SNS COLLEGE OF ALLIED HEALTH SCIENCES

SNS Kalvi Nagar, Coimbatore - 35

Affiliated to Dr MGR Medical University, Chennai

DEPARTMENT OF B.SC .OPERATION THEATRE &ANESTHESIA TECHNOLOGY

II YEAR

TOPIC – HAEMORROIDS

CASE HISTORY

A 41 yrs old female Reported to OPD With the presenting complaints of anemia since 2 months along with constipation, severe burning sensation in her anus which disrupt her daily activities , her symptoms gets aggravated on consuming spicy food,and less water intake. on examination her vitals are stable,advised to go for proctoscopy .

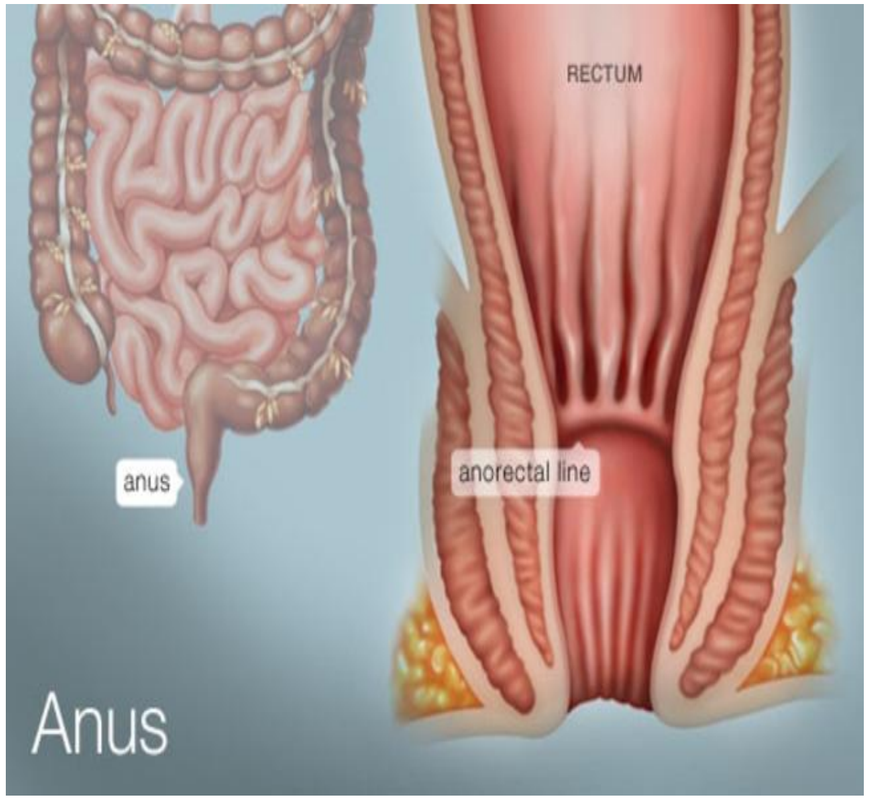
ANATOMY &PHYSIOLOGY

The rectum is a part of the lower gastrointestinal tract.

The rectum is a continuation of the sigmoid colon, and connects to the anus. The rectum follows the shape of the sacrum and ends in an expanded section called the rectal ampulla, where feces are stored before their release via the anal canal.

Artery: superior rectal artery

Nerve: inferior anal nerve,



INTRODUCTION

Hemorrhoids are vascular masses that protrude into the lumen of the lower rectum or perianal area.

Alternative Names

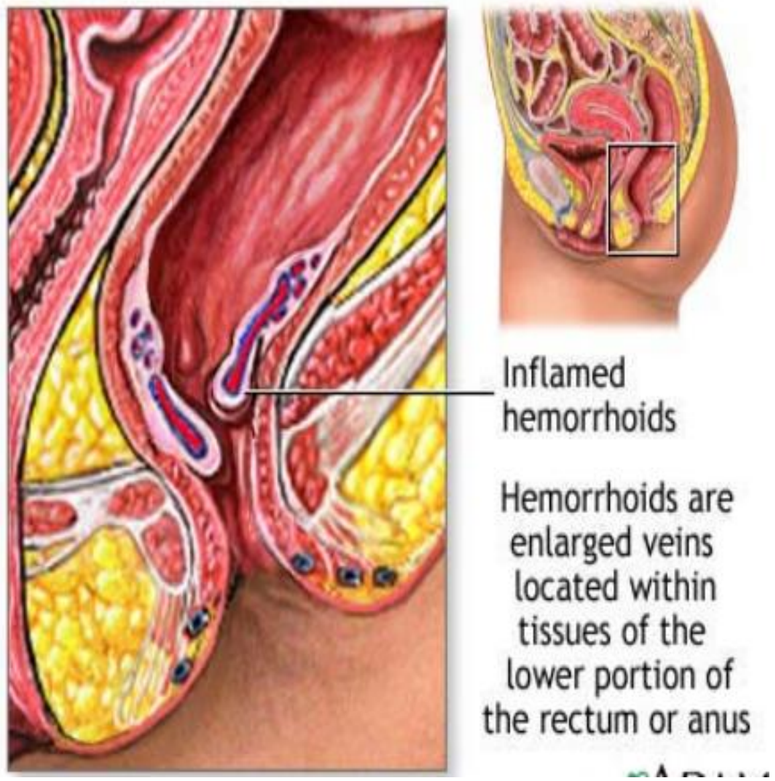
- Rectal Lump
- Piles
- Lump in the Rectum

DEFINITION

Dilated or enlarged veins in the lower portion of the rectum or anus.

