





ORIGINAL ARTICLE

Global treatment of haemorrhoids—A worldwide snapshot audit conducted by the International Society of University Colon and Rectal Surgeons

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Abstract

Aim: There is no universally accepted treatment consensus for haemorrhoids, and thus, management has been individualized all over the world. This study was conducted to assess a global view of how surgeons manage haemorrhoids.

Methods: The research panel of the International Society of University Colon and Rectal Surgeons (ISUCRS) developed a voluntary, anonymous questionnaire evaluating surgeons' experience, volume and treatment approaches to haemorrhoids. The 44 multiple-choice questionnaire was available for one month via the ISUCRS email database and the social media platforms Viber and WhatsApp.

Results: The survey was completed by 1005 surgeons from 103 countries; 931 (92.6%) were in active practice, 819 (81.5%) were between 30 and 60 years of age, and 822 (81.8%) were male. Detailed patient history (92.9%), perineal inspection (91.2%), and digital rectal examination (91.1%) were the most common assessment methods. For internal haemorrhoids, 924 (91.9%) of participants graded them I–IV, with the degree of haemorrhoids being the most important factor considered to determine the treatment approach (76.3%). The most common nonprocedural/conservative treatment consisted of increased daily fibre intake (86.9%), increased water intake (82.7%), and normalization of bowel habits/toilet training (74.4%). Conservative treatment was the first-line treatment for symptomatic first (92.5%), second (72.4%) and third (47.3%) degree haemorrhoids; however, surgery was the first-line treatment for symptomatic fourth degree haemorrhoids (77.6%). Rubber band ligation was the second-line treatment in first (50.7%) and second (47.2%) degree haemorrhoids, whereas surgery was the second-line treatment in third (82.9%) and fourth (16.7%) degree symptomatic haemorrhoids. Rubber band ligation was performed in the office by 645 (64.2%) of the participants. The most common surgical procedure performed for haemorrhoids was an excisional haemorrhoidectomy

See [Appendix](#) list of the ISUCRS author group.

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for both internal (87.1%) and external (89.7%) haemorrhoids – with 716 (71.2%) of participants removing 1, 2 or 3 sectors as necessary.

Conclusion: Although there is no global haemorrhoidal treatment consensus, there are many practice similarities among the different cultures, resources, volume and experience of surgeons around the world. With additional studies, a consensus statement could potentially be developed.

KEYWORDS

haemorrhoids, survey, treatment of haemorrhoids

INTRODUCTION

Haemorrhoids are a common benign anorectal condition, with a prevalence ranging from 4% to 39% worldwide [1–3]. This condition presents a significant healthcare concern that affects millions of individuals. Common haemorrhoidal symptoms include bleeding, swelling, discomfort or irritation, pruritus, faecal incontinence and a sense of incomplete evacuation [4]. Diagnosis is based on history and anorectal examination, including anorectal inspection, digital examination, and anoscopy [1]. Nonoperative management, office procedures, and surgical management can all be used during treatment [5–8].

Decision-making in the management of haemorrhoids is complex and there are numerous treatment considerations. In addition, treatment success can be influenced by a myriad of factors, such as the type, location and grade of the haemorrhoids and patient expectations and comorbidities. Furthermore, many treatment options may have drawbacks, such as uncertain or limited efficacy, high cost, or significant side effects [7, 9–11]. To combat these challenges, several societies have developed guidelines and practice parameters based on the current level of evidence. Despite this, there is no universally accepted treatment consensus, and thus, management of haemorrhoids has been individualized all over the world [8].

The aim of our study was to conduct a global survey to understand how surgeons approach and manage haemorrhoids across different regions, cultures and healthcare settings.

METHODS

A research panel of the International Society of University of Colon and Rectal Surgeons (ISUCRS) designed a 44 multiple-choice question survey to reveal surgeons' experience, volume and treatment of haemorrhoids globally (survey can be found on <https://form.123formbuilder.com/6276560/global-haemorrhoids-questionnaire>). The survey was conducted according to The Checklist for Reporting Results of Internet E-Surveys (CHERRIES), described by Eysenbach et al., and was exempted from the institutional ethics committee's approval as it was voluntary and anonymous [12]. We invited colorectal surgeons, general surgeons and proctologists worldwide to complete the questionnaire, which was widely

distributed via the ISUCRS email database, and social media platforms Viber, and WhatsApp. The survey was accessible for a duration of one month (March 2023). The questionnaire could only be submitted once per participant, and only returned questionnaire forms were included for analysis.

RESULTS

Clinical and demographic profile of participants

In total, we had 1005 survey responders from 103 countries. Most participants were male (81.8%) between ages 30 and 60 years (81.5%), with the majority from Europe (51.6%), followed by Asia (24.45%). Overall, 92.6% were active surgeons, with 93.9% performing proctological procedures. Most of the participants (359%–35.7%) were seeing 21 cases or more per month in their office with 126 (12.5%) performing 10 or more haemorrhoid operations in a month. However, a high number of participants (366%–36.4%) were performing less than five office-based procedures per month. Rubber band ligation was used in the office by 645 (64.2%) of the participants. No other office-based procedure other than rubber band ligation was found during the survey.

