

Case Report

Hemorrhoidal Thrombosis: Conservative Treatment

Morelos Adolfo García Sánchez¹*, Mireya De La Fuente González², Evelin Michelle Gómez Plascencia², Gerardo Cano Velázquez², Aline Denisse Cruz Mendez², Ricardo Leónidas Loo Intriago², Elizabeth Gutiérrez Hernández³, Fernando Jair Rosas Valencia³, Miriam Sarahí Preciado Aguiar⁴, Sergio Adrián Ramos Ramírez⁴, Génesis Abril Ramírez Gutiérrez⁴, Ramiro Sánchez Miramontes⁴, Benjamín González Amézquita⁴, Luis Gerardo Gómez Preciado⁴, Adriana Yazmín Ramos Ramírez⁴

¹Colonic and Rectal Surgeon, Surgical Department, General Hospital Specialized Medical Unit, National Autonomous University of México, México City, México

²General Surgeon, Department of Surgery, Dr. Gaudencio Gonzalez Garza General Hospital Specialized Medical Unit, La Raza National Medical Center, Mexican Social Security Institute, National Autonomous University of México, México City, México

³General Surgeon, Department of Surgery, Dr. Rubén Leñero General Hospital, Secretary of Health of México City, National Autonomous University of México, México City, México

⁴Medical Doctor, University of Guadalajara, Guadalajara City, México

Abstract

Hemorrhoidal thrombosis is a common complication of the hemorrhoidal disease, its symptoms are common and well known, still the diagnosis is usually straight forward. The objective is to present a case of a massive hemorrhoidal thrombosis (internal and external hemorrhoid involvement), with an infectious process, in which a medical conservative treatment was given with an auspicious response. Nevertheless, even nowadays with medical and technological advances available, the acute treatment of the aforementioned entity, in which any medical or surgical emergency is present, remains controversial, not so in the definite treatment which is surgical in all cases, on the contrary high recurrence will be the typical scenario.

Keywords: Hemorrhoidal disease; Hemorrhoidal thrombosis; Medical-surgical emergency

Abbreviations

HD - Hemorrhoidal disease

HT - Hemorrhoidal thrombosis

Introduction

Hemorrhoidal Disease (HD) is one of the most common proctological pathologies, given that its incidence varies between 10 and

*Corresponding author: Morelos Adolfo García Sánchez, Colonic and Rectal Surgeon, Surgical Department, General Hospital Specialized Medical Unit, National Autonomous University of México, México, Tel: +1 52 55245900; E-mail: morelosadolfo@hotmail.com

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14.7% of the population [1,2]. Hemorrhoids are described as normal anatomical structures present since birth, formed by arteriovenous connections between anal conduct and mucosa with squamous epithelium fixed by connective tissue. There are accounts of the disease since 400 AD in which Hippocrates described the treatment with sizzling iron for the prolapsing ones in his treatise, something not very distant to what is performed in modern times [3].

Hemorrhoidal Thrombosis (HT) is a common complication of the HD, and is even what motivates the patient to seek medical attention, if its not the presenting symptom. The purpose of this paper is to present the experience on one case with massive hemorrhoidal thrombosis which involved internal and external hemorrhoids in addition of an infectious process, submitted to conservative medical treatment.

Case Report

The patient is a 34 year old male, with an unremarkable medical history, who started its actual disease 10 years ago, he came to the emergency department complaining of intense and incapacitating persistent pain in anal region and rectal bleeding with an evolution of 48 hours, unmodified by defecation, with tumour sensation in the same zone, fever, asthenia and adynamia. At physical exam with pallor, and prolonged capillary refill at 7 seconds. Proctologic inspection in Sims' position revealed an evident massive mixed hemorrhoidal thrombosis with ischemia and necrosis with fibrin and mucous, with fridity of tissue and ready bleeding, as well as intense pain. Instrumental exam and rectal examination is missed out.

Laboratories reported Hemoglobin of 7.1 mg/dl, Hematocrit 23, and WBC 21,000 (Figure 1).



Figure 1: Massive hemorrhoidal thrombosis.

The patient is admitted and a conservative medical treatment consisting in NPO, sitz baths every 4 hours for 20 minutes with cold water and next with medical colostomy (Medical colostomy is defined as the lack of a physical colostomy on the patient, but obtaining the benefits of a real colostomy; this benefits are: Bypassing the fecal matter to avoid infection, nourishing or feeding the patient even though its pathology, rest of the affected anatomic area, avoiding abrasion, increase in pressure and pain in the patient, accelerated recovery, psychologic benefit given the patient is using the enteral route, at least for liquids, ingestion of some sort of calories, avoids overload by intravenous solutions. Furthermore the medical colostomy allows to avoid morbidity

and provides early recovery; by avoiding both the first surgery for the colostomy and the second for the reconnection). And consists of: Liquid hypercaloric diet and Loperamide for 1 week, double scheme antibiotics was used (metronidazole and ciprofloxacin), as well as NSAIDs (diclofenac) and analgesics. Ointment of topical steroids like fluorocinolone for 10 days.

Finally the patient is discharged 10 days later and continuously seen at office with a satisfactory evolution (Figure 2).