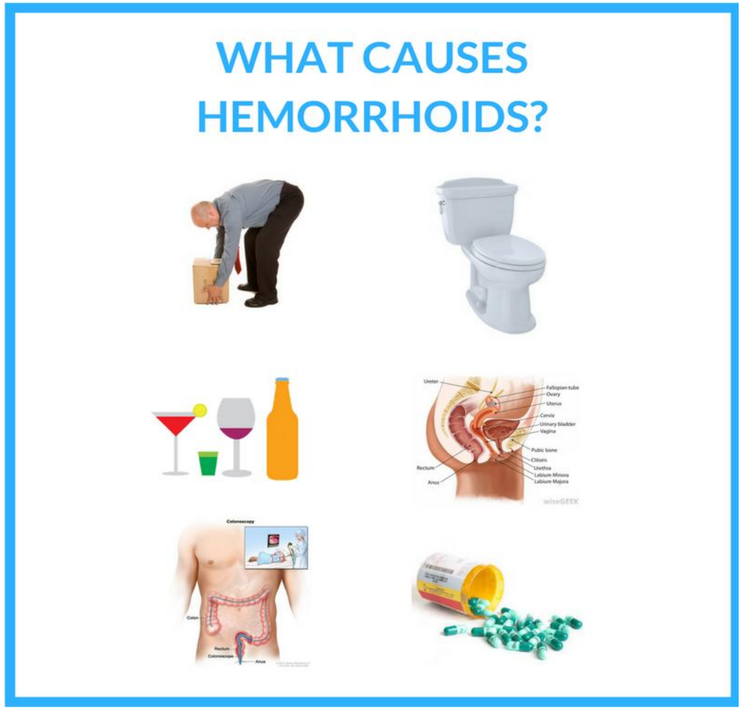
or

Swollen and inflamed veins in the rectum and anus that cause discomfort and bleeding



CAUSES

- **Pressure**
  - Constipation
  - Diarrhea
  - Sitting or standing for long periods of Time
  - Obesity
  - Heavy Lifting
  - Pregnancy
  - Anal Sex

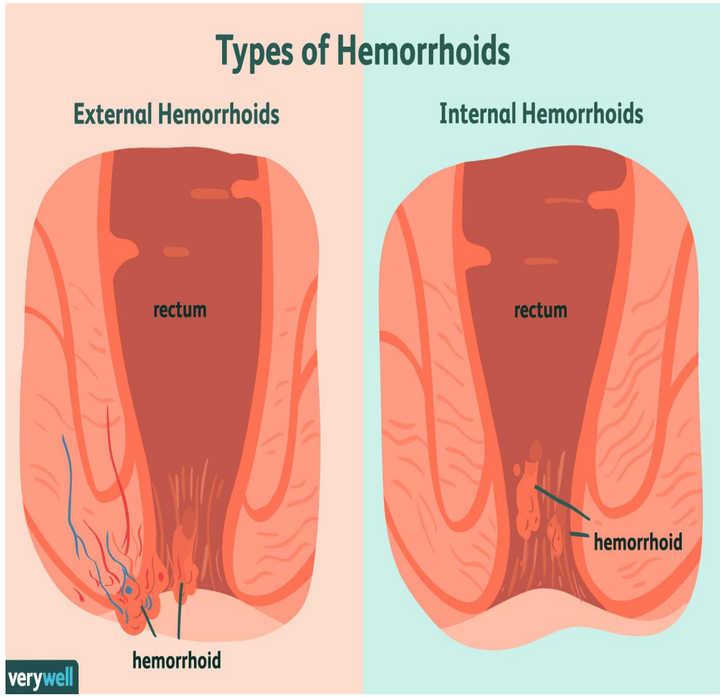


CLASSIFICATION OF HEMORRHOIDS

CLASSIFICATION:

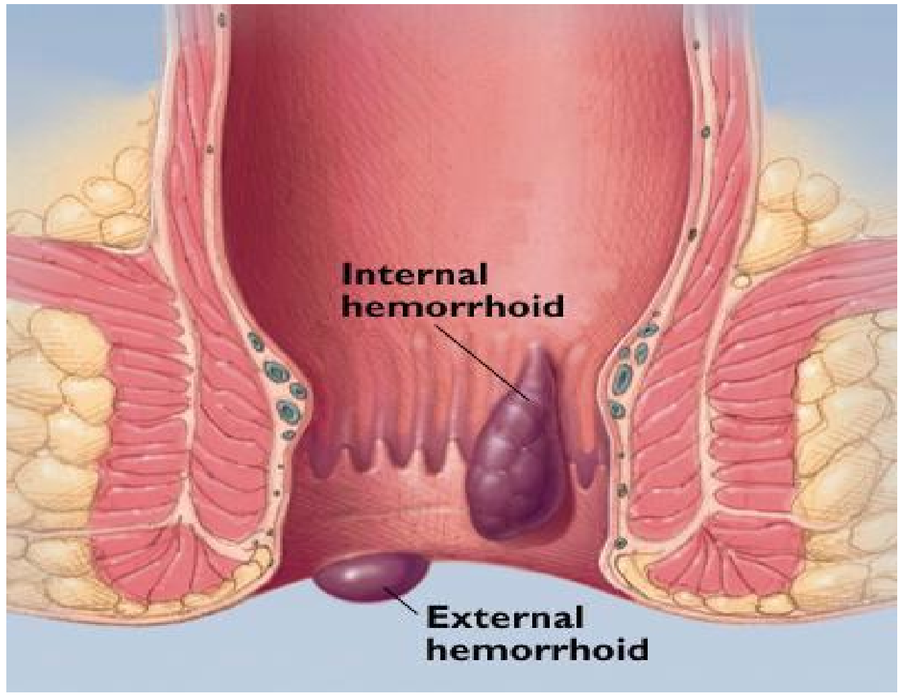
Those originating above the dentate line which are termed

internal (hemorrhoids appear above the internal sphincter)



CLASSIFICATION

- Those originating below the dentate line which are termed **external** (hemorrhoids appear outside the external sphincter)



