Review article

Prolapsed thrombosed haemorrhoids in pregnancy – a painfully difficult problem with special considerations

S A Karunananda[a]

Abstract

Haemorrhoids are a very common occurrence in pregnancy with a reported incidence of about 35%. It requires a holistic approach bearing in mind that the majority of medications and procedures are of unproven safety in pregnancy or with additional risks. Lots of general measures and therapies are available but none provides instant relief of a permanent cure sans risks. Conservatism is the rule but carefully considered surgery and even early delivery may be applicable in extreme cases where a combined caesarean and definitive treatment could be considered. As the problem is so common in pregnancy and no single ideal effective solution is available, yet with so many treatment options on offer, it is imperative that the obstetrician is fully aware of the possibilities.

Key words: prolapsed thrombosed haemorrhoids pregnancy

A woman presented in agony at 35 weeks into her otherwise uncomplicated first pregnancy with a painful rectal mass but no bleeding. The diagnosis of prolapsed thrombosed haemorrhoids was easy but the initial treatment was not yielding any results with severe distress to the patient! This situation made the author to dig deep to find all available treatment options of western and traditional systems and to share the knowledge gathered. Most of the general measures apply to another painful anal condition of fissure in ano which is easily recognisable on inspection.

Haemorrhoids are said to be more frequent during pregnancy occurring in over a third of patients[2]. The problem exacerbates during the third trimester, when the foetus is larger and puts pressure on the pelvic floor, the rectum and the sigmoid colon. The combined effect of increased blood flow to the perineum and the pressure of the weight of the foetus make matters worse. One other main causes of haemorrhoids is constipation. During pregnancy, an increase in progesterone can cause impairment of bowel motility. Iron therapy is a contributor too. Iron supplements are known to cause constipation as overall absorption of iron is poor. On average 10% of iron from food is absorbed by the body for women and 5% for men, the residual iron in the gut being the culprit.

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[a] *Senior Lecturer in Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya, Sri Lanka*

Correspondence: E-mail: asokakk@hotmail.com

https://orcid.org/0000-0001-8811-0148

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Management options

Ideally a colorectal surgeon and an anaesthetist /pain specialist and a dietician should be involved in a combined approach.

General measures include requesting the patient to avoid sitting for long periods of time as sitting puts pressure on the veins in the anus and rectum. The patient should be encouraged to lie on her side whenever possible instead. If she must sit, taking frequent breaks or sitting on a haemorrhoid pillow, also known as a ring cushion or doughnut is helpful.

As constipation contributes to haemorrhoids during pregnancy relieve or prevent constipation and irritation of anal area in susceptible women. Its best to avoid tuna or squids like fish and red meats well known to exacerbate the problem. Dairy foods are best avoided too[6,7]. Many people advice oily parts of pork perhaps to increase the lubricant effect of stools by increasing the non-absorbed fat content. High fibre kohila, murunga leaves and kohu amba (wild mango) known to ease constipation and eating lots of over boiled vegetables like leaks may be helpful being perfectly safe over laxatives. Physical activity the daily routine though preventive may not be easy when the haemorrhoids are thrombosed and prolapsed, but prolonged sitting is the worst thing that needs avoidance. Bulk forming laxatives and fecal softeners are often prescribed.

Soaking the anal region in a warm water filled tub with magnesium sulphate (sitz bath) is a standard practice which however is not an easy manoeuvre in late pregnancy. Therefore epsom salt paste can be home made for application directly on the haemorrhoidal masses. This can be home made by mixing 20ml of glycerine with 2 tablespoons of epsom salt until it forms a paste. Placing the paste on a gauze or tulle pad and applying it directly for 15 to 20 minutes should be repeated every four to six hours until the pain subsides.

Tonolane Anusol and lignocaine[12] cream are used but the absorption of lignocaine is an issue in pregnancy when overused. The American College of Obstetricians recommend, witch hazel, (Hamamelis virginiana) a type of flowering shrub, is highly effective at easing both vaginal discomfort and the haemorrhoids associated with pregnancy. The product is not freely available in Sri Lanka. Instead Aloe Vera (komarika) gel could be applied topically on the haemorrhoids two or more times a day. The gel acts on the haemor-rhoids reducing inflammation, giving relief in case of pain and relieving itching. It also acts on the circulation, reducing venous stasis.

Herdsman, (venosmil) gel, a synthetic bioflavonoid, is a capillary stabilising agent. Venosmil is a medicinal product indicated for short-term relief from oedema and symptoms related to chronic venous insufficiency. This again has been used without any guarantees of safety in pregnancy.

Diltiazem and verapamil cream is not recommended in pregnancy as is Botox therapy. Diclofenac suppository or oral therapy too could pose problems on long term usage. Nonsteroidal anti-inflammatory drugs (NSAIDs) use in pregnant women at 30 weeks gestation and later may cause premature closure of the foetal ductus arteriosus; NSAID use beyond 22 weeks is implicated in foetal renal dysfunction leading to oligohydramnios and, neonatal renal impairment. NSAID use in pregnancy prior to 22 weeks gestation should be based on a benefit-risk assessment; most authorities recommend avoiding NSAIDs throughout pregnancy.

