ORIGINAL RESEARCH

A study on clinical presentation of haemorrhoids in patients undergoing treatment at a tertiary care hospital

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ABSTRACT
Symptoms of haemorrhoids include rectal haemorrhage, discomfort, pruritis, and mass. Haemorrhoids may be seen in persons of all socioeconomic backgrounds, from the poor to the wealthy. Haemorrhoids develop as a result of anal cushion weakening and venous engorgement. In this study, 100 outdoor patients who complained of bleeding per rectum and whose mass had either naturally decreased (second degree) or required physical reduction of mass (third degree) over the course of a year were examined in the general surgery department at Mount Zion Medical College, Adoor. The study examined the results of rubber band ligation in cases of internal haemorrhoids in the second and third degree using observational cross-sectional prospective methods. The Institutional Ethical Committee cleared the study. According to the clinical presentation of the patients, bleeding was the primary symptom in the majority of participants (92%) followed by prolapse during faeces (81%); additional symptoms included pain (27%), irritation (22%)and discharge (18%).
Key words: Haemorrhoids, bleeding, prolapse

INTRODUCTION

Haemorrhoids are the most prevalent benign condition among recognized anorectal illnesses. It has a high incidence ranging from 2.9% to 27.9% globally, with more than 4% experiencing symptomatic haemorrhoids. Haemorrhoids are frequent in clinical practice and affect people of all ages. Both male and female sexes are impacted equally [1,2]. Symptoms of haemorrhoids include rectal haemorrhage, discomfort, pruritis, and mass. Haemorrhoids may be seen in persons of all socioeconomic backgrounds, from the poor to the wealthy. Haemorrhoids develop as a result of anal cushion weakening and venous engorgement.

Depending on the severity of the haemorrhoids, several medicinal, surgical, and instrumental treatments are offered. Laxatives and flavonoids are effective in medical treatments that involve a hot sitz bath. Our study is focused on the instrumental technique-the elastic ligation, which is not a surgery-rather than one of the several surgical methods, such as the more invasive Milligan-Morgan operation or the less invasive arterial ligation employing HAL (hemorrhoidal artery ligation) doppler. Despite the fact that many nonoperative methods, including rubber band ligation, photocoagulation, sclerotherapy, cryotherapy, and minimally invasive methods, are successful in managing symptoms in patients' prognosis, they are associated with recurrences [3,4].

METHODOLOGY

In this study, 100 outdoor patients who complained of bleeding per rectum and whose mass had either naturally decreased (second degree) or required physical reduction of mass (third degree) over the course of a year were examined in the general surgery department at Mount Zion Medical College, Adoor. The study examined the results of rubber band ligation in cases of internal haemorrhoids in the second and third degree using observational cross-sectional prospective methods. The Institutional Ethical Committee cleared the study.

Modified Golligher Grading was used to categorize haemorrhoids [7]. In this study, individuals with either grade II or grade III internal haemorrhoids who refused medical treatment along with the necessary measures for personal cleanliness and daily activities

in either gender and with 14 years of age or older were included. Excluded patients were those with first-degree, fourth-degree, external haemorrhoids, as well as those who missed their follow-up appointment.

Every patient had a thorough history and examination after giving informed, signed permission. Patients who met the requirements for inclusion underwent aseptic rubber band ligation in a daycare setting. Before the surgery, all patients received bowel preparation to prevent intestinal peristalsis for the first 24 hours in order to prevent ligature slippage. The rubber band ligation surgery was carried out in the left lateral sims position without the use of anaesthetic. The proctoscope was introduced and entered up to 1-2 cm above the dentate line after the topical administration of xylocaine jelly. Haemorrhoidal cushions were allowed to form in the proctoscope lumen following a gradual withdrawal, and they were then drawn into the Barron Ligator (Precise, Canada) under negative pressure.

The tissues were drawn into the tip of the cylindrical portion of the ligator until it was elongated and tightened. After that trigger was released, implementing a Barron rubber o-ring band with an inner diameter of about 1mm around the base of the haemorrhoid. All primary haemorrhoids were ligated in one setting. At the end of the procedure, all patients were kept under observation for 1-2 h to detect any early complications such as bleeding, pain, urinary retention, and vasovagal attack. We advised sitz bath at room temperature, a high fibre rich diet, stool softener, proper anal hygiene, to avoid constipation, and proper counselling regarding early and late complications. Outcome parameters such as post-ligation pain or discomfort, the requirement of an analgesic drug, any complications, and time off work were observed. Patients were followed on the 10th day, 1 month, and on 6 months after post-procedure.

Indicators of success included post-ligation pain or discomfort, the need for an analgesic, any complications, and time away from work. Following the procedure, patients were checked on at 10 days, 1 month and 6 months.

