

A Case Study of Hemorrhoid in a 39-Year-Old Man: Qualitative Study

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Abstract

Case Report

Haemorrhoids can be described as an enlarged tissue in the anal canal which contains blood vessels and surrounding supporting tissue, consisting of muscles and elastic fibers. The broad objective of this study was to determine the history, symptoms, and actively manage haemorrhoids in a patient. This study utilized a qualitative research design (case study). The sampling technique was purposive sampling technique. Data were collected through primary (interview, observation) and secondary (Documentation) sources. On admission the patient was restless and apprehensive with facial masked pain with pain rating scale of 3. Vital signs: BP – 120/80mmHg, Pulse – 90b/m, Respiration- 18c/m, Temperature 37.2 SpO₂-96, blood sugar level 6.5mmol/L. weight 60kg and Heart sound - S1, S2 heard. Anal examination revealed presence of redundant tissue, anoderm and a normal anal wink with stimulation confirms intact sensation. past history reviewed the patient avoids travelling and socialization due to pain experienced in prolonged settings and uncertainty of the situation in case of defecation. Other symptoms experienced by the patient include Mass around anal area, blood in stools, hard stools, Itching around anus and anxiety. Literature findings revealed that patients with haemorrhoids experience pain, especially during bowel movements, which consequently lead to delay in defecation, and delay in bowel movement causes constipation. The strain as a result of the constipation in the anal region increases pressure on the lower rectum and anus. This is termed haemorrhoid vicious cycle. The study concluded that haemorrhoids can be prevented and managed through lifestyle changes as lifestyle modification is crucial in managing haemorrhoids and conservative therapy should be considered first-line treatment for symptomatic haemorrhoids. This includes increased dietary fibre, stool softeners, and copious fluid intake.

Keywords: Anal canal, lower rectum, constipation, lifestyle modification.

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INTRODUCTION

Haemorrhoid is the engorgement of the haemorrhoidal venous plexus, they are among the most common anorectal illnesses with symptoms of bleeding per rectum, constipation, pain, protrusion of a mass, and discharge. It manifests as a result of poor feeding habit, extended standing, prolonged sitting, poor defecation habits, and significant psycho-social implications. Haemorrhoidal venous cushions are normal structures of the anorectum and are universally present unless a previous intervention has taken place. The cushion is richly vascularized, highly sensitive, and has tendency to engorge and prolapse. Symptoms can range from pruritus, to rectal bleeding (van Tol *et al*, 2019). Although haemorrhoids are a common condition diagnosed in clinical practice, many patients are too embarrassed to ever seek treatment to avoid examination of their private parts. Consequently, the true prevalence of pathologic haemorrhoids is not known. In addition, although haemorrhoids are responsible for a large

portion of anorectal complaints, it is important to rule out more serious conditions, such as other causes of gastrointestinal (GI) bleeding, before reflexively attributing symptoms to haemorrhoids.

Worldwide, the overall prevalence of haemorrhoids in the general population is estimated to be 4.4%. In the male surgical ward where the case review was done, between Jan 2025 and June 2025, 9 cases were recorded. Treatment Centre has also found that among people older than 45 years, 25% of people who develop haemorrhoids are female and 15% are men. Research has also shown there is a greater likelihood of men seeking treatment for their haemorrhoids than there is for women. Physiological changes that occur during pregnancy also increase the likelihood that haemorrhoids will become symptomatic and may increase the incidence of diagnosed cases in females.

Race: There is a paucity of data on the incidence of haemorrhoids by race, although it has been shown that

there is a greater likelihood of Caucasian individuals seeking treatment compared with other races.

Genetics: Some individuals are more genetically predisposed to haemorrhoids than others. These people should take measures to decrease the likelihood of developing the problem.

Age: Age is known to influence haemorrhoid risk, with the likelihood of haemorrhoids increasing as a person ages. In most cases, haemorrhoids develop in individuals who are over 30 years old, although haemorrhoids can develop at any age.

Location and Socioeconomic Status

People who live in rural areas and those with a higher socioeconomic background appear to be more likely to be affected by haemorrhoids.

