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Editorial

Gastroenterology and Digestive Diseases: Open Access Journal

Haemorrhoids – Give them a second chance?

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Received: February 04, 2018 | **Published:** February 15, 2018

Introduction

If a patient's little finger got infected most medical practitioners would simply treat the infection. They would only consider amputating the finger in case of an extreme condition like gangrene. Likewise, the internal anal cushions and haemorrhoids (which are an enlargement and distal displacement of these) are normally a useful functional part of human anatomy. If they become pathological why should medical practitioners not do their utmost to heal them before considering destroying or excising them?

Like in every field of medicine there are no hard and fast rules. The management of each patient depends, and should depend, on the particular findings and the general health of that patient. This paper is intended to spark a more general discussion whether the medical profession should err even further towards conservative management of haemorrhoids and reserve surgery as the very last resort. When referring to surgery I mean both minimal and more invasive procedures including infrared coagulation, rubber band ligation, stapled haemorrhoidectomy, open and closed haemorrhoidectomy etc.

After defaecation the haemorrhoids help secure the sealing of the anus thus helping to maintain continence. By avoiding surgery wherever possible this important function is preserved and in addition the patient is spared all the other risks of surgery which include a considerable proportion of postoperative complications like pain, bleeding, infection, sphincter damage and recurrence.[1–6]

A very high proportion of adults suffer with haemorrhoids and this makes it a very important condition for several medical specialties including general practitioners, gastroenterologists and surgeons.[7] The pathophysiology and development of haemorrhoids is multifactorial. The most widely accepted predisposing factors are sitting for a long time on the toilet, straining during defaecation and frequent bowel movements. Constipation can be the underlying cause for the first two of these factors. Most patients with haemorrhoids will improve if they are advised to increase the quantity of fibre in their meals, increase their water intake, improve local hygiene with the adoption of sitz baths and take bulk laxatives. There can be variations to this theme but in my opinion the most important thing is to stress to the patient that he/she should persevere with this conservative management for at least six to eight weeks and should not expect a dramatic improvement within a few days.[8] Frequent follow-up visits are advisable at the beginning of the treatment to ensure patient understanding of the treatment and also compliance. Very often haemorrhoids coexist with a fissure-in-ano. The same treatment works for both. A similar conservative management also works for thrombosed external haemorrhoids. There are multiple studies in the literature dealing with conservative management and the various methods used. The effectiveness of conservative management is usually quite high.[9]

I am sure that most doctors attempt conservative management before they consider surgical management. The aim of this paper is to make medical practitioners consider the option of persevering to a greater extent with conservative management before resorting to surgery. In my opinion there is a lot to be gained and very little to be lost.

Keywords: haemorrhoids, hemorrhoids, piles, fissure-in-ano, conservative treatment, non-surgical treatment, surgical treatment

Conflict of interest

The author declares he has no conflict of interest.

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