

Emergency Surgery for Thrombosed Prolapsed Piles

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Abstract

Background

Acutely painful, thrombosed, prolapsed hemorrhoids are traditionally managed conservatively with bed rest, analgesia, stool softeners and sitz baths. In severe cases, such management often necessitates prolonged hospitalization, sedation, and potent analgesics for 2 to 4 days. This study evaluates emergency surgical intervention as an alternative strategy to reduce complications, shorten pain duration, and decrease the length of hospital stay.

Methods

Twelve consecutive patients presenting with severe pain from painful, thrombosed, prolapsed piles were admitted to hospital and underwent surgical hemorrhoidectomy within 16 hours. None was pregnant. General anesthesia was administered in 9 cases and epidural anesthesia in 3. All patients received perioperative antibiotics.

Results

Post-operative pain remained significant during the first 18 hours but improved thereafter, allowing 9 patients to go home 24 hours postoperatively and 3 at 48 hours. Four patients experienced early difficulty in passing urine with only one requiring a single catheterization. No cases of septic complications, significant postoperative bleeding, or late anal stenosis were observed. Immediate surgery provided substantial early pain relief, shortened hospitalization, thus eliminating need for later readmission for recurrent prolapse or elective surgery.

Conclusions

Although many surgeons continue to favor conservative treatment for thrombosed, strangulated, prolapsed, painful piles, early surgical intervention should be considered an excellent option particularly in a Third-World setting to provide rapid symptom relief and reduce hospitalization.

Keywords: haemorrhoidectomy; prolapsed piles; surgical management; thrombosed.

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Introduction

Thrombosis of a haemorrhoid, locally described as piles, occurs when there is a clot within the already dilated rectal venous plexus and prolapse occurs when this complex protrudes beyond the anal canal. Once there is thrombosis and prolapse, the pain becomes quite severe such that the patient typically needs urgent medical care. In an acute presentation this may become painful enough to warrant hospitalization where the patient needs local anesthesia and sedation [1]. In the Caribbean, there is no precedence of immediate surgical management over conservative management.

Little literature exists to discuss surgical management as a first-line treatment. Surgical management is still considered to be a last resort due to the expectant complication severity and likelihood with reported complications being pain, urinary retention, infection, stricture, pelvic infection, strictures and incontinence [1].

To date, many hospitals prefer management through reduction, judicious analgesia, sitz baths,

stool softeners and dietary fiber [2]. This brings increased hospitalization time and use of resources in an already limited environment with results of symptom persistence or recurrence. We explore the option of urgent excisional haemorrhoidectomy offering the advantage of definitive treatment with no need for readmission or prolonged hospital stays with early and effective pain management [3].

Methods

Twelve consecutive patients with acute thrombosed prolapsed piles were assessed for surgery. Verbal informed consent was obtained from each patient to conduct and publish the study. After obtaining a focused history, the patient was asked to lie in a lateral recumbent position with legs flexed to be examined. Once diagnosis was confirmed, the patient was booked for surgery within 16 hours and an urgent excisional Milligan - Morgan haemorrhoidectomy was performed. Care was taken to preserve skin bridges between the piles; these bridges are mainly due to oedema and shrink rapidly post operatively.



Figure 1. (A) Preoperative appearance showing a large, protruding, inflamed mass in the perianal region, (B) Intraoperative image demonstrating surgical exposure and dissection of the lesion, (C) Post-excision view showing the surgical site following removal of the mass.



Figure 2. (A) Preoperative view showing a lobulated, protruding perianal lesion with smooth surface, (B) Intraoperative photograph demonstrating surgical excision with exposed underlying tissue, (C) Immediate postoperative appearance of the surgical site following complete removal of the lesion.

It is usually possible to preserve skin bridges, even in severe cases. (Figure 1 a, b & c; Figure 2a, b & c) Inclusion criteria consisted of patients who presented with acutely painful thrombosed prolapsed piles who required immediate treatment. No regard was paid to gender, age, race or comorbidities.

Exclusion criteria consisted of pregnant patients and outpatient cases of piles that did not require immediate management.

Ethical approval was granted by the ethics board of the Medical Associates Hospital and verbal consent was granted by each individual participant provided no identifying information was used.

Results

Twelve patients were included in the study, all of which were cases of confirmed thrombosed prolapsed piles. Post-operatively 9 patients noted significant improvement in pain after 18 hours and were subsequently discharged within 24 hours of surgery and 3 after 48 hours.

