STUDY GUIDE

AGA Clinical Practice Update on Diagnosis and Treatment of Hemorrhoids: Expert Review.

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Clinical Management of Hemorrhoids: Study Guide

This study guide provides a comprehensive overview of the diagnosis, classification, and treatment protocols for hemorrhoid disease based on expert review and Best Practice Advice (BPA) from the AGA Institute Clinical Practice Updates Committee.

I. Key Clinical Concepts

Diagnosis and Differentiation

Accurate diagnosis is critical to ensure appropriate treatment and to rule out coexisting or similar conditions.

- **Anoscopy:** This procedure should be performed on every new patient with suspected hemorrhoids prior to the initiation of treatment.
- **Anal Fissures:** Often characterized by sharp pain during defecation or digital rectal exams. Fissures coexist with hemorrhoids in approximately 20% of cases. When both are present, the anal fissure should be treated first.
- **External vs. Internal Hemorrhoids:**
  - **Internal:** Typically present with rectal bleeding; graded by the degree of prolapse.
  - **External:** Frequently associated with itching; descriptions are often subjective.
- **Pain Levels:** Hemorrhoids generally only cause significant pain when they are acutely thrombosed.
- **Skin Tags:** Harmless perianal redundant skin, often vestiges of previous thrombosed hemorrhoids, which should generally be left alone unless large and not associated with significant hemorrhoids.

Hemorrhoids vs. Rectal Prolapse

It is vital to differentiate these two conditions during clinical inspection:

Condition	Visual Characteristics	Pathophysiology
Prolapsed Hemorrhoids	Radial folds and engorged blood vessels.	Protrusion of hemorrhoidal tissue.
Rectal Prolapse	Circular folds of pink rectal mucosa.	Intussusception of the rectal wall through the anal canal due to loss of attachments.

Classification of Internal Hemorrhoids

Internal hemorrhoids are categorized using **Goligher's classification**, which is primarily based on the patient's history regarding the degree of prolapse.

Treatment and Management Guidelines

- **Topical Treatments:** Anesthetics, astringents (witch hazel), corticosteroids, and vasoactive agents may be considered, though there is limited data to support their efficacy.
- **Steroid Limitation:** Topical steroids must not be used for more than two consecutive weeks.
- **Surgical Thresholds:**
  - **Grade 3:** Surgical consultation is offered if banding procedures fail or if associated external hemorrhoids are present.
  - **Grade 4:** Requires surgical hemorrhoidectomy.
- **Inflammatory Bowel Disease (IBD):** In patients with active Crohn's disease or ulcerative colitis, hemorrhoid treatment must be delayed until the patient achieves complete remission.

II. Short-Answer Practice Quiz

1. According to BPA 3, what is the maximum duration for the use of topical steroids? *Answer:* Two weeks.

2. What rare but serious complication must be discussed during the informed consent process for hemorrhoid therapies? *Answer:* Pelvic sepsis.

3. If a patient presents with both an anal fissure and hemorrhoid disease, which should be treated first? *Answer:* The anal fissure.

4. What is the primary diagnostic tool that should be used on every new patient with suspected hemorrhoids? *Answer:* Anoscopy.

5. How does the mucosal appearance differ between rectal prolapse and prolapsed hemorrhoids? *Answer:* Rectal prolapse presents with circular folds of pink rectal mucosa, while prolapsed hemorrhoids present with radial folds.

6. What is the requirement for treating hemorrhoids in a patient with active Crohn's disease? *Answer:* Management must be delayed until the patient is in complete remission.

7. Which grade of internal hemorrhoids strictly requires a surgical hemorrhoidectomy? *Answer:* Grade 4.

III. Essay Questions for Deeper Exploration

1. Discuss the clinical significance of Goligher’s classification and why patient history is the primary driver of this system. *Guided thought:* Consider the subjective nature of prolapse and how examination findings might only confirm what is already established through the history of tissue protrusion and reduction.

2. Evaluate the risks and informed consent requirements associated with hemorrhoid therapies. *Guided thought:* Address the necessity of counseling patients on pelvic sepsis, the instruction to seek emergency care if indicated, and the legal/professional importance of identifying even small-possibility complications.

3. Analyze the limitations of topical treatments in hemorrhoid management according to current AGA expert review. *Guided thought:* Review the efficacy data for astringents and anesthetics, and explain the specific clinical rationale for limiting steroid use to a 14-day window.

IV. Glossary of Important Terms

- **Anoscopy:** A diagnostic procedure using an anoscope to visualize the anal canal and lower rectum.
- **Astringent:** A topical agent, such as witch hazel, used to shrink body tissues.
- **Goligher’s Classification:** A grading system for internal hemorrhoids based on the degree of prolapse.
- **Intussusception:** The sliding or "telescoping" of one part of the intestine into the adjacent part; in this context, refers to the rectal wall moving through the anal canal.
- **Pelvic Sepsis:** A severe, potentially life-threatening infection of the pelvic region identified as a rare complication of hemorrhoid therapy.
- **Skin Tags:** Harmless, redundant perianal skin often resulting from previous hemorrhoidal thrombosis.
- **Thrombosed Hemorrhoid:** A hemorrhoid in which a blood clot has formed, typically causing significant pain.
- **Vasoactive Agents:** Substances that affect the diameter of blood vessels, used in some topical hemorrhoid treatments.