History and clinical examinations

Detailed patient history (92.9%), perineal inspection (91.2%), and digital rectal examination (91.1%) were the most common evaluations used for examination.

Endoscopic recommendations

Patients with new-onset rectal bleeding (13.2%), blood mixed stool (10.9%), aged 45 years or more (10.1%), with high risk (patient with history of genetic syndrome, family history of colon cancer, IBD, etc.) (10%) were the most common indications for a flexible sigmoidoscopy. Colonoscopy was recommended in patients aged more than 45 years (25.7%), recent change in bowel function (24.6%), blood mixed with stool (21.8%), and dark rectal bleed (20.2%).

Grading of haemorrhoids

Almost all participants (92.4%–91.9%) graded haemorrhoids I–IV during their clinical examinations.

Treatment approach

First- and second-line treatment

Conservative treatment was the first-line treatment for symptomatic first (92.5%), second (72.4%) and third (47.3%) degree haemorrhoids. Increased daily fibre intake (86.9%), increased intake of water (82.7%), and normalization of bowel habits/toilet training (74.4%) were the most common conservative measures recommended to patients with symptomatic haemorrhoids. Office re-evaluation was recommended within 2–4 weeks (33.5%) and 4–8 weeks (30%), respectively. Only 72 (7.2%) participants used rubber band ligation as first-line therapy for first-degree haemorrhoids. For office rubber band ligation, 876 (87.2%) of surgeons would consider performing up to three banding sessions, however, 358 (35.6%) did not schedule patients for follow-up sessions – regardless of how many haemorrhoids were banded at the initial session.

Surgery was the first-line treatment for symptomatic fourth degree haemorrhoids (77.6%). Rubber band ligation was second-line treatment for first (50.7%) and second (47.2%) degree symptomatic haemorrhoids, whereas surgery was the second-line choice for third (82.9%) and fourth (16.7%) degree haemorrhoids.

Choice of anaesthesia and patient's position for surgery

Most of the participants (92.4%–91.9%), performed surgical procedures for haemorrhoids. Spinal anaesthesia was the most commonly used anaesthetic (37.6%–37.4%), followed by laryngeal mask anaesthesia (16.2%). Lithotomy was the most preferred patient position (64.7%–64.4%).

Main factors considered for choosing types of surgery

Degree of haemorrhoids (76.3%), circular prolapse (45.5%), segmental prolapse (42.6%), and bleeding (42.3%) were the most common factors considered by participants in deciding the type of surgery. Haemorrhoid artery ligation with or without haemorrhoidopexy (25.4%) was the most common surgery performed for grade I and II haemorrhoids, while an open Milligan–Morgan haemorrhoidectomy (42.3%) was the most used technique for grade III and IV haemorrhoids.

Surgical approach

The most common operative procedure performed for haemorrhoids was an excisional haemorrhoidectomy (87.1%), followed by haemorrhoidal artery ligation (42.9%), stapled haemorrhoidopexy (32.1%) and laser haemorrhoidoplasty (21.1%). During the surgical procedures, 888 (88.4%) excised the external component if the patient was concerned, with 58.9% of the participants excising them even if the patient was not concerned. Regarding surgical resection, an excisional haemorrhoidectomy was the most common operation performed (89.7%) – usually by electrocautery (38.6%) then by Ligasure (23.1%). When performing a haemorrhoidectomy, an open Milligan–Morgan (54%) was chosen more often than the closed Ferguson haemorrhoidectomy. Most of the participants (71.2%) would remove 1, 2 or 3 sectors as necessary. Less than half of all participants (47.2%) performed a staged haemorrhoidectomy for extensive grade III or IV haemorrhoids. If an external component was present, it was usually not removed (55.7%).

Pain management after the surgery

Oral flavonoids/phlebotonics (35.9%), oral metronidazole (30.2%), and topical pain killers (29.6%) were the medications most commonly prescribed after surgery to reduce pain. The injection of methylene blue was only used 12.5% of the time to reduce postoperative pain. Postoperative follow-up was usually scheduled within 2 weeks (54.7%).

Thrombosed external haemorrhoids and pregnancy

During pregnancy, conservative management of acute and symptomatic thrombosed external haemorrhoids was the most common treatment choice overall (42.8%), in the first or second trimester (63.1%) and third trimester (56.1%). Thrombectomy under local anaesthesia was the second most common treatment overall (34.1%) and in the first or second trimester (26.6%). Most of the patients were instructed to follow up within 2 weeks (52.1%).

DISCUSSION

Most of the participants in our study used to take history as mentioned in most of the guidelines. Anoscopy was done to support the diagnosis. Sigmoidoscopy or colonoscopy was performed in the cases with suspicious findings in either the history, digital rectal examinations or anoscopy as recommended by most of the guidelines [5, 6, 13, 14].

Classification of the pathology was done by most of the participants in our study but which classification they adopted for the practice was not evaluated. Most of the practitioners used the Goligher classification to classify haemorrhoids [6]. It was surprising to find out Italian guidelines did not focus on classification of the pathology [14]. European guidelines mentioned that classification

could be used to help healthcare providers choose the best therapeutic option for each patient [6].

