

Management

Management

Most patients with incontinence can be managed conservatively with dietary advice, stool bulking or constipating agents, cleansing enemas, rectal irrigation, nurse-led bowel retraining, including specific biofeedback programmes, or anal plugs, which expand within and thus seal the anal canal. Failure of such measures and the severity of symptoms may result in selection for surgery. Management

Exclusion of other causes of rectal bleeding, especially colorectal malignancy, is the first priority. In the absence of a specific predisposing cause, important measures include improving bowel and defecatory habits, adopting a defecatory position to minimise straining (see Chapter 73) and the addition of stool softeners and bulking agents. Various proprietary creams can be applied at night and before defecation. Suppositories of phlebotonics (plant-based flavonoid extracts) and synthetic James Barron, 1914–1996, surgeon, Henry Ford Hospital, Detroit, MI, USA. ability and increase lymphatic drainage. In patients with first- or second-degree internal haemorrhoids whose symptoms are not improved by conservative measures, injection sclerotherapy with submucosal injection of 5% phenol in arachis oil or almond oil may be used (Figure 80.21). The aim is to cause fibrosis that obliterates the vascular channels and a scar that supports prolapsing anorectal mucosa. It is important to inject about 3–5 mL not into the of sclerosant into the apex of the pedicle and haemorrhoid itself using a disposable needle and syringe. The procedure is repeated for each haemorrhoid complex and the patient reassessed after 8 weeks; if necessary, the injections are repeated. Pain upon injection means that the needle is in the wrong place and should be withdrawn. Injections that are too superficial are heralded by the rapid bulging of the mucosa, which turns white; this leads to superficial ulceration but rarely serious septic sequelae. However, injections placed too deeply can have serious consequences, including prostatitis and pelvic sepsis. For this reason, haemorrhoidal injection has largely been superseded by rubber band ligation. The Barron's bander is a commonly available device used to slip tight elastic bands onto the base of the pedicle of each haemorrhoid (Figure 80.22). It is essential that the band is applied above the dentate line as below can cause intense pain. The bands cause ischaemic necrosis of the piles, which slough off within 10 days; this may be associated with bleeding, about which the patient must be warned. The resulting fibrosis supports the remaining anal cushions. All three primary haemorrhoids may be treated at one session, and the process may be repeated after several weeks. Other ablative techniques such as cryotherapy and infrared photocoagulation are not commonly used.

Revision #1

Created 2025-12-31 15:29:17 UTC by Omar Ayman

Updated 2025-12-31 15:29:17 UTC by Omar Ayman