

Case 72 A pathological anal verge



Figure 72.1

Figure 72.1 demonstrates the perineum of a woman aged 50 years, who has been anaesthetized and placed in the lithotomy position on the operating table prior to surgery.

What pathology is demonstrated in Fig. 72.1?

The patient has fourth degree haemorrhoids or piles. The two words are synonymous, the first derived from the Greek, the second from old English.

What is the anatomical basis of this condition?

Haemorrhoids are dilatations of the venous cushions of the anal canal, which are the commencements of the superior rectal (haemorrhoidal) veins. These drain into the inferior mesenteric vein, then into the splenic vein and finally the portal vein.

There are usually three of these veins arranged roughly at the 3, 7 and 11 o'clock positions, as can be seen in Fig. 72.1. Inferiorly, these veins anastomose with the inferior rectal veins, which drain into the internal iliac veins, and hence form part of the portocaval anastomosis system (see Case 88, p. 179)

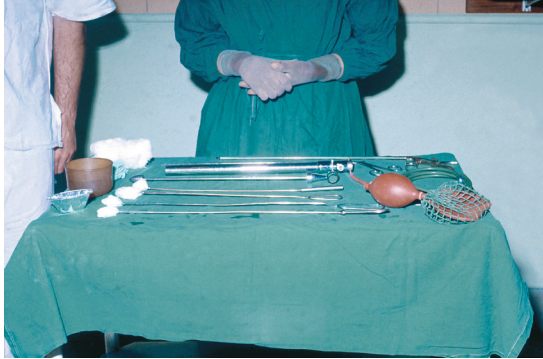
How are haemorrhoids classified, and what stage have they reached in this patient?

- First degree: The haemorrhoids remain in the anal canal; they may bleed, but do not prolapse.
- Second degree: The haemorrhoids prolapse on defaecation, but then return spontaneously within the anal canal.
- Third degree: The haemorrhoids prolapse outside the anal margin on defaecation; they may be manually replaced by the patient.
- Fourth degree: The haemorrhoids, as in this case, are permanently prolapsed.

What symptoms may trouble the patient with haemorrhoids?

The commonest is rectal bleeding, usually on defaecation. The blood is bright red, due to arteriovenous anastomoses in these veins. Other symptoms are prolapse, mucous discharge, pruritis ani; if the bleeding is heavy or persistent, the patient may present with anaemia – sometimes severe enough to require a blood transfusion.

The only time that haemorrhoids are painful is if they



(a)



(b)

Figure 72.2 Sigmoidoscopy: (a) instruments and (b) patient position for the procedure.

become strangulated. This may follow straining at stool, when the haemorrhoidal mass prolapses and is trapped by spasm of the anal sphincter (see Case 73, p. 147).

Rectal bleeding is an early feature of a rectal carcinoma. It is obviously extremely important to exclude this diagnosis in a patient with haemorrhoids. Indeed, not uncommonly the two conditions coexist. How was this done in this patient?

A careful history was taken and a full clinical examination carried out, including, of course, a digital rectal examination. This was followed by sigmoidoscopy using a rigid sigmoidoscope (Fig. 72.2a), which enabled visual examination of the whole of the rectum to be carried out. The patient is placed in the left lateral position with the knees drawn up to the chest (Fig. 72.2b). It is a painless – although uncomfortable – procedure and sedation is

only required in very anxious patients.

If there is any suspicion of a lesion higher in the large bowel, a fiberoptic sigmoidoscopy and/or barium enema examination may be indicated.

How are haemorrhoids treated?

First and second degree haemorrhoids can be treated on an outpatient basis by injection of a sclerosant agent, such as 5% phenol in almond oil, or by elastic banding. An advanced case, such as this, is treated by surgical excision – stapled haemorrhoidectomy in this case.

What serious complication may occur in the early days following haemorrhoidectomy?

- Haemorrhage – usually in the first 24 h postoperatively but sometimes delayed for a week to 10 days following surgery.
- Other common complications include urinary retention in men, and constipation due to fear of opening bowels – a mixture of osmotic and lubricant laxatives is usually given, such as lactulose and Milpar.