

Management of Hemorrhoids, Perianal Abscess, and Anal Fistula

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SCOPE

This guideline provides evidence-based recommendations for surgeons on the evaluation, diagnosis, and management of hemorrhoidal disease, perianal abscesses, and anal fistulas. It is intended for use in hospitals, outpatient, and operative settings.

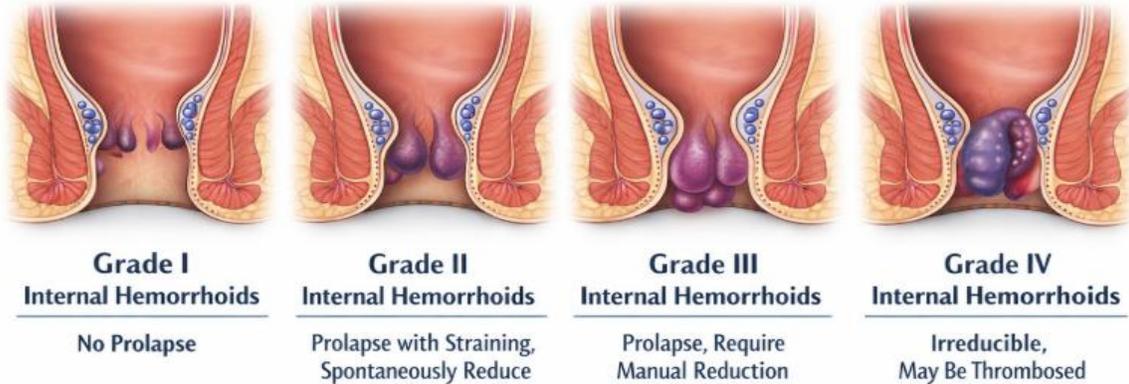
PURPOSE

To guide clinicians and surgeons in delivering optimal care, minimizing complications, and providing structured decision-making pathways. Mortality, morbidity, and complication rates are included where applicable.

DIAGNOSIS

Hemorrhoids

- Internal Hemorrhoids: Above dentate line, graded I–IV.
 - Grade I–II: Non-prolapsing or prolapsing with spontaneous reduction.
 - Grade III: Manual reduction required.
 - Grade IV: Irreducible, may strangulate.
- External Hemorrhoids: Below dentate line; extremely painful when thrombosed.
- Mixed Hemorrhoids: Straddle the dentate line.
- Presentation: Bright red blood per rectum, anal pruritus, pain.
- Complication Rates: Post-hemorrhoidectomy bleeding 2–5%, infection 1–2%, anal stenosis 1% (UpToDate, 2024; Cameron, 2022).



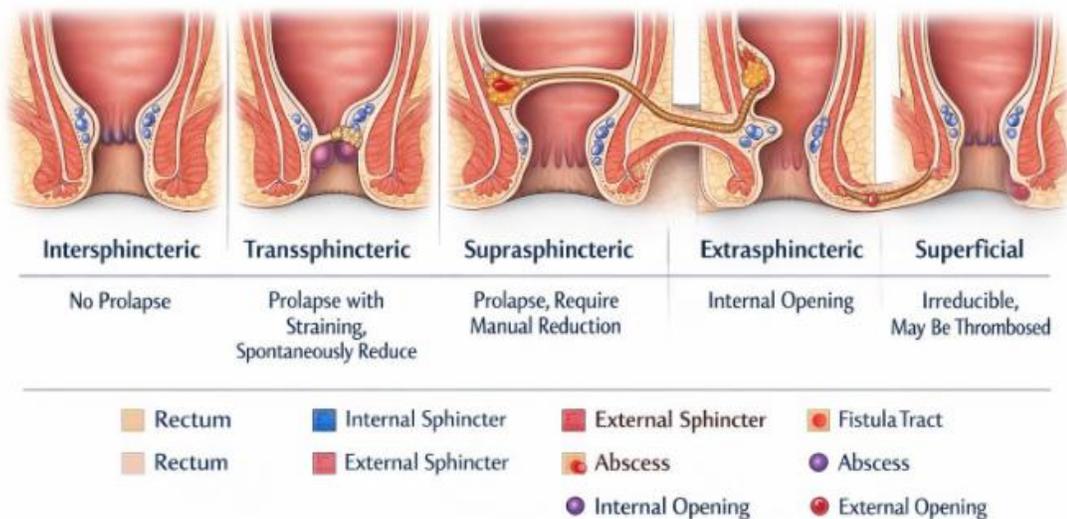
Perianal Abscess

- Acute manifestation of infectious perirectal process.
- Presentation: Pain, swelling, erythema, fever.
- Complications: Recurrence 10–20%; progression to fistula 30–50% depending on abscess location (Sabiston, 2020; Mentis et al., 2019).