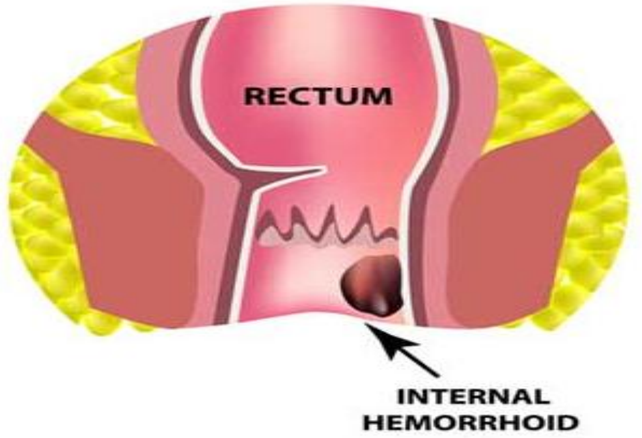
INTERNAL HAEMORRHOIDS

- Manifested by two main symptoms

  - Painless Bleeding

  - Protrusion

- (Pain is rare as they originate above dentate line)



- Most popular etiologic theory states that Hemorrhoids result from chronic straining at defecation

- Continued straining causes engorgement and bleeding, as well as hemorrhoidal prolapse

GRADES OF INTERNAL HAEMORRHOIDS

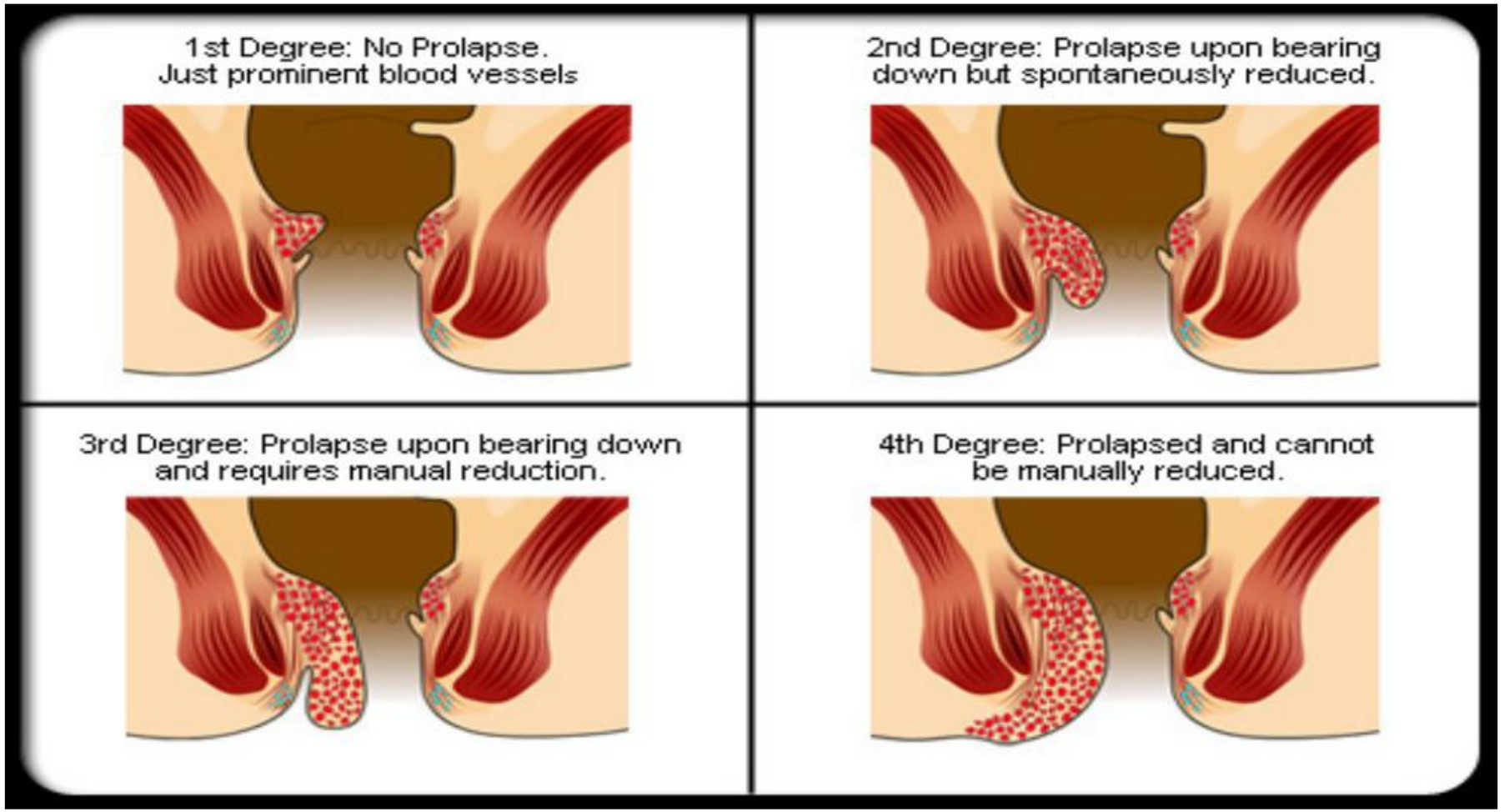
I- Hemorrhoids only bleed

II- Prolapse and reduce spontaneously

III- Require replacement

IV- Permanently Prolapsed

GRADES OF HEAMORRHIODS CONT....



