Innovative GI

Understanding & Managing Hemorrhoids

A Patient Guide to Hemorrhoid Care

What Are Hemorrhoids?

Hemorrhoids are normal cushions of blood vessels and tissue that line the anal canal and help control bowel movements — everyone has them. They become a medical problem when they swell, bleed, or protrude. They're classified as **internal** (above the dentate line, usually cause painless bleeding) or **external** (below the dentate line, can become suddenly painful if a clot forms inside them — a “thrombosed” hemorrhoid). Internal hemorrhoids are further graded I through IV based on how much they prolapse (protrude) with bowel movements: Grade I bleed but don't prolapse; Grade II prolapse with straining but reduce on their own; Grade III prolapse and need to be pushed back in by hand; Grade IV stay prolapsed all the time. This grade is what mainly guides which treatment below is likely to work best.

What Causes It?

- **Constipation & straining.** Hard stools and prolonged straining increase pressure on the veins and supporting tissue of the anal canal.
- **Prolonged sitting**, especially on the toilet (including reading or scrolling on a phone while seated), keeps steady pressure on this area and slows blood return.
- **Pregnancy & childbirth.** Increased pelvic pressure and hormonal changes both raise risk; symptoms often improve on their own after delivery.
- **Aging.** The connective tissue that anchors the anal cushions in place naturally weakens over time, making prolapse more likely.
- **Low-fiber diet or chronic diarrhea.** Both are independently linked to symptoms — it isn't only constipation that plays a role.
- **Heavy lifting and obesity**, which repeatedly increase pressure inside the abdomen and pelvis.
- **What hemorrhoids don't explain:** rectal bleeding is often assumed to be hemorrhoidal, but the same symptom can come from other conditions, including colon cancer — which is why new bleeding should always be evaluated rather than self-diagnosed.

How Hemorrhoids Are Treated

Treatment is stepwise: diet and lifestyle changes come first for almost everyone, topical or oral medications add symptom relief, and procedures are reserved for hemorrhoids that don't improve enough on their own. A couple of terms come up below: a study “compared to a dummy pill (placebo)” means some patients got the real treatment and others a fake version, without knowing which, so researchers could isolate the treatment's true effect. A “pooled analysis” (sometimes called a meta-analysis) means researchers combined results from several separate studies for a more reliable answer. “Office-based procedures” are quick treatments done in a clinic without general anesthesia, distinct from the surgical options further down, which require an operating room.

Diet & Behavioral Changes

Goal: reduce straining and stool trauma — first-line for every grade, and often enough on its own for milder cases.

• **Increase fiber intake** — aim for 25–30 grams a day from food, or a fiber supplement (psyllium, methylcellulose) if diet alone falls short.

Evidence: A pooled analysis of about 380 patients found that increasing fiber reduced ongoing symptoms by 53% compared with usual care without added fiber, and significantly reduced bleeding as well — one of the best-supported, lowest-risk treatments available.

• **Increase fluid intake** alongside fiber, to help keep stool soft and easy to pass.

• **Avoid straining and prolonged sitting on the toilet** — including reading or phone use while seated — and go when you feel the urge rather than delaying.

Evidence: Based on consistent clinical experience and expert guidance rather than a single trial; straining and prolonged sitting both raise pressure on the anal cushions directly.

Topical Treatments & Oral Supplements

Goal: relieve pain, itching, and bleeding while diet and lifestyle changes take effect — these treat symptoms, not the underlying hemorrhoid.

• **Over-the-counter topical treatments** containing hydrocortisone, phenylephrine, or pramoxine, applied as directed for a limited course.

Evidence: Shown to significantly improve pain, itching, and swelling. Hydrocortisone and pramoxine are considered safe and effective for use in late pregnancy. Prolonged, continuous use of products containing anesthetics, steroids, or antiseptics can cause allergic reactions and skin sensitization over time, so these work best as a short course rather than an everyday habit.

• **Prescription-strength hydrocortisone (2.5%)** — a stronger steroid than the 1% found in OTC products, available as a cream, suppository, or foam (Anusol-HC, Proctocort, Proctocream-HC, Proctofoam-HC, and similar), for inflammation and itching that don't settle with OTC strength.

Evidence: Effective for more significant inflammation, but meant for short, defined courses — generally 1–2 weeks for creams and suppositories, or up to 2–3 weeks for foam formulations — rather than everyday long-term use. Anal skin is thin, so continued steroid use here carries a real risk of skin thinning (atrophy), along with burning or secondary infection; check in with us if symptoms haven't improved by the end of a course rather than continuing it on your own.

