GASTROENTEROLOGY

Course Name: Over-the-Counter drugs

Course Code: 0521416

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GASTROENTEROLOGY

ABDOMINAL PAIN

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BACKGROUND

Abdominal pain is a symptom of many different conditions, ranging from acute self-limiting problems to life threatening conditions such as ruptured appendicitis and bowel obstruction.

AETIOLOGY

- Abdominal pain does not only arise from the GI tract but also from the cardiovascular and musculoskeletal system.

→ Therefore the aetiology of abdominal pain is dependent on its cause.

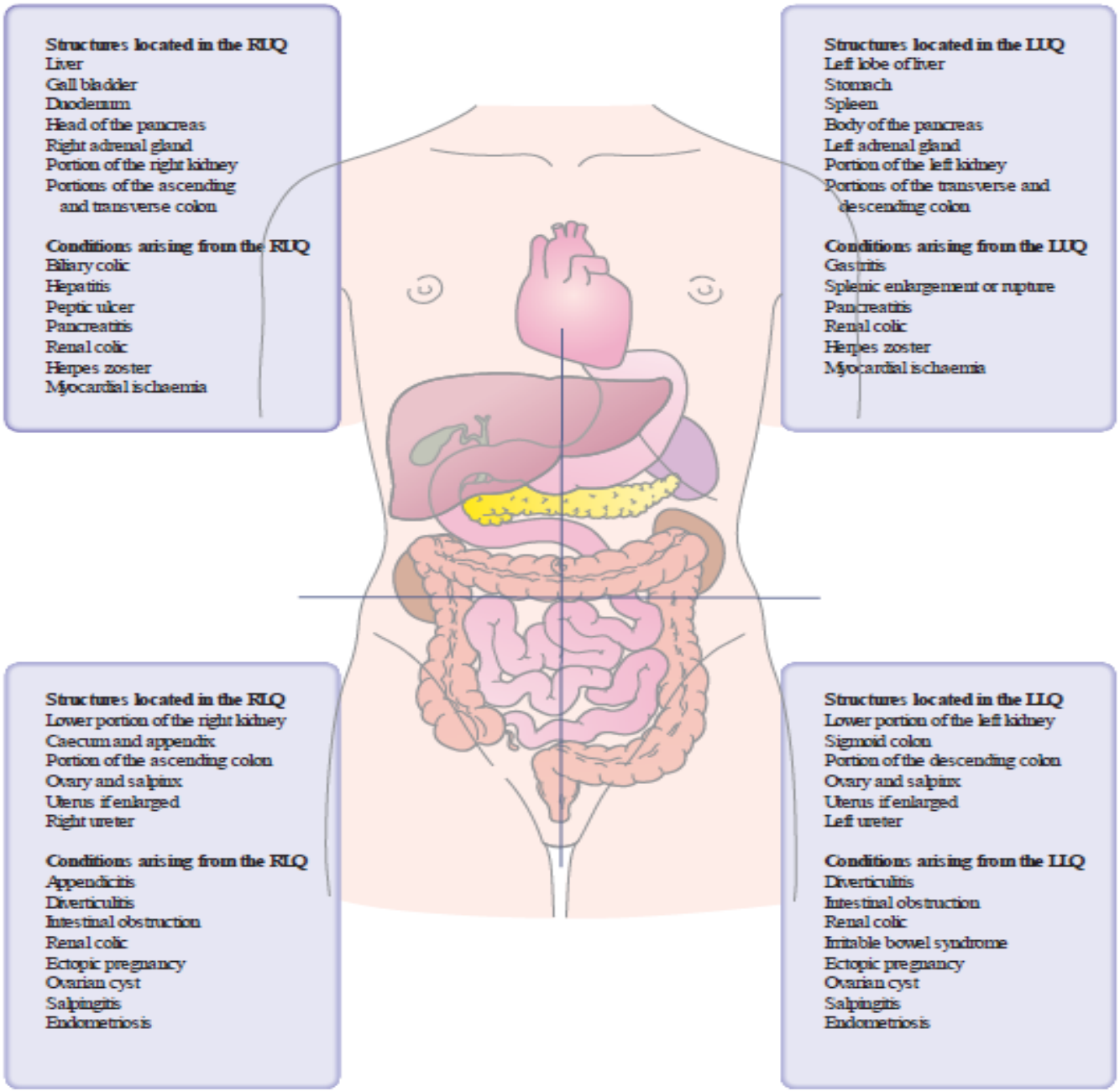
- **GI tract causes** include poor muscle tone leading to reflux (e.g. lower oesophageal sphincter incompetence), infections that cause peptic ulcers (from *H. pylori) and* mechanical blockages causing renal and biliary colic.
- **Cardiovascular causes** include angina and myocardial infarction whereas musculoskeletal problems often involve tearing of abdominal muscles.

Table 7.25
Causes of abdominal pain

Probability	Cause		
	Upper abdomen	Lower abdomen	Diffuse
Most likely	Dyspepsia	Irritable bowel syndrome, primary dysmenorrhoea	Gastroenteritis
Likely	Peptic ulcers	Diverticulitis (elderly)	Not applicable
Unlikely	Cholecystitis, cholelithiasis, renal colic	Appendicitis, endometriosis, renal colic	Not applicable
Very unlikely	Splenic enlargement, hepatitis, myocardial infarction	Ectopic pregnancy, salpingitis, intestinal obstruction	Pancreatitis, peritonitis

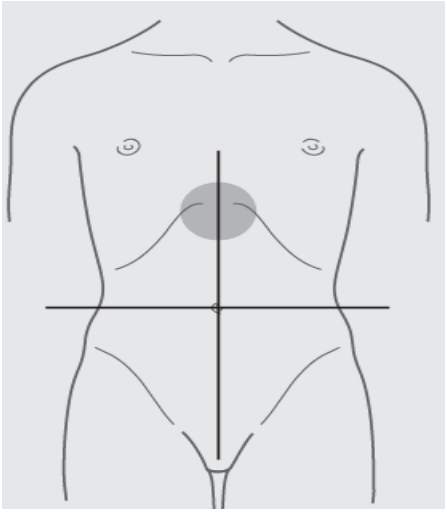
Anatomical location of organs and conditions that can cause abdominal pain.