ASSESSMENT

- Define Heamorrhoids
- list down the causes
- Differntiate intrnal & externa haemorrhoids

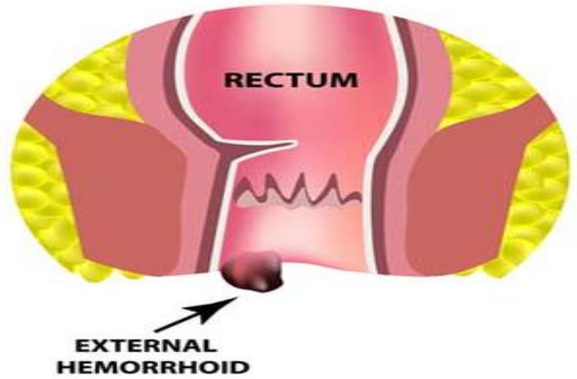
External Hemorrhoids

- Asymptomatic

  - except when secondary thrombosed

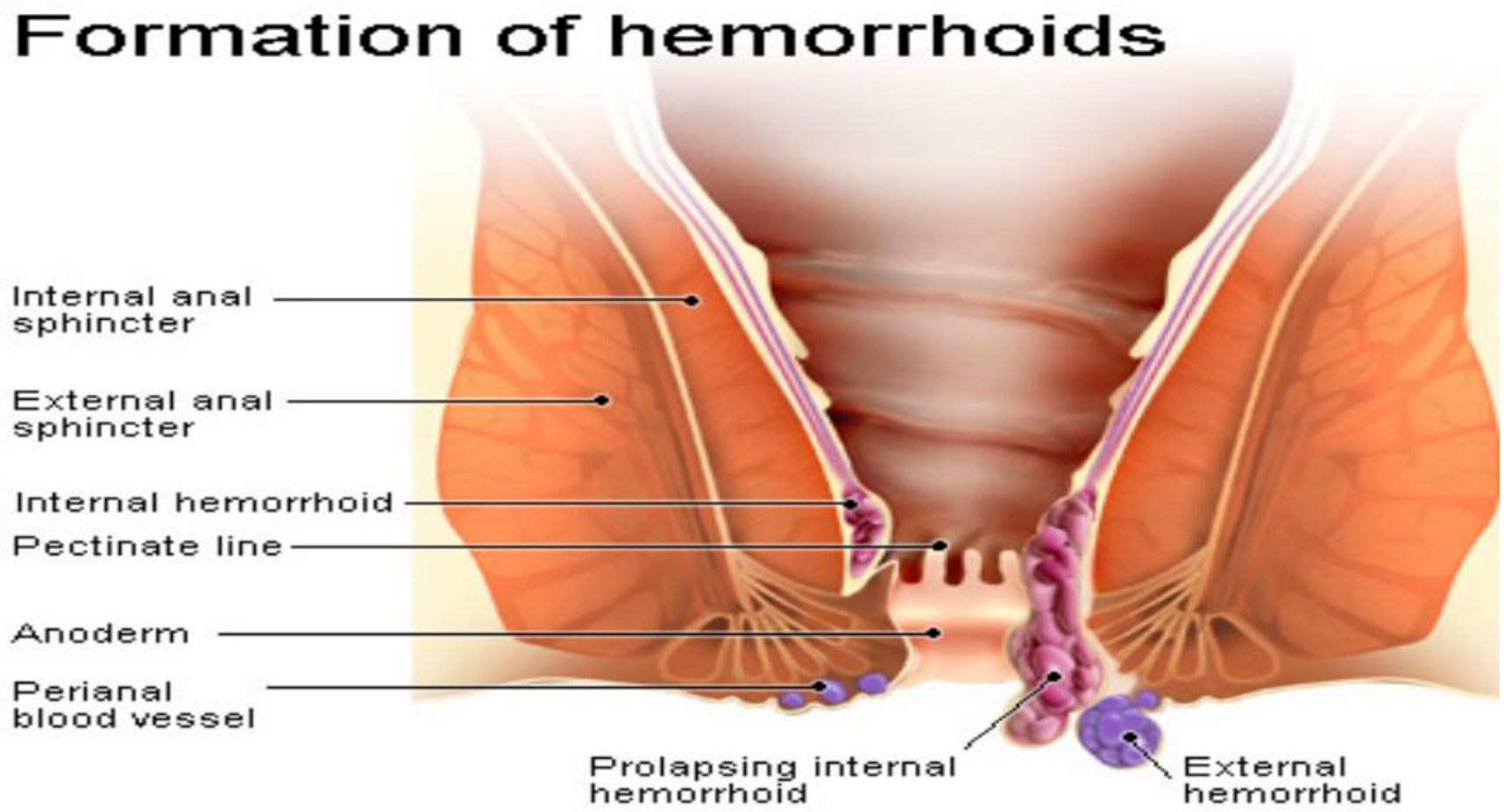
- Thrombosis may result from defecatory straining (OR) extreme physical activity or may be random event

- Patient presents with constant anal pain of acute onset



- Physical examination identifies external thrombosis as purple mass at anal verge

FORMATION OF HAEMORRHOIDS



PATHOPHYSIOLOGY

Due to Causes

Increased intra-abdom

inal pressure

Abnormal dilatation of veins of internal hemorrhoidal venous plexus.

Abnormal distension of the arteriovenous anastomoses.

Destruction of the anchoring connective tissue system.

Downward displacement or prolapse of anal cushions.

Hemorrhids

SIGNS SYMPTOMS

- ✓Bleeding during or after defecation, bright red blood on stool due to injury of mucosa covering hemorrhoid (most common)
- ✓Visible (if external) and palpable mass
- ✓Constipation, anal itching
- ✓Sensation of incomplete fecal evacuation
- ✓Infection or ulceration, mucus discharge

SIGNS SYMPTOMS CONT....

- ✓Pain during bowel movements
- ✓Pain noted more in external hemorrhoids
- ✓Sudden rectal pain due to thrombosis in external hemorrhoids
- ✓Rectal Prolapse (while walking, lifting weights)

ASSESSMENT

- 1.Describe about pathophysiology of Hemorrhoids ?????

- 2.How will you grade hemorrhiods with diagram ????

Complications

❖The blood in the enlarged veins may form clots and the tissue surrounding the hemorrhoids can die (Necrosis)

❖This causes painful lumps in the anal area.