• **Flavonoid oral supplements** (diosmin, often combined with hesperidin or other flavonoids; sold as Daflon, Vasculera, and similar products), typically used for a short course during a flare.

Evidence: Randomized trials found flavonoids improved bleeding, discharge, and pain compared with placebo; one trial found bleeding resolved within 4 days in up to 92% of patients taking diosmin. The exact mechanism isn't fully known, but flavonoids are thought to strengthen vessel walls, improve lymphatic drainage, and normalize how easily fluid moves across capillary walls.

Comfort Measures at Home

- **Warm sitz baths** — 10–15 minutes, 2–3 times a day and after bowel movements, to ease pain and spasm.
- **Ice packs** during the first 24–48 hours for a painful thrombosed external hemorrhoid.
- **Gently pat clean** with water or a fragrance-free wipe rather than rubbing with dry toilet paper.
- **Loose, breathable (cotton) underwear** to reduce irritation.
- **An over-the-counter stool softener** if needed, to avoid straining while dietary changes take effect.

Complementary & Alternative Options

Goal: an additional, low-risk option to add alongside the treatments above.

• **Witch hazel** (Hamamelis virginiana) — topical pads, wipes, or ointment applied to the affected area.

Evidence: Its tannins act as an astringent, constricting blood vessels and calming local irritation. Patient-care resources referencing ASCRS guidance list it as a reasonable over-the-counter option for external or mild internal hemorrhoids, with reported improvement in itching, mild bleeding, and swelling. For topical use only.

Office-Based Procedures

Goal: for symptoms that persist despite diet and lifestyle measures — usually grade I–III internal hemorrhoids. These are quick clinic procedures, preferred over surgery when they're an option because they offer similar benefit with fewer complications.

• **Rubber band ligation** — an elastic band is placed around the base of the hemorrhoid to cut off its blood supply; the most commonly used and generally most effective office procedure.

Evidence: Stops bleeding in up to 90% of patients and improves grade III disease in roughly 80%. Compared with the other office procedures below, banding has the lowest rate of symptoms returning over time, though it causes somewhat more post-procedure discomfort than sclerotherapy.

• **Injection sclerotherapy** — a solution is injected into the hemorrhoid to shrink it.

Evidence: About as effective as banding for controlling bleeding, with less post-procedure pain, but a somewhat higher chance that symptoms return over time and further treatment is needed.

• **Infrared coagulation** — a device applies brief pulses of infrared light to seal off the hemorrhoid's blood supply.

Evidence: Works best for lower-grade disease: about 78% improvement in grade I hemorrhoids, dropping to 51% in grade II and 22% in grade III. Roughly 13% of patients need a repeat treatment within 3 months, so it's best suited to milder, early-grade hemorrhoids.

Surgical Treatment

Goal: reserved for grade III–IV, external or mixed, or recurrent hemorrhoids that haven't responded to the options above — more effective long-term than office procedures, but with a longer recovery.

• **Excisional hemorrhoidectomy** — surgical removal of the hemorrhoidal tissue; still considered the "gold standard" for durability.

Evidence: A large randomized trial found fewer recurrences at both 1 and 2 years, and better quality-of-life scores, compared with stapled surgery. The trade-off is more post-operative pain and a longer recovery period.

• **Stapled hemorrhoidopexy** — a stapling device repositions the prolapsing tissue higher in the anal canal rather than removing it.

Evidence: Causes less post-operative pain, bleeding, and wound trouble than excisional surgery, but the same large trial found meaningfully higher long-term recurrence and prolapse. Rare but serious complications have also been reported, so it's used less often today than it once was.

When to Contact Our Office

- New, heavy, or persistent rectal bleeding — especially if you're over 45 and haven't had a prior colonoscopy, since bleeding from colon cancer can be mistaken for hemorrhoids
- Bleeding along with a change in bowel habits, unintentional weight loss, or abdominal pain
- Signs of anemia from ongoing blood loss, such as unusual fatigue, lightheadedness, or pale skin
- A firm, bluish, and severely painful lump at the anal opening that isn't improving with a couple days of home care — a possible thrombosed external hemorrhoid
- A prolapsed internal hemorrhoid that can't be pushed back in, or that becomes increasingly painful or discolored

This guide supports your personalized plan and isn't a substitute for individualized medical advice. Check with your provider before starting, stopping, or combining anything mentioned here.

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