Forenames **Lastname** **Hospital No.** **D.O.B.**	St Helens and Knowsley Teaching Hospitals NHS Trust **SDEC haemorrhoids & anorectal emergencies**

Thrombosed or strangulated internal haemorrhoid

Internal haemorrhoid may become strangulated and thrombosed when prolapsed part is left protruded until vascular compromise or venous stasis occurs. Patients usually present with acute irreducible and painful haemorrhoid. Foul-smelling discharge may be seen in those with mucosal necrosis. This condition is difficult to manage especially in case of extensive thrombosis and strangulation. Manual reduction of the haemorrhoid masses might help in reducing pain and tissue congestion.

Admission and emergency surgery are rarely needed.

Management- Ice packs, oral metronidazole, lignocaine gel, laxatives. Warn patient that may take 1-3 weeks to resolve. OPD with colorectal team in 6 weeks.

Variations

Bleeding haemorrhoid

Bleeding from haemorrhoid is characterized by a painless passage of bright-red blood during bowel movements, with or without prolapsed haemorrhoid. The blood may be spotted on toilet paper after cleansing or drip into toilet bowel. Bleeding tends to be mild except individuals having antiplatelet or anticoagulant therapy. Choices of treatment depend on the degree of bleeding, grade of haemorrhoid, patient's comorbidity and patient's preference. For low-graded haemorrhoid, management includes dietary and lifestyle modification & avoidance of constipation or diarrhoea.

Acutely thrombosed external haemorrhoid (perianal haematoma)

Classic symptoms of this condition are acute anal pain with a newly enlarged or tender bluish lump at the anal verge. Some patients may give a history of recent constipation or prolonged straining. Acutely thrombosed external haemorrhoid can be treated conservatively or surgically. Conservative management would be offered including anti-inflammatory analgesics, warm sitz bath, reducing activity and avoiding constipation

Differential diagnosis

Anal fissure

Painful defecation with a passage of red blood is a typical symptom of this condition. Pain is usually excruciating and may last from minutes to several hours.

Bleeding anorectal varices

Anorectal bleeding in patients with a history of longstanding or uncontrolled portal hypertension would give a clinician clues about this condition.

Irreducible or strangulated rectal prolapse

Clinicians should differentiate prolapsed rectum from circumferentially prolapsed internal haemorrhoid. Classic signs of rectal prolapse are protruding full thickness rectal wall with concentric rings of mucosa while haemorrhoid contains only mucosa

Anorectal abscess

An abscess forming in the anorectal region usually originates from an infected anal gland which is located in the anal mucosa and its opening is at the level of dentate line. Once the anal gland is infected, an abscess may form within an intersphincteric area or it could spread to an adjacent area such as perianal region, deep postanal space, ischiorectal fossa or, rarely, a supralevator space

Perineal necrotizing fasciitis (Fournier's gangrene)

Perineal necrotizing fasciitis is a severe and life-threatening form of skin and soft tissue infection in the anal and perineal region. It is usually polymicrobial infection that develops secondary to untreated anorectal abscess, genitourinary infection or cutaneous infection. It is more likely to occur in diabetic individuals and immunocompromised hosts.

Retained anorectal foreign bodies

Obstructing rectal cancer

Up to 15% of patients with rectal cancer present with acute distal colonic obstruction. Marked abdominal distension, obstipation and abdominal pain are among cardinal symptoms

Sexually transmitted disease as anorectal non-surgical emergencies

Some sexually transmitted diseases (STDs) may present in an emergency department manifesting as proctitis which could mimic other infectious proctitis and Crohn's disease.