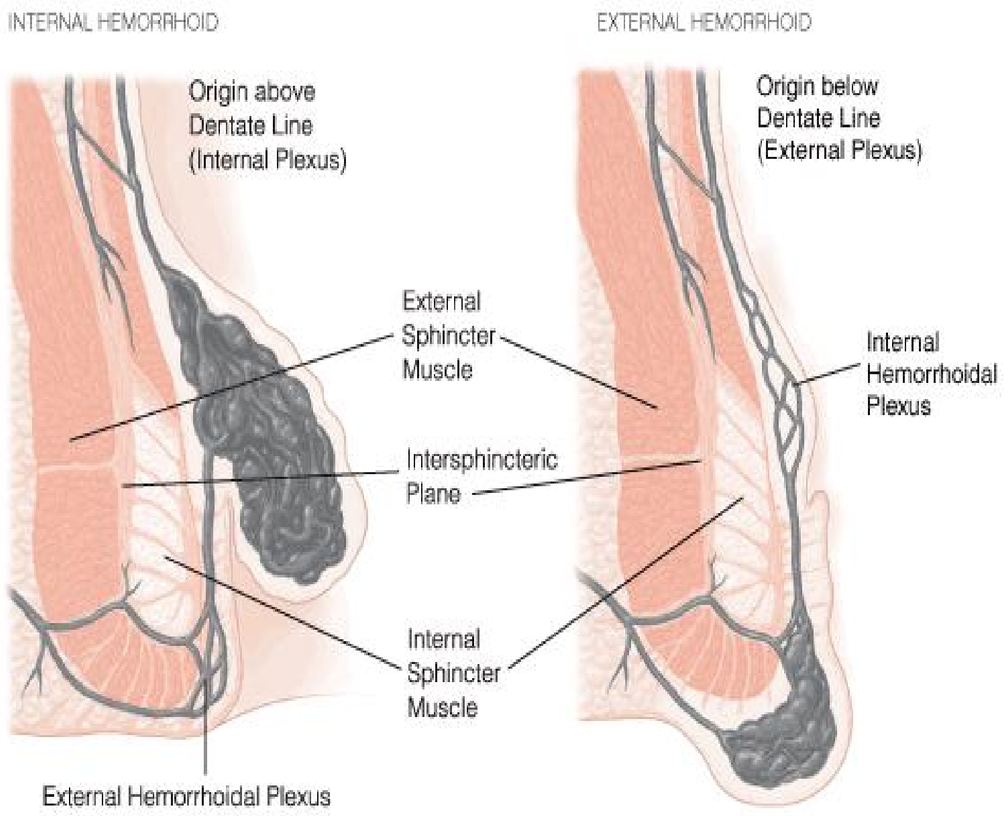
❖Severe bleeding can occur causing iron deficiency anemia.

DIAGNOSIS

- History collection
- Physical examination:
- Patients should be examined in the left lateral decubitus position (while asking the patient to bear down) lubricated finger should be gently inserted into the anal canal to be notated any rashes, condylomata, or eczematous lesions. external sphincter function Any abscesses, fissures or fistulae.

DIAGNOSTIC EVALUATION

- Rectal Examination
  - Visual
  - Digital
- Tests
  - Stool Guaiac (FOBT)
  - Sigmoidoscopy
  - Anaoscopy
  - Proctoscopy



Medical management

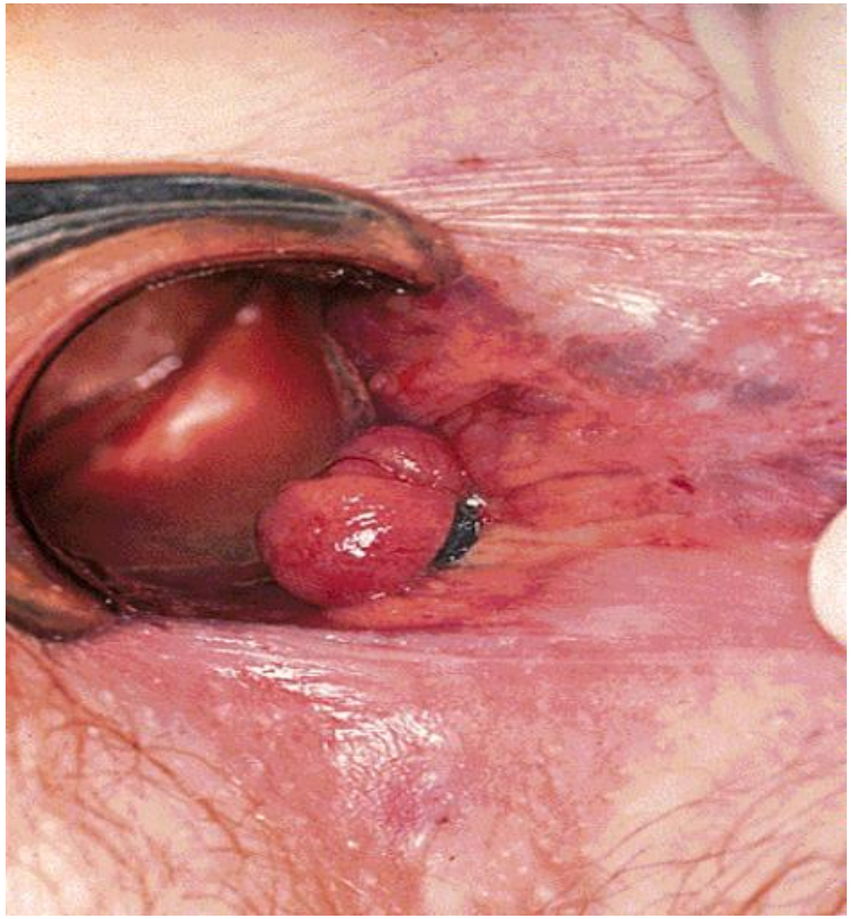
- Bowel habits should be regulated with nonirritating stool softeners and high-fiber diet to keep stools soft.
- Frequent, warm sitz baths to ease pain and combat swelling.
- Analgesics as needed.
- Topical creams, lotions, and suppositories to provide comfort (Tucks pads, Anusol cream/suppositories, Balneol lotion, ProctoFoam, Preparation H).
- Control of itching by improved anal hygiene measures and control of moisture.

