Greater Manchester EUR Policy Statement on:

Surgical management (including banding) of haemorrhoids and anal skin tags

GM Ref: GM042
Version: 2.0 (18 September 2019)
### Commissioning Statement

**Surgical management (including banding) of haemorrhoids and anal skin tags**

#### Policy Exclusions (Alternative commissioning arrangements apply)

Any perianal lesion or episodes of perianal bleeding that are suspected of being due to malignancy are excluded from this policy and should be referred via the normal 2-week pathway.

Treatment/procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).

#### Policy Inclusion Criteria

Haemorrhoids and anal skin tags are harmless. The majority respond to conservative measures although skin tags may persist (see *Treatment / Procedure* section). In some circumstances, surgical intervention may be needed – these are listed below:

**Surgical management (including banding) of haemorrhoids**

Haemorrhoidectomy will not be carried out unless there is evidence to demonstrate that recurrent and persistent bleeding has failed to respond to conservative treatment OR haemorrhoids cannot be reduced.

Haemorrhoidectomy is commissioned in line with one or more of the following:

- Recurrent or persistent bleeding, which has not responded to primary care management.
- Fourth degree haemorrhoids or third degree haemorrhoids that are too large for non-operative measures (haemorrhoidectomy may be needed).
- Combined internal and external haemorrhoids with severe symptoms (surgery may be required).
- Thrombosed haemorrhoids when bleeding is problematic, or there is chronic irritation or leakage.
- Extremely painful, acutely thrombosed external haemorrhoids presenting within 72 hours of onset (reduction or excision may be needed).
- Internal haemorrhoids that have prolapsed and become swollen, incarcerated, and thrombosed (haemorrhoidectomy may be needed).

Refer for evaluation as to whether or not surgery is indicated:

If the patient has an acute onset perianal haematoma (a blue or dark coloured swelling at the anal verge) within 24 hours of first occurring.

**NOTE:** Symptomatic haemorrhoids found as part of colonoscopy investigation can be banded if patient fully consented for the procedure, and this is included within the original costs, i.e. makes no change to the tariff charged.

#### Classification of internal haemorrhoids

<table>
<thead>
<tr>
<th>Grade</th>
<th>Physical findings</th>
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<tbody>
<tr>
<td>I</td>
<td>Prominent haemorrhoidal vessels, no prolapse</td>
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<tr>
<td>II</td>
<td>Prolapse with Valsalva and spontaneous reduction</td>
</tr>
<tr>
<td>III</td>
<td>Prolapse with Valsalva requires manual reduction</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------</td>
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<tr>
<td>IV</td>
<td>Chronically prolapsed manual reduction ineffective</td>
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**Funding Mechanism**

Monitored approval provided the patient meets at least one of the above. **NOTE:** May be the subject of contract challenges and/or audit of cases against commissioned criteria.

**Surgical management (including banding) of anal skin tags**

Not commissioned.

**Funding Mechanism**

Clinicians can submit an individual funding request outside of this guidance if they feel there is a good case for clinical exceptionality. Requests on the grounds of exceptionality should be submitted with all relevant supporting evidence, which must be provided with the request.

**Clinical Exceptionality**

Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. More information on determining clinical exceptionality can be found in the Greater Manchester (GM) Effective Use of Resources (EUR) Operational Policy. Link to [GM EUR Operational Policy](#).

**Fitness for Surgery**

**NOTE:** All patients should be assessed as fit for surgery before going ahead with treatment, even though funding has been approved.

**Best Practice Guidelines:**

All providers are expected to follow best practice guidelines (where available) in the management of these conditions.
Policy Statement

The GM Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission treatments/procedures in accordance with the criteria outlined in this document.

In creating this policy the GM EUR Steering Group has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

Equality & Equity Statement

CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GM EUR Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as more equal than any other protected characteristic group. This is because their ‘starting point’ is considered to be further back than any other group. This will be reflected in CCGs evidencing taking ‘due regard’ for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

The Greater Manchester Joint Commissioning Board has given delegated authority to the Greater Manchester Directors of Commissioning and Directors of Finance to approve GM EUR treatment policies for implementation. Further details of the governance arrangements can be found in the GM EUR Operational Policy.

Aims and Objectives

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.
- ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.
- promoting the cost-effective use of healthcare resources.

**Rationale behind the policy statement**

Whilst surgical treatment for haemorrhoids and skin tags are safe and effective they are not always necessary as the majority of haemorrhoids are usually painless, unless their blood supply slows down or is interrupted and minimally symptomatic haemorrhoids may be safely observed. Referral to secondary care for the treatment of most cases of haemorrhoids is unnecessary, particularly as the symptoms of haemorrhoids often clear up on their own or by using simple treatments that can be bought from a pharmacy without a prescription.

Anal skin tags are usually harmless.

In order to ensure that resources are aimed at those patients with haemorrhoids or skin tags who will get the most benefit from them, access for patients where there is no need for secondary care intervention is restricted.

This policy aims to improve people’s quality of life by promoting the most cost-effective care for individuals with haemorrhoids or skin tags.

**Treatment / Procedure**

**Haemorrhoids**

Haemorrhoids, also known as piles, are swellings containing enlarged blood vessels found inside or around the rectum and anus. In many cases, haemorrhoids don’t cause symptoms and some people don’t even realise they have them.