Salpingitis *is inflammation of the fallopian tubes, caused by bacterial infection*



CONDITIONS AFFECTING THE UPPER ABDOMEN

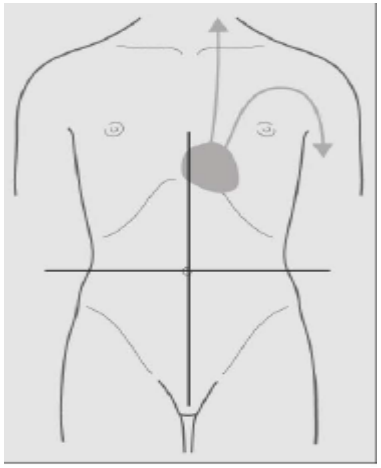
DYSPEPSIA/GASTRITIS



Patients with dyspepsia present with a range of symptoms that commonly involve vague abdominal discomfort (aching) above the umbilicus associated with belching, bloating, flatulence, feeling of fullness and heartburn.

It is normally relieved by antacids and aggravated by spicy foods or excessive caffeine. Vomiting is unusual.

CONDITIONS AFFECTING THE UPPER ABDOMEN
MYOCARDIAL ISCHAEMIA



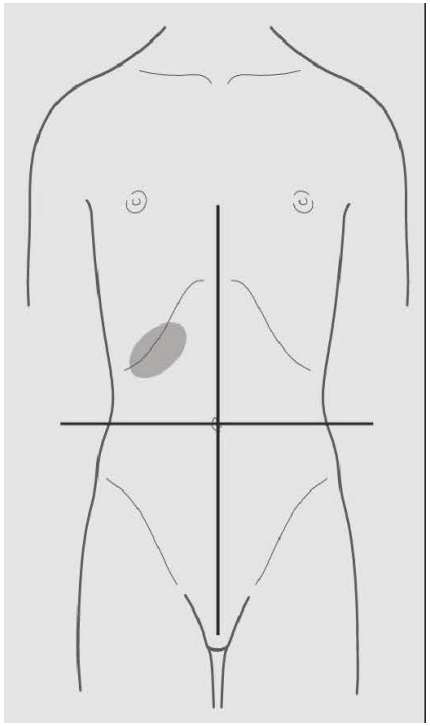
- Angina and myocardial infarction (MI) cause chest pain that can be difficult to distinguish initially from epigastric/retrosternal pain caused by dyspepsia.
- Pain of cardiovascular origin often radiates to the neck, jaw and inner aspect of the left arm.
- Typically, angina pain is precipitated by exertion and subsides after a few minutes once at rest.
- Pain associated with Ml will present with characteristic deep crushing pain .
- The patient will appear pale, display weakness and be tachycardia.

CONDITIONS AFFECTING THE UPPER ABDOMEN

ACUTE CHOLECYSTITIS AND CHOLELITHIASIS

- **Cholelithiasis** (presence of gall stones in the bile ducts, also called biliary colic) is the more common presentation.
- Typically, the pain lasts for more than 30 minutes, but less than 8 hours, is colicky in nature and often severe.
- Nausea and vomiting are often present. Classically, the onset is sudden, starts a few hours after a meal and frequently awakens the patient in the early hours of the morning.

- **Acute cholecystitis** (inflammation of the gall bladder) symptoms are similar but also associated with fever and abdominal tenderness. The pain may radiate to the tip of the right scapula.
- The incidence of both increases with increasing age and is most common in people aged over 50. It is also more prevalent in women than in men.

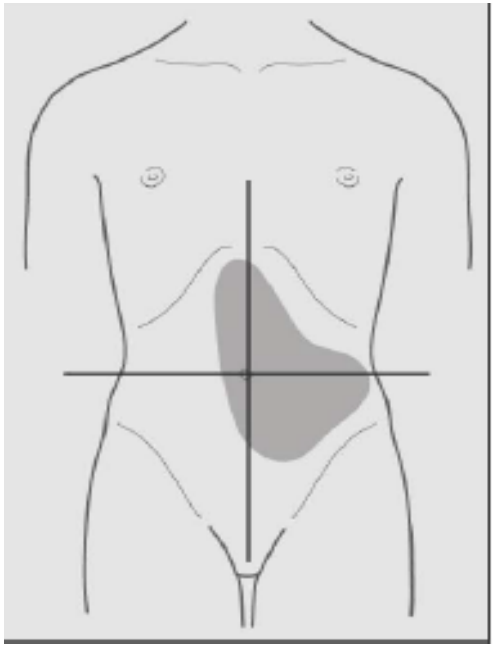


Right upper quadrant pain

CONDITIONS AFFECTING THE LOWER ABDOMEN

IRRITABLE BOWEL SYNDROME

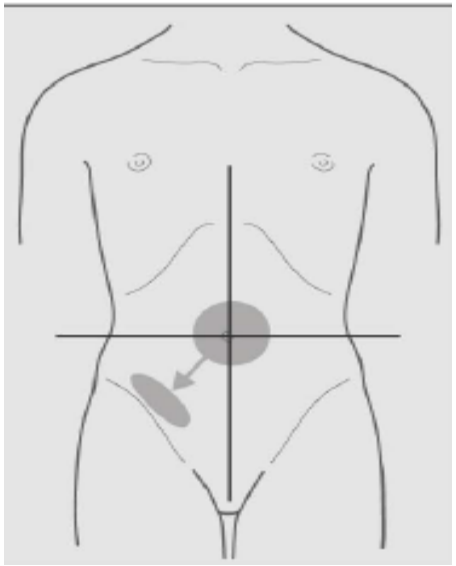
- Pain is most often observed in the left lower quadrant; however, the discomfort can be vague and diffuse and about one-third of patients exhibit upper abdominal pain.
- The pain is described as ‘cramp-like’ and is recurrent.
- Alternating diarrhoea and constipation and mucous coating the stools is also often present.



