



**ORIGINAL RESEARCH PAPER**

**Surgery**

**A STUDY ON MANAGEMENT OF BLEEDING HAEMORRHOIDS WITH CALCIUM DOBESILATE VS INJ SCLEROTHERAPY.**

**KEY WORDS:** Haemorrhoids, Calcium Dobesilate, Sclerotherapy

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**ABSTRACT**

**Introduction:** Hemorrhoids are very common anorectal conditions that should be treated as early as possible. The treatment options are surgery, injection sclerotherapy, rubber band ligation, conservative management with flavonoids,calcium dobesilate,diet modificatons. **Materials:** A prospective study was done at Amch Vijayapura. Detailed clinical examination was done, diagnosis of hemorrhoids were made.A total of 100 patients with grade 1 and 2 haemorrhoids with active bleeding were selected for the study and divided into 2 groups. Group A 50 patients treated with calcium dobesilate and Group B 50 patients with injection sclerotherapy.The patients were followed up at 2 weeks, and 1,6,9 month in terms of improvement in symptoms and any complications. **Results:** This study demonstrated that both calcium dobesilate and injection sclerotherapy had improved per rectal bleeding after 3 and 6 weeks of treatment, but injection sclerotherapy had better outcome over calcium dobesilate after 6 months of treatment (54% vs. 36%). In case of reduction of hemorrhoidal mass – injection sclerotherapy had significantly better outcome in all the follow-up visits, that is, 3 weeks (52% vs. 18%), 6 weeks (64% vs. 30%) and 6 months (60% vs. 28%). Injection sclerotherapy had superior overall treatment outcome after 6 weeks of treatment (66% vs. 42%) and long-term periods (56% vs. 28%). **Conclusion:** Injection sclerotherapy has been found to offer lasting benefits for the treatment of symptomatic hemorrhoids, unlike calcium dobesilate, which usually offers only temporary relief for per rectal bleeding. This means that while injection sclerotherapy leads to sustained improvement in symptoms, conservative management with calcium dobesilate tends to provide short-term relief specifically for bleeding per rectum.

**INTRODUCTION**

- Haemorrhoids are symptomatic enlargements of the internal
- Haemorrhoidal venous plexus (Greek: haima = blood, rhoos =flowing; synonym: piles, Latin: pila = a ball). Internal haemorrhoids characteristically lie in the 3, 7 and 11 o'clock positions (with the patient in the lithotomy position). Secondary haemorrhoids may develop between the primary positions.
- External haemorrhoids relate to venous channels of the inferior haemorrhoidal plexus deep in the skin surrounding the anal verge and are frequently confused with anal skin tags that are not true haemorrhoids.
- Internal hemorrhoids reside above the dentate line and are covered by transitional and columnar epithelium .
- First-degree internal hemorrhoids are not large and are often barely visible but result in painless bleeding during strained defecation.
- Second-degree hemorrhoids are large enough to protrude through the anal canal at the time of defecation and may bleed, but spontaneously reduce.
- Third-degree internal hemorrhoids protrude and bleed with defecation, but are large enough and stretched enough that they must be manually reduced.
- Fourth-degree internal or mixed hemorrhoids are a fusion of internal and external hemorrhoids as the vascular complexes and cushions descend in the submucosa and become permanently fixed below the dentate line and cannot be manually reduced.
- Internal hemorrhoids are the most common source of rectal bleeding.

**Calcium Dobesilate**

- Calcium dobesilate (2,5-dihydroxybenzene sulfonate) is a drug commonly used in the treatment of diabetic retinopathy and chronic venous insufficiency.
- The pharmacology of calcium dobesilate reveals its ability to decrease capillary permeability, as well as platelet aggregation and blood viscosity.

Furthermore, recent data show that calcium dobesilate increases endothelium-dependent relaxation owing to an increase in nitric oxide synthesis. (antioxidant properties)

**Injection-sclerosantTherapy**

- It is done in first degree and early second degree piles (internal)-outpatient procedure. Using proctoscope and Gabriel syringe, 3-5 mL of 5% phenol in almond oil is injected into the submucosal plane just above the anorectal ring to the pedicle. All three piles can be injected separately-3-5 mL to each site in single sitting. Technique can be repeated after 6 weeks.
- The drug causes fibrosis in the submucosal region (sclerosis leading to mucosal fixation on to deeper planes and occlusion of lakes) and thereby fixation of the anal cushions which do not prolapse, causes strengthening of the vessel wall and obliteration of the vessel lumen.
- It is quick and painless; gives 95% cure rate in first degree piles; done on OP basis.
- Contraindications are-thrombosed/prolapsed piles, presence of proctitis/fissure/ fistula-in-ano, pregnancy and diabetes mellitus.
- Complications-recurrence (15%), hypochondriac pain due to entry of drug into the portal system, tenesmus, mucosal sloughing/ulceration, submucosal abscess, anal canal pain, anal stricture.

**Aims And Objectives**

- To study efficacy of Sclerotherapy vs calcium dobesilate in management of acute bleeding hemorrhoids.
- To evaluate long term outcomes of sclerotherapy.