When symptoms do occur, they may include:

- bleeding after passing a stool – the blood is usually bright red
- itching
- a lump hanging down outside of the anus, which may need to be pushed back in after passing a stool
- a mucus discharge after passing a stool
- soreness, redness and swelling around the anus

Haemorrhoids aren’t usually painful, unless their blood supply slows down or is interrupted. Minimally symptomatic haemorrhoids may be safely observed.

The symptoms of haemorrhoids often clear up on their own, or by using simple treatments that can be bought from a pharmacy without a prescription.

**Managing Haemorroids**

Initial treatment / treatment of simple haemorrhoids is to suggest lifestyle changes.

**Advise:**

- on gradually increasing the amount of fibre in an individual’s diet
- on drinking plenty of fluid – particularly water, but avoiding or cutting down on caffeine and alcohol
• against 'stool withholding' and undue straining during bowel movements, both of which can worsen the condition.
• on avoiding medication that causes constipation
• on losing weight
• on exercising regularly
• on the importance of correct anal hygiene. The anal region should be kept clean and dry to aid healing and reduce irritation and itching. Recommend careful perianal cleansing with moistened towelettes or baby wipes, and to pat (rather than rub) the area dry.
• That when the haemorrhoid has healed, they should continue with dietary and lifestyle measures to reduce the risk of recurrence.

Manage any symptoms:
• Offer simple analgesia (such as paracetamol) for pain relief. Avoid opioid analgesics (such as codeine) as they can cause constipation, and avoid nonsteroidal anti-inflammatory drugs (NSAIDs) if rectal bleeding is present.
• Consider prescribing a topical haemorrhoidal preparation to provide symptomatic relief.

Anal skin tags
Anal skin tags, also called rectal skin tags, are growths that hang off the skin around the outside of the anus - and are usually harmless. Anal skin tags may be mistaken for warts or piles (haemorrhoids). Anal skin tags may also be called hypertrophied papillae or fibro epithelial polyps.

They are not contagious, but may be due to inflammation, a lesion, anal injury or skin left behind after treatment for a haemorrhoid.

Although anal skin tags are not a risk to health, they may cause problems in maintaining cleanliness after using the toilet. Skin tags may also trap moisture and cause irritation. They may also become irritated through contact (rubbing) with clothing or the movement associated with sitting. Anal skin tags may need to be checked to make sure they are harmless and not a cancerous growth.

Epidemiology and Need

The exact incidence of haemorrhoids is difficult to quantify because only a small percentage of people with haemorrhoids seek medical attention.

Community-based studies in the UK reported that haemorrhoids affect 13–36% of the general population. However, it is likely that this estimation may be higher than the actual prevalence because the studies mainly relied on self-reporting, and many anorectal symptoms are often wrongly attributed to haemorrhoids.

An epidemiological study in the US reported a prevalence of 4.4% in the general population:
• In both sexes, the peak prevalence occurred between the ages of 45–65 years.
• White people and people of higher socioeconomic status were affected more frequently than black people and people of lower socioeconomic status, although this association may reflect differences in health care-seeking behaviour rather than true prevalence.

Adherence to NICE Guidance

No NICE guidance relating to the commissioning of surgical interventions for haemorrhoids or anal skin tags.
Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

Date of Review

Five years from the date of the last review, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Analgesia</td>
<td>Medication that acts to relieve pain.</td>
</tr>
<tr>
<td>Anal skin tags</td>
<td>Growths that hang off the skin around the outside of the anus (the opening at the end of the alimentary canal through which solid waste matter leaves the body).</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>Swellings containing enlarged blood vessels found inside or around the rectum (the final section of the large intestine, terminating at the anus) and anus.</td>
</tr>
<tr>
<td>Haemorrhoidectomy</td>
<td>The surgical removal of a haemorrhoid.</td>
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<tr>
<td>Incidence</td>
<td>The number of new cases in a given period of time (usually a year).</td>
</tr>
<tr>
<td>Mucus discharge</td>
<td>Mucus (a slimy substance, typically not miscible with water, secreted by the mucous membranes and glands of animals for lubrication, protection, etc.) discharge (release of a liquid / mucus from a part of the body).</td>
</tr>
<tr>
<td>Prevalence</td>
<td>The total number of cases of a disease in a population over a given time (usually a year).</td>
</tr>
<tr>
<td>Prolapse</td>
<td>A slipping forward or down of a part or organ of the body.</td>
</tr>
<tr>
<td>Thrombosed</td>
<td>Affect with or be affected by thrombosis (local coagulation or clotting of the blood).</td>
</tr>
</tbody>
</table>

References

1. Greater Manchester Effective Use of Resources Operational Policy
2. NICE CKS: Haemorrhoids
## Governance Approvals

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Approved</th>
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<tbody>
<tr>
<td>Greater Manchester Effective Use of Resources Steering Group</td>
<td>17/05/2017</td>
</tr>
<tr>
<td>Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning</td>
<td>10/07/2018</td>
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<tr>
<td>Greater Manchester Joint Commissioning Board</td>
<td>18/09/2018</td>
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<td>Bolton Clinical Commissioning Group</td>
<td>26/10/2018</td>
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<tr>
<td>Bury Clinical Commissioning Group</td>
<td>18/09/2018</td>
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<tr>
<td>Heywood, Middleton &amp; Rochdale Clinical Commissioning Group</td>
<td>18/09/2018</td>
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<td>Manchester Clinical Commissioning Group</td>
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<td>Trafford Clinical Commissioning Group</td>
<td>20/11/2018</td>
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<tr>
<td>Wigan Borough Clinical Commissioning Group</td>
<td>07/11/2018</td>
</tr>
</tbody>
</table>
Appendix 1 – Evidence Review
Surgical management (including banding) of haemorrhoids and anal skin tags
GM042

