Patient Information

Royal Devon University Healthcare
NHS Foundation Trust

Haemorrhoids and Haemorrhoidal Surgery

We expect you to make a rapid recovery after your operation and to experience no serious problems. However, it is important that you should know about minor problems, which are common after this operation, and also about more serious problems that can occasionally occur. The section "What problems can occur after the operation?" describes these, and we would particularly ask you to read this. The headings from this section will also be included in the consent form you will be asked to sign before your operation.

What are Haemorrhoids?

Haemorrhoids (or piles) are enlarged, bulging blood vessels in and around the anus. These vessels/vascular cushions are part of the normal anatomy. They only cause problems if they become swollen or engorged or if they slide down from their normal position (prolapse).The exact cause of haemorrhoids remains unknown. However, the upright posture of humans makes us more prone to them than animals that walk on all fours. Other possible factors that can lead to increased pressure in the vascular cushions and can contribute to haemorrhoids include:

- pregnancy and childbirth
- chronic constipation and straining
- overuse of laxatives
- ageing

Haemorrhoidal symptoms are very common and over 50% of the population will have them at some time in their life.

Symptoms of haemorrhoids

Patients have variable symptoms that may include:

- Bright red rectal bleeding. This is usually after opening your bowel and may vary from a smear of blood on the toilet paper to profuse bleeding into the pan.
- A swelling protruding from the anus (prolapse). These lumps felt at the anal verge following bowel movements may reduce by themselves, require manual reduction or remain prolapsed.
- Itching around the anus with associated soreness or mucus discharge.
- Haemorrhoids can be painful but this is not common. This usually signifies that the haemorrhoid has thrombosed (prolapsed and clotted).

Reasons for having Surgery

If your symptoms are severe and have not improved with conservative treatments, you may benefit from surgery.

Diagnosis

You will be seen in clinic by a member of the surgical team. They will take an in depth medical history from you, including details about your current condition, your diet and any medications you are taking. They will then need to examine your back passage; this may include inserting a small tube (sigmoidoscope or proctoscope) into your bottom so they can assess your haemorrhoids fully.

You may then be referred to have an investigation called a colonoscopy or sigmoidoscopy to check more of your bowel lining. This is very common and you should not worry that there is anything wrong. Your surgeon may be able to band your haemorrhoids at the same time as performing the colonoscopy/ sigmoidoscopy.

What is the treatment for haemorrhoids?

The first step in the management of haemorrhoids is to try and reduce aggravating factors. Often this involves increasing the amount of fibre and fluid in the diet in order to keep the stools soft and reduce straining. Avoiding painkillers that can cause constipation (like codeine) is also helpful. Stool softeners may be necessary in some cases. If symptoms are still problematic after these simple measures have been taken, it is possible that further treatment may be beneficial.

Surgical options

Surgical treatment of haemorrhoids is tailored to the individual patient's symptoms and needs. There are various treatments available, many of which have been developed in the last 10 years. These procedures are less painful than more traditional surgical treatments and can allow for an earlier return to normal function.

Part of the procedure is a thorough examination and during this your surgeon may find that you have a slightly different condition than originally expected. Your surgeon will then perform the most appropriate type of surgery for your specific condition.

This may involve placing a telescope into your bottom to have a look at the inside of your bowel (sigmoidoscopy). If there are any areas of the bowel or surrounding tissues that look slightly unusual then your surgeon may take a sample of tissue from this area (biopsy). This is taken so that your surgeon can plan the most appropriate treatment for your condition. If your surgeon finds a tear in the tissues around your anus that has been contributing to your symptoms, your surgeon may inject the muscles around the anus with a drug called Botox (Botulinum Toxin A) which temporarily relaxes the outer muscles of the anus to allow the tear to heal. A side effect of this drug can be flu like symptoms that resolve after 7-10 days.

If your surgeon has needed to carry out any other procedure than originally expected to ensure that you have received the best treatment for your specific condition, they will discuss this with you before you are discharged home.

Banding

Rubber band ligation of haemorrhoids is suitable for smaller internal haemorrhoids or those that spontaneously reduce. A small rubber band is placed over the haemorrhoid, cutting off its blood supply. The band and the shrunken haemorrhoid falls off a few days later leaving a small scar at its base. This procedure may produce some discomfort and a feeling of urgency for a few days. Patients should expect some bleeding in the subsequent 5 to 7 days. Banding may need to be repeated for a full effect.

HALO (Haemorrhoidal Artery Ligation Operation) / THD (Transanal Haemorrhoidal Dearterialisation)

This operation requires a short general anaesthetic and is usually performed as a day case procedure. A miniature ultrasound device is used to locate the arteries supplying the haemorrhoids as they come down the rectum under the bowel lining. Once these blood vessels have been located, sutures are inserted to tie them off and cut off the blood supply to the haemorrhoids. Over the next few days to weeks, the haemorrhoids shrink away and the symptoms resolve. This procedure is especially good for patients with more significant bleeding from their haemorrhoids or who have symptoms that recur after banding.

For patients with elements of prolapse, the HALO procedure can be combined with a rectoanal repair that involves stitching up the prolapsing pile internally.

