THE NORTHERN HOSPITAL

HAEMORRHOIDS

"King Alfred the Great", from Illuminated Manuscript, Cotton Claudius D.ii, f.8, dated 1321. British Library.

This sumptuous manuscript contains priceless a collection of Anglo-Saxon, Norman and Angevin law-codes (Liber legum antiquorum regum), which can be precisely dated to 1321. The inclusion of a Latin translation of the Laws of King Alfred indicates the esteem in which Alfred was beheld a law-giver in the high Middle Ages (Alfred P. Smyth).

...Alfred wished to confirm his own mind in God's commandments, and when he realized that he was unable to abstain from carnal desire, fearing that he would incur God's disfavor if he did anything contrary to His will... he lay there prostrate praying a long while, turning himself totally to God, praying that Almighty God through His mercy would more staunchly strengthen his resolve in the love of His service by means of some illness....

After some time he contracted the disease of piles through God's gift; struggling with this long and bitterly through many years he would despair even of life, until that time when, having finished his prayers God removed it from him completely. But, alas, when it had been removed another more severe illness seized him at his wedding feast...

The king was pierced by many nails of tribulation, although placed in royal power. For from his twentieth till his forty fifth year, in which he now is, he has been constantly afflicted with a most severe attack of an unknown malady so that he has not a single hour's peace, in which he is not either suffering that infirmity or driven almost to despair by apprehension....

Asser, "The Life of Alfred",
Early 11th Century Monastic pseudo-life
of King Alfred the Great.

The late Ninth century West Saxon king Alfred is the only English monarch to have the epitaph "Great", and well he deserved it. He was not only a brilliant leader, holding off the incessant and ferocious Viking raids of the late Ninth century, he was also a brilliant scholar. He was literate in an age when the vast majority were not so and writing held a mystical, almost religious significance. He not only read but also wrote, translating Latin texts into the English vernacular. He was a great law giver, and his laws held sway well into the Middle Ages. And of course he was a very great general and soldier, the only leader of the Anglo-Saxons able to stem the tide of the Danelaw. He fought two long wars against the Vikings, the first from 871 to 878 A.D and a second from 893 to 896 A.D. He preserved his kingdom of Wessex against the heathen onslaught, and his descendents would build on his conquests to eventually unite all England under one King. Historians have struggled to understand Alfred and his times as the historical record from these "Dark Ages", ("dark" in the sense of our relative information when compared to ages that preceded and came after it) is very fragmentary indeed.

The prime sources for King Alfred's reign that were taken by most historians to be reliable, were threefold - Alfred's own writings, the Anglo-Saxon Chronicle, and a supposed contemporary biographer by the name of Asser. But then in 1995 came the controversial claim by the highly esteemed Oxford Historian, Professor Alfred P. Smyth, that "Asser" was a complete fake! Controversial because many prominent historians of

the time and the preceding century, including Dorothy Whitelock, W.H Stevenson, Simon Keynes and Michael Lapidge had based much of their work on the assumption that Asser was Alfred's contemporary and indeed a personal friend and tutor to the king! Immense ill feeling, needless to say followed!

Professor Smyth published his impressive research in 1995 in his book, "King Alfred the Great", in which he closely examined the supposed Asser biography. To an impartial lay person, separated from the heated emotions of the professional historians - Smyth presents a compelling argument indeed. He argues that "Asser" was actually an early Eleventh century monastic who wrote a religious hagiography of Alfred, but claiming to be Alfred's contemporary, in order to lend weight to his version of history. The more ones sees of Asser's account the more one agrees with Professor Smyth! The pseudo Asser, does not present Alfred as a supreme intellectual and magnificent general, leading his nation in a fight to the death against the Viking invaders but - quite laughably - presents him as a religious fanatic and a neurotic aesthetic, tormented by decades of piles! - a condition for which he prayed to God to contract in his youth so as to divert his carnal lusts! Unfortunately history records that Alfred married later in life - much to the consternation of "Asser" - and though he admits that Alfred was cured of his plies by this stage - he prayed again to God for another ever more severe disease in order to divert him from carnal lust for his wife - a not altogether successful prayer it seems as Alfred went on to have at least five known children! The nature of this second disease is totally obscure - and Asser says that no physician was able to diagnose it - it had to be a hidden disease Alfred stipulates - i.e not easily visible (such as piles) - or otherwise Alfred would never become king, as Kings who had visible deformity or disease were not allowed to rule in those times.

