Hemorrhoids and Anal Fissure: Anorectal Disease - Diagnosis and Treatment

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Learning Objectives

1. Review the anatomical classifications and characteristics of hemorrhoids and anal fissures.

2. Identify the preferred diagnostic approach for hemorrhoids and anal fissures.

3. Discuss prevention methods for hemorrhoids and anal fissures.

4. Review medications and modalities for the treatment of hemorrhoids and fissures.

Audience Engagement System
Let’s Talk About…

• Hemorrhoids (internal, external)
• Anal fissures
• Other possible differential diagnosis (proctalgia fugax, pilonidal cysts, condyloma)

Hemorrhoids - Epidemiology

• 4% have them M=F
• 40-60 y/o most common
• Uncommon under 20
Hemorrhoids - Pathology

- Dilation of vessels superior hemorrhoidal cushion vs inferior hemorrhoidal cushion

Image courtesy of Visible Body

https://commons.wikimedia.org/wiki/index.php?curid=4953948
Evaluation of Hemorrhoids = History

- Painful vs painless (mild vs mod vs I can’t sit)
- Blood?
- BM regularity, consistency, ease of evacuation
- What else are you doing besides the job at hand?
- Straining on the toilet?
- Incontinence, Prolapse

Evaluation of Hemorrhoids = History

- Interventions tried
  - Fiber
  - Stool softeners
  - Wet wipes
  - OTC (witch hazel, hydrocorizone, barrier)
  - Prescriptions
Evaluation: Physical Exam

- Left lateral side, knees bent
- External visual inspection
- Evert the skin
- Digital exam
- Valsalva prolapse

Rectal Exam & Anascope

• Left lateral position
• Well lubed
• Rectal exam form
• Slotted vs not
• Rotation with introducer in place

Dr. Joachim Guntau - www.Endoskopiebilder.de
http://anoscopyhighresolution.blogspot.com/2012/06/miscellaneous-findings.html
CASE #1

• 45 y/o male with extreme pain, refuses to sit down, awaken in the night due to pain. 10/10
• Symptoms started 24 hours ago, after bowel movement. Hard to pass
• No hx of hemorrhoids
• No bleeding
• Feels a lump
AES Question #1

Is this a:

A. Acute thromboses external hemorrhoid
B. Subacute thromboses external hemorrhoid
C. Internal hemorrhoid
D. Anal Fistula

Acute External Treatment (Grade A)

- Excision >
- Watch and wait >
- Incision and Drainage
- Ice, steroid
- Pain Management
S/P 2 Days I&D (Reoccurrence)

Acute Treatment

- RCT n=150 3 arms

- Day 4 pain = Early excision > nitroglycerin > thrombectomy
- Day 30 pain = Early excision = nitroglycerin = thrombectomy

- Hemorrhoid pain resolution excision 3-4 days vs 24 days in conservative management. Fewer reoccurrence.


Elliptical Excision

- Good visualization/ light
- Lidocaine with Epinephrine
- Excise ellipse, complete venous complex, to adipose
- Suture closed
- Sitz baths
- Pain control!

CASE #2

- 37 y/o female developed rectal pain 72 hours ago after a difficult to pass bowel movement
- Tried sitz bath, OTC creams, NSAIDS
- Still painful
AES Question #2

• Should you
  A. Elliptical excision?
  B. I&D
  C. Conservation (sitz baths, lidocaine ointment, anti-inflammatory creams)
  D. Refer for surgery

Subacute Thromboses Hemorrhoids: Tx

• Even though you want to cut it off…

• <48-72 hours excise

• >48-72 hours conservative management favored (expert opinion)

• Don’t forget pain management
Conservative Management

- Education
- Get ride of the constipation and straining
- Relieve symptoms

Fiber (Step 1, Grade A)

- Fiber showed 50% reduction in symptoms (RR = 0.53, 95% CI 0.38-0.73)
- 50% reduced risk of bleeding (RR = 0.50, 95% CI 0.28-0.89)
- Pain, itching and prolapse trended toward significance but individually were non significant
- Results persistent at 6 weeks and 3 months

