# CASE REPORT

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Surgery or Conservative Treatment in Acute Hemorrhoidal Crisis?A Case Report of Successful Surgical Intervention

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# Surgery or Conservative Treatment in Acute Hemorrhoidal Crisis? A Case Report of Successful Surgical Intervention

# Akut Hemoroidal Kriz Tedavisinde Hangisi Daha İyidir? Cerrahi mi Yoksa Konservatif Yaklaşım mı?

## ABSTRACT

"Haemorrhoids" are the vascular cushions located under the distal rectal mucosa and provide around one-fifth of the resting pressure following the closure of the anal canal. It is referred to as "hemorrhoidal disease" when they grow sufficiently large to cause symptoms and/or move towards the distal portion of the anal canal. Prolapse, pain, anal itching, and bleeding are the primary symptoms. The male-to-female ratio is similar, although the true incidence is unclear. Its frequency increases between the ages of 45 and 65. Strangulation of internal hemorrhoids and thrombosis of external hemorrhoids cause "hemorrhoidal crisis", which is painful and has high morbidity. In these situations, immediate surgical treatment is advised within the first 3 days after symptom onset, in contrast to the cautious approach followed in most centres. Surgical intervention removes the negative economic and psychological consequences of long-term recovery attained by a conservative strategy. Furthermore, it reduces the probability of surgical treatment in the advanced stages of the disease.
We present our case, who underwent surgery on the eighth day following a hemorrhoidal crisis, with the consideration that it would contribute to the selection of treatment. The postoperative pain complaint resolved on the first day, and the bleeding in the form of leakage resolved on the third day. In acute hemorrhoidal crises like ours, where surgical intervention is usually the primary requirement, delayed surgery was eventually undertaken and yielded a favorable outcome.

## Key Words

Anal diseases, Anal pain, Anal bleeding, Thrombosed hemorrhoids, Hemorrhoidectomy

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## ÖZ

"Hemoroidler" distal rektal mukozanın altında bulunan ve anal kanalın kapanmasını takiben istirahat basıncının yaklaşık beşte birini oluşturan vasküler yastıkçıklardır. Semptomlara neden olacak kadar ve/veya anal kanalın distal kısmına doğru büyüdüklerinde "hemoroidal hastalık" olarak adlandırılmaktadırlar. Prolapsus, ağrı, anal kaşıntı ve kanama başlıca semptomlarıdır. Gerçek insidansı tam olarak bilinmemektedir, erkek-kadın dağılımı benzerdir. Sıklığı 45-65 yaşları arasında artmaktadır. İç hemoroidlerin strangüle ve dış hemoroidlerin tromboze olması ağrılı ve morbiditesi yüksek olan "hemoroidal krize" neden olmaktadır. Bu durumlarda, merkezlerin çoğunda izlenen konservatif yaklaşımların aksine, semptomların gelişmesinden sonraki ilk üç gün içinde acil cerrahi tedavi önerilmektedir. Cerrahi tedavi, konservatif yaklaşım ile elde edilen uzun vadeli iyileşmenin olumsuz ekonomik ve psikolojik sonuçlarını ortadan kaldırmaktadır. Ayrıca hastalığın ilerleyen aşamalarında cerrahi girişim olasılığını da azaltmaktadır.

Tedavi seçimine katkıda bulunacağı düşüncesiyle hemoroidal krizden sonraki sekizinci gününde ameliyat edilen olgumuzu sunuyoruz. Ameliyat sonrası ağrı şikayeti birinci günde, sızıntı şeklindeki kanama ise üçüncü günde düzelmiştir. Olgumuzda olduğu gibi akut dönemde öncelikli olan cerrahi tedavi, geç bir aşamada yapılabilmiş ve faydalı olmuştur. Böyle durumlarda cerrahi tedavinin yararlı olabileceği akılda tutulmalıdır.



## Anahtar Kelimeler

Anal hastalıklar, Anal ağrı, Anal kanama, Tromboze hemoroid, Hemoroidektomi


## INTRODUCTION

Haemorrhoids are cushions made up of dilated arteriovenous vascular systems and connective tissue that help to maintain continence in the anal canal. They are normally located in the submucosal layer in the lower rectum. Haemorrhoids located closer to the dentate line are referred to as internal haemorrhoids, while those farther away are known as external haemorrhoids. The pudendal vein connects the two of them and drains them into the inferior vena cava. Internal haemorrhoids affect the anal sensation and the resting pressure in the anal canal (1). When they develop large enough to become symptomatic, they lead to hemorrhoidal disease, which is observed with varied clinical circumstances, such as self-limiting rectal bleeding to life-threatening anaemia (2). A condition known as "perianal thrombosis" is caused by thrombosis that occurs within the external hemorrhoidal plexus, which is a venous system surrounding the anal margin that has distinct drainage and sensitive skin coverings (3, 4). Hemorrhoidal disease has a complex aetiology. These include long periods of sitting, constipation, diarrhoea, low-fiber diets, pregnancy, age, and family history (5, 6). Its pathophysiology remains unclear. Venous congestion within the vascular component, caused by increased intra-abdominal pressure and/or changes in collagen composition over time, reduces stromal support. This weakening contributes to the downward displacement of the anal cushions, a key event in the pathogenesis of hemorrhoidal disease (4).