Search Strategy

The following databases are routinely searched: NICE Clinical Guidance and full website search; NHS Evidence and NICE CKS; SIGN; Cochrane; York; and the relevant Royal College and any other relevant bespoke sites. A Medline / Open Athens search is undertaken where indicated and a general google search for key terms may also be undertaken. The results from these and any other sources are included in the table below. If nothing is found on a particular website it will not appear in the table below:

<table>
<thead>
<tr>
<th>Database</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE</td>
<td>NICE Clinical Knowledge Summary: Haemorrhoids</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>Commissioning Guide: Rectal Bleeding (2013), Royal College of Surgeons</td>
</tr>
<tr>
<td>American Gastroenterological Association website</td>
<td>American Gastroenterological Association Technical Review on the Diagnosis and Treatment of Hemorrhoids, GASTROENTEROLOGY 2004;126:1463–1473 (not cited below as almost identical to the Practice Parameters paper)</td>
</tr>
</tbody>
</table>

Summary of the evidence

Whilst treatments for haemorrhoids and those for skin tags are effective they are not without risk. The majority of haemorrhoids and the majority of skin tags are harmless and painless and as such do not warrant the risks associated with surgical interventions.

There are a number of preventative measures and non-invasive conservative measures that are also effective and which should be tried before surgical intervention is considered.

The evidence

<table>
<thead>
<tr>
<th>Levels of evidence</th>
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<tbody>
<tr>
<td>Level 1</td>
<td>Meta-analyses, systematic reviews of randomised controlled trials</td>
</tr>
<tr>
<td>Level 2</td>
<td>Randomised controlled trials</td>
</tr>
</tbody>
</table>
**Level 3**  Case-control or cohort studies  
**Level 4**  Non-analytic studies e.g. case reports, case series  
**Level 5**  Expert opinion

### 1. LEVEL: N/A

**NICE Clinical Knowledge Summary: Haemorrhoids**

**MANAGEMENT**

- **Consider the need for admission or referral.**
  - **Consider admitting people with:**
    - Extremely painful, acutely thrombosed external haemorrhoids who present within 72 hours of onset (reduction or excision may be needed).
    - Internal haemorrhoids that have prolapsed and become swollen, incarcerated, and thrombosed (haemorrhoidectomy may be needed).
    - Perianal sepsis (a rare but life-threatening complication).
  - **Refer using the suspected cancer pathway referral (for an appointment within 2 weeks) if anal or colorectal cancer is suspected.** See the CKS topic on Gastrointestinal tract (lower) cancers - recognition and referral for detailed information on when to suspect anal or colorectal cancer.
  - **Refer to an appropriate specialist (using clinical judgement to determine the urgency) if another serious pathology, such as inflammatory bowel disease or a sexually transmitted infection, is suspected.**
  - **Refer for non-urgent assessment and management, people with:**
    - Fourth degree haemorrhoids or third degree haemorrhoids that are too large for non-operative measures (haemorrhoidectomy may be needed).
    - Perianal haematoma (a blue or dark coloured swelling at the anal verge) if symptoms are for less than 24 hours duration for clot evaluation.
    - Combined internal and external haemorrhoids with severe symptoms (surgery may be required).
    - Thrombosed haemorrhoids when bleeding is problematic, or there is chronic irritation or leakage.
    - Large skin tags (surgical excision may be required).

- **Ensure stools are soft and easy to pass.**
  - If the person is constipated, see the CKS topics on Constipation and Constipation in children for information on management for adults and young people.
  - If the person is not constipated:
    - Advise adequate dietary fibre intake by eating a balanced diet containing whole grains, fruits, and vegetables; this should be done gradually to minimize flatulence and bloating.
    - Advise that adequate fluid intake is particularly important with an increased fibre diet to maintain soft, well-lubricated stools and to prevent intestinal obstruction.

- **Give lifestyle advice to aid healing of the haemorrhoid.**
  - Advise on the importance of correct anal hygiene. The anal region should be kept clean and dry to aid healing and reduce irritation and itching. Recommend careful perianal cleansing with moistened towelettes or baby wipes, and to pat (rather than rub) the area dry.
  - Advise against ‘stool withholding’ and undue straining during bowel movements, both of which can worsen the condition.

- **Manage any symptoms.**
  - Offer simple analgesia (such as paracetamol) for pain relief. Avoid opioid analgesics (such as codeine) as they can cause constipation, and avoid nonsteroidal anti-inflammatory drugs
(NSAIDs) if rectal bleeding is present. See the CKS topics on Analgesia - mild-to-moderate pain and NSAIDs - prescribing issues for prescribing information.

- Consider prescribing a topical haemorrhoidal preparations to provide symptomatic relief.

**Advise the person that when the haemorrhoid has healed**, they should continue with dietary and lifestyle measures to reduce the risk of recurrence.

**Refer to secondary care for further investigation and management:**

- People who do not respond to conservative treatment.
- People with recurrent symptoms who do not respond to primary care management.

### Secondary care treatment options

**Secondary care treatments for haemorrhoids may be non-surgical or surgical, depending on the severity of symptoms and the degree of prolapse.**

**Non-surgical treatments include:**

- Rubber band ligation:
  - A band is applied to the base of the haemorrhoid. The strangulated haemorrhoid becomes necrotic and sloughs off. The underlying tissue undergoes fixation by fibrotic wound healing. Up to three haemorrhoids can be banded at one visit.
  - This is currently the best available outpatient treatment of haemorrhoids. About 2 in 10 people will require a second banding within 6 months for symptom control.
  - Minor complications include haemorrhoid thrombosis, band displacement, mild bleeding, and formation of mucosal ulcers.

