



Case Presentation and Discussion on GI Bleeding

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General Data

- R.L.
- 43 years old
- Male
- Paco Manila



Chief Complaint

- Anal bleeding



History of Present Illness

3 years PTC → anal mass, reduces spontaneously
blood streaked stools

↓

1 year PTC → anal mass, manually reducible
fresh blood with feces

↓

1 week PTC → bloody stools



Physical Examination

General: conscious, coherent, not in
cardiorespiratory distress

Vital Signs: BP=120/70

RR= 19

CR= 90

T= 37.4°C



Physical Examination

HEENT: Pink palpebral conjunctivae, anicteric sclerae

Chest and Lungs: Symmetric chest expansion, no retractions, clear and equal breath sounds

Heart: adynamic precordium, normal rate, regular rhythm, no murmurs



Physical Examination

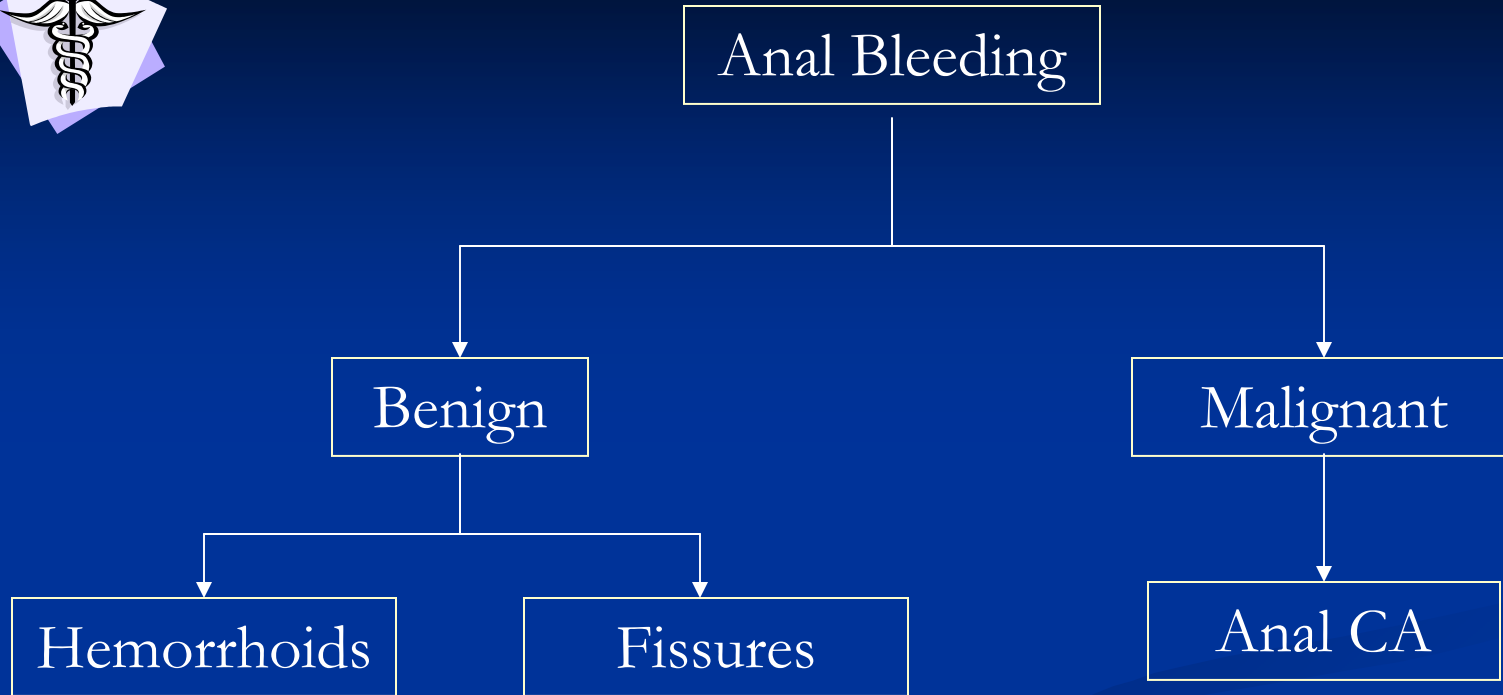
Abdomen: flat, normoactive bowel sounds, soft, no masses palpated, non tender