The Goligher classification, which comprises four phases, is the most widely used in practice, although other classifications in the literature reflect the severity of the disease (7). Thus, irreducible, permanently prolapsed haemorrhoids are described as stage four hemorrhoidal disease. Its treatment involves both conservative and surgical techniques (6, 8, 9). Although there is no evidence in the literature, it is advised to try conservative measures such as oral or topical analgesics, topical myorelaxants, high-fiber diets, increased fluid intake, oral phlebotonics, and stool softeners within the first 3 days of symptom onset (9, 10). Commonly performed office-based interventions for hemorrhoidal disease include rubber band ligation (RBL), sclerotherapy, and infrared coagulation (11). Options for surgical treatment include stapled hemorrhoidopexy and mucopexy, Doppler-guided haemorrhoid artery ligation, thrombectomy, and/or hemorrhoidectomy (4, 8, 9).

Not only is the patient's condition and the time of symptom development considered while selecting the treatment plan, but also the intensity of the symptoms (3, 12).

It was believed that the current case, in which surgery might be used to treat the acute hemorrhoidal crisis after the conservative method proved ineffective, would provide insight into the best course of treatment.

## CASE REPORT

The patient provided informed consent for this case report. A 76-year-old male patient presented to our emergency clinic with complaints of discomfort, bleeding, and swelling in the anal area that began abruptly after difficult defecation a week prior. The patient's body mass index was within the physiologically normal range, and the individual was employed in a shift-working occupation. A history of constipation was not elicited. It was discovered that the center he had previously applied to had administered oral phlebotonics, intravenous analgesics, and local ice, but there was no response to the medications. He had no history of surgery and no additional disease. On physical examination (Figure 1a), an acute hemorrhoidal crisis was observed in the anal region, with external and internal hemorrhoidal cushions, staged as grade four according to the Goligher classification. Rectal examination revealed increased anal sphincter tone and coagulum in the inner part of the anal region. Laboratory evaluation showed no evidence of anemia, and no additional proctological pathology was detected. Following hospital admission and completion of surgical preparation, the patient was transferred to the operating theater. He was taken into surgery in the lithotomy position under spinal anesthesia (Figure 1b and c).

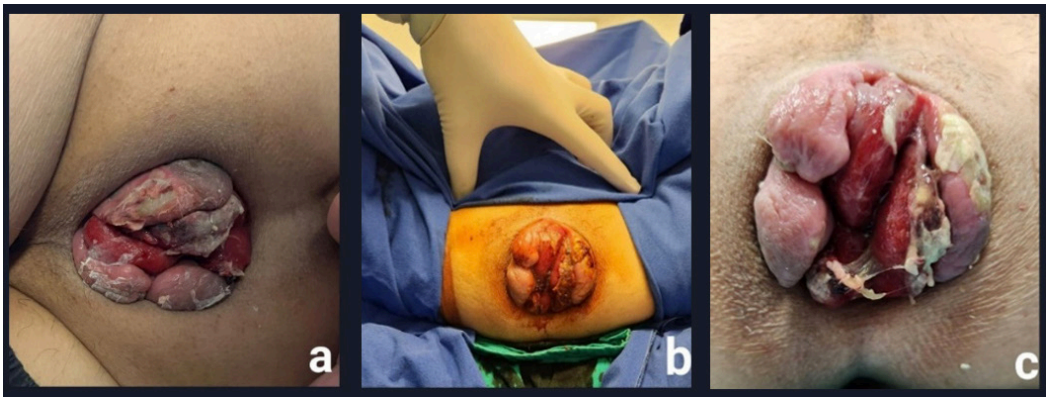


**Figure 1.** (a) Acute hemorrhoidal disease with external and internal components, staged as Grade 4 (b, c) Preoperative view of the anal region following unsuccessful medical treatment

A hemorrhoidectomy was performed utilizing the Ferguson technique for the internal and external hemorrhoidal complexes at the 4, 7, and 11 o'clock positions. The internal sphincter was preserved and mucosal bridges between hemorrhoidectomy sites were left intact (Figure 2a). The postoperative pain complaint resolved on the first day, and the bleeding in the form of leakage resolved on the third day. Following confirmation of complete hemostatic control, the patient was deemed stable and subsequently discharged. In the third and twelfth weeks, an outpatient clinic control was conducted (Figure 2b and c).