The motivation for "Asser" presenting Alfred in this way is completely obscure to 21st century sensibilities - but again Smyth comes to the rescue and gives us an explanation that does make sense. By the 11th century, when "Asser" was writing, England was once again under fierce and unrelenting Viking attack. England at this time was led by the relatively ineffectual King Ethelred II, known as the "Unready" - unready for kingship and unready for the trials of warfare with a terrifying invader! The purpose of the anonymous monastic writer was propaganda. A hero was needed for inspiration, and Ethelred was not that leader, and so to inspire the people he wrote his "Life of King Alfred" - however being a monastic this amusingly took the form not of great and manly warrior but as a neurotic, religious zealot, who prayed to God constantly to give him tormenting diseases! Great swathes of his "Life" Smyth demonstrates have be plagiarized by other hagiographical works of the saints of earlier centuries. Holy men were supposed to labour heroically despite having innumerable bodily diseases that would torment most normal people beyond despair. But the saints were beyond these bodily mortifications and conducted their great deeds despite their afflictions. So "Asser" invents an affliction for the young Alfred - piles ! and another "secret affliction" later in life for two purposes - one to show his saintliness - in stark contrast to the heathen invaders and two to show his rejection of "carnal lusts"....despite his five children. A most amusingly unbelievable image of the Great warrior king thus emerges! Smyth also demonstrates various anachronisms and points of "knowledge after the fact".

Smyth writes, "The image of the invalid and neurotic Alfred, clutching his childhood book of prayers, keeping secret nightly vigils prostrated in prayer in remote churches, and storming heaven for diseases to mortify his flesh, must be one of the last medieval fictions still taken seriously by modern historians....There is nothing to suggest a morbid interest in asceticism or the endurance of self -inflicted disease, nor is there any evidence for the self doubt or contradictions such a temperament would reveal under the stresses of public life and the challenge posed by the demands of warrior-kingship. The image of Alfred, the neurotic, saintly invalid, as portrayed in the king's "Life", has endured only for the most unworthy of reasons in Twentieth century English scholarship, underpinning as it does the gravest distortion of our assessment of this remarkable medieval king"

Of medial interest, doctors like to try and offer their professional opinions about the likely disease suffered by important historical persons. This however is a completely pointless exercise in the vast majority of cases, especially in the case of a king that died over eleven centuries ago! It is especially pointless when the historical information that they are basing their assertions on is completely false! Professor Smyth in this regard helpfully points out to his colleagues; "It is incumbent on historians to explain to medical experts researching on the history of medicine, that all studies into the precise nature of King Alfred's diseases, however well intentioned, are doomed to failure. Alfred has been diagnosed as suffering from "neuritis", epilepsy, sexually transmitted ano-genital warts, haemorrhoid like lesions, Crohn's disease, and it has even been seriously suggested that the king was infected by virtue of his being a passive homosexual".

Haemorrhoidal disease can be a most distracting affliction. Happily however, symptoms eventually settle over a period of some weeks. One must agree with Professor Smyth that the great King, bane of the Viking, was most unlikely to have suffered these - to the point of despair of life itself - for a period of decades - let alone to beseech God to afflict these upon him!

HAEMORRHOIDS

Introduction

Haemorrhoids (or Hemorrhoids, also known in lay terms as "**piles**") are disease complications of haemorrhoidal tissue.

Haemorrhoidal tissue is *normal vascular tissue* that lies within the anal canal

Haemorrhoidal disease can take a number of forms, including:

- Varicosity and bleeding
- Thrombosis
- Prolapse

In mild disease, symptoms can settle with conservative management.

In more severe disease, surgery will be required.

Anatomy

Haemorrhoidal tissue is essentially cushions of submucosal vascular tissue that help maintain anal continence.

The anal cushions contain a rich arteriovenous vascular network and are thought to help with the discrimination of flatus and faeces.

They are usually located in the **3, 7** and **11** o'clock positions as viewed with a patient in the lithotomy position.

Pathology

True haemorrhoids are enlarged, displaced anal submucosal vascular cushions.

They are subject to downward pressure during defecation.

