS (112) / LASER TREATMENT (111) :

Infrared coagulation can be administered where necrosis gangrene or sloughing is seen. The volume of tissue necrosed by the infra red coagulation probe is such smaller than that by cryodestruction, good results have been reported from infra red rays.

ANAL STRETCHING OR ANAL DIALATATION (113) :

Anal stretching was introduced by Peter H., Lord in 1968. This operation is rationale for haemorrhoids with an increased tone in
the sphincter complex plus straining at stool is the basis for the segmental prolapses which constitute haemorrhoids. Strangulated prolapsed piles are the end result of this process with the hypertonic shincter closed behind them.

The patient should be put in a left lateral position and general anaesthesia is administered. The stretching procedure should be gentle and stretched as far as possible. This stretching start using the index finger of each hand gradually inserting more fingers as the contriction is over come. In the male it allows for a six finger dialatation while in the female eight fingers can be inserted.

The dilatation procedure should be clear that there is no constriction between the upper rectum and the exterior and that defaecation is able to take place without rising the intrarectal pressure.

At the end without removing his fingers a spunge is inserted in the anus and is left there for a hour or so. It can then be removed. For the next day onwards, a rectal dialator of 3.5 cms size in diameter is introduced into anus daily for weeks and then trapped off over a period of six months.

This procedure is usually administered for third degree internal
haemorrhoids and prolapsed thrombosed piles but Lord does not advocate this procedure in those having poor sphincter tone particularly in old age. This procedure is also good for the patient having piles with fissure or spastic sphincter.

CRYOSURGERY : (Loyed William 1977) (109) (110)

It is the technique which is based on the principle of rapid freezing and rapid destruction of living human tissue, frozen tissue becomes white and solid.

This is carried out with the help of cryode chilled by expansion of ether liquid nitrogen producing local temperature of minus 180 oC, while nitrogen peroxide produce minus 89 oC. Nitrogen reduces the temperature upto minus 195 oC, while nitrous oxide reduces the temperature upto minus 95 oC. Generally nitrous oxide is preferred since it produces adequate freezing for cryohaemorrhoidectomy. Liquid nitrogen produces quick destruction and can damage the sphincter muscle. It requires special rewarming circuit for its release and is costlier while nitrous oxide requires without special rewarming circuits.

The patient may put either left-lateral or in the lithotomy position. Four finger dialatation should be done. It is advisable to use Clifrons speculum having a side slot which allows the
piles to prolapse into the lumen after the obturator is withdrawn and then cryoprobe is applied in the longitudinal axis of the internal pile and the pressure must be maintained above 700 pounds at the same time. The rapid adhesion occurs which allows traction and slight rotation in either direction drawing more pile into contact with the probe. When enough tissue is frozen, the probe is detached after warming. This occurs within 10 seconds if nitrous oxide is used. This procedure can be used as an office procedure for those patients who only have internal piles and nonspastic anus. The treatment is included when all the haemorrhoidal areas have been treated.

POST OPERATIVE COMPLICATIONS

1. Marked oedema and swelling
2. Profuse and copious discharge
3. Severe pain
4. Incontinence, if the sphincter muscle is destroyed.
5. Retention of urine, haemorrhage and sepsis are very seldom.

Healing is usually complete within three weeks. Controlled freezing enables treatment of stage II degree haemorrhoids.

It can perceptibly improve III degree haemorrhoids if there is any impediment to surgery. It is very useful for the frequent prolapses of the right anterio-lateral haemorrhoids, the so
called 5 o'clock position often resistant to other therapy.

SURGICAL TREATMENT : (Operative Treatment) (116) (117) (118) (119) (120) (121) (122) (134)

Various types of surgical measures can be adopted which are as follows:

1. Excision with high ligation (Salman quoted by Allingham and Allingham 1896) (130)
2. Excision with primary sutures (131)
3. Excision with clamp and cautery
4. Excision with low ligation (132) (133) (127)
5. Submucous resection of haemorrhoids

INDICATIONS : (126)

Following conditions are suitable for operative treatment.

1. III degree haemorrhoids (128)
2. Failure of conservative treatment of II degree haemorrhoids
3. Fibrosed haemorrhoids
4. Intero-external haemorrhoids
5. As an emergency treatment for the strangulated haemorrhoids and thrombotic external piles.
CONTRAINDICATIONS:

1. Dysenteric infections
2. Chron's disease
3. Prolapsed thrombosed haemorrhoids (139)
4. During pregnancy etc.

HAEMORRHOIDECTIONY: (123) (124)

Haemorrhoidectomy means surgical removal of haemorrhoidal tissue, is commonly accepted as the proper objective in the surgical treatment of haemorrhoids. It is well tolerated in the elderly patients than younger ones. Post operative treatment is necessary, 48 hours before operation and patient should be admitted to the hospital a day before the operation and soap water enema should be administered after admission. Anal region also saved before operation and patient should take bath. A laxative should be given if the patient is constipated and rectum is washed out with water by means of a funnel and a tube attached to a catheter of the morning of the operation. General anaesthesia is supplemented by local anaesthesia is best.
LIGATION AND EXCISION:

The patient is placed in a full lithotomy position with the buttocks lifted well down over the edge of the table. Dissection is required before proceeding to ligation. Two finger dilation of the anal canal is performed with gentle and the piles situated as left lateral right posterior and right anterior are grasped with forceps. When it is felt difficult to grasping the piles when they come out. Along with this when associated external piles are present, the skin in relation to each primary piles is also grasped with other forceps and both forceps are held in one hand. A further pair of blunt pointed straight scissors is taken and 'V' shaped flap of a skin is dissected up at the base of each primary pile, the apex of the 'V' being away from the centre of the anus and limbs of 'V' extending to, but not beyond the muco-cutaneous junction. Thus, exposed the subcutaneous parts of the external sphincter. The longitudinal and tough expansion of the rectal wall is found deep to this junction. As the pedicle is defined by the dissection, traction on the haemorrhoid should be released. When the pedicle is transfixied, it should be ligated with strong silk or catgut, with the knot tied on the lumen side so that ligature cannot slip. If the pedicle is large in size, a second ligature can be administered. The piles can be cut away along good cuff of a tissue distal to the ligature. It is observed that between each haemorrhoidal wound a bridge of anal
skin and rectal mucosa remains in continuity with the perianal skin. Hence the haemorrhoidal wounds can be reduced to great extent by suturing the mucus membrane to the skin.

Thus, this prevents any post operative stenosis of the anus. The final appearance of the operated area should resemble a three leafed clover and the wound should be absolutely dry before the dressing is applied. The gauze should be applied so that it lies flat and does not wrinkle. Then a pad of cotton wool is applied and held in place by gentle pressure with a 'T' bandage.

POST OPERATIVE CARE (137) (138) (141) :

Post operatively dressing are left undisturbed for 24 hours, but after this period, they should be changed twice daily. The liquid paraffins given daily in the evening. Final healing takes several weeks. Patient should be supplied analgesics to minimise the pain for 15 days.

COMPLICATIONS (135) (136) (140) :

1. Retention of urine
2. Reactionary haemorrhage
3. Secondary haemorrhage
4. Skin tag formation
5. Anal stricture
6. Cross healing
7. Stenosis and anal stricture
8. Abscess
9. Sepsis
10. Fissure in ano
11. Fistula in ano
12. Prolapse of the lower rectal mucosa
13. Incontinence of faeces etc.