CONDITIONS AFFECTING THE LOWER ABDOMEN

APPENDICITIS

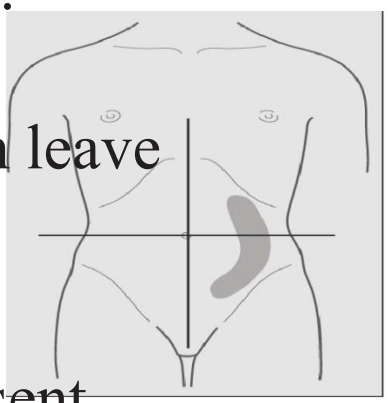
- Classically, the pain starts in the mid-abdomen region, around the umbilicus, before migrating to the right lower quadrant after a few hours, although right-sided pain is experienced from the outset in about 50% of patients.
- The pain of appendicitis is described as colicky or cramp-like but after a few hours becomes constant.
- Movement tends to aggravate the pain and vomiting might also be present.
- Appendicitis is most common in young adults, especially in young men.



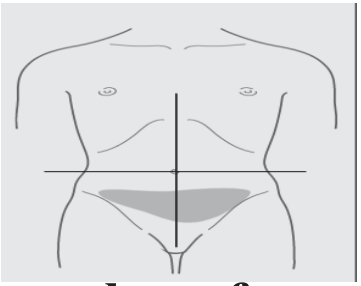
PAIN AFFECTING BOTH RIGHT AND LEFT UPPER QUADRANTS

RENAL COLIC

- Urinary calculi (stones) can occur anywhere in the urinary tract, although most frequently stones get lodged in the ureter.
- Pain begins in the loin, radiating around the flank into the groin and sometimes down the inner side of the thigh.
- Pain is very severe and colicky in nature. Attacks are spasmodic and tend to last minutes to hours and often leave the person prostrate with pain.
- The person is restless and cannot lie still.
- Symptoms of nausea and vomiting might also be present.
- It is twice as common in men than in women and usually occurs between the ages of 40 and 60 years old.



CONDITIONS AFFECTING WOMEN (OTHER THAN PERIOD PAIN)



Generalised lower abdominal pain can be experienced in a number of gynaecological conditions:

- **Ectopic pregnancy**: these are usually experienced between weeks 5 and 14 of the pregnancy. Patients suffer from persistent moderate to severe pain that is sudden in onset. Referred pain to the tip of the scapula is possible. Most patients (80%) experience bleeding that ranges from spotting to the equivalent of a menstrual period. Diarrhoea and vomiting is often also present.
- **Salpingitis** (inflammation of the fallopian tubes): occurs predominantly in young, sexually active women, especially those fitted with an IUD. Pain is usually bilateral, low and cramping. Pain starts shortly after menstruation and can worsen with movement. Malaise and fever are common.
- **Endometriosis:** patients experience lower abdominal aching pain that usually starts 5 to 7 days before menstruation begins and can be constant and severe. The pain often worsens at the onset of menstruation. Referred pain into the back and down the thighs is also possible.

Table 6.26
Specific questions to ask the patient: Abdominal pain

Question	Relevance
Location of pain	Knowing the anatomical location of abdominal structures is helpful in differential diagnosis of abdominal pain (Fig. 6.13)
Presence only of abdominal pain/discomfort	In general, patients without other symptoms rarely have serious pathology. The symptoms are usually self-limiting and often no cause can be determined
Nature of the pain	Heartburn is classically associated with a retrosternal burning sensation Cramp-like pain is seen in diverticulitis, IBS, salpingitis and gastroenteritis Colicky pain (pain that comes and goes) has been used to describe the pain of appendicitis, biliary and renal colic and intestinal obstruction Gnawing pain is associated with pancreatitis and pancreatic cancer and boring pain with ulceration
Radiating pain	Abdominal pain that moves from its original site should be viewed with caution Pain that radiates to the jaw, face and arm could be cardiovascular in origin Pain that moves from a central location to the right lower quadrant could suggest appendicitis Pain radiating to the back may suggest peptic ulcer or pancreatitis

Table 6.26

Specific questions to ask the patient: Abdominal pain

Question	Relevance
Severity of pain	Non-serious causes of abdominal pain generally do not give rise to severe pain. Pain associated with pancreatitis, biliary and renal colic and peritonitis tends to be severe (subjective scores higher than 6 out of 10)
Age of patient	With increasing age, abdominal pain is more likely to have an identifiable and serious organic cause. Appendicitis is the only serious abdominal condition that is much more common in young patients
Onset & duration	In general, if no identifiable cause can be found, abdominal pain with sudden onset is generally a symptom of more serious conditions. For example, peritonitis, appendicitis, ectopic pregnancy, renal and biliary colic. Pain that lasts more than 6 hours is suggestive of underlying pathology
Aggravating or ameliorating factors	Biliary colic can be aggravated by fatty foods Vomiting tends to relieve pain in gastric ulcers Pain in duodenal ulcer is relieved after ingestion of food Pain in salpingitis, pancreatitis and appendicitis are often made worse by movement
Associated symptoms	Vomiting, weight loss, melaena, altered bowel habit and haematemesis are all symptoms that suggest more serious pathology and require referral

GASTROENTEROLOGY

IRRITABLE BOWEL SYNDROME (IBS)

AETIOLOGY

- No anatomic cause can be found.