Medical management

- Avoid prolonged use of topical anesthetics on hemorrhoids
- Manual reduction of external hemorrhoids if prolapsed.
- Injection of sclerosing solutions (phenol 5%) to produce scar tissue and decrease prolapse.
- Cryodestruction (cryosurgery) freezing of hemorrhoids.
  - Profuse drainage and swelling occurs.
  - Foul-smelling discharge may last for 7 to 10 days after cryosurgery.

Non surgical Management
Rubber Band Ligation

- Grade I or Grade II hemorrhoids and, in some circumstances, Grade III hemorrhoids.
- Complications include bleeding, pain, thrombosis and life threatening perianal sepsis.

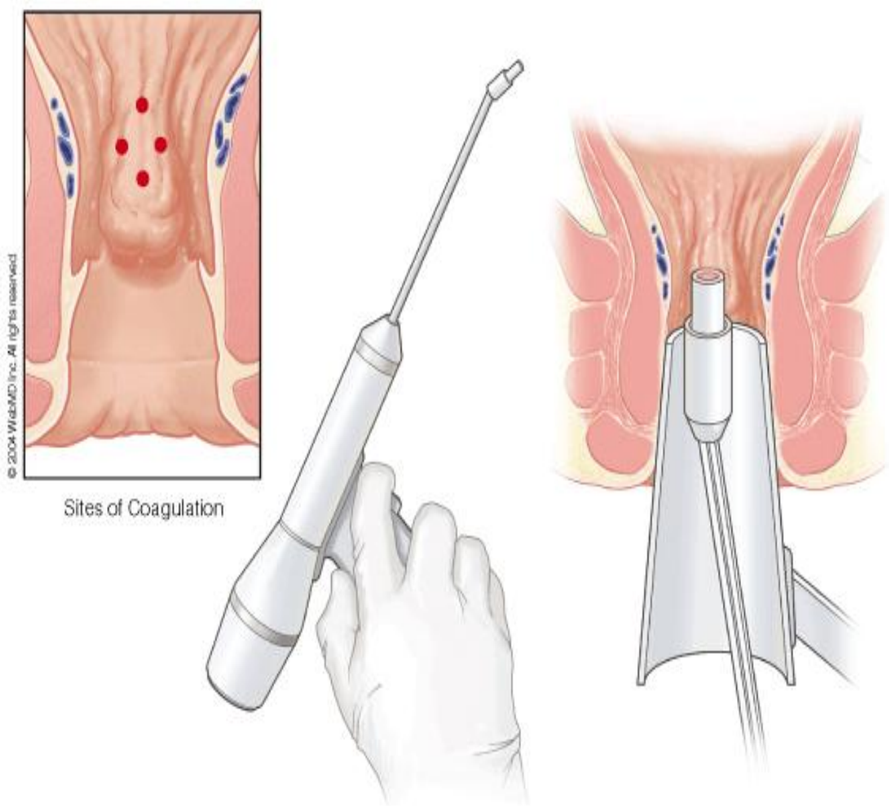


- Successful in two thirds to three quarters of all individuals with first and second degree hemorrhoids

Non Medical Management

INFRARED COAGULATION

- Generates infrared radiation which coagulates tissue protein and evaporates water from cells.
- Most beneficial in Grade I and small Grade II hemorrhoids.