If their fibromuscular supporting tissue is damaged, the anal cushions are displaced down the anal canal, become congested, and eventually prolapse beyond the anal verge

Haemorrhoidal disease can take a number of forms, including:

1. Varicosity and bleeding
2. Thrombosis:

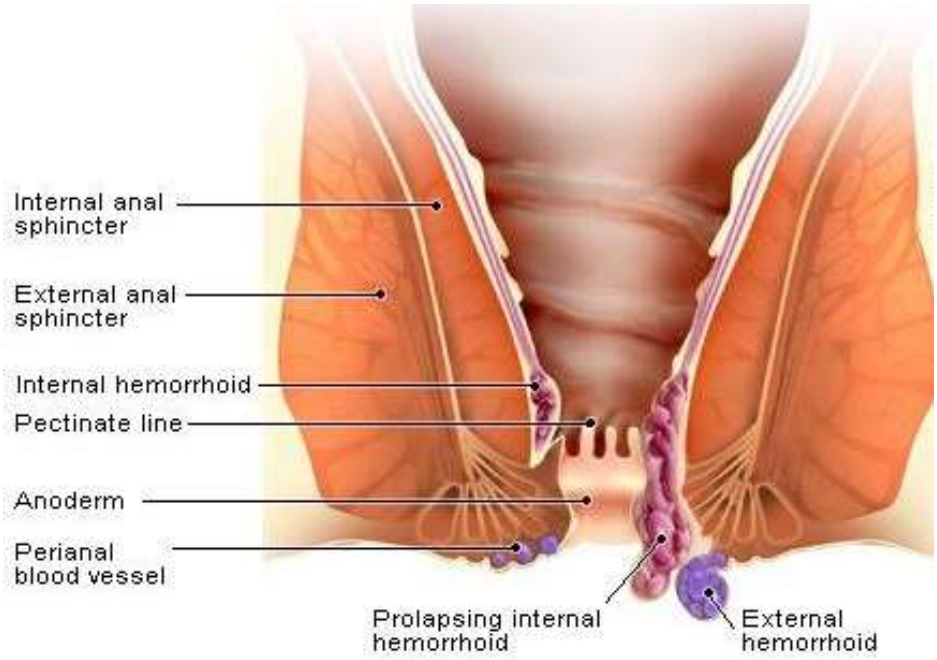
- A perianal haematoma is a painful tense blue swelling at the anal margin due to recent thrombosis of a vein, often after straining at stool.

  Thrombosed external haemorrhoid is a more appropriate name as the clot is contained within an endothelium-lined blood vessel, and so is not a true haematoma. [2]

3. Prolapse:

   - If mild these may reduce spontaneously or digitally.

   - In more severe cases, the relapsing haemorrhoids can become incarcerated and irreducible. Sever pain develops with ischemia, and eventually *gangrene* can occur.



Internal and external haemorrhoids, (Medicine.Net)

Causes:

Contributing factors include:

- Excessive straining/ constipation.
- Low dietary fiber
- Chronic diarrhea

- Pregnancy
- Liver cirrhosis with portal hypertension.

There is **no** evidence that dietary factors (such as "spicy" food) is related to the development of haemorrhoidal disease.

Clinical features

Clinical presentations of haemorrhoidal disease include:

1. Bleeding:

    - Bleeding is the **most common** symptom.
    - It is usually **bright red** blood
    - It is typically **painless** bleeding.
    - Nature of the bleeding:
        - ♥ Bleeding is typically described as a "splash" in the pan or as streaks on toilet paper.

    Note that bleeding *between bowel actions* or blood *mixed with the stool* is more typical of other pathologies such as diverticular disease or malignant disease, and requires further investigation.

2. Perianal pain:

    - When caused by haemorrhoidal disease, this usually indicates a thrombosed haemorrhoid or a prolapse.

      Examination may show skin tags - remnants of previous thrombosed haemorrhoids.

      There is a firm painful tender dusky-blue mass, typically with the appearance of a dark grape-like lump, situated at the margin of the anus

      Pain typically peaks at **48 hours**, before gradually subsiding.

3. Prolapse:

Grading of Internal Haemorrhoids

Grade of Haemorrhoid	Clinical features

Grade 1	Painless bleeding. Do not prolapse
Grade 2	Prolapse usually after straining at stool, but reduce spontaneously
Grade 3	Prolapse and require digital reduction
Grade 4	Prolapsed and irreducible

Investigations

None may be necessary, unless for:

- Secondary complications
- Pre-operative basement
- Ruling out differential diagnoses.

Management

Preventive measures:

Most haemorrhoids settle if patients adopt the following conservative measures: [2]

- Avoid constipation with an adequate intake of fibre and fluids
- Avoid excessive straining at stool
- Respond to the urge to defecate, and don't try to initiate defecation without this.

