



Anne L. Mounsey, MD
University of North Carolina,
Chapel Hill

Susan L. Henry, MLS
East Carolina University,
Greenville, NC

Which treatments work best for hemorrhoids?

Evidence-based answer

Excision is the most effective treatment for thrombosed external hemorrhoids (strength of recommendation [SOR]: **B**, retrospective studies). For prolapsed internal hemorrhoids, the best definitive treatment

is traditional hemorrhoidectomy (SOR: **A**, systematic reviews). Of nonoperative techniques, rubber band ligation produces the lowest rate of recurrence (SOR: **A**, systematic reviews).

Evidence summary

External hemorrhoids originate below the dentate line and become acutely painful with thrombosis. They can cause perianal pruritus and excoriation because of interference with perianal hygiene. Internal hemorrhoids become symptomatic when they bleed or prolapse (**TABLE**).

For thrombosed external hemorrhoids, surgery works best

Few studies have evaluated the best treatment for thrombosed external hemorrhoids. A retrospective study of 231 patients treated conservatively or surgically found that the 48.5% of patients treated surgically had a lower recurrence rate than the conservative group (number needed to treat [NNT]=2 for recurrence at mean follow-up of 7.6 months) and earlier resolution of symptoms (average 3.9 days compared with 24 days for conservative treatment).¹

Another retrospective analysis of 340 patients who underwent outpatient excision of thrombosed external hemorrhoids under local anesthesia re-

ported a low recurrence rate of 6.5% at a mean follow-up of 17.3 months.²

A prospective, randomized controlled trial (RCT) of 98 patients treated nonsurgically found improved pain relief with a combination of topical nifedipine 0.3% and lidocaine 1.5% compared with lidocaine alone. The NNT for complete pain relief at 7 days was 3.³

Conventional hemorrhoidectomy beats stapling

Many studies have evaluated the best treatment for prolapsed hemorrhoids. A Cochrane systematic review of 12 RCTs that compared conventional hemorrhoidectomy with stapled hemorrhoidectomy in patients with grades I to III hemorrhoids found a lower rate of recurrence (follow-up ranged from 6 to 39 months) in patients who had conventional hemorrhoidectomy (NNT=14).⁴ Conventional hemorrhoidectomy showed a nonsignificant trend in decreased bleeding and decreased incontinence.

A second systematic review of 25 studies, including some that were of

FAST TRACK

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lower quality, showed a higher recurrence rate at 1 year with stapled hemorrhoidectomy than with conventional surgery.⁵

Nonoperative techniques? Consider rubber band ligation

A systematic review of 3 poor-quality trials comparing rubber band ligation with excisional hemorrhoidectomy in patients with grade III hemorrhoids found that excisional hemorrhoidectomy produced better long-term symptom control but more immediate postoperative complications of anal stenosis and hemorrhage.⁶ Rubber band ligation had the lowest recurrence rate at 12 months compared with the other nonoperative techniques of sclerotherapy and infrared coagulation.⁷

Fiber supplements help relieve symptoms

A Cochrane systematic review of 7 RCTs enrolling a total of 378 patients with grade I to III hemorrhoids evaluated the effect of fiber supplements on pain, itching, and bleeding. Persistent hemorrhoid symptoms decreased by 53% in the group receiving fiber.⁸

When surgical hemorrhoidectomy is recommended

The American Society of Colon and Rectal Surgeons recommends adequate fluid and fiber intake for all patients with symptomatic hemorrhoids. For grade I to III hemorrhoids, the society states that banding is usually most effective. When office treatments fail, the society recommends surgical hemorrhoidectomy (SOR: **B**).

The society recommends excision of thrombosed hemorrhoids less than 72 hours old and expectant treatment with analgesia and sitz baths for thrombosed hemorrhoids present for longer than 72 hours (SOR: **B**).⁹

The American Gastroenterological Association recommends excision of symptomatic thrombosed external

TABLE	
Classification of symptomatic internal hemorrhoids	
GRADE	DESCRIPTION
I	Hemorrhoids do not protrude, but may bleed
II	Hemorrhoids protrude with defecation, but reduce spontaneously
III	Hemorrhoids protrude and must be reduced by hand
IV	Hemorrhoids are permanently prolapsed
Source: Madoff RD, et al. <i>Gastroenterology</i> . 2004. ¹⁰	

hemorrhoids that present early. Surgical hemorrhoidectomy should be reserved for when conservative treatment fails and for patients with symptomatic grade III and IV hemorrhoids.¹⁰ ■

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