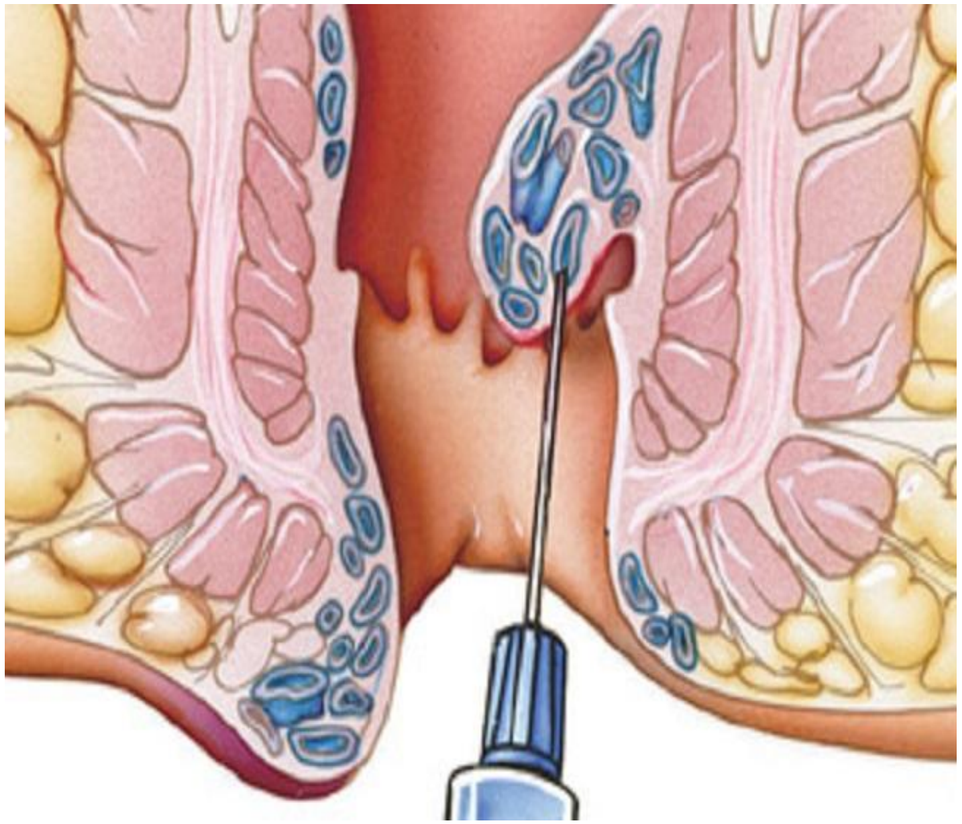


Non surgical Management

SCLEROTHERAPY

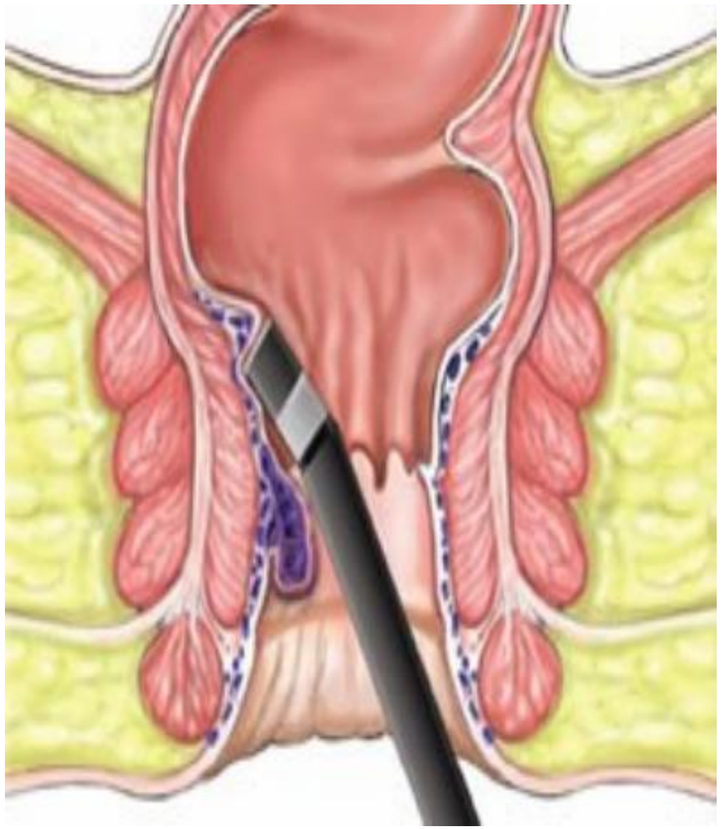
Injection of an irritating material into the sub mucosa in order to decrease vascularity and increase fibrosis.

Injecting agents have traditionally been phenol in oil, sodium morrhuate, or quinine urea.



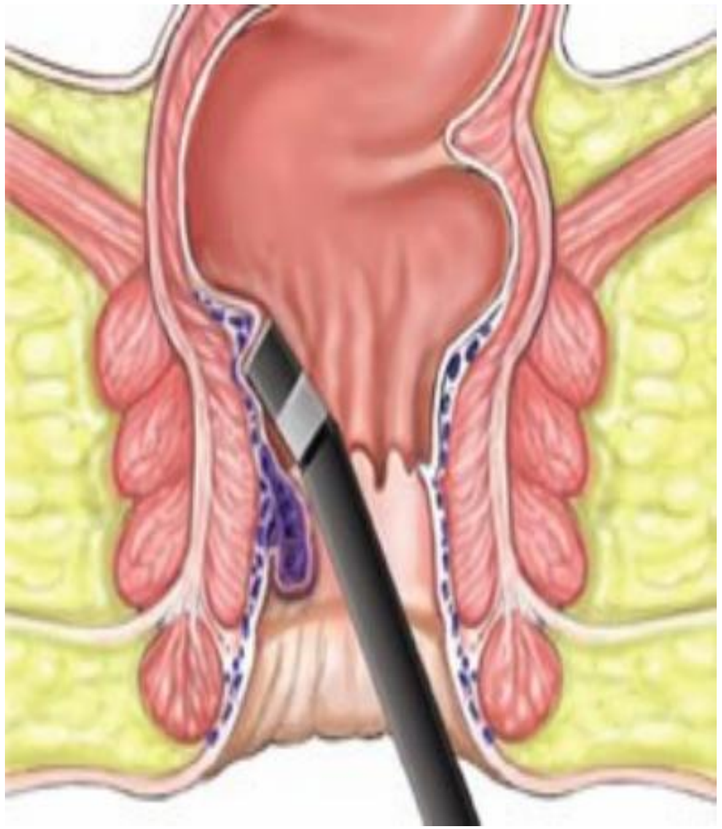
NON SURGICAL MANAGEMENT

- **Cryotherapy** for freezing the apex of the anal canal could result in decreased vascularity and fibrosis of the anal cushions.



NON SURGICAL MANAGEMENT

- **Cryotherapy** for freezing the apex of the anal canal could result in decreased vascularity and fibrosis of the anal cushions.



