

CASE REPORT

THIRD DEGREE HAEMORRHOIDAL-PROLAPSE: A CASE PRESENTED TO EMERGENCY DEPARTMENT

Asma Niaz Khan

Department of Anatomy, Karachi Institute of Medical Sciences. Pakistan.

ABSTRACT

Anatomically, the veins present in the rectal submucous layer are organised as internal and external haemorrhoidal plexus. Haemorrhoids develop due to abnormal varicose dilatations of the venous plexus in the rectal submucous layer. Haemorrhoidal disease is a common anorectal condition affecting 4% of the adult population. As far as prevalence is concerned, data is not easily available. Underreporting is very common and large numbers of cases are asymptomatic.

A 72years old male patient presented to emergency department with severe pain and per rectal bleeding due to third degree prolapsed haemorrhoids. He had co-morbidity of hypertension, diabetes and was asthmatic. His blood pressure was 180/96mmhg and blood random sugar was 330mg/dl, on examination of chest basal crepts were present and wheezing was also auscultated in the chest. The case was diagnosed as a complication of third degree haemorrhoid post banding attempt by an inexperienced GP. It was third or early fourth degree haemorrhoids, which was difficult to differentiate due to prolapse. The case was followed for 1 year, with no complications. Third degree haemorrhoids can be catered under local anaesthesia.

KEY WORDS: Third degree haemorrhoids, haemorrhoids, rubber band ligation

Corresponding Author

Dr. Asma Niaz Khan

Associate Professor

Department of Anatomy

Karachi Institute of Medical Sciences. Pakistan.

Email : pbltutor2012@gmail.com

INTRODUCTION

Anatomically, the veins present in the rectal submucous layer are organised as internal and external haemorrhoidal plexus. Haemorrhoids develop due to abnormal varicose dilatations of the venous plexus in the rectal submucous layer. Firstly, the superior haemorrhoidal plexus get involved causing varicosities leading to haemorrhoidal. One of the reason of rectal varicosities is lack of venous valves at this level, thus prolonged standing or increased intra abdominal pressure cause dilatations of haemorrhoidal plexus.¹⁻⁴ Haemorrhoidal disease is a common anorectal condition affecting 4% of the adult population.⁵⁻⁷

As far as prevalence is concerned, data is not easily available. Underreporting is very common and large numbers of cases are asymptomatic. Many

techniques and modalities have been developed to treat hemorrhoids ranging from simple dietary measures and bowel habit regulation, non-operative procedures, to different techniques of excision of diseased anal cushions. Satisfaction rate is low from patient feedback and follow-ups, thus vast amount of treatment options as none are close to perfection, nonoperative procedures are effective in controlling symptoms, at least from the patient's perspective, they all share the common problem of recurrence. Among all the treatment modalities surgical haemorrhoidectomy is more definitive in symptom control, but it is reputed for being a painful procedure for a relatively benign disorder. First degree, uncomplicated second and third degree hemorrhoids can be treated by nonsurgical methods in outpatient clinics while severe prolapsed or circumferential hemorrhoids can be treated using a variety of surgical techniques, e.g. Milligan Morgan,

Longo and others. Nonsurgical methods aim at tissue fixation (sclerotherapy, cryotherapy, photo-coagulation, laser)³

CASE REPORT

A 72years old male patient presented to emergency department with severe pain and per rectal bleeding due to third degree prolapsed haemorrhoids. He had co-morbidity of hypertension, diabetes and was asthmatic. His blood pressure was 180/96mmhg and blood random sugar was 330mg/dl, on examination of chest basal crepts were present and wheezing was also auscultated in the chest, thus the patient was also suffering from acute asthma. The patient was not fit for spinal or general anesthesia; clearance was not given by the anesthesia team. A different treatment modality, which was not practiced yet at our setup for prolapsed haemorrhoids before was used. A small dose of sedation was given just to relax and make the patient sleep (sedation) but not unconscious, than local anesthesia was applied. The patient was placed in lithotomy position and prolapsed haemorrhoids were reduced inside manually, anus was retracted with parks anal retractor, haemorrhoids at 7°, 3°, & 9° clock were identified and were grasped with artery forceps. The largest haemorrhoid at 3° clock position which was one of the prolapsed haemorrhoids also was treated first; the pedicle was sutured with chromic catgut 3/0, to secure hemostasis and rectal mucosectomy was done. The other prolapsed haemorrhoid at 9° clock was also removed the same way. The 7° clock was 2nd degree haemorrhoid, it was left for treatment in the follow-up visit after one month by rubber band ligation. Voren pessary was kept for pain relief. The postoperative period was uneventful, and patient was discharged next day. Band ligation of remaining haemorrhoid was done after 2 months. The

patient was followed till one year, the patient remain uneventful. Third degree haemorrhoids can be catered under local anesthesia. There is a need of more studies to bring this procedure into practice and prove it as functional.

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