Anal Fistula

- Often secondary to abscess; diagnosed via exam under anesthesia.
- Classification: Intersphincteric, Transsphincteric, Suprasphincteric, Extrasphincteric, Superficial.
- Complication Risks: Incontinence risk 5–15% with complex fistulas; recurrence 10–20% after fistulotomy (UpToDate, 2024).

Types of Anal Fistulas



TREATMENT GUIDELINES

Hemorrhoids

Management is based on symptom severity, hemorrhoid grade, and response to conservative therapy. A structured, stepwise approach should be followed before proceeding to operative intervention, with attention to long-term prevention through constipation control.

External Hemorrhoids

- **Non-surgical therapy:** Sitz baths, oral analgesics, adequate dietary fiber, and stool softeners to minimize straining and reduce pain.
- **Surgical intervention:** Excision is indicated for thrombosed external hemorrhoids within 72 hours of symptom onset or for cases involving severe pain or tissue necrosis.
- **Morbidity expectations:** Minor bleeding (2–5%), infection (1–2%), recurrence approximately 10%.

Internal Hemorrhoids

- **Conservative therapy:** Lifestyle modification, increased dietary fiber, topical therapies, and stool softeners.
- **Office-based procedures:** Rubber band ligation for Grade II–III hemorrhoids; recurrence rates range from 10–20%.
- **Definitive surgical treatment:** Excisional hemorrhoidectomy for Grade III–IV disease or cases refractory to conservative measures.
- **Reported morbidity:** Postoperative pain (30–50%), bleeding (2–5%), anal stenosis (1–3%) (Cameron, 2022).

Constipation and Prevention

- Constipation should be optimally controlled for **6–8 weeks prior to surgery**, as **50–70%** of patients may experience symptom resolution and avoid operative intervention.
- Recommended goals: **25–30 g of fiber daily**, adequate hydration, stool softeners as needed.
- Lifelong attention to bowel habits and prevention of constipation is essential to reduce recurrence risk—**counseling is a key component** of care.

Preoperative Colonoscopy Considerations

Patients with bleeding should undergo colonoscopy prior to hemorrhoidectomy if any of the following are present:

- Age \geq 40 without recent colonoscopy.
- Persistent bleeding after hemorrhoidectomy or non-resolution of symptoms.
- Associated abdominal symptoms (abdominal pain, bloating) or new/worsening constipation, suggesting alternate pathology.

Perianal Abscess

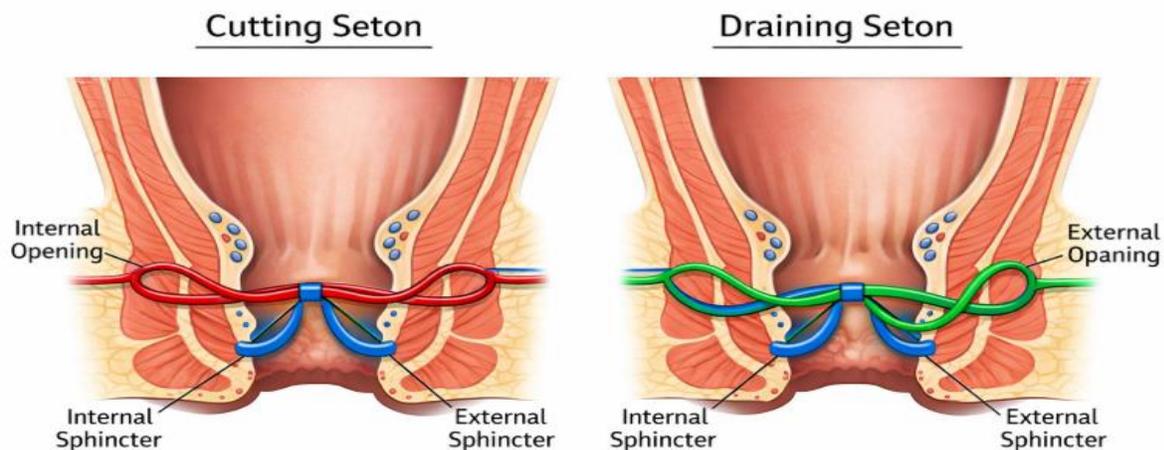


Treatment focuses on adequate drainage and early identification of fistula-in-ano.