- Injection sclerotherapy:
  - Phenol in oil is injected into the submucosa of the rectum, around the pedicles of the haemorrhoids. It induces a fibrotic reaction which obliterates the haemorrhoidal vessels, causing atrophy of the haemorrhoids.
  - Provides short-term benefit in most people.
  - Complications include pelvic infection and erectile dysfunction due to incorrectly sited injections (rare).

- Infrared coagulation/photocoagulation:
  - This involves using infrared energy to produce an area of submucosal fibrosis leading to mucosal fixation and a reduction in the tendency to prolapse.
  - It may be as effective as rubber band ligation and injection sclerotherapy in the treatment of first degree and second degree haemorrhoids.

- Bipolar diathermy and direct-current electrotherapy:
  - Causes coagulation and fibrosis after local application of heat.
  - Success rates are similar to those of infrared coagulation, and complication rates are low.

**Surgical treatments include:**

- Haemorrhoidectomy:
  - Only symptomatic haemorrhoids are excised as this conserves the sensitive anoderm for continence.
  - Complications include post-operative urinary retention, secondary haemorrhage 7–10 days after the operation (from the vascular pedicle or from the edges of the wound), anal stricture, abscess, fistula, formation of skin tags, infection, pseudopolyps, and faecal incontinence.

- Stapled haemorrhoidectomy:
  - A circular stapling gun is used to excise a doughnut of mucosa from the upper anal canal and lift the haemorrhoidal cushions back within the canal.
  - Although termed haemorrhoidectomy, it is more accurately termed a haemorrhoidopexy as the haemorrhoids are not excised but relocated within the anal canal.
  - Retroperitoneal sepsis, rectal perforation, anovaginal fistula, and substantial haemorrhage are rare, but serious, complications.

- Haemorrhoidal artery ligation:
Using a proctoscope, the haemorrhoidal arteries are ligated with sutures (above the dentate line) to remove the flow of blood to the haemorrhoids. For larger prolapsing haemorrhoids, an adjunctive mucosal plication procedure is done; the prolapsing mucosa is plicated up to the level of the dentate line where it is fixed by ligation of the plicating sutures (haemorrhoidopexy).

Current evidence shows that this procedure is an efficacious alternative to conventional haemorrhoidectomy or stapled haemorrhoidopexy in the short and medium term, and that there are no major safety concerns.

References for the above

Basis for recommendation

Admission or referral
- These recommendations are largely based on expert opinion in review articles on haemorrhoids [Kaidar-Person et al, 2007; Sneider and Maykel, 2010; Sanchez and Chinn, 2011; Lohsiriwat, 2012; BMJ, 2013; BMJ, 2016].
  - The pain of a thrombosed haemorrhoid usually peaks 48–72 hours after onset, and is self-limiting in 7–14 days [Kaidar-Person et al, 2007; BMJ, 2016]. Admission is therefore generally recommended only for people who present within 72 hours of onset.
  - Expert opinion in a review article is that people with a perianal haematoma should be referred for clot evacuation if symptoms are less than 24 hours old [BMJ, 2013].

Ensuring stools are soft and easy to pass and giving lifestyle advice
- Expert opinion in guidelines and review articles is that all people with haemorrhoids should be offered information on lifestyle and dietary modifications, as most cases can be managed conservatively with advice to increase fibre and fluid intake, avoid straining, and maintain good anal hygiene [Appalaneni et al, 2010; Lohsiriwat, 2012; BMJ, 2013; RCS, 2013; NICE, 2015; BMJ, 2016].
- Expert opinion in a review article is that passing hard stools increases shearing force on the anal cushions [Lohsiriwat, 2012].

Offering a simple analgesia
- This recommendation is based on what CKS considers to be good clinical practice.

Considering a topical haemorrhoidal preparation
- Although there is no evidence showing their benefit for prevention or long-term treatment of haemorrhoids [Sanchez and Chinn, 2011], topical haemorrhoidal preparations are recommended in the RCS guideline [RCS, 2013], a NICE interventional procedure guideline [NICE, 2015], and review articles on haemorrhoids [Sneider and Maykel, 2010; Lohsiriwat, 2012; BMJ, 2013; BMJ, 2016].
- The British National Formulary (BNF) states that soothing preparations containing mild astringents may give symptomatic relief in haemorrhoids [BNF 71, 2016].

Preventing recurrence
- The risk of recurrence of haemorrhoids is highest in people with ongoing risk factors [BMJ, 2016].
- Expert opinion in the RCS commissioning guideline is that after treatment of haemorrhoids, people should be advised to remain on a high fibre diet and good fluid intake to prevent recurrence [RCS, 2013].

Referring people who do not respond to conservative treatment or have persistent recurrent symptoms
This recommendation is based on expert opinion in the RCS commissioning guideline [RCS, 2013] and in BMJ review articles [BMJ, 2013; BMJ, 2016].