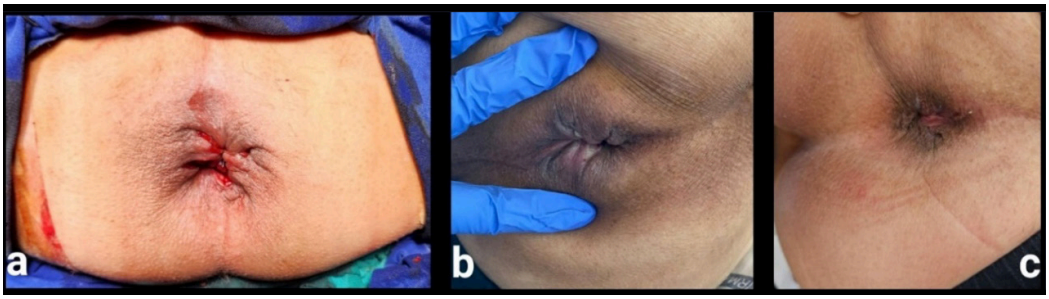


**Figure 2.** (a) Postoperative view (b) Third week postoperative view (c) Twelfth week postoperative view.

A colonoscopy was performed at the patient's third-month follow-up, and the colon was found to be normal. It was noted that there were no wound site issues or consequences, such as fecal incontinence or anal stenosis. Follow-up was successfully concluded.

## DISCUSSION

Correct clinical staging is the first step towards a successful treatment plan for hemorrhoidal disease. As a result, conservative techniques are the main treatment strategy for early disease, such as stages one and two. The first medical prescription for every patient is to increase water intake, along with a high-fibre diet, to help regulate bowel movements, minimise colon transit time, and raise faecal weight (13). Phlebotonics are commonly used in medical treatment to reduce symptoms because they raise venous tone by stabilising capillary permeability, enhancing lymphatic drainage, and lowering hydroxyl radicals. According to the review by Perera et al., phlebotonics was not associated with any change in pain or pain scores during the post-hemorrhoidectomy phase, but it was significantly beneficial in cases of pruritus ani, bleeding, post-hemorrhoidectomy bleeding, and anal area leakage compared with the control group (14). Gallo et al. high-

lighted that the application of profibrinolytic activity-containing mesoglycan decreased pain scores (15). Despite the wide range of alternatives available, topical agents are generally ineffective. Conversely, the most recent consensus states that excisional hemorrhoidectomy is the gold standard in cases of severe illness, such as those in stages three and four (16). In our case, oral phlebotonics, topical calcium channel blocker, intravenous analgesic, and oral stool softener were employed as conservative measures to manage the hemorrhoidal crisis. For around a week, the treatment was continued, but no improvement was seen. Even with successful conservative treatment, the recurrence rate in cases of acute hemorrhoidal crisis is significant, and the likelihood of symptom eradication is low. In these situations, surgical techniques should be used rather than referring the patient to an advanced surgical center. The problem can be resolved with the aid of basic surgical instruments and the appropriate method. In actuality, the successful treatment approach we used is an illustration of this.

There are numerous techniques for excisional hemorrhoidectomy, as detailed by Milligan, Morgan, Parks, Ferguson, and Whitehead. Regarding complications, patient satisfaction, postoperative discomfort, and the need for analgesics, there are no differences between the procedures. After six to eight weeks, postoperative anal stenosis is reported at a rate of 1-7.5% as a result of inadequate surgical technique following excisional hemorrhoidectomy. Anal incontinence is a significant problem that affects 2-11% of patients (16). The prevalence of these disorders is higher following acute hemorrhoidal crisis surgery. The Ferguson technique, which involves using cautery to approximate the wound edges with absorbable (ideally 3-0 round polyglactin) suture material following internal and external hemorrhoidectomy and promotes comparatively better wound healing, was chosen in this instance. Three areas underwent excisional hemorrhoidectomy, protecting the mucosal bridges and internal sphincter. At the 12-week follow-up, there had been a significant decrease in postoperative symptoms and the recovery had been completed without the emergence of predicted problems such as anal stenosis or incontinence.

According to the study by Sammarco et al., conservative measures were given priority in cases that persisted for more than 3 days, while surgical therapy was given priority within the first 3 days following the onset of acute symptoms. The study highlights the need to treat acute hemorrhoidal crises based on the patient's needs and symptom severity, rather than the length of the crisis (3). Supporting this viewpoint, surgical treatment, which was the primary necessity in our case, could be undertaken at a late stage and was advantageous.

Because mesoglycan was not available in the area, it could not be used. Furthermore, because it was not part of our surgical equipment, the Doppler ultrasonography device, which is supposed to be useful in the surgical treatment of advanced hemorrhoidal disease and enable hemorrhoidal artery ligation, could not be used.

## CONCLUSION

Irrespective of the timing of symptom onset, we believe that management decisions for advanced hemorrhoidal disease should be made on a case-by-case basis, grounded in clinical staging through a thorough physical examination and the severity of clinical manifestations. Multicenter, prospective, randomized trials with large numbers of cases are necessary to verify this. Surgical treatment needs to be given priority in the management of severe hemorrhoidal crises. It is not appropriate to insist on conservative treatment approaches during this procedure that have a poor success rate and a high chance of relapse. The success of the surgical approach, rather than symptom onset timing, symptom intensity, or disease stage, appears to be the principal factor influencing postoperative outcomes.

**Informed Consent**

All the participants' rights were protected and written informed consents were obtained before the procedures according to the Helsinki Declaration.

**Conflict of Interest**

The authors have no conflict of interest to declare.

**Financial Disclosure**

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