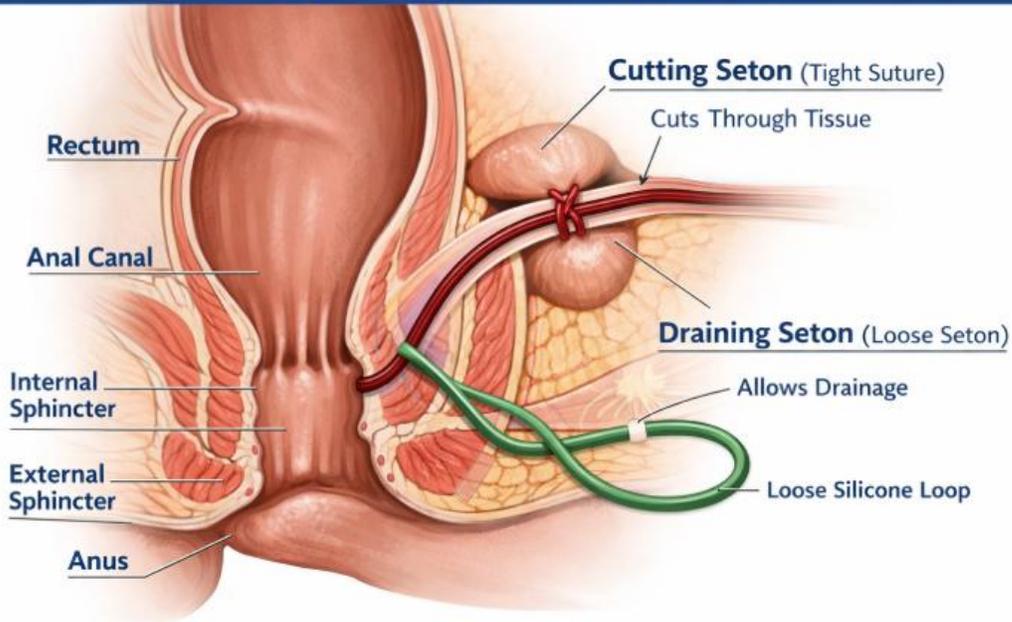
- **Bedside incision and drainage** under local anesthesia is appropriate for small, localized abscesses.
- **Operative drainage** in the OR is recommended for large or complex abscesses, with evaluation for an internal opening when feasible.
- **Antibiotic use** should be limited to patients who are immuno-compromised, display systemic inflammatory signs, or have surrounding cellulitis.
Recommended regimens include:
 - Amoxicillin-clavulanate 875/125 mg PO BID
 - Ceftriaxone 1 g IV q24h + Metronidazole 500 mg IV q8h (UpToDate, 2024)
- **Complications:** Recurrence occurs in approximately 10–20%, and fistula formation in up to 30% (Sabiston, 2020).

Anal Fistula

- Simple Fistulas: Fistulotomy; recurrence <10%, incontinence <5%.
- Complex Fistulas (>30% sphincter involvement): Staged procedures or sphincter-sparing techniques:
 - Seton placement (draining or cutting setons).
 - LIFT procedure (ligation of intersphincteric fistula tract).
 - Endoanal advancement flap.
 - Fistula plug or fibrin glue.
- Complications: Recurrence 10–20%; incontinence 5–15% depending on technique (Mentes et al., 2019; UpToDate, 2024).
- Referral to colorectal surgery recommended for high-complexity fistulas.



Seton Placement - Sagittal View



Perioperative Considerations

- Preoperative antibiotics if immunocompromised or systemic infection.
- Postoperative pain management with multimodal analgesia.
- Monitor for bleeding, infection, incontinence.
- Early mobilization and stool softeners recommended.

SUMMARY TABLE: Management Approach

Condition	Initial Management	Operative Management	Complications	Mortality
External hemorrhoids	Sitz bath, analgesia, stool softeners	Excision if <72h or necrotic	Bleeding 2–5%, infection 1–2%	<1%
Internal hemorrhoids	Fiber, lifestyle, banding	Excisional hemorrhoidectomy for Grade III–IV	Pain 30–50%, bleeding 2–5%, stenosis 1–3%	<1%
Perianal abscess	Incision & drainage (bedside or OR)	OR drainage for complex abscess	Recurrence 10–20%, fistula 30%	<1%
Anal fistula	Observation only for asymptomatic	Fistulotomy, Seton, LIFT, Flap, Plug	Recurrence 10–20%, incontinence 5–15%	<1%

Version Control Record

Version	Date	Author/Reviewer	Description of Changes
1	1/9/26	Paul Wisniewski, D.O. Brian Patterson, M.D	Initial review and update to reflect latest evidence/practice

REFERENCES

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