Rectal: (+) skin tags, good sphincteric tone, (+) mass, soft nontender palpated at the left lateral position, full rectal vault, brown feces on tactating finger, (+) fresh blood on tactating finger



Salient Features

- 43 years old
- Male
- Skin tags
- Anal mass
- History of anal bleeding
- Blood on tactating finger





Initial Impression

- Lower GI Bleed Secondary to
 1. Hemorrhoids 95%
 2. Anal CA 5 %



Paraclinical Diagnostic Procedure

- Do I need to do a paraclinical diagnostic procedure?

No



Treatment

- GOALS:

- To resolve the cause of the bleeding



Treatment Options

	Benefit	Risk	Cost	Availability
Medical	■(-) removal of the bleeding tissue ■SR <50% for (3,4)	■Bleeding	(+)	available
Sclerotherapy	■ removal of hemorrhoid ■ SR 70% ■(1,2)	■Full thickness injury ■bleeding	(++)	Not Available
Rubber Band Ligation	■ removal of hemorrhoid ■ SR 75% (1,2,3,4)	■Sepsis ■bleeding	(++)	Not Available
Hemorrhoidectomy	■ removal of hemorrhoid ■SR 95% (1,2,3,4)	■Bleeding ■Damage to sphincter	(+)	Available



Treatment Plan

Hemorrhoidectomy



PRE-OPERATIVE MANAGEMENT

- INFORMED CONSENT
- PSYCHOSOCIAL SUPPORT
- OPTIMIZE PATIENT'S PHYSICAL STATUS
- SCREEN FOR ANY CONDITION THAT
WILL INTERFERE WITH TREATMENT
- PREPARE MATERIALS



Operative Management

- Patient in prone position under SAB
- Asepsis/antisepsis done
- Sterile drapes placed
- Hemorrhoidal tissues identified at right anterior, right posterior and left lateral position
- Hemorrhoidal vessel identified and ligated with Chromic 3-0
- Diamond incision done, carried down to just above the internal sphincter
- Hemorrhoidal pedicle ligated and cut
- Mucosa and skin left open
- DSD



Intraoperative Findings

- Enlarged hemorrhoidal tissues with thrombosed vessels noted at the right anterior, right posterior and left lateral positions. Specimen had skin and mucosal covering.



Post Operative Care

- Adequate analgesia
- Adequate hydration
- Early ambulation
- When fully awake, may have diet as tolerated – 6 hours post PACU
- Daily wound care – 1st POD
- To come back any time if with problems regarding the operation



Final Diagnosis

Mixed Hemorrhoids, Grade III



- Patient was discharged:
 - Improved
 - Free of complications
 - No disability
 - Happy and contented with the outcome

■ Post op Advice:

1. Dietary Modification

- A. High fiber diet
- B. Inc. OFI

2. Lifestyle Change

- A. Avoidance of straining
- B. Good toilet habits



Discussion

■ Classification of Hemorrhoids

1. Grade 1 - bleeding
2. Grade 2 - bleeding and prolapse then reduce spontaneously
3. Grade 3 - bleeding, prolapse, manually reducible
4. Grade 4 - bleeding, prolapse, cannot be reduced



■ **Novel Technique: Radiofrequency Coagulation -- A Treatment Alternative for Early-Stage Hemorrhoids** by Pravin J. Gupta, MS
[Medscape General Medicine \[TM\]](#) Posted 07/31/2002

For early-stage hemorrhoids, in which bleeding is the primary symptom, conventional approaches to management include injection of sclerosing solutions, band ligation, and infrared coagulation. In our study, we used the radiofrequency coagulation technique as an alternative strategy to treat early-stage hemorrhoids

Although the initial results of coagulation of hemorrhoids by radiofrequency appear quite exciting and encouraging, long-term follow-up is needed to assess the duration of relief and potential side effects.



- Felz, Michael W. et al **Anal Melanoma: An Aggressive Malignancy Masquerading as Hemorrhoids**, South Med J 94(9):880-885, 2001.

