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Treatment of giant thrombosed external hemorrhoids – a case report

Leczenie olbrzymich, zakrzepowo zmienionych hemoroidów – opis przypadku

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Summary

Hemorrhoid thrombosis is a rare but dangerous complication of hemorrhoid disease. The main symptom of the disease, causing patients to go to hospital is severe pain. This is caused by hypertonicity of the internal sphincter. The pain itself is expressed during sitting and defecating. Our report describes the case of 64-year-old patient admitted to the emergency room due to external thrombosed gangrenous hemorrhoids. He presented inability to defecate due to excessive pain, mild abdominal pain, discomfort and irritation withholding him from walking and sitting. In his medical records, only arterial hypertension was noted and treated pharmacologically for the last ten years. The patient previously was treated for 5 years in a non-operative manner; this included diet, sitz-baths, suppositories and banding of hemorrhoids in the outpatient room.

Following a short preoperative work up, the patient was qualified for emergent surgery. He received antibiotic therapy (amoxicillin with clavulanate potassium 1,2 g x 3 daily) and antithrombotic prophylaxis (nadroparine 0,4 ml x 1 daily s.c.). A Milligan-Morgan open procedure was performed as method of choice. The hemorrhoids were dissected from the sphincter mechanism and all were resected. All three quadrants were excised identically. Pedicles were then ligated, thus hemostasis was satisfactory. The course of surgery was uneventful, the wound healed without swelling, pain subsided and the patient was discharged on the 3rd post-operative day in good general condition.

Conclusions: Patients with thrombosis hemorrhoids should be operated on as soon as possible because of threatening septic complications, including Fournier gangrene. Antibiotic treatment and prophylaxis is necessary. Surgical treatment of patients with thrombosed hemorrhoids results in prompt and good therapeutic outcome.

INTRODUCTION

Thrombosis of external hemorrhoids are among the most acute anorectal diseases attended to in the emergency department or proctology outpatient clinic (1, 2). The main symptom of the disease, causing patients to go to hospital is severe pain. This is caused by hypertonicity of the internal sphincter. The pain itself is expressed during sitting and defecating, however it is also often present during standing and walking in serio-

usly advanced states. Further symptoms accompanying large external thrombosed hemorrhoids are bleeding, failure to pass stool, constipation, swelling, mild discomfort, irritation, abdominal pain and mild fever (1-3).

Anatomically hemorrhoids are submucosal vascularized cushions lined in three columns around the anal canal. We distinguish three positions – right anterior, right posterior and left lateral. It's important to understand that their presence is physiological and they play a considerable role

Key words

hemorrhoids, thrombosed external hemorrhoids

of protecting the anal sphincter and preventing incontinence by propagating the closure of the anal canal during increased abdominal pressure (3-5). Some authors presume that hemorrhoids also differentiate stool, from liquid and gas residing in the anal canal (3, 4, 6).

CASE REPORT

A 64-year-old male patient was admitted to the Department through the emergency room due to severe pain caused by giant thrombosed external hemorrhoids (grade IV) (fig. 1). He presented inability to defecate due to excessive pain, mild abdominal pain, discomfort and irritation withholding him from walking and sitting. Fever was not noted at the time being. Bleeding was reported in past history but not observed during per rectum examination. His medical history, besides arterial hypertension treated pharmacologically for the last ten years, recorded no other comorbidities. Though during history taking the patient admitted to a 5 year non-operative treatment (diet, sitz-baths, suppositories and banding) of hemorrhoids in the outpatient room.

He received an antibiotic (amoxicillin with clavulanate potassium at a dose of 1.2 g three times daily i.v.) and a prophylaxis of low molecular weight heparin (nadroparine 0.4 ml once a day s.c.). After a short pre-op work up he underwent surgical treatment following the next day on an urgent basis. To perform the hemorrhoidectomy we chose the open Milligan-Morgan technique as the best method of treatment for this particular patient and in caution as multiple quadrants were excised, which left only a scarce line of anoderm thus potential closure was at risk. General anesthesia was applied, however local anesthetic was injected directly to the hemorrhoids. For appropriate exposure we used Ferguson-Hill retractors. The thrombosed necrotic hemorrhoid was elevated and an incision was carried out to the external skin and anoderm. Careful identification of vascular structures

was performed and arteries were suture ligated with PDS 2.0 absorbable sutures. The hemorrhoid was dissected from the sphincter mechanism and resected. All three quadrants were excised identically. Pedicles were ligated and hemostasis was satisfactory.

A three day post-operative hospitalization was uneventful. The pain was considered minor by the patient in comparison with that of before the operation. Bleeding was absent on the second post-operative day and wound dressing was no longer required. On the third day following the operation the pain was resolved and the patient passed stool without any complications (fig. 2). Prior to discharge the patient was informed about diet and feeding habits, personal anal hygiene and sitz-baths. Histopathology showed thrombosed hemorrhoids with necrotized tissue.