2. **LEVEL: N/A**

Commissioning Guide: Rectal Bleeding (2013), Royal College of Surgeons

**EXTRACT OF RELEVANT SECTIONS**

**Background**
Rectal bleeding is a very common symptom in adults of all ages. In most people, it is intermittent and often self-limiting. The majority of patients with rectal bleeding will have benign anal conditions such as haemorrhoids or an anal fissure, but rectal bleeding may also be a symptom of inflammatory bowel disease or colorectal cancer. Other potential causes of rectal bleeding include, but are not limited to:

- diverticular disease
- colonic polyp
- radiation proctitis
- infectious gastroenteritis
- angiodysplasia
- ischaemic colitis
- solitary rectal ulcer
- anal cancer
- sexually transmitted diseases
- anorectal trauma

The age of the patient acts as a guide to the range of potential causes of rectal bleeding. For example, younger patients under 30 years are more likely to have haemorrhoids, anal fissure or inflammatory bowel disease whereas a patient over the age of 50 years with rectal bleeding has a higher risk of colorectal cancer.

The prevalence of rectal bleeding is poorly studied but available evidence suggests that one-year prevalence in adults is about 10% in the UK. Only a minority of people with rectal bleeding will seek medical advice. The majority of patients seek advice because they are concerned that the bleeding indicates something serious or because the symptoms are troublesome.

**Cost to the NHS**
In the financial year 2011/2012, the tariff cost to the NHS of colonoscopy and flexible sigmoidoscopy (endoscopic procedures commonly used to investigate rectal bleeding symptoms but also used for other indications) was about £94 million. During the same period, the tariff cost for procedures to treat haemorrhoids and anal fissures (two benign causes of rectal bleeding) was about £28 million.

The market for over the counter (OTC) haemorrhoidal treatments is worth £22 million a year and the OTC laxative market is worth £50 million a year (data kindly provided by the Proprietary Association of Great Britain).

1.3 **Primary care management**

In low risk patients with rectal bleeding who are not overly anxious, it is reasonable to manage their symptoms with treatment and adopt a ‘watch and wait’ policy. Minimally symptomatic haemorrhoids may be safely observed.

Patients with symptomatic haemorrhoids should be given advice about topical treatment, oral fluid intake, high fibre diet and fibre supplementation. Consideration should be given to referral to a specialist community or secondary care provider of colorectal services if symptoms persist/alter or are particularly troublesome.

An acute anal fissure is a tear in the skin of the anal canal, and may be treated with dietary advice and a bulking agent. Topical glyceryl trinitrate (GTN) 0.4% ointment should be considered for chronic fissures (duration of symptoms >6 weeks or clinical appearances of chronicity) with appropriate advice about application and duration of treatment. Low risk patients with rectal bleeding who are concerned about colorectal malignancy should be considered for direct access (direct to test) flexible sigmoidoscopy. Please see the directory of patient information websites with information leaflets.
1.5 Secondary Care

Haemorrhoids

Treatment of bleeding haemorrhoids depends on the degree of prolapse and severity of symptoms. Rubber band ligation is currently the best available outpatient treatment for haemorrhoids with up to 80% of patients satisfied with short term outcomes.16 About 20% of patients require a second banding procedure within six months for symptom control. Local service providers may offer outpatient injection sclerotherapy with oily phenol or infra-red coagulation (laser) therapy, but neither is as effective as suction banding.

At present surgery is reserved for bleeding or prolapsing haemorrhoids that have not responded to outpatient treatment (ASCRS Practice Parameters for the Management of Hemorrhoids).16 Doppler-guided haemorrhoidal artery ligation and stapled haemorrhoidopexy are alternatives to formal haemorrhoidectomy.17 These are associated with lower pain scores but neither procedure has long term outcomes data available yet.

3. LEVEL 1: SYSTEMATIC REVIEW


Introduction: Haemorrhoids are cushions of submucosal vascular tissue located in the anal canal starting just proximal to the dentate line. Haemorrhoids are a common condition. The incidence is difficult to ascertain as many people with the condition will never consult a medical practitioner.

Methods and Outcomes: We conducted a systematic overview, aiming to answer the following clinical question: What are the effects of haemorrhoidal artery ligation for haemorrhoidal disease? We searched: Medline, Embase, The Cochrane Library, and other important databases up to October 2014 (BMJ Clinical Evidence overviews are updated periodically; please check our website for the most up-to-date version of this overview).

Results: At this update, searching of electronic databases retrieved 150 studies. After deduplication and removal of conference abstracts, 70 records were screened for inclusion in the overview. Appraisal of titles and abstracts led to the exclusion of 46 studies and the further review of 24 full publications. Of the 24 full articles evaluated, one systematic review and seven RCTs were added at this update. We performed a GRADE evaluation for 11 PICO combinations.

Conclusions: In this systematic overview, we categorised the efficacy for seven comparisons, based on information about the effectiveness and safety of haemorrhoidal artery ligation versus closed haemorrhoidectomy, injection sclerotherapy, infrared coagulation, open excisional (Milligan-Morgan) haemorrhoidectomy, radiofrequency ablation, rubber band ligation, and stapled haemorrhoidectomy.

Key Points:

Haemorrhoidal disease occurs when there are symptoms such as bleeding, prolapse, pain, thrombosis, mucus discharge, and pruritus.

Incidence is difficult to ascertain as many people with the condition will never consult a medical practitioner. One study reported a prevalence of 39%, with nearly half of those identified reporting haemorrhoidal symptoms.

First- and second-degree haemorrhoids are classically treated with some form of non-surgical ablative/fixative intervention. Third-degree are treated with rubber band ligation or haemorrhoidectomy and fourth-degree with haemorrhoidectomy.

Eventual choice of treatment will be based on a number of individual and operative factors.

