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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). Hemorrhoids may also cause itching. However, 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, you may be asked by your doctor to undergo a colonoscopy or barium enema to further investigate this.

These symptoms 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. Most 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 anosopic 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 lower most colon. Again, these examinations usually cause little or no discomfort. 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.

At some point during your visit, you will be given a booklet entitled, "*The Hemorrhoid Book.*" This should be read in its entirety and carefully. If you have not received this booklet, please call the office and we will arrange for you to obtain a copy, either at a visit or by mail.

TREATMENT OPTIONS

1) Fiber Supplements:

You may be asked to take a fiber supplement, which is usually first-line therapy for hemorrhoids. Fiber supplements include Metamucil, Citrucel and Fiber Con. 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 in those patients who have no problems with their bowel movements. Therefore, you will likely be asked to take fiber supplements even if you are having no problems in this regard.

Depending on your symptoms, in addition to bulking agents you may be asked to do warm tub or sitz bath 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 which 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, then 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 and infrared coagulation. 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 Ambulatory Surgical Facility on the first floor of the Reichert Building.

4) Procedure for Prolapse and Hemorrhoids (Stapled Hemorrhoidopexy)

A relatively new operation for some patients with hemorrhoids is the stapled hemorrhoidopexy. This procedure repositions hemorrhoids to their anatomic position by excising and stapled 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.

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, please let your doctor know this is case it needs to be discontinued.

You will be asked to take two Fleets enemas, either the night before or the morning prior to 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 45 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 while taking this medication. 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 make you nauseated. Narcotic pain medications may cause constipation. Avoid this 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*). This medication is not a narcotic. It may be taken in addition to the prescribed narcotic pain medication. However, other NSAID medications or aspirin should not be taken at the same time without your physician's advice.

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. If you have not had a bowel movement within 48 hours after surgery, you should call our office. The prescribed bulking agent (*Metamucil or Citrucel*) should be helpful with this particular problem. We may recommend another medication to assist you (*e.g. Milk of Magnesia*). It is important not to go four, five, or six days after surgery without a bowel movement. This can lead to impaction of stool within the rectum, which, under the worst of circumstances, may require a trip to the operating room to remove.

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 sepsis resulting in gangrene of the tissues of the anus, rectum, and tissues around the rectum has been described after standard and stapled hemorrhoidectomies.

6) Anal Skin Tags

You should not expect 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 and 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 three percent and is probably less.

9) Recurrence

A well-performed hemorrhoidectomy rarely results in recurrence. The incident of this complication is probably about five percent.

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

You will be given a prescription for pain medication to be taken by mouth. One of these prescriptions may be a narcotic. **You should not drive, drink alcohol, perform strenuous exercises or make important decisions while**

taking this medication. Some of the side effects include itching, shortness of breath and constipation.

DO NOT TAKE ON AN EMPTY STOMACH, since it may make you nauseated. *(Most pain medications can cause constipation. Avoid this by watching your diet and following the measures below).*

You may also be given another pain prescription medication referred to as a non-steroidal anti-inflammatory drug or NSAID. This medication is not a narcotic. It may be taken in addition to the prescribed narcotic medication. However, medications such as aspirin, Motrin and other NSAID medication should not be taken at the same time.

3) Bulking Agents

You may be asked to take Metamucil, Citrucel, Fibercon 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 such as Metamucil or Citrucel 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 the 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.

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. If you do not have a bathtub, a hand held shower works well. You may have gelatin packing in your anal canal. It is flesh colored and will pass with the first bowel movement. You do not need to remove it yourself.

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

If you have not had a bowel movement within 48 hours after surgery, you should call our office. Excessive straining to have a bowel movement or if you feel uncomfortable prior to that time, we may recommend another medication to assist you with this (*e.g. Milk of Magnesia*). Some patients do well with 4 dulcolax tablets on the 2nd or 3rd night if a bowel movement has not occurred by that time. If there is still no bowel movement by the next day, then a plain Fleets enema is a good option. It is very important not to go four, five, or six days after surgery without a bowel movement. This can lead to fecal impaction in the rectum, which under the worst circumstances may require a trip to the operating room to remove.

8) Activity

You may return to your usual physical activity. This would include walking or climbing stairs. Jogging, running, bicycle riding and other exertional activities should be avoided at least until your post-op visit, at which time you will be given further instructions. You should not drive a car if you are taking a narcotic pain medication.

9) Other Complications

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

- 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.
- Failure to resolve pain.
- Continued drainage within 2 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

- a) www.nlm.nih.gov/medlineplus/tutorials/hemorrhoidsurgery/htm/index.htm
- b) www.omni.ac.uk/browse/mesh/D006484.html
- c) www.hemorrhoidsinplainenglish.com
- d) www.pphinfo.com

