Non Surgical Treatment for Hemorrhoids

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Affliction from hemorrhoids has been noted in the writings of various cultures throughout history such as Babylonian, Hindu, Greek, Egyptian, and Hebrew. In the United States, as well as other industrialized countries, hemorrhoidal disease is extremely common. Estimates have indicated that 50% of persons over 50 years of age have symptomatic hemorrhoidal disease at one time or another and up to one-third of the total US population have hemorrhoids to some degree.

The causes of hemorrhoidal disease are similar to those of varicose veins. Like varicose veins, predisposition to development of hemorrhoids depends on genetic make up, excessive venous pressure, pregnancy, long periods of standing or sitting, straining at stool and heavy lifting are considered the major factors. Most patients have more than one predisposing factor.

Presenting symptoms are itching, burning, irritation with passage of stool, swelling of the anus and perianal region, blood on the toilet paper or in the bowl, and seepage of mucus. Most patients attribute all rectal symptoms to hemorrhoids, however, rarely are internal hemorrhoids painful or cause itching. Usually the hallmark of a hemorrhoid eruption is bleeding or protrusion which is noted following passage of stool. Pain from internal hemorrhoids occurs when they become strangulated from prolapse and with thrombosis. Any other pain associated with hemorrhoids is usually due to a coexisting lesion such as a fissure. Itching is rarely associated with internal hemorrhoids except where there is excess mucus discharge.

Internal hemorrhoids are classified according to symptomology and finding on examination. Stage I hemorrhoids bleed but do not protrude. Stage II hemorrhoids protrude following bowel movement, and then spontaneously reduce. Stage III hemorrhoids protrude with stool and must be manually reduced. Stage IV hemorrhoids protrude and are not reducible. Stages II, III, and IV may or may not bleed and a Stage IV hemorrhoid presents the possibility of strangulation resulting in decreased blood flow and eventual thrombosis.

In contrast to the United States and the United Kingdom, hemorrhoids are rarely seen in parts of the world where high-fiber, unrefined food diets are consumed. A low-fiber diet, high in refined foods, contributes greatly to the development of hemorrhoids. Individuals consuming a low-fiber diet tend to strain more during bowel movements, since their smaller and harder stools are more difficult to pass. This straining increases the pressure in the abdomen, which obstructs venous return. The increased pressure will increase pelvic congestion and may significantly weaken the veins, causing hemorrhoids to form.

Treatment

A high-fiber diet is perhaps the most important component in the prevention of

hemorrhoids. A diet rich in vegetables, fruits, legumes, and grains promotes peristalsis because many fiber components attract water and form a gelatinous mass which keeps the feces soft, bulky, and easy to pass. The net effect of a high-fiber diet is significantly less straining during defecation.

Another important, but only recently recognized, dietary factor is breakfast. An age, sex and pregnancy matched case–control study carried out in an outpatient clinic found a remarkable 7.5-fold increase in the odds of suffering from hemorrhoids or anal fissures in matched subjects who did not eat breakfast!

Topical treatments for acute or chronic hemorrhoids involving the use of suppositories, ointments, and anorectal pads, in most circumstances, only provide temporary relief. Many over-the-counter products for hemorrhoids primarily contain natural ingredients, such as witch hazel (Hamamelis), cocoa butter, Peruvian balsam, zinc oxide, allantoin or homeopathic preparations, to name a few. Many patients will use hydrocortisone cream to help with itching that they associate with hemorrhoids. Prolonged use can often aggravate the pruritis ani setting up a cycle of continued use.

Surgical treatment

Hemorrhoidectomy, or the surgical removal of redundant tissue is by far the most invasive of the hemorrhoid procedures. This procedure often requires an outpatient surgical setting and results in lost time from activities of daily living so healing can take place. Most patients seek alternative treatments in order to avoid surgery and its complications such as pain and rectal sphincter instability.

The Keesey Galvanic technique is a monopolar direct current treatment that is purely an in-office procedure. What makes the Keesey technique attractive is that the patient may be freely ambulant after completion of the procedure and can return to their normal activities of daily living. The hemorrhoid will disappear in 7 to 10 days after the treatment. Each separate hemorrhoid is treated in the same manner and larger hemorrhoids may need to be treated more than once.

Infra red coagulation (IRC) is effective with Stage I and II hemorrhoids but can be combined with the Keesey treatment for Stage III and IV. While the Keesey technique utilizes current, the infra red coagulator utilizes a burst of intense heat generated internally and shot through a blue anodized sapphire tip to the surface of the hemorrhoid. The IRC painlessly “coagulates” the redundant tissue to a depth that is a function of the amount of time of the light burst, usually 1 to 1.5 seconds.

External Hemorrhoids

External hemorrhoids occur when there is dilation of the external rectal plexus or thrombosis following an episode of constipation, diarrhea, heavy lifting or valsalva from sneezing, coughing or childbirth. The patient will notice an often-painful perianal lump and may have some bleeding associated with it. External hemorrhoids usually pose mild to little discomfort and will largely resolve on there own if homeostasis is restored.

External anal skin tags found on examination are the remnants of previous external hemorrhoids.

If however the hemorrhoid becomes thrombosed, a cycle of acute edema and pain is set up which may lead to surgical intervention. As the lesion becomes increasingly distended, varying degrees of pain and swelling can be found which is often exacerbated by passage of stool or from prolonged sitting. The patient may report that there is bleeding after stool due to a disruption of the hemorrhoid [50].

Treatment

Unless the hemorrhoid has thrombosed and the patient is in excessive pain, the condition can usually be managed medically. Initial treatment should be to relieve the pressure and dissolve whatever thrombosis has formed. As this occurs, long term management in the form of patient education, dietary changes and enhancing vascular integrity should be undertaken to help prevent further episodes.

Initial treatment with the enzyme Protease 2400 mcu's, two capsules between meals TID and two capsules at bed time will help to reduce the thrombosis and decrease pain. Alternating Sitz baths act to relieve pain and increase blood flow. A number of homeopathic medicines such as Aesculus, Aloe, Hamamelis, Muriatic acid, Ratanhia and Sepia are effective in relieving pain and speeding the course of healing.

In patients who are experiencing an acute episode of a thrombosed external hemorrhoid, prompt surgical excision or incision are in order. Because the external skin is innervated by somatic nerves, administration of anesthesia prior to evacuation of the clot will be needed. Excision, leaves a wound that should not be sutured but allowed to heal by second intention, but leads to increased postoperative pain. Incision and debridement of the clot allows for less pain, but may close too early and lead to reformation of the thrombus. A minor or rectal and colon surgical text should be consulted as to proper surgical technique.