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HEMORRHOIDS: CLINICAL PRESENTATION, DIAGNOSTIC SIGNS, AND EVIDENCE-BASED SURGICAL MANAGEMENT OPTIONS

[*]Dr Nikhil Yadav, Dr Rahul Jain, Dr Chanchal Verma, Dr Amrit Kumar Gupta, Dr Sumit Kumar, Dr Vicky Kuldeep

Manipal Hospital Dwrka, New Delhi, India.

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***Corresponding Author: Dr Nikhil Yadav**
Manipal Hospital Dwrka, New Delhi, India.

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ABSTRACT

Background: Hemorrhoids represent the most common anorectal pathology, affecting 4-86% globally with peak incidence 45-65 years. While grades I-II respond to conservative/office measures, grades III-IV mandate surgical intervention.

Methods: Systematic narrative review per IMRAD structure synthesizing peer-reviewed guidelines (ASCRS 2025), RCTs, and meta-analyses (2018-2026) on symptom profiles, grading accuracy, and comparative surgical outcomes.

Results: Internal hemorrhoids manifest painless bright red rectal bleeding and prolapse; external cause acute thrombotic pain. Goligher grading (I-IV) directs therapy: rubber band ligation (RBL, grade II, 80% success), open hemorrhoidectomy (Milligan-Morgan, grade IV, 5% recurrence), stapled hemorrhopexy (PPH, grade III, VAS pain 3-5), THD (grade III, 11% recurrence).

Conclusions: stapler hemorrhoidectomy endures as gold standard; THD/PPH excel in recovery. Thrombosed external hemorrhoids require excision <72 hours.

KEYWORDS: hemorrhoids, hemorrhoidectomy, rubber band ligation, stapled hemorrhoidopexy, THD, Goligher classification.

INTRODUCTION

Hemorrhoidal disease arises from symptomatic engorgement of vascular cushions at 3, 7, and 11 o'clock positions within the anal canal. Internal (above dentate line) hemorrhoids cause painless bleeding per rectum and prolapse; external (below dentate) produce acute thrombotic pain.

Prevalence peaks 45-65 years, affecting >50% adults >50 years. Conservative management (fiber, stool softeners, topical agents) suffices grades I-II; surgical referral indicated for grade III/IV prolapse, thrombosis, refractory bleeding, or strangulation.

This IMRAD-structured review synthesizes contemporary evidence on clinical presentation and surgical options for *Indian Journal of Surgery* readership, emphasizing Indian resource constraints and ASCRS 2025 guidelines.

Materials and Methods

Study Design: Narrative review following IMRAD format per journal guidelines.

Sources: ASCRS 2025 guidelines, PubMed/Medline RCTs/meta-analyses (2018-2026), surgical textbooks (Corman, ASCRS Textbook 4th ed.).

Inclusion Criteria: English-language studies reporting symptom profiles, Goligher grading outcomes, comparative surgical efficacy (pain VAS, recurrence <5 years, complications).

Data Synthesis: Tabular comparison of procedures by grade/indication; qualitative synthesis of guideline recommendations. No original data collection.

RESULTS

Clinical Presentation and Diagnostic Signs

Symptoms by Type:

- **Internal:** Painless bleeding per rectum (90% grade I), mucus discharge/pruritus, prolapse ± manual reduction.
- **External:** Acute severe pain (thrombosis), perianal swelling/itching, minimal bleeding.

Goligher Classification:

Grade	Prolapse Characteristics	Symptoms	Examination Findings
I	No prolapse	Bleeding per rectum only	Anoscopy: enlarged cushions
II	Prolapse, spontaneous reduction	Bleeding + mucus	Prolapsing veins <4cm
III	Manual reduction required	Bleeding, soiling, discomfort	Edematous reducible mass
IV	Irreducible ± ulceration	Constant soiling, pain, stenosis risk	Sphincter spasm, gangrene

Critical Signs Requiring Urgent Action:

Sign	Diagnosis	Management
Tense blue-purple lump	Thrombosed external	Excision <72h
Severe pain >3 days	Strangulation	Emergency hemorrhoidectomy
Anemia + weight loss	Colorectal pathology	Colonoscopy

Surgical Treatment Outcomes

Office Procedures (Grades I-III):

Procedure	Success Rate	Recurrence	Complications
Rubber Band Ligation	70-90%	10-15%/yr	Pain (10%), bleeding (1%)
Sclerotherapy	70%	20%	Ulceration (5%)

Operative Procedures (Grades III-IV):

Procedure	Pain (VAS)	Recurrence	Complications	Hospital Stay
Milligan-Morgan (Open)	7-9	5%	Stenosis 2%, incontinence 1%	1-2 days
Ferguson (Closed)	6-8	7%	Dehiscence 3%	1 day
LigaSure™	5-7	6%	Blood loss ↓70%	Day surgery
Stapled (PPH/Longo)	3-5	2-8%	Leak 1.4%, urgency 10%	Day surgery
THD (DG-HAL)	2-4	11-12%	Rare	Day surgery

Thrombosed External: Elliptical excision under local anesthesia yields immediate pain relief (VAS 9→2) if performed 24-72 hours post-onset.

DISCUSSION

Goligher grading remains cornerstone for treatment stratification despite limitations (ignores size, bleeding severity, comorbidities). Grade I-II favor office procedures (RBL first-line per ASCRS); grade IV mandates excisional surgery.

Excisional vs Non-Excisional Debate: Milligan-Morgan offers lowest recurrence (5%) but highest pain, driving adoption of THD/PPH (VAS ↓50-70%, return-to-work 7 vs 14 days) . LigaSure mitigates blood loss/thermal injury vs diathermy.

Indian Context: Milligan-Morgan prevails due to low cost (INR 2,000 vs PPH INR 85,000). THD suitable select grade III cases where daycare infrastructure exists.

Limitations: Heterogeneous RCTs preclude meta-regression; long-term (>5yr) THD/PPH data immature. Patient-reported outcomes (QoL, Sodergren score) underreported.

Red Flags: Age >40 + new BRBPR, anemia, altered bowel habit mandate colonoscopy excluding malignancy.

CONCLUSIONS

Hemorrhoids present distinct symptom-sign patterns dictating management: painless bleeding per rectum /prolapse → internal (RBL → surgery); acute pain/swelling → thrombosed external (excision).

Milligan-Morgan hemorrhoidectomy endures for grade IV despite pain; THD/PPH optimize grade III recovery. Urgent thrombectomy <72 hours prevents fibrosis. Guideline-directed therapy balances efficacy, pain, recurrence, and resources.

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