Anatomy: The anus is the opening to the lower gastrointestinal (GI) tract and connects to the rectum, which connects to the colon, which travels backwards, connects to the small intestine, the stomach, the oesophagus, and finally the mouth. The anus is approximately 2 to 3 inches long and composed of skin-type cells, also known as squamous cells. There are two sphincter muscles: an internal sphincter muscle, which can be felt as a muscular ring, beyond which is the rectum; and an external sphincter muscle. The upper portion of the anus, or that part that connects to the rectum, is known as the squamocolumnar junction (Fa et al, 2018). This is where the columnar or glandular epithelial cells of the rectum transition to the squamous cells of the anus. This border is somewhat irregular and dynamic, meaning that it can be seen as a fluctuating, undulating edge. There is a "toothed" or jagged line that corresponds to columns, also known as the dentate line, which can be seen with the naked eye and is just below the squamocolumnar junction or towards the outside. This is followed by the anal canal, which leads to the anal verge, which is the junction on the outside of the anus of hair-bearing and non-hair-bearing skin.

Pathophysiology of Hemorrhoidal Disease

The exact pathophysiology of hemorrhoidal development is poorly understood. For years, the theory of varicose veins, which postulated that haemorrhoids were caused by varicose veins in the anal canal, had been popular, the theory is presently obsolete as haemorrhoids and anorectal varices are proven to be distinct entities. In fact, patients with portal hypertension and varices do not have an increased incidence of haemorrhoids (Rubini & Ascanelli, 2019). Today, the theory of sliding anal canal lining is widely accepted. This proposes that haemorrhoids develop when the supporting tissues of the anal cushions disintegrate or deteriorate (Sun &, Migaly, 2016). Haemorrhoid cushions are a part of normal human anatomy and become a pathological disease only when they experience abnormal changes. There are three main cushions present in the normal anal canal. These are

located classically at the left lateral, right anterior, and right posterior positions. They are composed of neither arteries nor veins, but blood vessels called sinusoids, connective tissue, and smooth muscle. Sinusoids do not have muscle tissue in their walls, as veins do. This set of blood vessels is known as the haemorrhoidal plexus.

Haemorrhoid cushions are important for continence. They contribute to 15–20% of anal closure pressure at rest and protect the internal and external anal sphincter muscles during the passage of stool. When a person bears down, the intra-abdominal pressure grows, and haemorrhoid cushions increase in size, helping maintain anal closure. Haemorrhoid symptoms are believed to result when these vascular structures slide downwards or when venous pressure is excessively increased. Increased internal and external anal sphincter pressure may also be involved in haemorrhoid symptoms. Two types of haemorrhoids occur: internals from the superior haemorrhoidal plexus and externals from the inferior haemorrhoidal plexus. The dentate line divides the two region (Rubini & Ascanelli), 2019.

Haemorrhoids are therefore the pathological term to describe the abnormal downward displacement of the anal cushions, causing venous dilatation. The anal cushions of patients with haemorrhoids show significant pathological changes. These changes include abnormal venous dilatation, vascular thrombosis, degenerative process in the collagen fibres and fibroelastic tissues, distortion and rupture of the anal subepithelial muscle. In addition to the above findings, a severe inflammatory reaction involving the vascular wall and surrounding connective tissue has been demonstrated in haemorrhoidal specimens, with associated mucosal ulceration, ischemia, and thrombosis.

Clinical Presentation

Symptoms of haemorrhoids can include the following:

- Painless rectal bleeding
- Anal itching
- Pain
- Tissue bulging around the anus

Rectal bleeding: Many people with haemorrhoids notice bright red blood on their stool, in the toilet, or on the toilet tissue after a bowel movement. The amount of blood is usually small. However, even a small amount of blood in the toilet bowl can cause the water to appear bright red, which can be frightening. Less commonly, bleeding can be heavy.

Itching: Haemorrhoids commonly cause itching and irritation of skin around the anus.

Pain: Haemorrhoids can become painful.

Causes: The veins around the anus tend to stretch under pressure and may bulge or swell. Swollen veins

(haemorrhoids) can develop from increased pressure in the lower rectum due to:

- Straining during bowel movements
- Sitting for long periods of time on the toilet
- Chronic diarrhea or constipation
- Obesity
- Pregnancy
- Anal intercourse
- Low-fibre diet
- Haemorrhoids are more likely with aging because the tissues that support the veins in the rectum and anus can weaken and stretch.

Types

Internal haemorrhoids: These lie inside the rectum. They can't be seen or felt, and they rarely cause discomfort. But straining or irritation when passing stool can damage a haemorrhoid's surface and cause it to bleed. Occasionally, straining can push an internal haemorrhoid through the anal opening. This is known as a protruding or prolapsed haemorrhoid and can cause pain and irritation.

External haemorrhoids: These are under the skin around the anus. When irritated, external haemorrhoids can itch or bleed. And May course discomfort sitting down.