In previous versions of this overview we evaluated the evidence for a broad range of interventions for haemorrhoids, including closed haemorrhoidectomy, infrared coagulation/photocoagulation, injection sclerotherapy, open excisional (Milligan-Morgan) haemorrhoidectomy, radiofrequency ablation, rubber band ligation, and stapled haemorrhoidectomy. Haemorrhoidal artery ligation (HAL; also known as transanal haemorrhoidal de-arterialisation) has grown in popularity since the last overview. For this update we have, therefore, focused on the evidence for the effectiveness of HAL and how it compares to other selected surgical and non-surgical interventions for haemorrhoids. We evaluated evidence from RCTs and systematic reviews of RCTs.
We found insufficient evidence to judge the effectiveness of haemorrhoidal artery ligation compared with injection sclerotherapy, infrared coagulation, rubber band ligation, or radiofrequency ablation.

For haemorrhoidal artery ligation compared with stapled haemorrhoidectomy, closed haemorrhoidectomy, and open excisional (Milligan-Morgan) haemorrhoidectomy, the RCT evidence showed that there was a balance between the benefits (e.g., symptom and quality of life improvement, shortened length of hospital stay) and harms (e.g., postoperative pain, overall complications) associated with each procedure.

4. LEVEL: N/A


Haemorrhoidectomy is regarded as a procedure of low clinical priority and therefore not routinely funded by the Commissioner.

Criteria for Commissioning
Haemorrhoidectomy will be considered only if:
- Conservative treatment has failed
- Haemorrhoids are recurrent
- There is persistent bleeding
- Haemorrhoids cannot be reduced.

5. LEVEL 1: SYSTEMATIC REVIEW AND LEVEL 5 CLINICAL OPINION


Recommendations

1. The evaluation of patients with hemorrhoids should include a directed history and physical examination. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C

The diagnosis of hemorrhoids is almost always a clinical one. The initial assessment should include a thorough targeted history and physical examination, with focus on the extent, severity, and duration of symptoms, such as bleeding, prolapse, issues of hygiene and pain, and fiber and fluid intake, as well. In addition, a careful review of bowel habits including frequency, consistency, and ease of evacuation should be performed. All patients with rectal bleeding require a detailed family history with particular emphasis on intestinal disease. The presence of malignant conditions should be evaluated to assess for sporadic or hereditary colon and rectal cancer, and thus for the need for extended colonic evaluation. The physical examination should typically include visual inspection of the anus, digital examination, and anoscopy and/or proctoscopy looking for evidence of thrombosis or concomitant anorectal pathology, such as fissure, fistula, abscess, or evidence of Crohn's disease. Internal hemorrhoids, located above the dentate line, can be assigned a grade based on the definitions in Table 1, which will help to guide therapy. Laboratory evaluation is not typically required.
### Classification of internal Haemorrhoids

<table>
<thead>
<tr>
<th>Grade</th>
<th>Physical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Prominent hemorrhoidal vessels, no prolapse</td>
</tr>
<tr>
<td>II</td>
<td>Prolapse with Valsalva and spontaneous reduction</td>
</tr>
<tr>
<td>III</td>
<td>Prolapse with Valsalva requires manual reduction</td>
</tr>
<tr>
<td>IV</td>
<td>Chronically prolapsed manual reduction ineffective</td>
</tr>
</tbody>
</table>

2. **Complete endoscopic evaluation of the colon is indicated in select patients with hemorrhoids and rectal bleeding. Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1B**

Although commonly associated with hemorrhoids, complaints of rectal bleeding may be a symptom of other disease processes, such as colorectal cancer, inflammatory bowel disease, other colitides, diverticular disease, and angiodysplasia. A thorough personal history, a detailed family history, and a physical examination, which may include proctoscopy and/or flexible sigmoidoscopy, will identify high-risk patients requiring more extensive evaluation. Those who fulfill the select criteria should have a full colonic evaluation with colonoscopy. Patients unable to undergo colonoscopic evaluation may be considered for flexible sigmoidoscopy combined with barium enema or other diagnostic modalities per consensus guidelines.

3. **Dietary modification consisting of adequate fluid and fiber intake is the primary first-line nonoperative therapy for patients with symptomatic haemorrhoid disease. Strong recommendation based on moderate quality evidence 1B**

Constipation and altered bowel habits can play a significant role in many patients with symptomatic hemorrhoids. Whereas more aggressive office-based or operative treatment is usually required for advanced hemorrhoidal disease (grades III to IV or those with significant external components), increased fiber and fluid intake has been shown to improve symptoms of mild to moderate prolapse and bleeding. A Cochrane review of 7 randomized studies including 378 patients demonstrated a benefit in both the reduction of symptomatic prolapse (RR _ 0.53, 95% CI 0.38–0.73) and bleeding (RR _ 0.50, 95% CI 0.28–0.89) in patients with increased fiber intake.8–11 Patients should also be counseled as to maintaining proper bowel habits, such as the avoidance of straining and limiting prolonged time on the commode, because this has been associated with higher rates of symptomatic hemorrhoids.

4. **Most patients with grade I, II, and III haemorrhoid disease in whom medical treatment fails may be effectively treated with office-based procedures, such as banding, sclerotherapy and infrared coagulation. Hemorrhoid banding is typically the most effective option. Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1B**

The goals of all office-based procedures are 3-fold: to decrease vascularity, reduce redundant tissue, and increase hemorrhoidal fixation to the rectal wall to minimize prolapse. These procedures are all relatively well tolerated, causing minimal pain and discomfort. However, patients should understand they all have a variable recurrence rate and may require repeated applications.