Symptom Relief - Short Term

- Oral Venoactive agents (dobesio, Calcium dobesilate, Hydroxyethylnutosides -not available in the US) (Grade B)
- Analgesics (topical lidocaine)
- Steroid creams (hydrocortisone)
- Antispasmodic (calcium channel blockers)
- Sitz baths/Ice

Med tx- Phlebotonics (where can I buy them)

- Flavanoids, hydroxyethylnutoside, calcium dosbesilate,
- Improve pruritus (OR= 0.23 (95% CI 0.07-0.79)
- Bleeding (OR=0.12 (95% CI 0.04- 0.37))
- Discharge & leakage (OR=0.12 (95% CI 0.12 95% CI 0.04-0.42)
- Overall symptom improvement (OR15.99 (95% CI 5.97-42.84)
Topical (No Data of Benefit)

- Analgesics (topical lidocaine)
- Steroid creams (hydrocortisone)
- Antispasmodic (calcium channel blockers)
- Sitz baths/Ice

External Hemorrhoid Tags

- 34 y/o MSM would like a cosmetically concerning anal skin tag removed
- Mild constipation over lifetime
- Can feel it when he wipes
Excision of External Tag - picture

- Lidocaine with Epi 3-5 cc
- 27-30 gauge needle
- Ligation
- Excision
Case #3

• 52 y/o male, long standing constipation
• Feels something come out with every bowel movement. Sometimes spontaneously resolves, other times stays prolapsed for days. This has been going on for months.
• Intermittent bleeding with it. Sometimes clots in the toilet. Denies any dizziness.
• No hx of colon cancer screening
AES Question #3

- What is the stage of this hemorrhoid?
  A. Stage 1
  B. Stage 2
  C. Stage 3
  D. Stage 4

Stage 1- No prolapse just prominent vessels
Stage 2- Hemorrhoid prolapse with valsalva but spontaneously resolves
Stage 3- Prolapse with pressure, requires manual reduction
Stage 4- Prolapse and unable to reduce
Internal Hemorrhoids- Will They Go Away?
Future Prevention

- Soften your Cleaning
- Soften your stool = the most important 10 min conversation
- Exercise
- Topicals
- Surgery (Don’t take off things that don’t need to come off)
The Most Important Conversation

• 1 soft, easy to pass bowel movement
• “Soft”
• “Easy to Pass”

Stool Softening

• Fiber 25-30 grams a day (slow increase)
• Polyethylene glycol 3350 (nnt=3), lactulose (nnt=6), milk of mag (Am J Gastroenterol. 2006 Jan; 101(1):181-8)
• Rescue therapy (stimulant, suppository)
• Docusate -1 tab po bid, then go up
• Probiotics (bifidobacterium)
• Senna (ex lax, laxative teas)
Prevention Chronic Constipation & Hemorrhoids

• Step 1- Education & Partnering
• Step 2- Diet & Exercise
• Step 3- Fiber
• Step 4- Osmotic diuretics
• Step 5- Prokinetics (lubiprostone and linaclotide)
• Step 6- Last resort surgery

Office Based Internal Hemorrhoid Treatment

• Rubber banding
• Infrared Coagulator
• Sclerotherapy
• Laser, Cryo
Rubber Banding
Infrared Coagulator
Office Based Procedures

- Rubber band=93% cure grade 2-3, 11-49% reoccurrence

- IRC - 81% cure in grade 1-2, 28% reoccurrence. Less pain and quicker return to work vs rubber band

- Sclerotherapy- 20% success rate at 1 year in grade 2-3, up to 80% successful in grade 1, agent dependent

Complications

- Perianal sepsis (rare) (worsening pain, fever)
- Urinary dysfunction
- Bleeding (common)
- Pain (misplaced rubber band, burn)
Referral for Surgery (Grade A)

- Grade 3-4
- Rectal prolapse
- Unable to tolerate office procedure
- Improved resolution vs office base in grade 3-4
- Surgery has increased pain and higher complication rates compared to office procedures

What Did We Miss?