Many factors can contribute to disease expression and include **motility dysfunction**, **diet** and **genetics** (In a small proportion of cases symptoms appear after bacterial gastroenteritis).

- Psychological factors also influence symptom reporting (stress or depression).
- Symptoms of diarrhoea and constipation appear to be linked with hyperactivity of the small intestine and colon in response to food ingestion and parasympathomimetic drugs.

Table 6.21
Specific questions to ask the patient: IBS

Question	Relevance
Duration	NICE Guidance (CG61) states that primary care clinicians should consider a diagnosis of IBS if the patient has had any of the following symptoms for 6 months: Abdominal pain or discomfort Bloating Change in bowel habit
Age	IBS usually affects people under the age of 45 Particular care is required in labelling middle-aged (i.e. over 45 years old) and elderly patients with IBS when presenting with bowel symptoms for the first time. Such patients are best referred for further evaluation to eliminate organic bowel disease
Periodicity	IBS tends to be episodic. The patient might have a history of being well for a number of weeks or months in between bouts of symptoms. Often patients can trace their symptoms back many years, even to childhood

Question	Relevance
Presence of abdominal pain	The nature of pain experienced by patients with IBS is very varied, ranging from localised and sharp to diffuse and aching. It is therefore not very discriminatory; however, the patient will probably have experienced similar abdominal pain in the past. Any change in the nature and severity of the pain is best referred for further evaluation
Location of pain	Pain from IBS is normally located in the left lower quadrant. For further information on other conditions that cause pain in the lower abdomen see page 183
Diarrhoea and constipation	Patients with IBS do not have textbook definitions of constipation or diarrhoea but bowel function will be different than normal Constipation predominant IBS is more common in women

TRIGGER POINTS indicative of referral: IBS

Symptoms/signs	Possible danger/reason for referral
Blood in the stool	The presence of blood in the stool is not usual in IBS and can suggest inflammatory bowel disease
Fever Nausea and/or vomiting Severe abdominal pain	Not usually associated with IBS. Suggests origin of symptoms from other abdominal causes
Children under 16 Patients over 45 with recent change to bowel habit	IBS unusual in these age groups. Refer for further investigation.
Steatorrhoea	Associated with malabsorption syndromes

EVIDENCE BASE FOR OVER-THE-COUNTER MEDICATION

- Before medicines are recommended it might be useful to discuss if stress is a factor and if this can be avoided.
- Dietary modification has shown to be effective for some patients. Suspected food products must be excluded from the diet for a minimum of 2 weeks and then gradually reintroduced to determine if the food item triggers symptoms.
- **Antispasmodics** are considered first-line pharmacological intervention for IBS, these include mebeverine, alverine, hyoscine and peppermint oil.
- **Bulk-forming and stimulant laxatives** can be used to treat constipation-predominant IBS and **loperamide** for diarrhoea-predominant IBS.

Table 6.22
Practical prescribing: Summary of IBS medicines

Name of medicine	Use in children	Likely side effects	Drug interactions of note	Patients in which care exercised	Pregnancy & breastfeeding
Hyoscine	>12 years	Constipation and dry mouth	Tricyclic antidepressants, neuroleptics, antihistamines and disopyramide	Glaucoma, myasthenia gravis and prostate enlargement	Avoid if possible
Mebeverine	>10 years	None	None	None	OK
Peppermint Oil	>15 years	Heartburn	None	None	OK in pregnancy; try to avoid in breastfeeding
Alverine	>12 years	Rash	None	None	OK

HINTS AND TIPS BOX 6.7: IRRITABLE BOWEL SYNDROME

Dietary advice (taken from NICE CG61)	Have regular meals and avoid missing meals Drink at least eight cups of fluid per day, especially non-caffeinated drinks Reduce intake of alcohol and fizzy drinks Consider limiting intake of high-fibre food Reduce intake of 'resistant starch' often found in processed or re-cooked foods Limit fresh fruit to three portions per day
Hypnotherapy	This has been subject to a Cochrane review. Current trial data is inconclusive as to its effectiveness, although some data does show promising findings. A register of IBS therapists specialising in hypnotherapy can be found at http://www.ibs-register.co.uk (accessed 8 November 2012)

CONSTIPATION

- **Constipation** is defined as difficult or infrequent passage of stool, at times associated with straining or a feeling of incomplete defecation.
- In Western populations 90% of people defecate between three times a day and once every 3 days.
- However, many people still believe that anything other than one bowel movement a day is abnormal.
- Underlying causes of constipation should be identified when possible and corrective measures taken (eg, alteration of diet or treatment of diseases such as hypothyroidism).

CONSTIPATION

Table 6.18
Specific questions to ask the patient: Constipation

Question	Relevance
Change of diet or routine	Constipation usually has a social or behavioural cause. There will usually be some event that has precipitated the onset of symptoms
Pain on defecation	Associated pain when going to the toilet is usually due to a local anorectal problem. Constipation is often secondary to the suppression of defecation because it induces pain. These cases are best referred for physical examination
Presence of blood	Bright red specks in the toilet or smears on toilet tissue suggest haemorrhoids or a tear in the anal canal (fissure). However, if blood is mixed in the stool (melaena) then referral to the GP is necessary. A stool that appears black and tarry is suggestive of an upper GI bleed
Duration (chronic or recent?)	Constipation lasting 6 weeks or more is said to be chronic. If a patient suffers from longstanding constipation and has been previously seen by the GP then treatment could be given. However, cases of more than 14 days with no identifiable cause or previous investigation by the GP should be referred
Lifestyle changes	Changes in job or marital status can precipitate depressive illness that can manifest with physiological symptoms such as constipation