If NSAID use is necessary between 20- and 30-weeks' gestation ultrasound monitoring of amniotic fluid should be considered if NSAID use extends beyond 48 hours; if oligohydramnios occurs, discontinue NSAID and treat appropriately.

As there is no ready cure in western medicine, patients often explore time tested remedies of alternative medicine which surprisingly runs on parallel lines and reasoning. Ayurvedic approaches to management of haemorrhoids are similar in many aspects but more holistic than in the western system; herbal remedies to loosen stools and with analgesic effects, vegetarian lifestyle changes, meditation, and even minimally invasive procedures forming part of their treatment plans. Medication, or bhaishajya chikitsa, herbal application, or kshara and surgical intervention, or sastra chikitsa are in the package as with western practices. Kshara is a caustic, alkaline paste used to manage haemorrhoids. The paste is made of an herbal blend and has a cauterizing action. Kshara is applied to the haemorrhoid using a specialized slit proctoscope. The paste then chemically cauterizes the haemorrhoid, whether these applications are safe in pregnancy is unknown. There is reference to even cauterization, or agnikarma and tying off the base of the haemor-rhoids.

A combination of western and ayurvedic medicine is often an approach resorted to by patients trying to avoid haemorrhoidectomy due to its reputation for severe post-operative pain. If all conservatism fails or the situation is extreme, surgery has to be resorted to. There is a reluctance to operate for fear of increased risk of haemorrhage and the hope that the problem would go away after partus.

A common agonising complication of external haemorrhoids is the formation of blood clots inside the vessel, or a thrombosed haemorrhoid. Proper treatment for such thrombosed haemorrhoids consists of an "incision and drainage" an emergency room can perform this procedure.

Banding is an office procedure used to treat internal haemorrhoids but not when prolapsed and thrombosed. Also called rubber band ligation, this procedure involves using a tight band around the base of the haemorrhoid to cut off its blood supply. Banding is not applicable when anticoagulants or low dose aspirin is in use because of the high risk of bleeding complications.

The alternative of sclerotherapy tends to have the best success rates for only small, internal haemorrhoids. Coagulation therapy, cold coagulation or infrared photocoagulation is an office procedure. Haemorrhoidal artery ligation (HAL), also known as Trans anal haemorrhoidal dearterialization (THD), is another option to remove a haemorrhoid. This method locates the blood vessels causing the haemorrhoid using ultrasound and ligates, or fibroses, those blood vessels. It's more Haemorrhoidopexy is sometimes referred to as stapling. It's usually handled as a same-day surgery in a hospital, and it requires only local anaesthesia. Stapling is used to treat prolapsed haemorrhoids. A surgical staple fixes the prolapsed haemorrhoid back into place inside the rectum and occludes its blood supply. Stapling recovery takes less time and is less painful than recovery from a dreaded haemorrhoidectomy effective than rubber banding, but costs a lot more. A relatively atraumatic method often overlooked is the forceful dilatation of the anus. This has been advocated as a simple and effective method of therapy for patients with symptomatic haemorrhoids[1]. It has been suggested, however, that patients should use a large anal dilator as well as a bulk laxative for a few months. Patients were only considered suitable for treatment by anal stretch if two fingers could not be introduced into the anal canal. A six to eight finger anal dilatation was originally performed under general anaesthesia in the left lateral position[1]. Stretching the tight sphincter helps correct the underlying abnormality, thus allowing the fissure to heal. The number of fingers used and the amount of time for which the stretch is applied vary among surgeons. Although the sphincter stretch does provide symptomatic relief from haemorrhoids as well as anal fissures, it is rarely performed today, because of the high rate of impaired faecal or flatus continence observed in about 15% of patients as a consequence of uncontrolled stretching and subsequent tearing of the internal and external sphincter but this still needs some consideration in a pregnant woman in distress refusing more invasive surgery.

Haemorrhoidectomy is not the preferred first option for taking care of haemorrhoids during pregnancy. However, this type of surgery is not uncommonly resorted to during pregnancy or puerperium. Haemorrhoidectomy is used for large external haemorrhoids and internal hemorrhoids that have prolapsed or are not responding to nonsurgical management.

The use of the ultrasonic harmonic scalpel minimizes the damage to surrounding tissues, and suture closure is not required for haemostasis during the haemorrhoidectomy. This limited spread reduces anal spasms, allows for a bloodless surgery, and can result in reduced postoperative pain and faster wound-healing. In LASER haemorrhoidectomy the haemorrhoid is vaporized or excised using carbon dioxide or NdYag LASER. The smaller LASER beam allows for precision and accuracy; and rapid unimpaired healing. It is painless at least during the procedure, which is the main concern for patients considering surgery.

The haemorrhoid in the picture was successfully managed conservatively but required a 4 finger anal dilatation as she was fearful of more conventional invasive surgery. She was made aware of the risk of transient incontinence but opted to accept the risk than other forms of surgery. She was delivered by caesarean section at 37 weeks, at her request justified by a wish to avoid a relapse by bearing down.

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