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Summary

Understanding haemorrhoids, fissures and other benign proctological conditions: From symptoms to solutions

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This educational talk for gastroenterologists covers the diagnosis and management of common benign proctological conditions including haemorrhoids, anal fissures, and thrombosed external haemorrhoids, emphasizing proper clinical assessment and stepwise treatment approaches.

KEY POINTS

- Symptomatic haemorrhoids present with bleeding and prolapse but not pain; the Goliger classification describes prolapse severity, not symptom burden, and should not guide treatment decisions automatically.
- Conservative management with stool regulation, fibres, laxatives, and behavioural modification should be attempted before referral; the speaker recommends rubber band ligation as the preferred office-based treatment when conservative measures fail.
- Anal fissures cause severe pain during and after defaecation; treatment escalates from conservative measures to topical nitrates or calcium channel blockers for 6-8 weeks, with the speaker personally preferring diltiazem to avoid nitrate-related headaches.
- Thrombosed external haemorrhoids can be treated with thrombectomy if seen within 2-5 days, otherwise managed conservatively; if the lump is red with fever, the patient should be referred to the emergency department for abscess drainage.
- Proper clinical assessment requires a detailed history, perianal inspection, digital rectal examination, and anoscopy; clinicians should start with symptoms rather than presumed diagnoses and remember that not everything is haemorrhoids.
- Skin tags are redundant skin, not haemorrhoids, and steroids should not be used long-term in any proctological condition as they cause skin atrophy and ulceration.

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