Table 6.20
Practical prescribing: Summary of medicines for constipation

Name of medicine	Use in children	Likely side effects	Drug interactions of note	Patients in which care exercised	Pregnancy & breastfeeding
Bulk forming					
Ispaghula husk	>6 years	Flatulence and abdominal bloating	None	None	OK
Methylcellulose	>7 years				
Sterculia	>6 years				
Stimulant					
Senna	>2 years	Abdominal pain	None	None	OK, but use other laxatives in preference to stimulants in pregnancy and breastfeeding
Glycerol	Infant upwards*				
Sodium picosulphate	>10 years				
Bisacodyl	>4 years				

The foundation of treatment

Table 6.20
Practical prescribing: Summary of medicines for constipation

Name of medicine	Use in children	Likely side effects	Drug interactions of note	Patients in which care exercised	Pregnancy & breastfeeding
Osmotic					
Lactulose	Infant upwards*	Flatulence, abdominal pain and colic	None	None	OK
Magnesium hydroxide	Not recommended				
Stool softeners					
Docusate	>6 months	None reported	None	None	OK

*If prescribing to children less than 6 years of age then the pharmacist must be competent in prescribing laxatives for children.

TRIGGER POINTS indicative of referral:

Symptoms/signs	Possible danger/reason for referral
Pain on defecation, causing patient to suppress defecation reflex	Check for anal fissure
Patients over 40 years of age with sudden change in bowel habits with no obvious cause	Danger symptom for rectal carcinoma
Greater than 14 days' duration with no identifiable cause	Suspect underlying cause that requires fuller investigation by GP
Tiredness	Check for anaemia or thyroid dysfunction

DIARRHOEA

✓**Diarrhoea** can be defined as an increase in frequency of the passage of soft or watery stools relative to the usual bowel habit for that individual. It is not a disease but a sign of an underlying problem such as an infection or gastrointestinal disorder.

It can be classed as:

→Acute (less than 7 days),

→ Persistent (more than 14 days)

→ Chronic (lasting longer than a month).

✓Most patients will present to the pharmacy with a self-diagnosis of acute diarrhoea.

✓Management of diarrhea focuses on preventing excessive water and electrolyte losses, dietary care, relieving symptoms, treating curable causes, and treating secondary disorders.

✓Bismuth subsalicylate is marketed for indigestion, relieving abdominal cramps, and controlling diarrhea, including traveler's diarrhea, but may cause interactions with several components if given excessively.

DIARRHOEA

Table 6.14
Specific questions to ask the patient: Diarrhoea

Question	Relevance
Frequency and nature of the stools	Patients with acute self-limiting diarrhoea will be passing watery stools more frequently than normal Diarrhoea associated with blood and mucus (dysentery) requires referral to eliminate invasive infection such as *Shigella*, *Campylobacter*, *Salmonella* or *E. coli* 0157 Bloody stools is also associated with conditions such as inflammatory bowel disease
Periodicity	A history of recurrent diarrhoea of no known cause should be referred for further investigation
Duration	A person who presents with a history of chronic diarrhoea should be referred. The most frequent causes of chronic diarrhoea are IBS, inflammatory disease and colon cancer
Onset of symptoms	Ingestion of bacterial pathogens can give rise to symptoms in a matter of a few hours (toxin producing bacteria) after eating contaminated food or up to 3 days later. It is therefore important to ask about food consumption over the last few days, establish if anyone else ate the same food and to check the status of his or her health
Timing of diarrhoea	Patients who experience diarrhoea first thing in the morning might well have underlying pathology such as IBS Nocturnal diarrhoea is often associated with inflammatory bowel disease
Recent change of diet	Changes in diet can cause changes to bowel function, for example when away on holiday. If the person has recently been to a non-Western country then giardiasis is a possibility
Signs of dehydration	Mild (<5%) dehydration can be vague but include tiredness, anorexia, nausea and light-headedness Moderate (5 to 10%) dehydration is characterised by dry mouth, sunken eyes, decreased urine output, moderate thirst and decreased skin turgor (pinch test of 1 to 2 seconds or longer)

Table 6.16
Practical prescribing: Summary of medicines for diarrhoea

Name of medicine	Use in children	Likely side effects	Drug interactions of note	Patients in which care exercised	Pregnancy & breastfeeding
ORS	Infant upwards	None	None	None	OK
Loperamide	>12 years	Abdominal cramps, nausea, vomiting, tiredness	None	None	OK
Bismuth	>16 years	Black stools or tongue.	Quinolone antibiotics	None	Avoid if possible
Morphine salts	>12 years	None	None	None	OK

HINTS AND TIPS BOX 6.5: DIARRHOEA

Reconstitution of ORS Oral rehydration solution (ORS)	All proprietary sachets require 200 mL of water per sachet to reconstitute Different brands come in different flavours: • Dioralyte – blackcurrant and citrus • Diorolyte Relief – apricot, raspberry or blackcurrant • Electrolade – banana, blackcurrant, lemon and lime and orange Once reconstituted ORS must be stored in the fridge and drunk within 24 hours Note Oralyte is sold as a ready to drink product and requires no reconstitution.
Rough guidelines for referral for children	<1 year old: refer if duration >1 day <3 years old: refer if duration >2 days >3 years old: refer if duration >3 days
Kaolin and morphine	Subject to abuse. Store out of sight
Alternative to ORS	Patients can be advised to increase their intake of fluids, particularly fruit juices with their glucose and potassium content, and soups because of their sodium chloride content