Thrombosed haemorrhoids: Sometimes blood may pool in an external haemorrhoid and form a clot (thrombus) that can result in severe pain, swelling, inflammation, and a hard lump near the anus.

GRADES

Grade I: haemorrhoids project into the anal canal and often bleed but do not prolapse

GRADE 2: Grade II haemorrhoids may protrude beyond the anal verge with straining or defecating but reduce spontaneously when straining ceases (ie, return to their resting point by themselves)

GRADE 3: Grade III haemorrhoids protrude spontaneously or with straining and require manual reduction (ie, require manual effort for replacement into the anal canal)

GRADE 4: Grade IV haemorrhoids chronically prolapse and cannot be reduced; these lesions usually contain both internal and external components and may present with acute thrombosis or strangulation

Diagnostic Considerations

Most gastrointestinal and surgical societies advocate anoscopy and/or flexible sigmoidoscopy to evaluate any bright-red rectal bleeding.

Hematologic Tests: A complete blood cell (CBC) count may be useful as a marker for infection. Anaemia due to haemorrhoidal bleeding, Hematocrit testing is suggested if excessive bleeding with concomitant anaemia is suspected.

Coagulation studies are indicated if the history and physical examination suggest coagulopathy.

Other Diagnostic Imaging Studies

Proctoscopy may be performed to supplement anoscopy, and proctography may be indicated in rectal prolapse.

Colonoscopy, virtual colonoscopy, and barium enema are reserved for cases of bleeding without an identified anal source. These symptoms are not attributable to haemorrhoids and are considered to be non-outlet-type bleeding. Barium enema study or virtual colonoscopy is also suggested if proximal colonic and intestinal diseases must be excluded, and if endoscopy is not helpful.

Full evaluation of the large bowel with colonoscopy is recommended for patients with significant abdominal symptoms, weight loss, change in bowel habits, age older than 50 years, or other risk factors for colonic malignancy.

Histologic Features: Routine histologic examination of haemorrhoidal tissue is usually rewarding, especially if it is grossly examined by an experienced anorectal surgeon. Any suspicious tissue must be sent for microscopic evaluation.

Differential Diagnoses

- Acute Proctitis
- Condyloma Acuminatum
- Rectal Prolapse

Management of Haemorrhoid

Conservative management

Conservative management consists of foods rich in dietary fibre, intake of oral fluids to maintain hydration, topical analgesics, nonsteroidal anti-inflammatory topical drugs, sitz baths, and rest. Increased fibre intake has been shown to improve outcomes and may be achieved by dietary alterations or the consumption of fibre supplements. Evidence for benefits from sitz baths on haemorrhoids includes pain relief, keep anal region clean, and relief purities.

Non-operative options: Rubber band ligation, sclerotherapy, infrared photocoagulation, cryotherapy, manual anal dilatation, LASER haemorrhoidectomy, the harmonic ultrasonic scalpel haemorrhoidectomy, Doppler-guided haemorrhoidal artery ligation, and the new atomizing technique that uses the atomizer wand to excise and vaporize haemorrhoids.

Operative options: The clamp and cautery haemorrhoidectomy, open haemorrhoidectomy, closed haemorrhoidectomy, submucosal haemorrhoidectomy, whitehead circumferential haemorrhoidectomy, stapled haemorrhoidectomy, radiofrequency ablation and suture fixation haemorrhoidectomy, pile suture method, and the bipolar diathermy haemorrhoidectomy. Operative

haemorrhoidectomies are reserved mainly for third- and fourth-degree haemorrhoids.

Complications

Complications of haemorrhoids are very rare but include:

Anaemia: Rarely, chronic blood loss from haemorrhoids may cause anaemia.

Strangulated haemorrhoid: If the blood supply to an internal haemorrhoid is cut off, the haemorrhoid may be "strangulated," another cause of extreme pain.

Prognosis

According to Marx *et al* (2016), most haemorrhoids resolve spontaneously or with conservative medical therapy alone. However, complications can include thrombosis, secondary infection, ulceration, abscess, and incontinence. The recurrence rate with nonsurgical techniques is 10-50% over a 5-year period, whereas that of surgical haemorrhoidectomy is less than 5%. Regarding complications from surgery, well-trained surgeons should experience complications in fewer than 5% of cases. Complications include stenosis, bleeding, infection, recurrence, nonhealing wounds, and fistula formation. Urinary retention is directly related to the anaesthetic technique used and to the perioperative fluids administered. Limiting fluids and the routine use of local anaesthesia can reduce urinary retention to less than 5%.

