PROCEDURE

# Hemorrhoid surgery

Hemorrhoid surgery removes or repositions enlarged hemorrhoids that have not improved with simpler treatments.

**PURPOSE**
Remove or reposition hemorrhoids causing persistent symptoms

**PROCEDURE TYPE**
Therapeutic surgery performed through the anus

**WHERE IT IS DONE**
Operating theatre, usually as day surgery

**ANAESTHESIA**
General, spinal, or local with sedation

**HOW LONG IT TAKES**
About 30 to 60 minutes

**PREPARATION**
Fasting, medicine review, and bowel preparation if instructed

**RECOVERY**
Home same day; no driving for at least 24 hours

**MAIN RISKS**
Bleeding, urinary retention, infection, anal narrowing

**RESULTS**
Immediate; several days if tissue undergoes laboratory testing

## Overview

Hemorrhoid surgery treats enlarged hemorrhoids in or around the anus. Hemorrhoids are normal blood vessel cushions that help control bowel movements. They can become enlarged, bleed, protrude from the anus, or cause discomfort.

Surgery is usually considered when symptoms are severe, hemorrhoids remain outside the anus, or simpler treatments have not worked. It may also be used for large internal and external hemorrhoids occurring together.

Several operations are called hemorrhoid surgery. The most common is an excisional hemorrhoidectomy , which removes hemorrhoid tissue. Other procedures lift prolapsed internal hemorrhoids or close the arteries supplying them.

The best option depends on the hemorrhoids being treated and what matters most to you. Some procedures cause less early pain but have a greater chance of hemorrhoids returning.

## Why the procedure is performed

Surgery may be offered to control ongoing bleeding, protruding tissue, irritation, discharge, or difficulty keeping the area clean. It is not usually the first treatment for mild hemorrhoids.

Common reasons for considering surgery include:

Rectal bleeding can have causes other than hemorrhoids. Your healthcare team may recommend an examination or tests before surgery, especially if the cause of bleeding is uncertain.

- Large internal hemorrhoids that regularly protrude
- Hemorrhoids that cannot be pushed back inside
- Combined internal and external hemorrhoids
- Symptoms that continue after office treatments
- Repeated bleeding linked to hemorrhoids
- A painful, clotted external hemorrhoid in selected cases

## Who should and should not have it

Hemorrhoid surgery may suit you if symptoms significantly affect daily life and less invasive treatments have not given enough relief. Your surgeon should explain which operation is proposed, its likely benefits, and its recovery time.

Surgery may not be the right next step when symptoms are mild or likely to improve with changes to bowel habits. Office treatments often provide enough relief for smaller internal hemorrhoids without the longer recovery of an operation.

The procedure may be delayed if you have an active infection, uncontrolled bleeding risk, or a medical condition that makes anaesthesia unsafe at that time. Active inflammation around the anus, including inflammation related to Crohn's disease, may affect whether surgery is appropriate and how it is performed.

Hemorrhoid surgery is usually avoided during pregnancy unless there is a pressing reason. Pregnancy-related hemorrhoids often improve after delivery.

Blood-thinning medicine does not automatically rule out surgery. However, it can increase

bleeding risk. Your surgical and prescribing teams need to make a safe plan rather than having you stop it on your own.

## How to prepare

Follow the treating facility's own instructions, as they take priority over general information. Instructions differ according to the operation and type of anaesthesia.

Tell the team about all medicines, vitamins, and supplements you use. This is especially important for anticoagulants and antiplatelet medicines, which reduce blood clotting. Do not stop prescribed medicine unless the team responsible for your care tells you to.

You may be told not to eat for several hours before surgery. Clear liquids may be allowed until a specified time. Some facilities ask you to use an enema or another bowel preparation, but a full bowel cleanse is not always needed.

Arrange for a responsible adult to take you home. If you are having sedation or general anaesthesia, you may also need someone to stay with you for the first night.

Plan for time away from work and arrange help with childcare or other responsibilities. Have suitable food, fluids, and any recommended pain relief or stool-softening medicine available at home.

## What happens during the procedure

Before surgery, the team confirms the planned operation and anaesthesia. You may have general anaesthesia, which makes you unconscious, or spinal anaesthesia, which numbs the lower body. Some procedures can be done with local anaesthetic and sedation.

During an excisional hemorrhoidectomy, the surgeon removes enlarged hemorrhoid tissue through the anus. The wounds may be closed with dissolvable stitches or left partly open to heal naturally.

A stapled hemorrhoidopexy uses a circular stapling device inside the rectum. It removes a ring of tissue above the hemorrhoids, lifting prolapsed internal tissue and reducing its blood supply. It does not remove external hemorrhoids.

Hemorrhoidal artery ligation uses a small ultrasound probe to identify arteries supplying the hemorrhoids. The surgeon ties these arteries and may stitch prolapsed tissue higher inside the anal canal. This is also called transanal hemorrhoidal dearterialization.

Afterward, you are monitored while the anaesthetic wears off. Most people go home the same

day once they can drink, move safely, and pass urine.

