CASE FIVE

Short case number: 3_8_5
Category: Gastrointestinal & Hepatobiliary Systems
Discipline: Surgery
Setting: General Practice
Topic: Internal and external haemorrhoids

Case

Lin Bui, aged 31 years, presents complaining of rectal bleeding. The last 2 times she has been to the toilet and opened her bowels she has noticed fresh red blood on the toilet paper. Last time blood dripped into the toilet bowel. She is worried she has cancer.

Questions

1. What further history and examination would you undertake?
2. You suspect she has internal haemorrhoids, how would you confirm this on examination?
3. What are the differences between true rectal prolapse, mucosal prolapse and internal haemorrhoids?
4. In a table summarise the definition and treatment of 1st, 2nd, 3rd & 4th degree internal haemorrhoids
5. How do external haemorrhoids present and how are they managed?

Suggested reading:

1. Henry MM, Thompson JN, editors. Clinical Surgery. 3rd edition. Edinburgh: Saunders; 2012. Chapter 25.
2. Garden OJ, Bradbury AW, Forsythe JLR, Parks RW, editors. Davidson's Principles and Practice of Surgery. 6th edition. Philadelphia: Churchill Livingstone Elsevier; 2012. Chapter 17.

ANSWERS

1. **What further history and examination would you undertake?**
   - haemorrhoidal protrusion or bleeding
   - bleeding may be minimal, appearing only on toilet paper, or it may occasionally be severe enough to cause anaemia
   - bleeding is usually bright red, coats the stool (rather than being mixed with it)
   - haemorrhoids are usually painless (unless there is thrombosis, ulceration or gangrene)

2. **You suspect she has internal haemorrhoids, how would you confirm this on examination?**
   - in cases of protrusion the haemorrhoids are graded according to the level of prolapse
   - first degree internal haemorrhoids do not prolapse, the proctoscope (anoscope) must be used to visualise them
   - second degree internal haemorrhoids prolapsed with defecation and return spontaneously to their anatomic position
   - third degree internal haemorrhoids prolapsed with defecation and require manual reduction
   - fourth degree haemorrhoids are not reducible (Fig. 16-23)
   - there is no classification for external haemorrhoids; they are either present or absent
   - mixed haemorrhoids are a combination of internal and external haemorrhoids

3. **What are the differences between true rectal prolapse, mucosal prolapse and internal haemorrhoids?**
   - haemorrhoids are usually found in three constant position: left lateral, right anterior & right posterior
   - internal haemorrhoids originate above the dentate line
   - external haemorrhoids are located below the level of the dentate line
   - because the rectal mucosa above the dentate line is relatively insensate, bleeding from internal haemorrhoids is usually painless
   - conversely external haemorrhoids are covered by richly innervated anoderm and usually cause pain when thrombosis occurs

4. **Definition and treatment of 1st, 2nd, 3rd &4th degree internal haemorrhoids**

degree	definition	treatment
first	bulge in the anal canal lumen; does not protrude outside the lumen	asymptomatic: take stool bulking agents, avoid constipation; increase water intake
		symptomatic: same as above; rubber band ligation; infra-red coagulation
second	protrudes with defaecation reduces spontaneously	conservative management (see above) or rubber band ligation
third	protrudes with defaecation must be reduced manually	selected cases: rubber band ligation mixed: surgical haemorrhoidectomy
fourth	protrudes permanently incarcerated	surgical haemorrhoidectomy

5. **How do external haemorrhoids present and how are they managed?**
   - usually cause few problems
   - large external haemorrhoids may interfere with perianal hygiene and thus be indirectly associated with pruritis ani. In these cases excision may be indicated.