Acute haemorrhoidal disease:

1. Analgesia:
    - This may be required for significant pain due to thrombosis or prolapse.
    - Constipating agents, such as *opioids* should be **avoided.** Use paracetamol, NSIADS.
    - Topical **nitroglycerine** and **nifedipine** have also been used to relieve symptoms associated with anal sphincter spasm. These agents should

however be used with caution because of associated side effects, such as hypotension.

- Sitz baths can also help symptoms.

2. Laxatives:

   - These may be taken to avoid straining and constipation.

3. Local anaesthetics/ corticosteroids/ vasoconstrictors: [2]

   A wide range of ointments and suppositories containing varying combinations of emollients, mild astringents, local anesthetics and vasoconstrictors are available as over-the-counter treatments for haemorrhoids.

   - They are frequently used for perianal symptoms that have *not* been caused by haemorrhoids.

   - There is little evidence that these proprietary preparations "cure" haemorrhoids, although they can relieve symptoms.

   - Their *prolonged* use should be *avoided* in favour of treating the underlying condition, as they may have adverse effects

     Short-term use of corticosteroids may provide symptomatic relief but can also exacerbate candidiasis and other local infections. An additional risk is that these preparations may cause local skin sensitisation or dermatitis (dermatitis medicamentosa).

4. Surgery:

   Profuse or persistent **bleeding** and higher degrees of **prolapse** of internal haemorrhoids should be managed surgically.

   Options include:

   - Rubber band ligation:

     - ♥ A band ligature is passed through an anoscope and placed on the rectal mucosa proximal to the dentate line. The tissue necroses and sloughs off in 1-2 weeks, leaving an ulcer that later fibroses. No anesthesia is required; complications are uncommon and usually benign.

   - Sclerosant injection:

     - ♥ For hemorrhoids above the dentate line.

- Haemorrhoidectomy:

  Surgical hemorrhoidectomy is the most effective treatment for all hemorrhoids and in particular is indicated in the following situations:

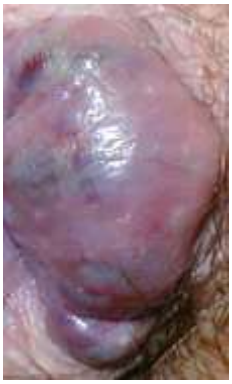
  - ♥ Conservative or nonsurgical treatment fails (persistent bleeding or chronic symptoms)
  - ♥ Grade III and IV hemorrhoids with severe symptoms
  - ♥ Presence of concomitant anorectal conditions (e.g., anal fissure or fistula, hygiene trouble caused by large skin tags, a history of multiple external thromboses, or internal hemorrhoid trouble) requiring surgery
  - ♥ Patient preference

- Stapled haemorrhoidopexy:

  - ♥ This procedure is mainly used to treat internal hemorrhoids that are not amenable to conservative and non-operative therapies. It is suggested for patients with large internal hemorrhoids and minimal external component.

Haemorrhoids developing during pregnancy are best managed conservatively, as most will resolve after delivery.

Thrombosed external haemorrhoids: [2]



Typical appearance of a thrombosed external pile.

Without treatment the pain will begin to settle spontaneously within in **1 - 3 weeks.**

- The haematoma will resorb spontaneously, often leaving a **skin tag.**
- If pain is severe and acute (within **48 hours**) it can be relieved by **excision and evacuation of the haematoma** under **local anaesthesia.** This will generally result in resolution of symptoms within **4 days.**

- A perianal haematoma may rupture spontaneously, thus resolving the symptoms.

Prolapsed haemorrhoids:

- Grade 3 and 4 prolapsed internal haemorrhoids require surgery
- Reduction in the ED:

  Prolapsed haemorrhoids can sometimes be reduced in the ED with

  - ♥ Adequate analgesia
  - ♥ A foot-upwards tilted trolley
  - ♥ Ice
  - ♥ Local anaesthetic
  - ♥ Firm slow pressure applied digitally

  If successful the need for surgery may change from emergency to urgent elective.

"The Alfred Jewel", Anglo-Saxon, enamel and quartz enclosed in gold, Late 9th century. Discovered in 1693, Ashmolean Museum, Oxford. Inscribed "AELFRED MEC HEHT GEWYRCAN", ("Alfred ordered me made").

References

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Further reading:

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July 2015.