Abstract

Anal melanoma is a devastating malignancy easily confused with benign hemorrhoids. Physician unfamiliarity with this bleeding rectal lesion can lead to delays in diagnosis and therapy. Four cases of anal melanoma, all initially mistaken for hemorrhoids, have been documented in the past 4 years at our institution. Despite surgical intervention and chemoimmunotherapy, each patient succumbed to widely metastatic disease. Average survival was 15.2 months. The clinical, pathologic, surgical, and oncologic features of anal melanoma are reviewed to enhance physician recognition of this unusual anorectal disorder.



- Lienert M, Ulrich B. **Doppler-guided ligation of the hemorrhoidal arteries. Report of experiences with 248 patients** Dtsch Med Wochenschr. 2004

BACKGROUND AND OBJECTIVE: Since the beginning of 2001, Doppler-guided ligation of the hemorrhoidal arteries (DG-HAL) has been used at this clinic in almost all patients with various forms of hemorrhoidal disease. Aim of this study was to ascertain whether this intervention can be done without general anaesthesia, the hemorrhoidal knots regress and this procedure provides advantages over the classical methods of treating hemorrhoids.



- Tan BK, Tsang CB, Nyam DC, Ho YH. Management of acute bleeding per rectum. *Asian J Surg.* 2004 Jan

BACKGROUND: Bleeding per rectum is a common indication for acute hospital admissions to the colorectal department. The frequencies of aetiologies in Singapore are different from those in Western populations. A retrospective analysis of the demography, pathology and management of acute bleeding per rectum was performed to determine the outcome and difference in aetiology from the West.



RESULTS: Of the patients admitted, 87% were admitted due to perianal conditions diagnosed at bedside proctoscopy, where haemorrhoids made up 94%. One percent bled from the upper gastrointestinal tract, while 12% bled from colorectal pathology. Massive bleeding from the colorectum was uncommon. Less than one third of the 47 patients required blood transfusions. Colonoscopy was the most useful diagnostic tool for bleeding from the colorectum. The more common colonic pathologies were diverticular disease (33%), adenomas (18%), and malignancy (26%), accounting for the majority of acute patient admissions. Colonic causes of bleeding were less common and were most stable. There were differences in the frequencies of aetiologies in our population compared to Western populations. Understanding the common pathologies and outcomes guides the management for our patients.



References

1. Gupta, Pravin J. MS, Novel Technique: Radiofrequency Coagulation -- A Treatment Alternative for Early-Stage Hemorrhoids, Medscape General Medicine, 2004.
2. Lienert M, Ulrich B. Doppler-guided ligation of the hemorrhoidal arteries. Report of experiences with 248 patients Dtsch Med Wochenschr. 2004
3. Tan BK, Tsang CB, Nyam DC, Ho YH. Management of acute bleeding per rectum. Asian J Surg. 2004 Jan.
4. Felz, Michael W. et al Anal Melanoma: An Aggressive Malignancy Masquerading as Hemorrhoids, South Med J 94(9):880-885, 2001.



Questions

■ MCQ #1

This is the success rate for medical management for grade III and IV internal hemorrhoids.

- a. <50%
- b. 51-60%
- c. 61-69%
- d. >70%



Questions

- MCQ #2
- This is the reason why rubber band ligation is not used in the treatment of external hemorrhoids.
 - a. Size – may be too large
 - b. Vascularity – may bleed profusely
 - c. Innervation – may cause too much pain
 - d. Location – may prove difficult to apply to band

Questions

- MCR #1 (a=1,2,3; b=1,3; c=2,4; d=4 only; e=all)
- The primary hemorrhoidal tissues are found in the following locations:
 1. left anterior
 2. Left lateral
 3. Right lateral
 4. Right anterior

Questions

- MCR #2 (a=1,2,3; b=1,3; c=2,4; d=4 only; e=all)
- These are some of the new techniques employed in the treatment of hemorrhoids.
 1. Infrared coagulation
 2. Radiofrequency coagulation
 3. Sclerotherapy
 4. Doppler guided ligation

Questions

- MCR #3 (a=1,2,3; b=1,3; c=2,4; d=4 only; e=all)
- Grade III internal hemorrhoids can be treated by the following methods:
 1. Rubber band ligation
 2. Sclerotherapy
 3. Excision
 4. photocoagulation

THANK YOU.