Figure 2: Same patient massive hemorrhoidal thrombosis in second week treatment.

The patient was programmed for hemorrhoidectomy months latter.

Discussion

The HT is a common complication of the HD, to make a proper diagnosis the patient must be explored, given that it is a clinical diagnosis [2]; the treatment is what remains controversial nowadays [4]. It is clear that the surgical complications increase considerably if, taking in account the intense pain as an emergency [5], the surgeon decide to operate in acute. Between the complications to consider we have in case of the acute ones: important transoperative bleeding conducting to hypovolemic shock, accidental sphincter lesion and secondary infection even more in ischemic, inflamed and edematous tissues; and the chronic ones: anal stenosis, incontinence including its different grades and disease recurrence as a result of deformed anatomical structures [6]; all these are considered by the authors and is poorly described in the literature.

The HT has several management lines, and the tendency for conservative treatment is not improper [2,5,6,7]; however most of the authors prefer thrombectomy (elliptical excision) with local anesthetics [1-5,8]. It is important to mention the role of phlebotonics as diosmine, troxerutin and hesperidin with encouraging results but not definite yet [9]. The ligation guided by doppler has no applicability for HT, given that it is only indicated on minor grades haemorrhoids and even in that instance it fails having complications as pain, hemorrhage and hemorrhoidal prolapse [10].

Other option is the so called “emborrhoid” technique which consists in embolisation of superior rectal hemorrhoidal arteries with clinical success of 72% but limited to only 14 patients and non specific for HT [11]. It is also to mention the use of recombinant streptokinase suppositories for HT at a 100,000 to 200,000 UI dose with sodium salicylate which offer a significative clinical improvement of symptoms in 5 days, although its promising cost must be evaluated as well as mid and long term complications [12]. Lastly the use of the Merocel anal

pack which is a polyvinyl alcohol sponge biocompatible and highly absorbent that is used for epistaxis treatment, accelerating the reduction on the internal hemorrhoids prolapse in acute phase but with partial results and still in research [13]. As noted, the management of HT is multiple and it will depend on each individual case, as well as the physician's experience.

Conclusion

The treatment of the HT is wide and multiple; however we conclude that it must satisfy the basic ethical principles of healing without harming or putting at risk the patients health unnecessarily. On the other hand its clear that each behaviour will depend on the experience and knowledge of the galenical work.

References

1. Mirhaidari SJ, Portes JA, Slezak FA (2016) Thrombosed external hemorrhoids in pregnancy: a retrospective review of outcomes. *Int J Colorectal Dis* 31: 1557-1559.
2. Estalella L, López-Negre JL, Parés D (2013) Enfermedad hemorroidal. *Med Clin* 140: 38-41.
3. Abarca-Aguilar F, Alfonso-Nuñez R, Anido-Escobar V, Aillaud II L, Fidel Llorente F, et al. (2010) *Rev Mex Coloproctología* 16: 4-14.
4. Chan KKW, Arthur JDR (2013) External haemorrhoidal thrombosis: evidence for current management. *Tech Coloproctol* 17: 21-25.
5. Rodríguez-Wong U (2009) Trombosis hemorroidaria: opciones de tratamiento. *Rev Hosp Jua Mex* 76: 81-83.
6. Barrionuevo-López M, Perren A, García R, Cardozo D, Olivato C, et al. (2015) Terapéutica de la fluxión hemorroidal. *Rev Arg Coloproct* 26: 54-58.
7. Lohsiriwat V (2012) Hemorrhoids: From Basic pathophysiology to clinical management. *World J Gastroenterol* 18: 2009-2017.
8. Trompetto M, Clerico G, Cocorullo GF, Giordano P, Marino F, et al. (2015) Evaluation and management of hemorrhoids: Italian society of colorectal surgery (SICCR) consensus statement. *Tech Coloproctol* 19: 567-575.
9. Giannini I, Amato A, Basso L, Tricomi N, Marranci M, et al. (2015) Flavonoids mixture (diosmin, troxerutin, hesperidin) in the treatment of acute hemorrhoidal disease: a prospective, randomized, triple-blind, controlled trial. *Tech Coloproctol* 19: 339-345.
10. Scheyer M, Antonietti E, Rollinger G, Lancee S, Pokorny H (2015) Hemorrhoidal artery ligation (HAL) and rectoanal repair (RAR): retrospective analysis of 408 patients in a single center. *Techniques in Coloproctology* 19: 5-9.
11. Vidal V, Sapoval M, Sielezneff Y, De Parades V, Tradi F, et al. (2015) Emborrhoid: a new concept for the treatment of hemorrhoids with arterial embolization: the first 14 cases. *Cardiovasc Intervent Radiol* 38: 72-78.
12. Hernández-Bernal F, Valenzuela-Silva CM, Quintero-Tabío L, Castellanos-Sierra G, Monterrey-Cao D, et al. (2013) Recombinant streptokinase suppositories in the treatment of acute haemorrhoidal disease. Multicentre randomized double-blind placebo-controlled trial (THERESA-2). *Colorectal Dis* 15: 1423-1428.
13. Tan WJ, Yusof S (2014) The Merocel anal pack: an innovative use for symptomatic hemorrhoids. *Tech Coloproctol* 18: 1127-1128.