Post-operative complications were experienced by 4 patients. These patients experienced difficulty passing urine with only one requiring a single catheterization. No further cases of complications were noted by our participants. Immediate surgery provided significant pain relief and shortened hospitalization supporting our recommendation for this class of procedure to be a first line management.

Discussion

Piles are vascular dilations arising from a network of arteriovenous connective tissues draining into the inferior and superior haemorrhoidal veins [4]. In the diagnosis of piles the primary presenting complaint is painless bleeding with intermittent tissue protrusion that is usually reducible. Thrombosed prolapsed piles however present as painful, irreducible protrusions from the rectum. Prolapse has been noted to precede thrombosis [5]. While conservative management of thrombosed hemorrhoids may improve symptoms temporarily over a period of time, surgical excision provides a significantly shorter time to pain relief, lower risk of recurrence and faster return to daily

activity. Surgical excision of piles is now being recommended with excision of both the thrombus and the hemorrhoidal plexus beneath [6]. The rich vascular network beneath promotes rapid healing.

Although conservative therapy is recommended as the first line of treatment for piles in the majority of clinical guidelines, patients who come with acute prolapsed piles may not be well served by this paradigm, especially if the prolapse is painful, irreducible, or thrombosed. Since many simple hemorrhoids go away with dietary and behavioral changes, current guidelines strongly advocate non-operative therapy [7]. These recommendations, however, may not apply to acute presentations with notable edema, venous congestion, severe pain and sphincter spasm because they are derived from research based on mild or moderate disease.

Literature suggests that for certain individuals, early surgical intervention offers significant clinical benefits. In contrast to conservative treatment, *Greenspon et al.* showed that surgical excision of thrombosed hemorrhoids led to a much faster remission of symptoms and a decreased rate of recurrence at follow-up [8]. Rapid symptom relief is not merely just comfort; in susceptible patients, severe anorectal pain can cause urine retention or functional decline interfering with sleep, movement, and oral intake. After surgery notably, a rate of 3 to 50% of patients are noted to have urinary retention [9]. This is in part due to spasming of pelvic floor muscles secondary to pain, nerve disruption and may be due to local anesthesia usage. Definitive treatment at presentation may consequently lessen patient suffering and subsequent healthcare utilization. Recurrence prevention is a clinically relevant endpoint in acute presentations, where repeated episodes may otherwise lead to recurrent emergency visits.

Pathophysiologic considerations also support early operative management. Acutely prolapsed hemorrhoids frequently develop venous obstruction, thrombosis, and progressive edema, producing a cycle of swelling and pain that is unlikely to resolve rapidly with conservative therapy alone. Surgical

excision directly decompresses the affected vascular plexus and removes ischemic tissue, thereby addressing the mechanical basis of symptoms rather than temporizing them. Some clinical data acknowledge that urgent surgery is appropriate in cases of strangulation or irreducibility, underscoring that operative intervention is not inherently a last resort but rather an indicated treatment in specific presentations [7].

Randomized and comparative studies evaluating operative versus non-operative modalities for prolapsed hemorrhoids also support the efficacy of surgery as definitive therapy. Excisional hemorrhoidectomy has consistently shown superior symptom control and lower recurrence compared with office-based interventions such as rubber band ligation for advanced prolapse [10]. Systematic review data further indicate that while alternative techniques may modify early postoperative outcomes, surgery remains the most reliable intervention for eliminating prolapsed hemorrhoidal tissue [11].

Concerns regarding postoperative morbidity should be interpreted in context. Hemorrhoidectomy is associated with recognized complications such as pain, bleeding, and urinary retention, yet these events are generally transient and manageable [1,4]. Serious complications including sepsis or incontinence are uncommon in contemporary practice, particularly when procedures are performed by experienced surgeons. Thus, the relevant clinical question is not whether surgery carries risk, but whether those risks outweigh the morbidity of untreated acute prolapse. In appropriately selected patients, current evidence suggests they often do not. From our small series, we recommend emergency surgery rather than conservative management for thrombosed, prolapsed piles.

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Conclusions

When combined, the data suggests a tailored approach to treatment, where patients with acute thrombosed prolapsed piles may benefit from immediate surgery as a first-line treatment. Early surgical therapy, particularly emergency surgery can offer quick relief, stop the progression of ischemic problems, and lower the risk of recurrence when symptoms are severe, prolapse is irreducible, or thrombosis is evident. Individuals who are most likely to benefit from immediate operative intervention may have their definitive care delayed by a strict stepwise strategy that requires conservative therapy prior to surgery.

Recommendation

On the basis of findings, generalize the study to different settings.

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