## Recovery and what to expect afterward

Pain: Pain is expected after an excisional hemorrhoidectomy and may be worse during bowel movements. It usually improves gradually over the following days and weeks. Take pain relief as directed. Warm shallow baths may help relax the area. Avoid taking more than one product containing the same pain-relieving ingredient.

Eating: You can usually eat when you feel ready. Fluids and fibre help keep stools soft. Your team may recommend a stool softener or laxative because straining can increase pain and pressure on the wound. Some stronger pain medicines can cause constipation.

Activity: Gentle walking is encouraged. Avoid heavy lifting, strenuous exercise, and activities that increase anal pressure until your surgeon says they are safe. A small amount of blood or clear discharge can occur, particularly after a bowel movement. A pad can protect clothing.

Driving: Do not drive for at least 24 hours after sedation or general anaesthesia. Wait longer if you are taking opioid pain medicine or cannot sit comfortably, turn your body, or make an emergency stop safely.

Going back to work: Return time depends on the operation and your work. Recovery after excisional surgery often takes longer than after artery ligation or stapled surgery. Desk work may be possible sooner than heavy physical work. Full healing can take several weeks.

## Risks and possible complications

Your surgeon should discuss risks specific to the operation being proposed. Possible complications include:

Serious injury to the muscles controlling bowel movements is uncommon, but lasting problems with bowel control are possible. Stapled procedures can cause complications related to the staple line and are not suitable for every type of hemorrhoid.

- Bleeding during recovery or, less commonly, heavier delayed bleeding
- Difficulty passing urine, sometimes requiring temporary catheter drainage
- Infection or an abscess near the surgical site
- Constipation or hard stool that worsens pain
- Temporary difficulty controlling gas, mucus, or stool

- Anal narrowing caused by scar tissue
- A persistent wound or abnormal passage called a fistula
- Hemorrhoids or prolapse returning

## Results and follow up

The surgeon usually knows immediately whether the planned hemorrhoid tissue was removed or repositioned. Symptom improvement is assessed as swelling settles and the area heals.

Removed tissue may be sent to a laboratory for examination under a microscope. If so, results usually take several days or longer, depending on the facility. Ask how and when you will receive them.

A routine follow-up visit may be arranged to check healing, review bowel function, and discuss any remaining symptoms. Keep stools soft and avoid straining to reduce pressure on the healing area. These steps can also lower the chance of new hemorrhoid problems, although surgery cannot guarantee that symptoms will never return.

## Alternatives

Alternatives depend on the hemorrhoid's size, location, and symptoms.

Improving fibre and fluid intake, avoiding straining, and limiting time on the toilet may control mild symptoms. These measures avoid a procedure but may not correct large or permanently prolapsed hemorrhoids.

Rubber band ligation places a small band around an internal hemorrhoid so it loses its blood supply and shrinks. It has a faster recovery than surgery but may require repeat treatment and is not used for external hemorrhoids.

Injection treatment, called sclerotherapy, and infrared coagulation shrink internal hemorrhoids by scarring or sealing their blood supply. They are less invasive but are generally used for smaller hemorrhoids and may provide less lasting control.

For a recently clotted external hemorrhoid, removing the clot or the affected hemorrhoid under local anaesthetic may provide faster relief in selected cases. If symptoms are already improving, pain relief and time may be reasonable alternatives.

Choosing no procedure is also an option when symptoms are manageable and there is no concerning cause of bleeding. Ask what is likely to happen without surgery and how each alternative compares for pain, recovery, and recurrence.

## When to call your healthcare team

Contact your surgical team promptly if you have increasing pain rather than gradual improvement, fever, worsening swelling, foul-smelling drainage, or difficulty passing stool despite following the bowel plan.

Call urgently if you cannot pass urine, have repeated vomiting, or develop bleeding that is more than the amount your team said to expect.

Seek emergency care for heavy or continuous bleeding, large blood clots, fainting, severe weakness, chest pain, or difficulty breathing. Routine spotting after a bowel movement does not usually require emergency care, but mention persistent bleeding at follow-up.

## Common questions

Will I be asleep?

Many hemorrhoid operations use general anaesthesia, so you are asleep. Spinal anaesthesia or local anaesthetic with sedation may be suitable for some procedures. Your anaesthesia team will explain the plan before surgery.

Can I drive home?

No. Arrange for someone else to take you home. Anaesthesia, sedation, and pain medicine can impair reaction time and judgment.

How painful is hemorrhoid surgery?

Excisional hemorrhoidectomy can be painful, especially during bowel movements, but pain usually improves as healing progresses. Stapled surgery and artery ligation may cause less early pain, although they may not suit your hemorrhoids and can have a higher risk of recurrence in some situations.

When will I know if it worked?

The surgeon can usually tell you what was achieved after the operation. It may take several weeks to judge relief because swelling, pain, and discharge need time to settle.

When can I have a bowel movement?

You can have a bowel movement when your body is ready. The first one may be uncomfortable. Use prescribed stool-softening treatment, drink fluids, and avoid delaying the urge or straining.

Will the hemorrhoids come back?

They can. Recurrence risk differs among procedures and is generally higher after some tissue-sparing operations than after excisional hemorrhoidectomy. Keeping stools soft and avoiding repeated straining may reduce future problems.

## Sources

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