American Gastroenterological Association Medical Position Statement: Diagnosis and Treatment of Hemorrhoids

This document presents the official recommendations of the American Gastroenterological Association (AGA) on Hemorrhoids. It was approved by the Clinical Practice Committee on January 8, 2004, and by the AGA Governing Board on February 13, 2004.

Hemorrhoids are a common affliction in the adult population. Symptoms include bleeding, pain, protrusion, and itching. However, because none of these symptoms are specific for hemorrhoids, the diagnosis should only be made after an appropriate physical examination has ruled out other disorders, such as anal fissure, fistula, or abscess.

Hemorrhoids are optimally visualized using an anoscope. Hemorrhoidal bleeding is bright red and can appear as scanty blood on the toilet paper or copious blood squirting into the toilet bowl. All patients who report rectal bleeding should undergo sigmoidoscopy. The proximal colon should be evaluated by colonoscopy or air-contrast barium enema to assess bleeding that is not typical of hemorrhoids (e.g., dark blood or blood mixed in the feces), guaiac-positive stools, or anemia. The individual patient’s risk factors for colorectal cancer (age, family history, or personal history of polyps) should also be considered when deciding on the extent of colonic evaluation.

Internal hemorrhoids are classified according to the symptoms they cause. In the most commonly used classification, first-degree hemorrhoids bleed but do not protrude, second-degree hemorrhoids protrude with defection but reduce spontaneously, third-degree hemorrhoids protrude and require digital reduction, and fourth-degree hemorrhoids cannot be reduced. External hemorrhoids usually do not cause symptoms unless thrombosis occurs, in which case the patient experiences acute pain.

Treatment of hemorrhoids depends on their severity. Medical therapy is most appropriate for first-degree hemorrhoids. The cornerstone of medical therapy is adequate intake of fiber and water. Topical corticosteroids and analgesics are useful for managing perianal skin irritation due to poor hygiene, mucus discharge, or fecal seepage. Prolonged use of potent corticosteroid preparations may be harmful and should be avoided.

Nonoperative techniques for ablating hemorrhoids include injection sclerotherapy, diathermy coagulation, bipolar coagulation, infrared coagulation, and rubber band ligation. Cryotherapy has a high complication rate and is no longer recommended. Nonoperative techniques are most appropriate for second- and third-degree hemorrhoids but are also indicated when medical treatment of first-degree hemorrhoids has failed. Each of these therapies can be used for outpatients and may be repeated as needed; none require anesthesia. Complications are infrequent and usually minor; however, immunocompromised patients are at an increased risk for severe infection, particularly after rubber band ligation. Choice of individual technique depends in part on the physician’s training, experience, and preference. Meta-analyses of nonoperative therapy show that patients who undergo sclerotherapy (used only for first- and second-degree hemorrhoids) have a relatively high relapse rate and that rubber band ligation causes relatively more discomfort than other techniques. However, postbanding pain is usually minor and rubber band ligation is associated with the lowest recurrence rate of the nonoperative techniques.

If diagnosed early, thrombosed external hemorrhoids are best managed by excision under local anesthesia in the office or clinic. Excision is not required for patients whose symptoms are resolving, because the pain associated with hemorrhoidal thrombosis typically resolves after 7–10 days.

Hemorrhoidectomy, the most effective treatment for hemorrhoids, is associated with significantly more pain and complications than nonoperative techniques. Accordingly, surgery should be recommended only for a small minority of patients. Indications for elective hemorrhoidectomy include the following: (1) failure of medical and nonoperative therapy; (2) symptomatic third-degree, fourth-degree, or mixed internal and external hemorrhoids; (3) symptomatic hemorrhoids in the presence of a concomitant anorectal condition that requires surgery; and (4) patient preference, after discussion of treatment options with the referring physician and sur-
A number of operative techniques are acceptable for hemorrhoidectomy, depending on the surgeon’s training, experience, and preference. Manual dilatation of the anus is not recommended, given the associated risk of sphincter injury and incontinence. Laser hemorrhoidectomy has no advantage over hemorrhoidectomy using conventional techniques and is more costly. Stapled hemorrhoidectomy is a relatively new procedure that is associated with significantly less pain than conventional hemorrhoidectomy. Results appear comparable to conventional hemorrhoidectomy, although follow-up is relatively short to date and a small number of serious complications have been reported. Patients with acutely prolapsed, incarcerated, and thrombosed hemorrhoids should undergo either hemorrhoidectomy or excision of the external component with rubber band ligation of the internal hemorrhoids.