HISTORY OF DISEASE

&

VARIOUS TREATMENT
Although Haemorrhoids have been recognised and written about for many centuries, there is no universal agreement as to its cost. The suggested etiological considerations are based on hereditary, diet and bowel habits which may be divided into:

1. Predisposing causes
2. Exciting causes

(1) Predisposing Causes:

(a) Man's erect posture: Taylor and Egbert have demonstrated that the pressure within the haemorrhoidal veins is considerably increased in erect posture by means of manometry readings. This happens because of absence of valves in portal system of veins and so the entire column of blood. The superior rectal vein, inferior mesentric vein and portal vein pierce directly on the superior haemorrhoidal plexus.

(b) Hereditary: It has been found that many members of the same family have been affected often at an early age, association of varicosity of leg veins with haemorrhoids also suggests a definite inherited or congenital weakness of venous wall.
(c) Epidemiology & Diet: Epidemiological studies by Burkitt have implicated the low residue diet as the cause of haemorrhoids. Elimination of cereal fibre from the diet causes a considerable delay in fecal transit time in bowel and a high incidence of chronic constipation. For this reason haemorrhoids are rare in rural Africa and almost unknown in primitive countries.

(d) Tone alteration of anal sphincters: Hancock and Smith observed increase sphincteric tone in patients with Haemorrhoids.

(2) Exciting Causes:

(a) Constipation & Diarrhoea: Repeated straining at stools, passage of large hard stool greatly magnify the distending effect of normal defecation on the haemorrhoidal plexus. The rise of intra-rectal pressure noted by (Best & Taylor) is from 20 to 200 mm. of Hg. Similar effects are also observed in diarrhoea associated with tenesmus and hence haemorrhoids are common with ulcerative colitis and some forms of chronic or acute dysentry.
(b) Pregnancy: It leads to haemorrhoids due to obstruction of the superior rectal venis by a gravid uterus and also by the greatly increased vascularity and laxity of pelvic tissues as a result of progesterone effect on smooth muscles in the vessel wall.

(c) Carcinoma of Rectum: When associated with haemorrhoids it is because of obstruction to the superior rectal vein tributaries and alternate constipation and diarrhoea because of disease which needs definitive treatment of carcinoma.

(d) Portal Hypertension: Jacob encountered 28% of patients of portal Hypertension who had internal haemorrhoids.

**TREATMENT MODALITIES FOR HAEMORRHOIDS**

The different methods of treatment available now a days are:

(a) Conservative or medical treatment

(b) Active treatment

(1) Injection Therapy

(2) Rubber-band ligation

(3) Cryosurgery

(4) Haemorrhoidectomy

(5) Lord’s dilatation

(6) Infra-red photo co-agulation
Active treatment like rubber-band ligation, injection therapy and cryo-surgery are so safe and painless procedures that there is seldom any justification for treating haemorrhoids by medical measures alone in large number of cases.

(1) Injection therapy: Morgon and Dublin were the first person to practice the treatment using iron-per-sulphate. Planchard used a weaker solution of 5% phenol in almond oil in the dose of 3-5 ml. Recently quinine, urea hydrochloride solution have also been used.

The possible modes of action are:

(1) Constriction of submucosal veins by fibrous tissue formed as a result of local inflammatory reaction.

(2) Increased fixation of prolapsed mucosa to the underlying muscular coat due to fibrosis.

(2) Rubber-band ligation: The method was developed by Barron as a modification of out patient ligature method originally proposed by Blaisbell. Recently the modifications have been done by Van Hoorn and Thomson. The mode of action includes tight rubber band at the base of haemorrhoids with cuts of the blood supply and causes necrosis.
The necrossed tissue separates out within 5-7 days leaving a mucosal ulcer which heals by cicatrization.

(3) Cryosurgery: Lewis was the first person to introduce this method causing rapid freezing of the haemorrhoids and brings about cellular destruction. The mode of action includes necrosis due to thrombosis of micro-circulation and cellular destruction causing destruction of cellular membrane.

(4) Haemorrhoidectomy: The operative treatment has been practiced since many years. Salmon, Allingham described high ligation and excision. Milligan and Morgan described modified technique to avoid anal stenosis. White head described circular excision pile bearing area which is popular in USA as a modified Anoplasty. Furgeson and Heaton described closed method of haemorrhoidectomy. Parke's introduced painless submucous resection.

(5) Manual Dilatation of Anus: Lord described outpatient treatment as dilatation of haemorrhoids. The mode of action in this treatment is to reduce tone of internal sphincter at the muco-cutaneous junction.

(6) Infra Red Photo - Coagulation: Neiger described this treatment. It is still not well accepted by medical paternity, in India.