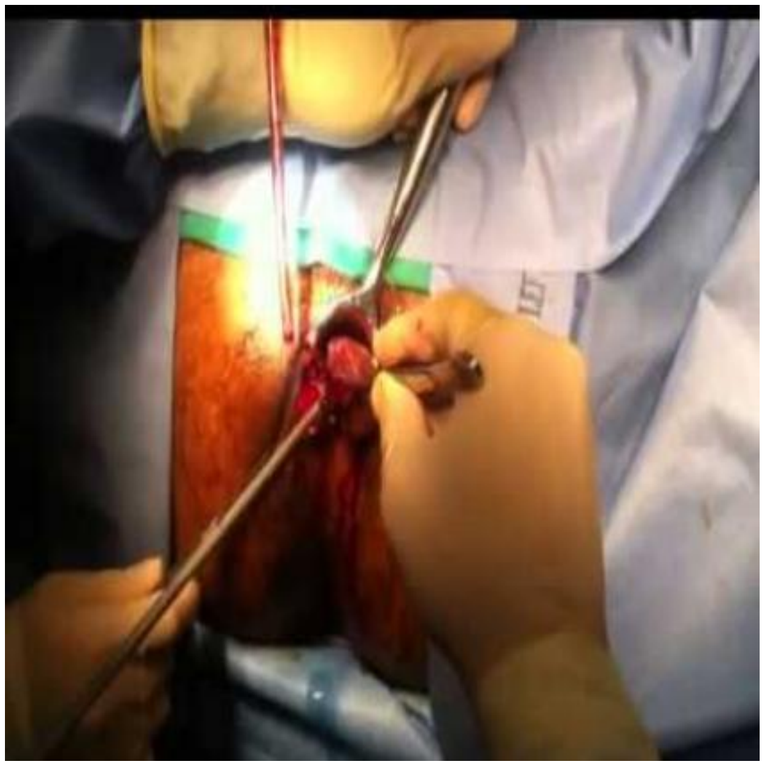
SURGICAL MANAGEMENT

- **HEMORRHOIDECTOMY**

The triangular shaped hemorrhoid is excised down to the underlying sphincter muscle.

Wound can be closed or left open

Stapled hemorrhoidectomy has been developed as an alternative to standard hemorrhoidectomy



POST OPERATIVE NURSING CARE

After thrombosis or surgery, assist with frequent positioning, using pillow support for comfort.

Provide analgesics, warm sitz baths, or warm compresses to reduce pain and inflammation.

Apply anal pads, creams, or suppositories as ordered to relieve discomfort.

Observe anal area postoperatively for drainage and bleeding; report if excessive.

Administer stool softener/laxative to assist with bowel movements soon after surgery, to reduce risk of stricture

POST OPERATIVE NURSING CARE

Encourage regular exercise, high-fiber diet, and adequate fluid intake (8 to 10 glasses per day) to avoid straining and constipation.

Discourage regular use of laxatives ”firm, soft stools dilate the anal canal, decreasing stricture formation.

Determine patient's normal bowel habits, and identify predisposing factors in order to educate patient about changes necessary to prevent recurrence of symptoms.

PREVENTION

Eat high fiber diet

Drink Plenty of Liquids

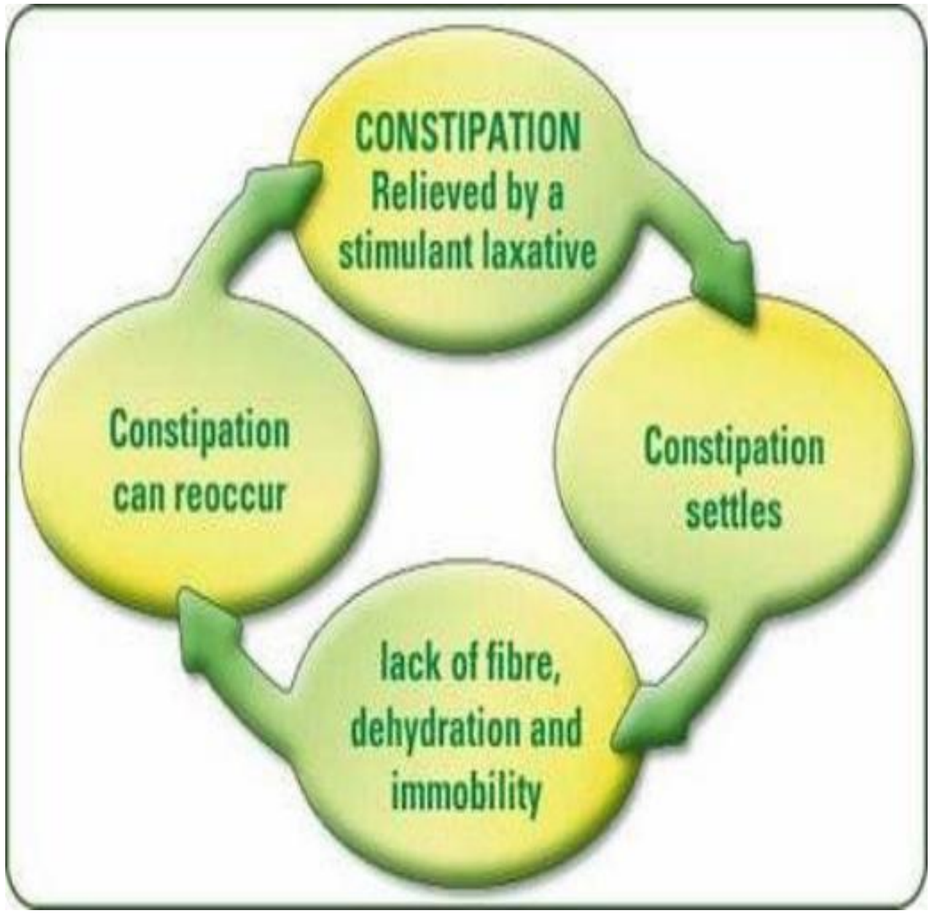
Fiber Supplements

Exercise

Avoid long periods of standing or sitting

Don’t Strain

Go as soon as you feel the urge



REFEENCE

Black .J.M. & Hawks .J.H, (2004), Medical surgical nursing, 7th edition, New Delhi: Elsevier publication, Pp. 1248-1250

Fauci .A.S, Braunwald .E, et.al. (Ds.), (2001), Harrison's principles of internal medicine – II, 15th edition, New York: McGraw Hill, Pp. 2402-2404.

Holloway .N.M. (1999), Medical surgical care planning, 3rd edition, Pennsylvania; Springhouse, 789-790.

Lewis .S.M, Heitkemper .M.M & Dirksen .S.R, (2004), Medical surgical nursing, 6th edition, Missouri : Mosby, Pp. 1572-1575.


Thank
you!