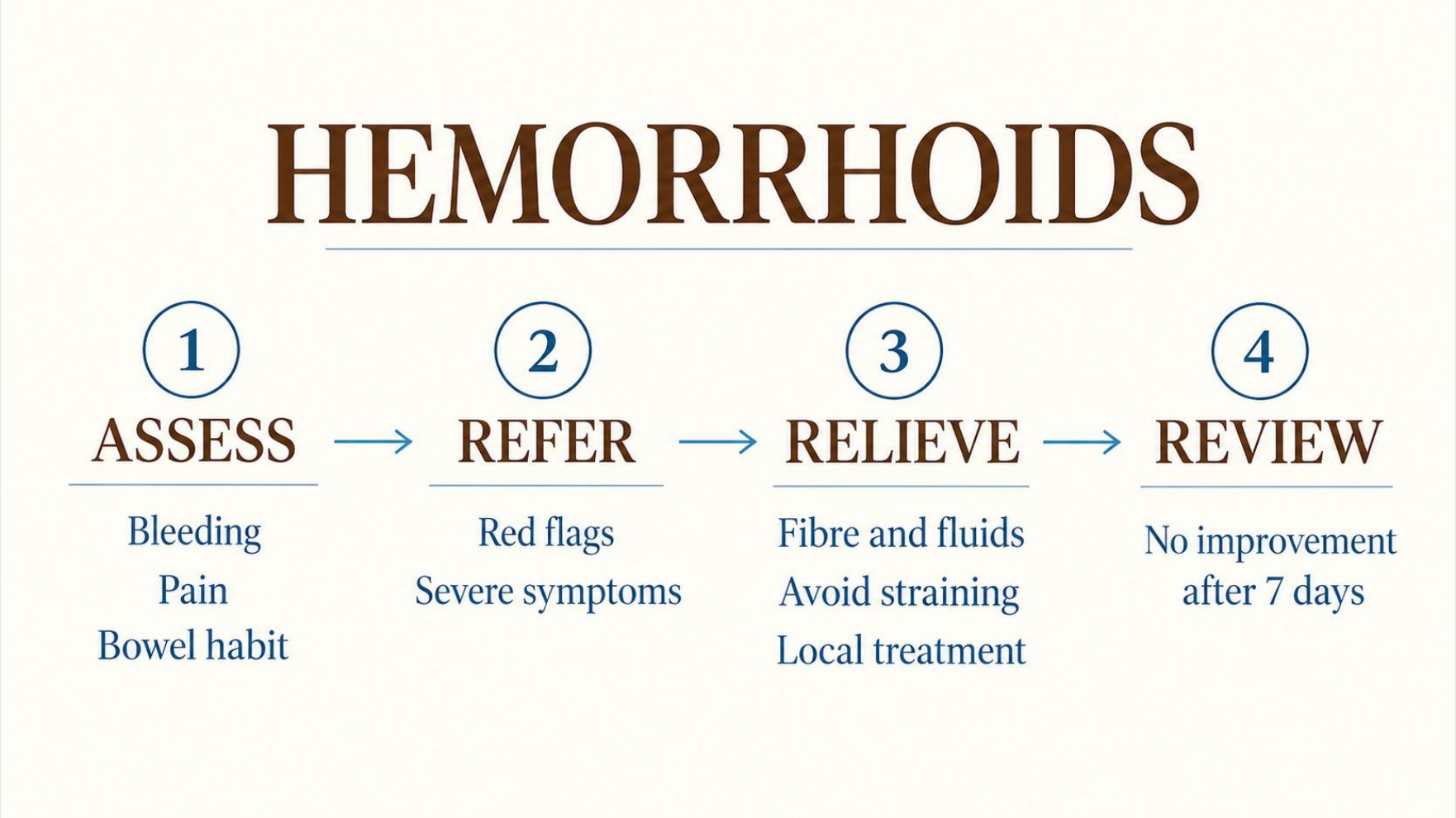
Hemorrhoids



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Hemorrhoids: types and contributing factors

Type / grade	Clinical distinction
Internal / external / mixed	Above / below the dentate line; mixed means both. Internal hemorrhoids are usually painless unless complicated.
Contributing factors	Tissue degeneration, increased anal pressure, straining, low fibre / fluid intake and pregnancy. More common at age 45–65; uncommon under 20.

Hemorrhoids are enlarged vascular cushions and supporting tissue within or around the anal canal.

Internal hemorrhoids: grading

Grade	Prolapse and reduction
I	No prolapse outside the anal canal
II	Prolapse during defecation and reduce spontaneously
III	Require manual reduction
IV	Cannot be reduced

Grades III and IV require referral. Severe painful prolapse may indicate thrombosis or compromised blood supply.

Assessment and referral

Bleeding and pain

First episode of rectal bleeding needs assessment. Blood mixed with stool, dark / tarry stool, heavy bleeding or bleeding unrelated to defecation needs investigation.

Bleeding on warfarin or another anticoagulant: urgent referral.

Severe pain may reflect thrombosis or strangulation. Sharp pain during defecation suggests fissure.

Other referral triggers

Symptoms >3 weeks; grade III / IV; persistent or recurrent irritation; persistent change in bowel habit.

