Executive Summary - The Association of Colon & Rectal Surgeons of India (ACRSI) Practice Guidelines for the Management of Haemorrhoids—2016

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Abstract This paper outlines the recommendations from the Association of Colon & Rectal Surgeons of India (ACRSI) practice guidelines for the management of haemorrhoids—2016. It includes diagnosis and management of haemorrhoids including dietary, non-surgical, and surgical techniques. These guidelines are intended for the use of general practitioners, general surgeons, colorectal surgeons, and gastrointestinal surgeons in India.

Keywords Haemorrhoids · Haemorrhoidectomy · Consensus · Flavonoids · Electrosurgery · Anal canal · Haemorrhoids practice guidelines 2016

Introduction and Methodology

Haemorrhoidal disease is one of the most common anorectal conditions encountered in daily practice by general practitioners,

general surgeons, and gastrointestinal surgeons in India. It has been projected that about 50% of the population would have haemorrhoids at some point in their life probably by the time they reach the age 50, and approximately 5% population suffer from haemorrhoids at any given point of time [1, 2]. Taking into account the devastating nature of the disease and high prevalence in India, the evidence-based practice appears essential in the management of haemorrhoids. Present practice parameters aim at developing evidence-based recommendations for the management of haemorrhoids in Indian perspectives.

This practice guideline for the management of haemorrhoids, framed by the Association of Colon & Rectal Surgeons of India (ACRSI) has been developed by experts from across the country with immense experience in managing patients with haemorrhoids. Each section was reviewed by an individual expert in the committee, which was later presented and discussed; and a consensus statement was arrived at by the entire committee. A modified GRADE system was used to derive quality of evidence as 1 (high-quality evidence from consistent results of well-performed randomised trials), 2 (moderate-quality evidence from randomised trials), 3 (low-quality evidence from observational studies, opinions gathered from respected authorities), or 4 (practice point). The strength of recommendations was categorised as either A (“RECOMMENDED”, strong recommendation) or B (“SUGGESTED”, weak recommendation) [3].

Summary of Recommendations

Clinical Evaluation and Diagnosis

Patient history and physical examination are the essential components in the diagnosis of haemorrhoidal disease. Bleeding per rectum, prolapse (something coming out per rectum), perianal swelling, and itching are the common

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symptoms of haemorrhoids. Pain occurs in cases with complicated haemorrhoids. Symptoms like feeling of incomplete evacuation, change in bowel habits, and weight loss need to be further evaluated to rule out other pathologies such as anal and rectal carcinomas, anal condylomata, and inflammatory bowel disease. A diagnosis is made using proctoscopy and sigmoidoscopy. Further, a full colonoscopy is recommended in selected patients with suspicious symptoms as above and in those with rectal bleeding, occult gastrointestinal bleeding, iron-deficiency anaemia, positive faecal occult blood test, and age ≥ 50 years and not having a complete colon examination within the past 10 years. (Grade A, Evidence Level 3) [2, 4–7]

The consensus committee also proposed a new classification of haemorrhoids as presented in Table 1.

Management of Haemorrhoids

See Fig. 1 for a general approach for the management of haemorrhoids.

Dietary and Lifestyle Modifications

Haemorrhoidal patients should be recommended to follow a dietary modification involving increased fibre intake with adequate fluid as a first-line treatment. (Grade A, Evidence Level 2) [8, 9]

If constipation is a predominant factor, it should be treated carefully using laxatives like polyethylene glycol, lactulose, and bulking agents. (Grade A, Evidence Level 4)

Medical Management

Medical management by micronised purified flavonoid fraction (MPFF) is recommended as a first-line treatment for grade I–II (a–c) and selected/minor grade III (a–c) haemorrhoids. Acutely bleeding haemorrhoids can be effectively treated by MPFF. In an acute haemorrhoidal attack, MPFF 1000 mg can be prescribed at a dose of three tablets

daily for 4 days followed by two tablets daily for 3 days. Further, a maintenance dose of MPFF 1000 mg is preferred once daily for a minimum period of 2 months or more at physician's discretion. (Grade A, Evidence Level 1) [10, 11]

MPFF also serves as an effective adjuvant to surgery and other procedures. Other existing veno-active drugs like calcium dobesilate, heparan sulphate, *Euphorbia prostrata*, and *Ginkgo biloba* have a low level of evidence in the management of haemorrhoids. Calcium dobesilate has been associated with an increased risk of agranulocytosis. (Grade B, Evidence Level 3) [12–17]

The long-term use of topical products, particularly, preparations containing steroid should be avoided due to their detrimental effects. (Grade B, Evidence Level 4)