RESULTS

In this study, the least percentage of patients were under the age of 25 years (5%), with the majority of patients being between the ages of 36 and 45(68%). (Figure 1)

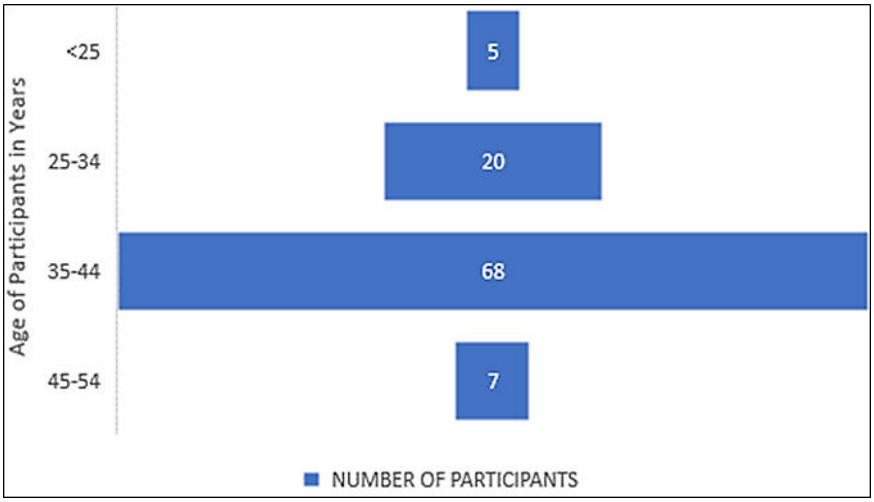

Fig 1: Percentage of participants in different age groups

According to the clinical presentation of the patients, bleeding was the primary symptom in the majority of participants (92%) followed by prolapse during faeces (81%); additional symptoms included pain (27%), irritation (22%) and discharge (18%). (Figure 2)

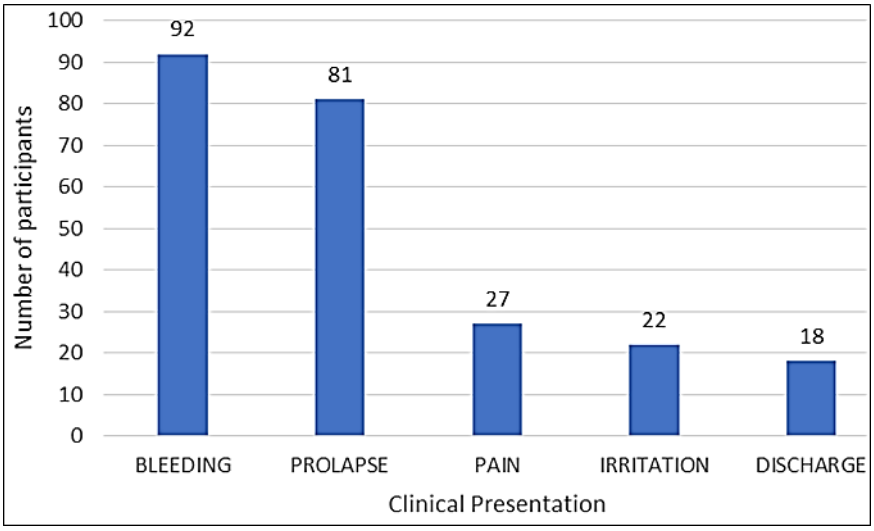

Fig 2: Distribution of participants according to clinical presentation

Only 17% of the subjects received rubber band ligation for second-degree haemorrhoids, which included bleeding and spontaneously reducible mass per rectum. The other 83% of patients had third-degree haemorrhoids, which required manual reduction due to symptoms of bleeding and mass per rectum.

DISCUSSION

There are several therapeutic options available nowadays based on the clinical characteristics and severity of the haemorrhage. It must be safe to undertake haemorrhoidal surgery and no potentially fatal condition must exist. Open haemorrhoid surgery, or the 1937-illustrated Milligan-Morgan procedure, is still often carried out today with a few slight alterations, notably for strangulated and fourth-degree haemorrhoids. In spite of being correlated with post-operative discomfort, it is generally recognized around the world. The rubber band ligation device was first reported by Blaisdell in 1954 and then improved by Barron [5]. Barron conducted a rubber band ligation treatment on 400 patients with first-, second-, and third-degree haemorrhoids and on 750 patients with second- and third-degree haemorrhoids [6]. Worldwide, clinical investigations employing rubber band ligation alone or in contrast to other surgical treatments have shown an average success rate of about 75% or as high as 92%. This study's effectiveness rate was 89%, which is consistent with the studies listed above [7].

It has been shown in several studies that the repeat necessity for rubber band ligation ranged from 6% to 20%, and in the Bayer *et al*. research, 18% of the patients needed repeat rubber band ligation whereas 2.1% of the patients needed traditional haemorrhoidal surgery [8]. In this study, 11% of participants still experience symptoms after six months that call for a traditional hemorrhoidectomy.

CONCLUSION

According to the clinical presentation of the patients, bleeding was the primary symptom in the majority of participants (92%) followed by prolapse during faeces (81%); additional symptoms included pain (27%), irritation (22%), and discharge (18%).

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