Abdominal pain, vomiting, tenesmus, fecal seepage, malaise, fever or weight loss. Known Crohn’s / ulcerative colitis with rectal bleeding.

Review products already tried and medicines causing constipation. No improvement after 1 week of treatment: see a doctor.

Non-drug management

Measure	Practical advice
Fibre and fluid	Increase dietary fibre and fluids to reduce constipation and straining.
Toilet habits	Do not delay defecation. Avoid prolonged sitting on the toilet; limit sitting to 2–5 minutes.
Pressure and straining	Avoid heavy lifting and excessive straining. Pain-related avoidance of defecation can worsen constipation.
Hygiene and comfort	Wash the perianal area with warm water after each bowel movement. A warm bath may soothe discomfort.

Constipation and laxatives

Short-term relief

A stimulant laxative may be used for 1–2 days to relieve constipation while dietary fibre and fluids are being increased.

Pain can cause avoidance of defecation, worsening constipation, straining and bleeding.

Longer-term management

A bulk-forming laxative may be used long term when adequate dietary change is not achievable.

Select a licensed preparation and follow its dose and administration instructions.

Review medicines that cause constipation. Suspected drug-induced constipation requires medication review.

Topical ingredients and mechanisms

Class	Examples	Purpose / mechanism
Local anesthetics	Lidocaine, benzocaine	Reduce pain and itching
Astringents	Bismuth, zinc, Peru balsam	Surface protein precipitation forms a protective coat, reducing irritation
Anti-inflammatory	Hydrocortisone	Reduces inflammation, swelling, pain and itching
Protectants	Zinc oxide, aluminium hydroxide, calamine, shark liver oil	Barrier limits irritation, itching and moisture loss
Counter-irritants	Menthol	Tingling sensation provides relief from pain and itching
Vasoconstrictors	Phenylephrine, ephedrine	Reduce swelling and related pain / itching

Products may combine ingredients. Availability and OTC classification depend on the country and formulation.

Formulations and frequency

Creams and ointments

Use externally; use internally only when licensed for rectal administration.

Usually apply morning and evening and after each bowel movement, following the product-specific instructions.

Creams and ointments can deliver treatment directly to the affected anal area.

Suppositories

Used for internal hemorrhoids.

A suppository may move into the rectum and melt beyond the anal canal, reducing local delivery.

The solid preparation must dissolve before releasing its ingredients, giving a relatively slower onset than other local formulations.

Hydrocortisone: limits and monitoring

Duration and eligibility

Self-care age threshold: adults >18 years, no longer than 7 continuous days. Follow local age licensing; younger patients need professional advice.

Prolonged use may thin skin. Local anesthetics may cause sensitization.

If symptoms persist after 7 days or recur promptly, obtain medical review.

Clinical role

Hydrocortisone reduces inflammation and swelling, relieving pain and itching.

It may be combined with local anesthetics or other soothing ingredients.

OTC access and age restrictions depend on the licensed product and country.

Persistent or recurrent symptoms require reassessment rather than prolonged treatment.

Rectal ointment and retention

Stage	Technique
Choose	Use a rectal formulation with its supplied applicator. An applicator can reach farther into the anal canal; a finger may be used only if the product permits.
Prepare / insert	Lubricate the applicator with the ointment before gentle insertion. Follow the product’s insertion and cleaning instructions.
Retain	After rectal ointment or a suppository, lie on the left side with knees bent for at least 15–20 minutes to keep treatment near the affected area.

Suppositories: preparation and positioning

Step	Technique
1. Check firmness	If soft, refrigerate for a few minutes or cool under running water.
2. Unwrap / moisten	Remove wrapper. Dip briefly in lukewarm water to moisten the exterior.
3. Position	Lie on the left side with knees bent, or use knee-to-chest position. Left-side position facilitates self-administration.

For prescribed pediatric use, a caregiver may hold a small child in a crawling position. Use only an age-appropriate product.

Suppositories: insertion and retention

Step	Technique
Insertion	Relax the buttocks and insert gently past the anal sphincter. Follow the preparation-specific leaflet for orientation and insertion depth.
Orientation	Tapered-end-first insertion is commonly described. Base-first insertion has also been proposed to improve retention; follow the specific product instructions.
If expelled	A suppository that slips out may not have passed the sphincter. Reinsert correctly according to the product instructions.
Retention	Lie on the left side with knees bent for 15–20 minutes. Keep the buttocks together; a caregiver may gently hold a child's buttocks closed when appropriate.
Bowel movement	Try to avoid defecation for up to 1 hour after insertion to allow the intended action.

Anal fissure and painful complications

Suspected fissure

A small tear in the anal canal, often associated with constipation, causes sharp pain during defecation. Refer for assessment.

Conservative treatment addresses constipation. A local anesthetic cream / gel may relieve symptoms.

Clinician-directed treatment

Prescribed rectal glyceryl trinitrate (GTN) or topical diltiazem relaxes the anal sphincter. Some severe cases require an operation.

Strength, dose and duration require a specific prescription.

Thrombosis or compromised blood supply can cause intense pain and needs urgent assessment.

References

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Online verification

NHS: hydrocortisone for piles and itchy bottom