**Methodology**

- Prospective study.
- **Sample Size:** A sample of 100 patients divided into 2 groups-Group A Conservative by calcium dobesilate of 50 patients and Group B Sclerotherapy of 50 patients

**Inclusion Criteria:**

- 1<sup>st</sup>, 2<sup>nd</sup>, Early 3rd degree hemorrhoids who refused for surgical management.

**Exclusion Criteria:**

- Patients not given consent
- Late 3rd degree haemorrhoids
- Thrombosed, Prolapsed haemorrhoids

**Age Distribution**

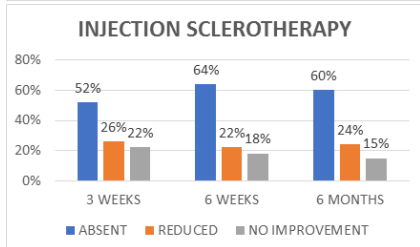
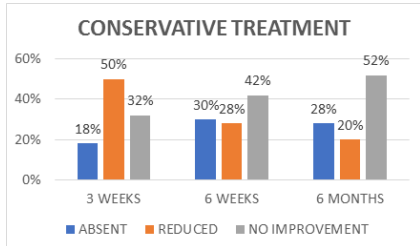
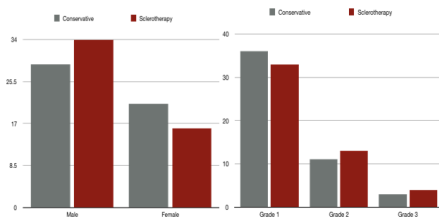
- Most of the patients were of age group 30 yrs to 50 yrs 38 patients in conservative group and 36 patients in sclerotherapy group.

**Sex Distribution**

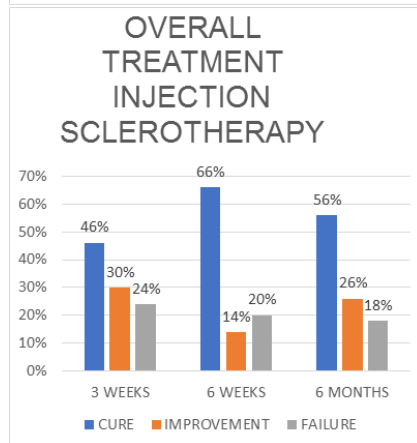
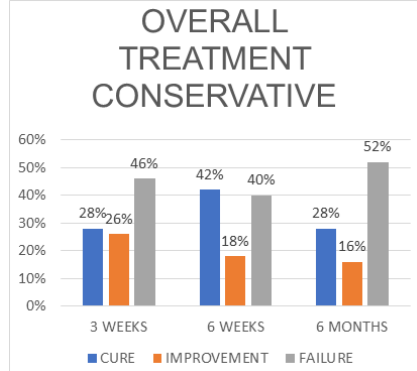
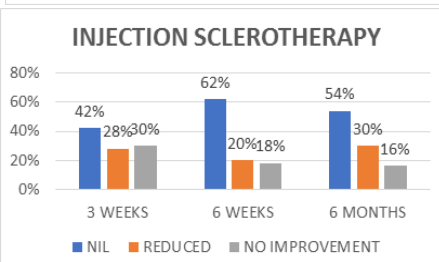
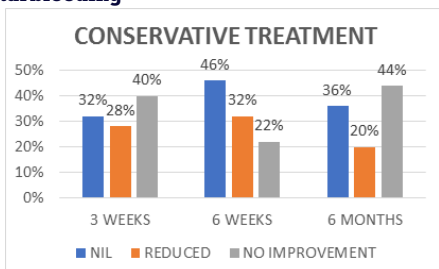
- Most of the patients were males 27 in conservative group and 34 in sclerotherapy group, females 23 in conservative group and 16 in sclerotherapy group.

**Grade Of Haemorrhoids**

- Most of the patients selected were of grade 1 haemorrhoids 36 in conservative group and 32 in sclerotherapy group.



**Perrectal bleeding**



**RESULTS**

- This study demonstrated that both calcium dobesilate and injection sclerotherapy had improved per rectal bleeding after 3 and 6 weeks of treatment, but injection sclerotherapy had better outcome over calcium dobesilate after 6 months of treatment (54% vs. 36%).
- In case of reduction of hemorrhoidal mass – injection sclerotherapy had significantly better outcome in all the follow-up visits, that is, 3 weeks (52% vs. 18%), 6 weeks (64% vs. 30%) and 6 months (60% vs. 28%).
- Injection sclerotherapy had superior overall treatment outcome after 6 weeks of treatment (66% vs. 42%) and long-term periods (56% vs. 28%).
- Complications associated with Calcium dobesilate were fever 8% , nausea 4%, vomiting 12%, whereas complications of Sclerotherapy were reactionary bleeding 10%, discomfort 16%, urinary retention 6% and infection 20%.

**CONCLUSION**

- Injection sclerotherapy has been found to offer lasting benefits for the treatment of symptomatic hemorrhoids, unlike calcium dobesilate, which usually offers only temporary relief for per rectal bleeding.
- This means that while injection sclerotherapy leads to sustained improvement in symptoms, conservative management with calcium dobesilate tends to provide short-term relief specifically for bleeding per rectum.

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