Open haemorrhoidectomy

Open haemorrhoidectomy is a surgical procedure that involves cutting out the internal and external components of the haemorrhoids. The wounds are usually left open and heal naturally over the following weeks. This procedure usually has a longer recovery period and causes more pain than the newer techniques mentioned above, and is usually only performed if other treatments have failed.

What about the anaesthetic?

You will receive a general anaesthetic for your surgery; you will see your anaesthetist on the day of surgery who will discuss your anaesthetic further with you.

What happens before the operation?

Prior to your admission you will have seen a member of the surgical team to discuss the surgery and its risks and benefits.

You will have a pre-operative assessment where you are likely to be examined by a practitioner, have bloods taken and be asked about your past medical history, previous surgeries and asked about any medications you may be taken. At times you may be asked to stop taking certain medications prior to surgery, these may impose an added risk to surgery such as blood thinning medications.

Upon admission on to the ward you will be shown where to sit, where you will be seen by a number of different people. You will be seen by a nurse who will take some information from you and will attach patient identification bands around your wrists or ankles. You will be given a gown to wear for theatre and white stockings to wear to help prevent blood clots. You will also be seen by a member of the surgical team who will go through the consent form for your procedure with you, an anaesthetist who will discuss your anaesthetic. Please stay on the ward so that you may be seen by all these people to avoid delays in your surgery.

When your theatre team is ready for you, a member of the team will walk to the ward to collect you; they will check a few details with you and then walk you to theatre (if you are able). You will then be taken into the anaesthetic room where you will be met by your anaesthetist. A member of the theatre team will ask you to lie on a theatre bed, and will attach a blood pressure cuff to your arm; a probe onto your finger to measure your oxygen levels and three stickers attached to wires will be placed onto your chest to monitor your heart. You will also have a needle placed into a vein on the back of your hand or arm; this allows the anaesthetist to administer the medications required for your anaesthetic.

What happens after the operation?

After your surgery you will be taken into the Recovery Unit where you will receive individual specialist care whilst you are waking up from the anaesthetic. When you are awake and feel ready you will be given something to eat and drink. You will be encouraged to get up and mobilise to reduce the risk of developing blood clots.

You will be prescribed stool softeners as it is very important that you do not get constipated and strain to open your bowels as this would affect the success of the operation. You may find that you are sore following your operation; your surgeon will have prescribed painkillers for you to take to ease your discomfort.

If your surgeon has placed an absorbent dressing into your bottom during surgery (your surgeon will advise you of this), you will pass this next time you open your bowels.

Discharge from hospital

When you are comfortable you will be discharged from hospital later that day. Please make sure you have somebody to collect you as you will not be able to drive and ensure you have someone staying with you for 24 hours whilst you recover from the anaesthetic.

What problems can occur after the operation?

Bleeding

You may find that you bleed following your surgery. This is common and should not be large amounts. If you are passing large amounts of blood please contact your GP or the ward you have been discharged from.

Infection

There is a small risk of infection with this type of surgery due to the area being operated on and this is usually treated with antibiotics. In extreme cases you may need to go to theatre for the infection to be drained.

Deep vein thrombosis (DVT)

Deep vein thrombosis is a possible problem, but is uncommon. If you are at particular risk then special precautions will be taken to reduce the risk. Moving your legs and feet as soon as you can after the operation and walking about early, all help to stop thrombosis occurring.

Band displacement (Banding only)

There is a risk of the bands that have been applied falling off – there are generally multiple bands applied to your haemorrhoids so this may not necessarily affect the efficacy of the operation.

Urgency

With all haemorrhoidal surgery it is common that you may get the feeling of urgency and need to rush to empty your bowel. This usually settles in time.

Scarring

You may develop some scarring from your surgery, however this rarely causes any problems. In extreme cases you may develop some narrowing of your anal canal.

Ulcers

There is a small risk of ulceration following haemorrhoidal surgery. These normally resolve on their own without any need for treatment.

Rectal Perforation

This is uncommon; if however your rectum inadvertently perforates you will be given antibiotics and in extreme cases you may require surgery.

Urinary Retention

This is uncommon, however if you were to go into urinary retention you may need to have a catheter tube inserted into your bladder to drain your urine. This is usually only temporary.

Incontinence

There is a small risk of damage to your muscles that control emptying your bowels resulting in faecal incontinence. You may require further treatment to help improve this.

The risks of a general anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- **Common temporary side effects** (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.
- **Infrequent complications** (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems with speaking.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and damage to the voice box. These are very rare and may depend on whether you have other serious medical conditions.

What should you do if you develop problems?

Please contact your GP who will then decide on the most appropriate treatment for you. They will be able to contact the hospital if necessary.

Do you need to return to hospital for a check?

You will not be routinely given an appointment following your surgery , but if your GP has any concerns they can contact your surgeon and request an appointment.

Who should you contact in an emergency?

Please attend your local Emergency Department or if your condition is life threatening please call for an ambulance.

The Trust cannot accept any responsibility for the accuracy of the information given if the leaflet is not used by Royal Devon staff undertaking procedures at the Royal Devon hospitals.

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