A control visit in the outpatient room was carried out 6 weeks following the operation. The patient was examined and reported no constraints in everyday activities, thus quality of life was in general considered exceptional (fig. 3). Compliance was satisfactory in this case.

DISCUSSION

Decent history taking and examination is necessary, as symptoms arising from hemorrhoid pathology are similar to other diseases. Therefore a proper differentiation should be carried out eliminating the possibility of an anal fissure, fistula, abscess, rectal prolapse, inflammatory bowel disease and neoplasms (7-9). Bleeding although common for diseased hemorrhoids isn't pathognomic and rarely presents patients with anemia (2, 10). The patient should be asked to take a knee-chest or left lateral position for adequate inspection of the anus and perianal area. Anoscopy is obligatory before taking any surgical steps as method of treatment – this will allow for exclusion of internal hemorrhoids or fissures. Apart from image diagnostics, a supplementary sigmoidoscopy will identify the presence of neoplasm or inflammatory bowel disease (11-13).

Hemorrhoidectomy of thrombosed external hemorrhoids is performed in order to relieve the patient from pain, reduce



Fig. 1. Thrombosed external hemorrhoids – grade IV.



Fig. 2. Post-operative day 3 anus examination.

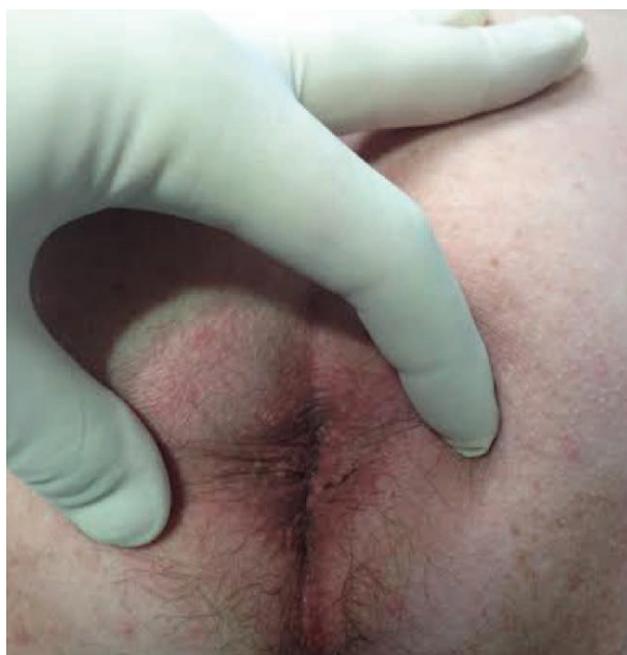


Fig. 3. Examination 6 weeks following operation.

blood flow and excise excessive necrotic tissue. The Milligan-Morgan technique was applied as a caution since multiple quadrants were excised, which left only a scarce line of anoderm thus potential closure was at risk. In such a case when treating gangrenous hemorrhoids, it's advised to leave the wound open for future healing. Secondly this allows to decrease the risk of wound infections especially caused by anaerobic bacteria. According to available data found on Medline, patients benefit more from surgical than conservative treatment (11-15). The most significant advantages of

surgery over non-operative management of thrombosed external hemorrhoids are shorter sensation of pain following treatment, approx. 4 vs 24 days respectively, while overall recurrence rate is up to 6 times higher following conservative vs surgical treatment (9, 15, 16).

In our opinion treatment of such advanced gangrenous external thrombosed hemorrhoids should be aggressive. The patient should receive surgical treatment promptly from diagnosis and admittance due to a high risk of septic complications, including Fournier's gangrene. Immediate administration of antibiotics and antithrombotic prophylaxis is necessary. We advocate the use of the Milligan-Morgan technique as a safe method of operative treatment. Furthermore when leaving the wound open to heal, it allows minimization of post-operative infections, especially anaerobic infections. It's best to begin the procedure by suture ligating the hemorrhoid artery which decreases intraoperative hemorrhage and facilitates proper hemostasis.

CONCLUSIONS

Our report presents a rather unexpected advanced state of thrombosed external hemorrhoids treated successfully using the operative manner. A full excision was in this case life-saving and justified, bringing a great boost in the quality of life for the patient. Detailed work-up along with patient compliance prove good late post-operative outcome according to literature and result in a long-term recurrence free period.

Patients with thrombosed external hemorrhoids should be operated in the quickest possible period due to the risk of septic complications including Fournier's gangrene. Administration of antibiotics and antithrombotic prophylaxis is obligatory. Operative treatment of patients with thrombosed external hemorrhoids results in prompt and good outcome.

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