**Rubber Band Ligation.** Rubber band ligation is a commonly used and effective way of treating symptomatic internal hemorrhoids. In a meta-analysis of 18 randomized prospective studies, rubber band ligation was superior to injection sclerotherapy and infrared coagulation in the treatment of grades I, II, and III hemorrhoids in terms of the need for repeated treatments. However, the risk of complications, albeit small, and pain tended to be greater for rubber band ligation in comparison with the other modalities. Rubber band ligation has also been directly compared with excisional hemorrhoidectomy for grade III hemorrhoids. A systematic review of randomized controlled trials found that, overall, it was less effective and more likely to require multiple procedures than surgical excision. However, rubber band ligation was associated with less pain and fewer complications than the operative approach. A recent Cochrane review by the same group reported that band ligation may be the preferred choice for grade II hemorrhoids, and even considered for first-line therapy in
grade III hemorrhoids, whereas surgical excision may be more appropriately reserved for grade III or rubber band treatment failures.

Banding is commonly performed with either a suction apparatus or a forceps ligator. In direct comparison, suction ligation of second- and third-degree hemorrhoids was noted to be beneficial in comparison with forceps ligation in terms of pain tolerance, use of analgesics, and intraprocedural bleeding. However, both methods are acceptable, because, in general, banding is very well tolerated. The most common complications are postband anorectal pain, rectal bleeding, thrombosed external hemorrhoids, and vasovagal symptoms, which have been reported in 1% to 3% of patients.19,20 A careful and detailed history should be specifically obtained from the patient in regard to the presence of coagulation disorders, either intrinsic, such as those with thrombocytopenia, or acquired, as seen with antiplatelet therapy (Plavix), or anticoagulated with warfarin (Coumadin) or heparin products. In general, the performance of a banding procedure is contraindicated in this group because the exceedingly high incidence of postprocedure bleeding.

**Sclerotherapy.** Sclerotherapy involves injection of 3 to 5 mL of a sclerosant into the apex of an internal hemorrhoid. This relatively simple procedure may be used for small, bleeding internal hemorrhoids with success rates reported in 75% to 89% of patients with grades I to III disease. Unfortunately, longer follow-up intervals often demonstrate a relatively higher rate of symptomatic recurrence. This approach may be particularly appealing in those with bleeding tendencies, such as the patient receiving antiplatelet or anticoagulation therapy. Complications are uncommon; the most frequent one is minor discomfort or bleeding with injection. Rare, serious complications have resulted from erroneous injection site placement or systemic effects of the solution itself, including the creation of rectourethral fistulas, rectal perforations, and necrotizing fasciitis. These complications have been described in isolation or in conjunction with the simultaneous application of rubber bands.

**Infrared Coagulation.** Infrared coagulation involves the direct application of infrared waves that results in protein necrosis within the hemorrhoid. This is most commonly used for grade I and II hemorrhoids. Although previous reports have demonstrated high rates of recurrence, especially with grades III and IV,34 recent randomized studies have demonstrated outcomes similar to rubber band ligation.

**Complications.** Overall, the incidence of major complications is rare; yet, one must remember that perianal sepsis has been described as a life-threatening complication with all office-based procedures. The onset of urinary retention and fever immediately after an office-based procedure may be the initial sign of perianal sepsis and mandates emergent patient evaluation. As such, patients should be counselled regarding these rare but devastating complications with all office-based hemorrhoid procedures, and patients should be counselled appropriately.

5. **Most patients with thrombosed external haemorrhoids benefit from surgical excision within 72 hours of the onset of symptoms. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C**

Although most patients treated conservatively will experience eventual resolution of their symptoms, excision of thrombosed external hemorrhoids results in more rapid symptom resolution, lower incidence of recurrence, and longer remission intervals. Most excisions can be safely performed in the office setting, although extensive large thrombosed hemorrhoids and those extending into the anal canal may require a more formal surgical approach in the operating room. One should avoid lancing techniques with simple incision and drainage, because they tend to result in higher rates of reaccumulation and may worsen symptoms with further expansion of the thrombosis.

6. **Surgical hemorrhoidectomy should be reserved for patients who are refractory to office procedures, who are unable to tolerate office procedures, who have large external hemorrhoids, or who have combined internal and external hemorrhoids with significant prolapse (grades III to IV). Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1B.**
## Appendix 2 – Diagnostic and Procedure Codes

Surgical management (including banding) of haemorrhoids and anal skin tags

GM042

(All codes have been verified by Mersey Internal Audit’s Clinical Coding Academy)

| GM042 – Surgical management (including banding) of haemorrhoids and anal skin tags |
|---------------------------------|---------------------------------|
| **OPCS-4 Procedure Codes**     |                                 |
| Haemorrhoidectomy               | H511                            |
| Partial internal sphincterotomy for haemorrhoid | H512 |
| Stapled haemorrhoidectomy       | H513                            |
| Other specified excision of haemorrhoid | H518 |
| Unspecified excision of haemorrhoid | H519 |
| Rubber band ligation of haemorrhoid | H524 |
| Unspecified destruction of haemorrhoid | H529 |

**With the following ICD-10 diagnosis code(s):**

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third degree haemorrhoids</td>
</tr>
<tr>
<td>Fourth degree haemorrhoids</td>
</tr>
<tr>
<td>Perianal venous thrombosis</td>
</tr>
</tbody>
</table>