Preventive measures

The best way to prevent haemorrhoids is to keep the stools soft, so they pass easily.

High-fibre foods: eating fruits, vegetables, and whole grains softens the stool and increases its bulk, which will prevent straining that can cause haemorrhoids. Fibre should be added slowly to the diet to avoid problems with gas. Copious fluid intake. Six to eight glasses of water and other liquids (not alcohol) should be taken daily to help keep stools soft.

Fibre supplement, studies have shown that over-the-counter fibre supplements, such as Metamucil and Citrucel, improve overall symptoms and bleeding from haemorrhoids. These products help keep stools soft and regular. If fibre supplements are used, be sure to drink at least eight glasses of water or other fluids every day. Otherwise, the supplements can cause constipation or make constipation worse.

Avoid straining during defecation: Straining and holding breath when trying to pass a stool creates greater pressure in the veins in the lower rectum.

Do not delay when there is an urge to defecate. When the urge to defecate is delayed, water is reabsorbed in the colon, and the stool could become dry and be harder to pass.

Exercise: Stay active to help prevent constipation and to reduce pressure on veins, which can occur with long periods of standing or sitting. Exercise can also help lose excess weight that may be contributing to haemorrhoids.

Avoid long periods of sitting. Sitting too long, particularly on the toilet, can increase the pressure on the veins in the anus.

CASE REPORT

Name: D.V.

DOB: 1986

AGE: 39YRS

GENDER: MALE

OCCUPATION: CIVIL SERVANT

MARRITAL STATUS: MARRIED

ETHNICITY: IZON

Past medical history

2005- He was treated for malaria.

2008- He was treated for malaria and typhoid

2010- He had a surgery, appendicectomy

2013-He reported with throbbing right ear pain for 8months with watery discharges. In the Federal Medical Centre, he was diagnosed with chronic serous otitis media and was managed in the outpatient department, and the condition resolved.

2014- He was involved in a road traffic accident, which resulted in facial laceration and traumatic amputation of two upper teeth (incisors). He lost consciousness after the accident and was moved to the Federal Medical Centre. In the hospital, he was diagnosed with a soft tissue laceration at the angle of the nose with avulsion injury 2 ° RTA. He was managed and discharged home after 5 days.

Present medical history

He presented on 20th May, 2025, with a complaint of anal pain and anal prolapse, which has lasted for 4 years. In the hospital, he was diagnosed with 3^ohaemorrhoids (uninflamed).

On 30/05/2025, he was admitted and booked for Haemorrhoidectomy and placed on preoperative medication, which included Dulcolax tab. 1/1 noctre stat, then Dulcolax suppository 1/1 bd 2/7.; Liquid paraffin 10ml b.d x 3/7; Infusion 5%dextrose 1 litre 6 hours to alternate with Normal saline 9% 1 litre x 6 hours.

Medical Management

Mr. D.V was placed on the following Dulcolax tab. 1/1 noctre stat, then Dulcolax suppository 1/1 bd 2/7.; Liquid paraffin 10ml b.d x 3/7; I.V Pentazocine 30mg 6hrly x3/7, Diclofenac suppository 1 bd x3/7, I.V cefuraxime 500mg 8hrly x5/7, Infusion 5%dextrose 1 litre 6hours to alternate with Normal saline 9% 1 litre x 6hours for possible surgery on 01/06/2025. All other pre-surgical investigations were carried out.

Surgical Management

Mr. D.V had surgery (circumferential Haemorrhoidectomy) on the 4th June 2025

Postoperative medication: I.V PCM 6 hourly x 72hours, I.V Pentazocin 30mg 6 hourly x 72 hours.. I.V Metronidazole 500ml 8hrly x 72hrs, I.V Ceftriazone 500mg 8hrly x 2/7.

**Nursing Management
30/05/2025****Assessment**

Mr. D.V. appears restless and apprehensive with facial masked pain.

Pain Intensity Rating Scale

§ 0: No pain

§ 1: Mild pain

§ 2: Moderate pain

§ 3: Severe pain

§ 4: Very severe pain

§ 5: Worst possible pain

Patient verbalized pain that was rated 3 on the rating scale as above.

He was placed on Nil per oral for possible surgery on the 01/06/2025.

Vital signs: BP: 120/80mmHg, Pulse – 90b/m, Respiration- 18c/m, Temperature 37.2 SpO2-96, blood sugar level 6.5mmol/L. weight 60kg

Heart sound: S1, S2 heard.