GASTROENTEROLOGY

HAEMORRHOIDS

PREVALENCE AND EPIDEMIOLOGY

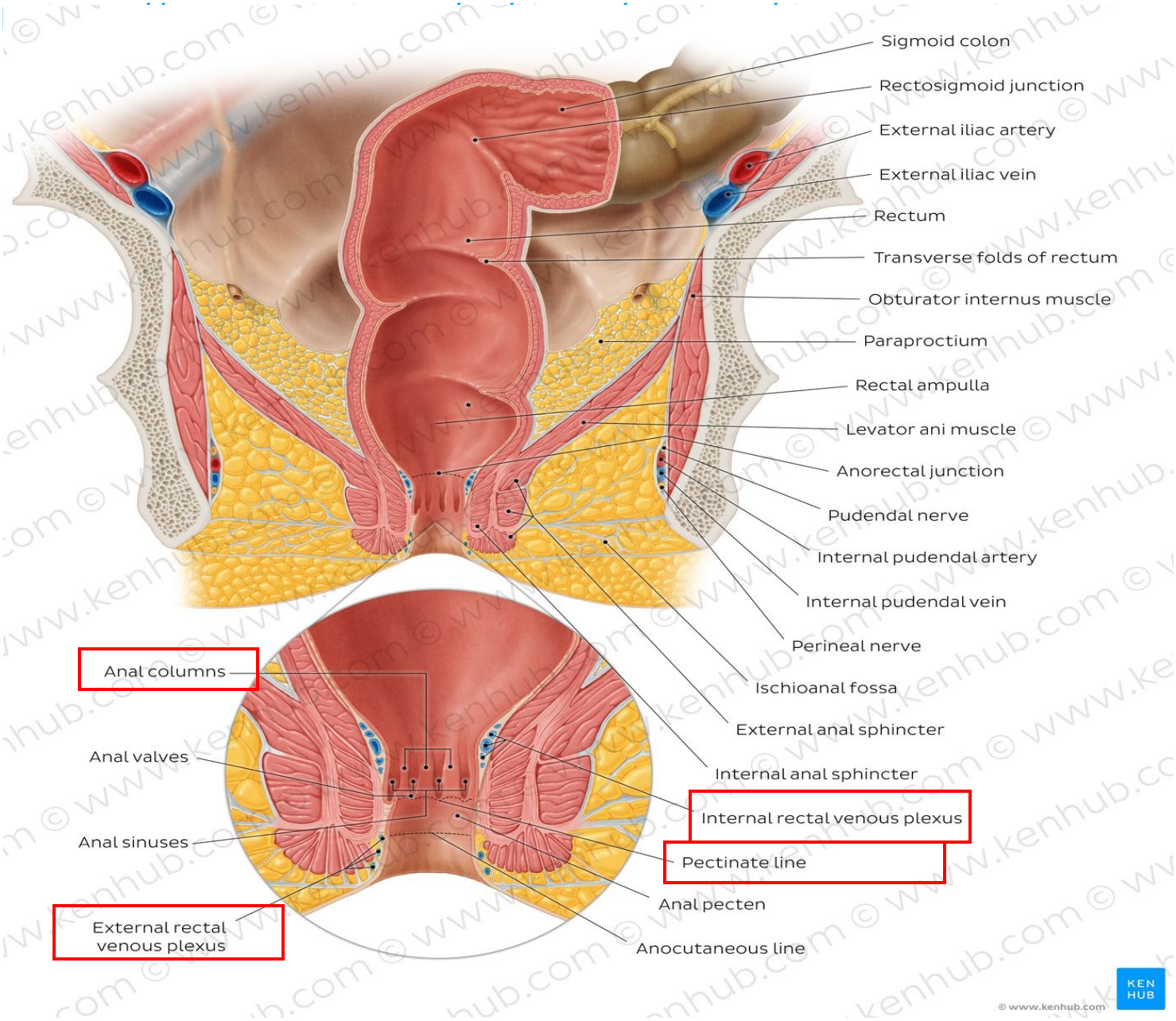
- Haemorrhoids (piles) are the most common problem affecting the anorectal region.
- The exact prevalence of haemorrhoids is **unknown** but it is estimated that **one in two** people will experience at least one episode at some point during their lives.
- Haemorrhoids can occur **at any age** but are rare in children and adults under the age of 20.
- It affects **both sexes equally** and is more common with **increasing age**; especially in people aged between 45 to 65 years of age.
- There is a high incidence of haemorrhoids in **pregnant women.**

AETIOLOGY

- The cause of haemorrhoids is probably multifactorial with **anatomical** (degeneration of elastic), **physiological** (increased anal canal pressure) and **mechanical** (straining at stool} processes implicated.
- Haemorrhoids have been traditionally described as engorged veins of the haemorrhoidal plexus. The analogy of varicose veins of the anal canal is often used but is misleading.
- Current thinking favours the theory of **prolapsed anal cushions.**
- Anal cushions are 3 consistently placed submucosal vascular plexuses formed by anastomosis of rectal veins within anal columns.
- Anal cushions maintain fine continence and are submucosal vascular structures suspended in the canal by a connective tissue framework derived from the internal anal sphincter and longitudinal muscle.
- Within each of the three cushions is a venous plexus that is fed by arteriovenous blood supply. Veins in these cushions fill with blood when sphincters inside them relax and empty when the sphincters contract.
- **Fragmentation of the connective tissue supporting the cushions leads to their descent.**
- The prolapsed anal cushion has impaired venous return resulting in venous stasis and inflammation of the cushion's epithelium.