The American Academy of Family Physicians recommends fibre intake as an effective first-line, nonsurgical treatment for haemorrhoids [15]. Similarly, daily oral intake of fibre can be equally beneficial in decreasing the risk of bleeding [13]. Most of the participants preferred fibre intake as an effective nonsurgical treatment for the haemorrhoids in our study. This statement is also strongly endorsed by other international guidelines [5, 14, 16].

Rubber band ligation (RBL) was the second-line treatment for first and second degree haemorrhoids in addition to conservative management in our study. Most of the participants used to do this as an office-based procedure. The European Society of Coloproctology guidelines also strongly recommend RBL as a treatment modality for these grades [6, 13, 14]. Multiple RBL settings are associated with perianal pain, vasovagal reflex, and urinary symptoms [17]. In our study most of the participants used to perform three sessions on the same patients.

Conservative treatment was the first-line treatment for symptomatic grade I to III and surgery was the treatment of choice in grade IV haemorrhoids in our study, which was different to the recommendation by the previously mentioned societies. Medical management is strongly recommended for grade I and II haemorrhoids [13]. It also recommends the use of micronized purified flavonoid fraction even in the cases of acute bleeding. RBL can also be used in grade II haemorrhoids. However, surgery is strongly recommended for grade III and IV haemorrhoids [6, 16].

In our study, the grade of haemorrhoids was the determining factor for the need and the choice of surgery. In contrast, the European Society of Coloproctology issued guidelines suggesting that surgical treatment should be determined by considering patient preferences, availability of procedures and fitness for surgical procedures [6].

Topical 2% diltiazem, glyceryl trinitrate ointment, lateral sphincterotomy can be used to decrease pain postoperatively [14]. In our study, oral flavonoids/phlebotonics, oral metronidazole, and topical pain killers were the medications commonly prescribed after surgery to reduce pain (Table 1).

In our study, most of the participants managed thrombosed external haemorrhoids (pregnant and nonpregnant condition) by conservative approach. Even in the third trimester, conservative treatment was the treatment of choice for most of the participants. Conservative management for thrombosed external haemorrhoids was supported by most guidelines given by the different societies [6, 13, 16].

In our study, excisional haemorrhoidectomy was the most common surgery performed for haemorrhoids, removing 1, 2 or 3 sectors as necessary. Staged haemorrhoidectomy was the most common method to deal with extensive grade III or IV haemorrhoids. External component was separately excised by most of the participants.

Our study obviously had some limitations. First, we cannot be sure that all consecutive patients were enrolled in the study. Second, not all the invited surgeons accepted the invitation to

TABLE 1 Treatment options of the haemorrhoidal disease.

Grading of haemorrhoids before treatment	91.9%
Common forms of conservative treatment	
Increased daily fibre intake	86.9%
Increased intake of water	82.7%
Normalization of bowel habits/toilet training	74.4%
Common surgical approaches	
Excision haemorrhoidectomy	87.1%
Haemorrhoid artery ligation	42.9%
Stapled haemorrhoidectomy	32.1%
Consideration of external component	
Patient concerned	88.8%
Patient not concerned	58.9%
Rubber band ligation	
Second line treatment	
Grade I	50.7%
Grade II	47.2%
As office-based procedure	64.2%
Sessions up to 3	87.2%

participate – but this still represents real world data and practices all over the world. Moreover, limitations inherent to surveys included participant bias, question errors or omission. However, a multinational group created our survey, and we did achieve a high completion rate. Moreover, this is the largest international haemorrhoidal treatment audit, which adds many insights into the worldwide proctology.

CONCLUSION

Although no single global consensus exists for haemorrhoidal treatment, our survey identifies many practice similarities among the many different cultures, resources, and experiences of surgeons around the world. With additional studies, a global consensus statement could potentially be developed.

AUTHOR CONTRIBUTIONS

Narimantas E. Samalavicius: Conceptualization; investigation; validation; project administration; supervision; writing – review and editing. **Rakesh Kumar Gupta:** Data curation; formal analysis; methodology; writing – original draft. **Joseph Nunoo-Mensah:** Conceptualization; methodology; project administration; supervision. **Richard Fortunato:** Supervision; project administration; writing – review and editing; conceptualization; resources. **Varut Lohsirawat:** Conceptualization; visualization; software; data curation; writing – review and editing. **Bhawani Khanal:** Writing – original draft; methodology; visualization; formal analysis; data curation. **Abhijeet Kumar:** Investigation; visualization; formal analysis; supervision. **Bikash Sah:** Data curation; software; formal analysis; methodology; validation. **Dovile Cerkauskaitė:** Writing – original draft; writing – review and editing; formal analysis.

Audrius Dulskas: Writing – original draft; conceptualization; methodology; validation; visualization; project administration; data curation; supervision.

FUNDING INFORMATION

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

ETHICS STATEMENT

This work followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines. The study was reviewed and approved by the Institutional Review Board.

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