Non-surgical Office Procedures

Rubber band ligation, injection sclerotherapy, and infrared coagulation can all be used in the treatment of grade I–II and selective grade III haemorrhoids. The success rates are highest with rubber band ligation albeit with a higher complication rate. (Grade A, Evidence Level 2) [18, 19]

Surgical Management of Haemorrhoids

Haemorrhoidectomy Haemorrhoidectomy is a suitable option for the treatment of grade III–IV haemorrhoids; however, it may be associated with postoperative complications. The closed procedure has more advantages in terms of postoperative pain and bleeding than an open procedure. Advanced techniques like ligasure, harmonic scalpel, and mono- or bipolar modes of electrosurgery could be helpful in overcoming some of the disadvantages of conventional haemorrhoidectomy. (Grade A, Evidence Level 2) [20–22]

Stapled Haemorrhoidopexy Stapled haemorrhoidopexy is recommended in the treatment of grade III–IV (a–c) haemorrhoids. Stapled haemorrhoidopexy compared to conventional haemorrhoidectomy is more effective in pain control

Table 1 A new proposed classification of haemorrhoids

Grade	Characteristics
I	Remaining inside the anal canal
II	Protrude during defecation and reduce spontaneously
III	Need further manual reposition
IV	Piles that remain prolapsed outside and external haemorrhoids
Each of the above primary grades of haemorrhoids is categorised further, depending on number of piles, and presence of circumferential piles or thrombosis, by the suffix as below	
a	Single pile mass
b	Two piles but <50% circumference
c	Circumferential piles occupying more than half circumference of the anal canal
d	Thrombosed or gangrenous piles (complicated)

Fig. 1 Haemorrhoid management algorithm

and wound healing and reduces hospital stay and time for return to work. The usage of newer stapling devices may overcome the complications of stapled haemorrhoidopexy. (Grade A, Evidence Level 2) [23]

Doppler-Guided Haemorrhoidal Artery Ligation Doppler-guided haemorrhoidal artery ligation (DGHAL)/transanal haemorrhoidal dearterialisation (THD) is recommended in the treatment of grade II–IV haemorrhoids. Although recurrence of grade III and IV haemorrhoids may be a limiting factor, a combination of current techniques like anopexy/mucopexy with DGHAL could address this limitation and broaden the applicability to the grade III and IV haemorrhoids. (Grade A, Evidence Level 2) [24, 25]

Haemorrhoids in Special Situation

Patients on Anticoagulants Treatment should be based on the grades of haemorrhoids with the cautious management of anticoagulation that does not cause cardiac compromise. Injection sclerotherapy is preferable over rubber band ligation due to the risk of postoperative bleeding complications. (Grade A, Evidence Level 3) [26–29]

Patients Infected with HIV Conservative treatment should be the first-line approach for the management of symptomatic haemorrhoid patients infected with human immunodeficiency virus (HIV). If conservative management fails, surgical procedures should be offered with proper management of CD4 counts and prophylactic antibiotics. (Grade A, Evidence Level 3) [30–32]

Haemorrhoids in Pregnancy All pregnant women with symptomatic haemorrhoids should be managed by a conservative approach, including diet and lifestyle modifications (intake of fibre rich diet, high liquid intake, constipation cessation, personal cleanliness, and lying on the left side to relieve pain and other symptoms) and medical therapy. (Grade A, Evidence Level 4)

Medical therapy with MPFF is safe and effective in the management of haemorrhoids in pregnant women (usage is not advised during the first trimester in the absence of evidence). In the antenatal period, maintenance treatment with MPFF 1000 mg once daily significantly reduces both the frequency and duration of relapses of symptoms of acute haemorrhoids. (Grade A, Evidence Level 3) [33]

Surgical or non-surgical procedures may be advised only in cases with failure of conservative management. Surgical procedure should be reserved for strangulated or thrombosed haemorrhoids and performed under local anaesthesia. (Grade A, Evidence Level 4)

Portal Hypertension and Haemorrhoids Conservative approach should be tried in all patients with portal hypertension. Differentiation between haemorrhoids and rectal varices should be done in portal hypertensive patients with active rectal bleeding. There are conflicting reports about the use of rubber band ligation in advanced cirrhosis with portal hypertension. Stapled haemorrhoidopexy is a good option for the portal hypertensive haemorrhoids patients, and haemorrhoidectomy should be reserved for the patients who are refractory to other approaches. (Grade A, Evidence Level 4)

Haemorrhoids in Children Dietary lifestyle modifications, proper toilet training, and medical management are the first-line options for management of haemorrhoids in children. Non-surgical office procedures may be reserved if conservative management fails. (Grade A, Evidence Level 4)

Compliance with Ethical Standards

Conflict of Interests All the authors declare that they have no conflict of interest.

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