Macroscopic anatomy of anal canal

REFERENC

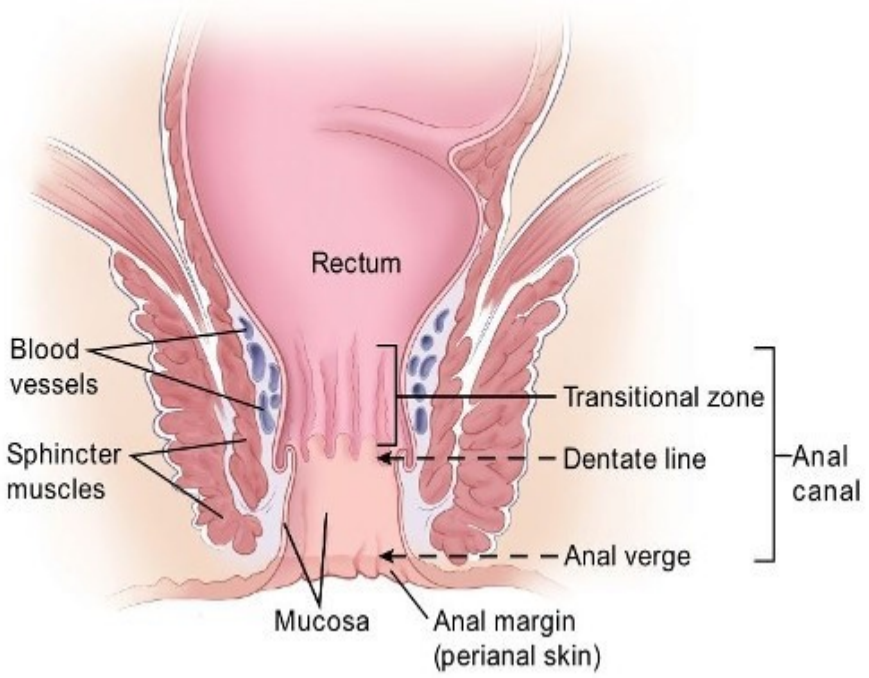


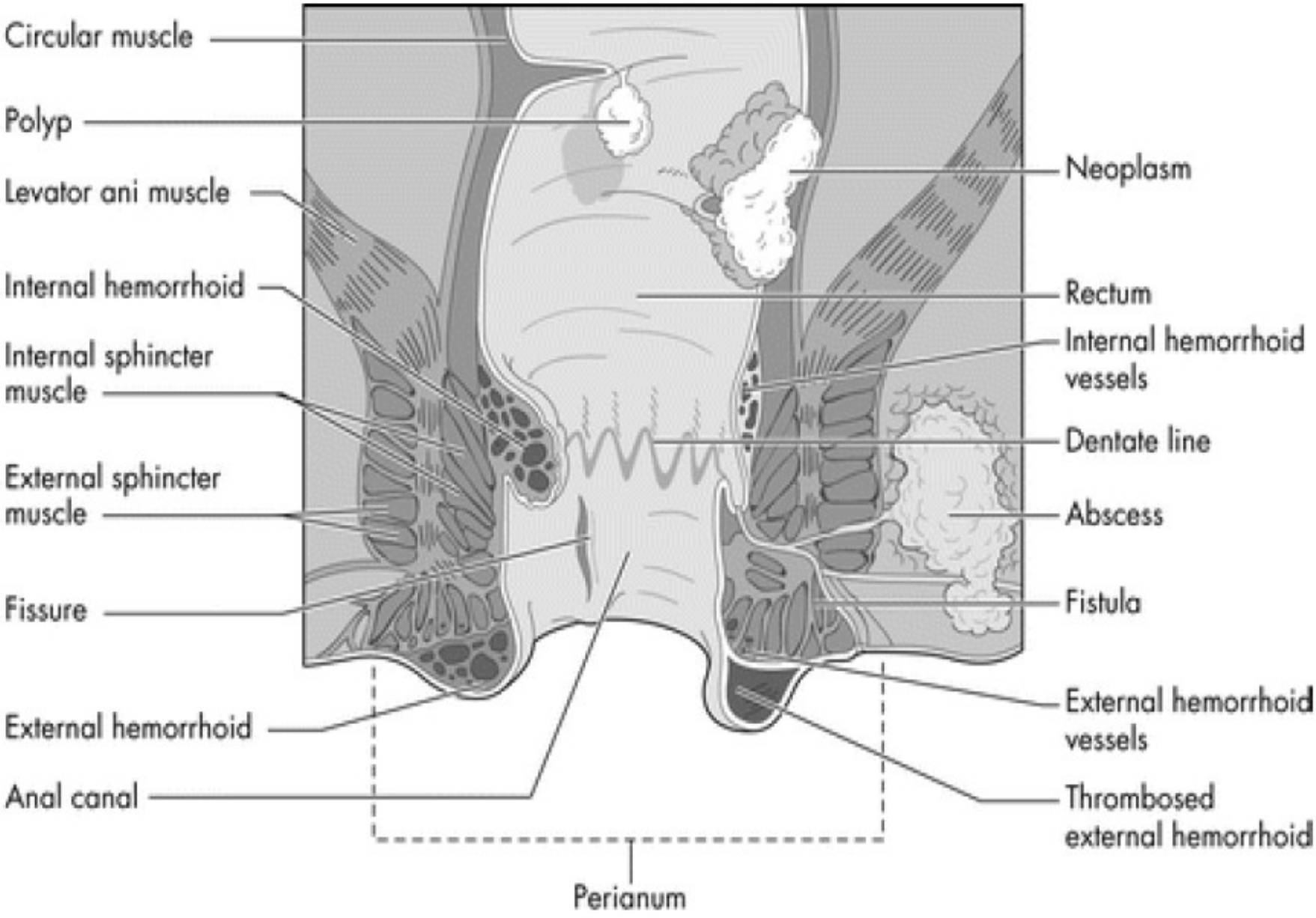
AETIOLOGY (Haemorrhoids classification)

- Haemorrhoids are classified as either **internal or external.** This distinction is an anatomical one.

- Superior to the anal sphincter there is an area known as the dentate line. At this junction epithelial cells change from squamous to columnar epithelial tissue.