- Complete colonic eval?
- Hemorrhoid bleeding most common missed opportunity to establish a colon diagnosis?
- Should all hemorrhoids have a colonoscopy?
- Review any previous endoscopy reports
Indications for Colonoscopy

• >50yrs old
• >40 yrs old or 10 years younger than the age at Dx of 1 or more 1st degree relative with Colorectal cancer or advance adenoma at <60 yrs old
• Positive fecal immunochemical testing
• Positive FIT- fecal DNA test

(Rex Et al. Colorectal cancer screening: recommendations for physicians and patients from US multi-Society task force on Colon cancer, Am J Gastroenterology, 2017; 112:1016-1030.)

Anal Fissure

• 42 y/o male with rectal bleeding and pain with every bowel movement
• “Like crapping a piece of glass”
• Frequent constipation
• Pain lasts for 1-2 hours after bowel movement
• Some bleeding on the toilet paper and in toilet
Physical Exam

- visual inspection
- rectal exam painful

Anal Fissure - Tx Step 1

- Treat constipation (warm baths + fiber healed 50%)
- Fiber 15g + sitz > 7.5 g > lidocaine or hydrocortisone cream
- Lower rate of reoccurrence
- Relaxation of internal sphincter
- Atraumatic passage of stool
- Pain relief
- Sitz baths, fiber, topical anesthetic creams

Anal Fissure - Tx Step 2

• Sphincter relaxation and blood flow
• Topical nitroglycerin > placebo (49% vs 37%, \( p < 0.004 \))
• Topical = Nitroglycerin (58-70%), Diltiazem (70%), Bethanecol (small studies showing benefit)
• Oral = Nifedipine (60%), Diltiazem (38%) Higher reoccurrence rate

Anal Fissures - Step 3

• Injectable = Botox injection (73% - 95%) (when compared side to side botox = topical)
• If other topical treatments failed, Botox low success rate (27%)
• 1/3 of Botox treated patients go on to surgery
Anal Fissures Step 4

- Surgical = Lateral Sphincterotomy (95% healing, 45% with transient incontinence, 6-30% long term)
- Dilation = 4 fingers for 4 min (95% pain relief, reoccurrence 16%)
- Surgical > Dilation (Efficacy OR = 3.35; 95% CI = 1.55–7.26) and incontinence to flatus or feces (OR = 4.03; 95% CI = 2.04–7.46)

Anal Fissure - Special Consideration

- Chrons
- HIV+ = ulcer vs fissure
Case #4

- 56 y/o male presents for colonoscopy for eval for rectal pain
- Occurs intermittently, usually last 30 min.
- Has left work
- PMHx GAD
- no pain with bowel movements, no itching or burning

Proctalgia Fugax (Acute)

- severe intermittent episodes of rectal pain, self limited (secs - min), not associated with other pelvic pathology
- Dx of exclusion
- Tx- sitz, topical calcium channel blockers, biofeedback, oral anti hypertensives
Case 5

• 34 y/o female with intense anal itching
• work up so far has excluded pin worms (was presumptively treated once), hemorrhoids, or fissures
• Exam shows some lichinification.

Pruiritis Ani

• Itch scratch cycle
• Inflammation, infectious, neoplastic, anorectal disorder, fecal contamination
• Tx based on underlying disorder
Perianal Condyloma

- 30 y/o female with large volume perianal wart. Hygiene difficult, can be painful
- Tx Topical
- Irritants - Podophylin (20-50%), TCA (20-50%), 5FU+epinephrine (50%)
  - Immunomodulators - Immiqimod 40-70%, Interferon Alpha (25-80%)
    Sinecatechins (55%)
- Surgery
  - Cryo (63%-92%)
  - Infrared Coagulation (61%-74%)
  - Laser Therapy (100%, reoccurrence 45%)
  - Excision (36%)

Practice Recommendations - Tags

- No more then 1/4-1/3 of circumference per visit
- Why do they need to come off?
Practice Recommendation
Internal Hemorrhoids

• Fiber fixes
• 1 Soft easy to pass bowel movement a day
• Symptomatic treatment as needed
• Rubber banding and Infrared Coagulation can easily be done in the office and are well tolerated.

Practice Recommendation – Anal Fissure

• Soften the stool
• Topical nitro +/- topical Calcium Channel blockers
• Oral Calcium Channel blockers
• Botox
• Surgery
Practice Recommendation - Other

- All that hurts is not hemorrhoids and fissures.
Questions

Contact Information

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