**ICD-10 codes (Exceptions)**

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>First degree haemorrhoids</td>
</tr>
<tr>
<td>Second degree haemorrhoids</td>
</tr>
<tr>
<td>Residual haemorrhoidal skin tags</td>
</tr>
<tr>
<td>Other specified haemorrhoids</td>
</tr>
<tr>
<td>Haemorrhoids, unspecified</td>
</tr>
<tr>
<td>Haemorrhoids in pregnancy</td>
</tr>
<tr>
<td>Haemorrhoids in the puerperium</td>
</tr>
</tbody>
</table>

**The following OPCS-4 codes might be used**

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryotherapy to haemorrhoid</td>
</tr>
<tr>
<td>Infrared photocoagulation of haemorrhoid</td>
</tr>
<tr>
<td>Injection of sclerosing substance into haemorrhoid</td>
</tr>
<tr>
<td>Other specified destruction of haemorrhoid</td>
</tr>
</tbody>
</table>
### Appendix 3 – Version History

**Surgical management (including banding) of haemorrhoids and anal skin tags**

GM042

The latest version of this policy can be found here: GM Haemorrhoids and anal skin tags (Surgical management (including banding) of) policy

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>29/12/2016</td>
<td>Initial draft</td>
</tr>
</tbody>
</table>
| 0.2     | 18/01/2017 | The GM EUR Steering Group meeting agreed the following changes to the policy, following which the policy could go out for a period of clinical engagement:  
  - The title of the policy changed from ‘Surgical management of haemorrhoids and anal skin tags’ to ‘Surgical management of haemorrhoids (including banding) and anal skin tags’
  
  **Commissioning Statement: Policy Inclusion Criteria**  
  - Under ‘Surgical management of haemorrhoids is commissioned for the following’:  
    - Title amended to read: ‘Surgical management (including banding) of haemorrhoids’  
    - Statement added to read: ‘Haemorrhoidectomy will not be carried out unless there is evidence to demonstrate that recurrent and persistent bleeding has failed to respond to conservative treatment OR haemorrhoids cannot be reduced.’  
    - Haemorrhoidectomy is commissioned in line with the following:  
      - First bullet point amended to read: ‘Recurrent or persistent bleeding, which has not responded to primary care management.’  
      - ‘Who present’ on 6th bullet point amended to read ‘Presenting’  
      - Note added to read: **Note:** Symptomatic haemorrhoids found as part of colonoscopy investigation can be banded if patient fully consented for the procedure, and this is included within the original costs, i.e. makes no change to the tariff charged.’  
      - Funding mechanism added to read: ‘Individual prior approval provided the patient meets at least one of the above. Requests should be submitted with all relevant supporting evidence, which must be provided with the request.’  
  - Under ‘Surgical management of anal skin tags is commissioned for the following’:  
    - Title amended to read: ‘Surgical management (including banding) of anal skin tags’  
    - Bullet point amended to read ‘Not commissioned.’  
    - Funding mechanism added to read ‘Individual funding request (exceptional case) approval: Requests should be submitted with all relevant supporting evidence, which must be provided with the request.’ |
| 0.3     | 17/05/2017 | The GM EUR Steering Group reviewed the feedback from the period of clinical engagement agreed the following changes to the policy:  
  **Commissioning Statement: Policy Inclusion Criteria**  
  - Funding mechanism for ‘Surgical management (including banding) of haemorrhoids’ changed from individual prior approval to monitored approval.  
  - First sentence in the first paragraph changed from ‘Haemorrhoids and anal skin tags are harmless and the majority respond to conservative measures (see Treatment / Procedure section).’ to ‘The majority respond to conservative measures although skin tags may persist (see Treatment /
Subject to the above changes being made the GM EUR Steering Group agreed that the policy could progress through the governance process.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Change Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.4</td>
<td>24/04/2018</td>
<td>Diagnostic and Procedures codes added to Appendix 2</td>
</tr>
<tr>
<td>1.0</td>
<td>18/09/2018</td>
<td>Approved by Greater Manchester Joint Commissioning Board.</td>
</tr>
<tr>
<td></td>
<td>05/10/2018</td>
<td>Branding changed to reflect change of service from Greater Manchester Shared Services to Greater Manchester Health and Care Commissioning.</td>
</tr>
<tr>
<td>1.1</td>
<td>15/01/2019</td>
<td>Links updated as documents have all moved to a new EUR web address&lt;br&gt;- Commissioning Statement:&lt;br&gt;  - ‘Best Practice Guideline’ section moved to bottom of ‘Commissioning Statement’&lt;br&gt;  - ‘Best Practice Guideline’ section added</td>
</tr>
<tr>
<td>1.2</td>
<td>17/04/2019</td>
<td>Surgical management (including banding) of haemorrhoids – 3rd bullet point re perianal haematoma moved to bottom of list of what is commissioned and reworded for clarity.</td>
</tr>
<tr>
<td>1.3</td>
<td>01/08/2019</td>
<td>Clinical Exceptionality Section updated to read: Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. More information on determining clinical exceptionality can be found in the Greater Manchester (GM) Effective Use of Resources (EUR) Operational Policy. Link to GM EUR Operational Policy</td>
</tr>
<tr>
<td>2.0</td>
<td>18/09/2019</td>
<td>The GM EUR Steering Group reviewed the policy. The usual evidence review was carried out in August 2019. No new high level evidence, national policies or guidance were found. It was agreed therefore that no changes were necessary to the policy. Policy to be reviewed again in five years unless new evidence warrants earlier review.</td>
</tr>
</tbody>
</table>