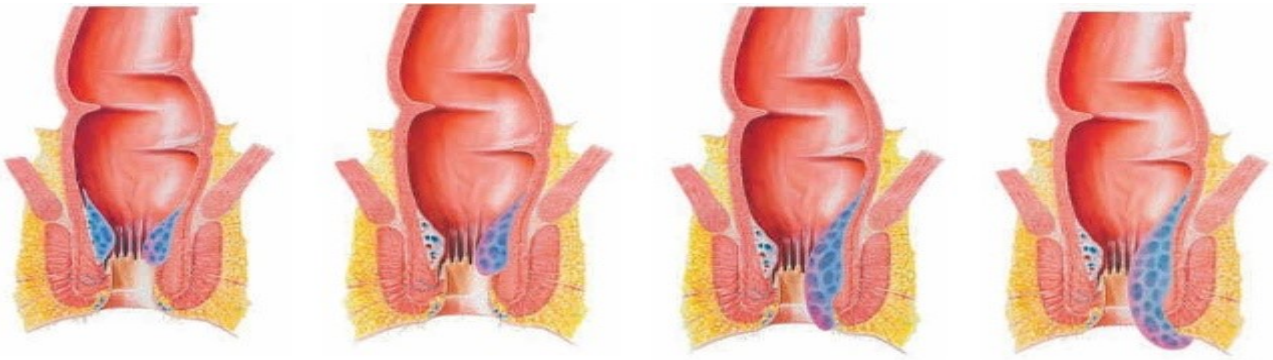
- Above the dentate line haemorrhoids are classed as internal and below, external.




Circular muscle
Polyp
Levator ani muscle
Internal hemorrhoid
Internal sphincter muscle
External sphincter muscle
Fissure
External hemorrhoid
Anal canal
Neoplasm
Rectum
Internal hemorrhoid vessels
Dentate line
Abscess
Fistula
External hemorrhoid vessels
Thrombosed external hemorrhoid
Perianum

AETIOLOGY (Internal Haemorrhoids Grades)

- **Internal haemorrhoids** are graded according to severity: **grade I**, do not prolapse out of the anal canal; **grade II**, prolapse on defecation but reduce spontaneously; **grade III**, require manual reduction; and **grade IV**, cannot be reduced.



ARRIVING AT A DIFFERENTIAL DIAGNOSIS

- In the first instance most patients with anorectal symptoms will self-diagnose haemorrhoids and often self-treat due to embarrassment about symptoms.

- Bleeding tends to cause the greatest concern and often instigates the patient to seek help.

- Invariably, rectal bleeding is of little consequence but should be thoroughly investigated to exclude sinister pathology.

- A number of haemorrhoid –specific questions should always be asked

CLINICAL FEATURES OF HAEMORRHOIDS

- Symptoms experienced by the patient are dependent upon the severity or type of haemorrhoid and can include bleeding, perianal itching, mucus discharge and pain.
- Often patients are asymptomatic until the haemorrhoid prolapses.
- Any blood associated is bright red and is most commonly seen as spotting around the toilet pan, streaking on toilet tissue or visible on the surface of the stool.
- Symptoms are often intermittent and each episode usually lasts from a few days to a few weeks.
- Internal haemorrhoids are rarely painful, whereas external haemorrhoids often cause pain due to the cushion becoming thrombosed.
- Pain is described as a dull ache that increases in severity when the patient defecates leading to patients ignoring the urge to defecate.
- This can then lead to constipation, which in turn will lead to more difficulty in passing stools and further increase the pain associated with defecation.

CONDITIONS TO ELIMINATE

- **Dermatitis→** dermatitis often caused by toiletries or even threadworm infection.
- **Medication →** medicines that are prone to causing constipation.
- **<u>Conditions causing rectal bleeding:</u>**
  - ✓**Anal fissure→** Pain can be intense on defecation and can last between a few minutes and a few hours after defecation. Bright red blood is commonly seen.
  - ✓**Ulcerative colitis and Crohn's disease →** These tend to be stools that are watery, abdominal pain in the lower left quadrant, weight loss and fever.
  - ✓**Upper Gl bleeds→ The color of the stool** is related to the rate of bleeding. Stools from GI bleeds can be:
  - →**Tarry** (indicating a bleed of 100 to 200 mL of blood)
  - → **Black** (indicating a bleed of 400 to 500 mL of blood
  - ✓**Colorectal cancer→** Colorectal bleeds depend on the site of tumor, for example sigmoid tumors lead to bright red blood in or around the stool. Any patient over 40 years of age with persistent rectal bleeding and a change of bowel habit must be urgently referred.

TRIGGER POINTS indicative of referral: Haemorrhoids

Symptoms/signs	Possible danger/ reason for referral
Persistent change in bowel habit in patients over 40 years of age Unexplained rectal bleeding	Sinister pathology?
Patients who have to reduce their haemorrhoids manually	OTC treatment will not help
Severe pain associated with defecation	Anal fissure?
Blood mixed in the stool Fever	Suspect GI bleeds or inflammatory bowel disease

EVIDENCE BASE FOR OVER-THE-COUNTER MEDICATION

Diet

- Patients should try to eat more fruit, vegetables, bran, and whole meal bread.
- If this is not possible then fibre supplementation with a bulk-forming laxative could be recommended.
- Bulk-forming laxatives will take 2-3 days to relieve constipation and may take up to 6 weeks to improve symptoms of haemorrhoids.

Pharmacological Intervention

→ Anaesthetics (lidocaine, benzocaine and cinchocaine)

→Astringents (allantoin, bismuth, zinc, Peru balsam)

→ Anti-inflammatories (hydrocortisone)

SUMMARY

- With so little data available on effectiveness of pharmacological interventions.
- It is impossible to say whether any product is a credible treatment for haemorrhoids, and many medical authorities regard them as little more than placebos.
- **Until such time, it seems prudent to recommend products containing a local anaesthetic or hydrocortisone as they do have proven effectiveness in other similar conditions.**
- Treatment should only be recommended to patients with mild haemorrhoids.
- Any person complaining of prolapsing haemorrhoids, which need reducing by the patient should be referred, because these patients might require non-surgical intervention with sclerotherapy or rubber band ligation.
- If these fail to cure the problem then a haemorrhoidectomy might be performed.