Chest: clinically clear (normal bi-lateral air entry)

Abdomen: hyperactive bowel sound (more than 30sounds) in a minute

Abdominal: soft and pliable

Anal examination was performed through visual inspection of the rectum and digital rectal examination. The patient was placed on left lateral decubitus position with the patient's knees flexed toward the chest. A topical anaesthesia 5% lidocaine ointment, was applied to help reduce any discomfort caused by examination. The entire peri-anal area was examined. Because patient apprehension is great before any anal examination, patient was reassured. Gentle spreading of the buttocks allowed easy visualization of most of the anoderm; this includes the distal anal canal. Location and size of skin tags were noted. Normal corrugation of the.

The following are the findings:

Redundant tissue - Present

Skin tags from old thrombosed external haemorrhoids- Nil

Fissures - Nil

Fistulas – Nil

Signs of infection or abscess formation -Nil

Digital examination of the anal canal revealed the following:

ulcerated areas – Nil

Masses- Nil

Tenderness +++

Mucoid discharge – Nil

Blood +

Good rectal tone.

Current evidenced-based practice guidelines from most gastrointestinal and surgical societies advocate anoscopy and/or flexible sigmoidoscopy to evaluate any bright-red rectal bleeding. Colonoscopy should be considered in the evaluation of any rectal bleeding that is not typical of haemorrhoids, such as in the presence of strong risk factors for colonic malignancy or in the setting of rectal bleeding with a negative anorectal examination.

Patient rescheduled surgery due to personal issues on 01/06/2025.

Patient was continuously monitored, and adequate nursing care was rendered. He was rescheduled for surgery on 03/06/2025.

Surgery was cancelled again and rescheduled for 07/06/2025 due to organizational factor.

Within this period, the patient refused to eat and reduced his oral fluid intake for fear of pain during defecation and complained of sleeplessness due to discomfort in the anal region.

Pre-operative nursing care**Nursing diagnosis 1**

Acute pain related to irritation, pressure, and rectal sensitivity as evidenced by the patient verbalizing pain.

Intervention

Nurse-patient relationship established to enhance trust and cooperation

- Patient was reassured and made to understand that he will be assisted to relieve discomfort.
- Pain assessment was used to identify the level of the patient's pain. The location, quality, frequency, and duration of pain were ascertained.
- Diversional therapy was done
- A warm saline sitz bath was administered
- Patient was encouraged to maintain the position of comfort.
- Prescribed analgesic administered.

Evaluation

Mr. D.V verbalized less pain within 30minutes of nursing intervention.

Nursing diagnosis 2:

Impaired mood regulation related to the postponement of surgery evidenced by patient being irritable

Intervention

- Patient was reassured
- Reasons for delayed surgery were explained to patient and the patient's significant others.
- Collaboration with the surgical team to ascertain when the surgery will be carried out.
- Patient vital signs were monitored
- Prescribed medications were administered
- Patient made comfortable in a calm environment

Evaluation

Patient became calm and slept within 1 hour of nursing intervention

Nursing diagnosis 3

Deficient fluid volume related to patient inability to take enough fluid as verbalized by the patient evidenced by loss of skin turgor

Intervention

- Patient was encouraged to take oral fluid
- Relatives were asked to provide beverages
- Patient was educated on the importance of adequate fluid intake
- Intravenous fluid was administered as prescribed.
- Fluid Input and out- put monitored and documented
- Other vital signs were also monitored regularly
- Patient was reassured

Evaluation

The patient was rehydrated, and skin elasticity was maintained.

Nursing diagnosis 4

Risk for Imbalanced nutrition less than the body requirement related to the patient's refusal to eat.

Intervention

- Patient was educated on the role of diet in healing
- Patient was encouraged to take fluid diet, fruits, and vegetables.
- Patient and patient's significant others were educated on the types of diets to be provided based on the patient's preference
- Patient was monitored to ensure he follows the diet regimen

Evaluation

Patient was observed to comply with the diet regimen within 2 days of nursing intervention, as evidenced by the patient eating food served.

Nursing diagnosis 5

Disturbed sleep pattern related to pain, evidenced by the patient's verbalization (I don't sleep well at night)

Intervention

- Patient's level of sleeplessness was assessed
- Patient was encouraged to verbalise fears, anxiety, and concerns.
- Environmental stressors and visitors were restricted, and patient's significant others were informed of why he should not be disturbed.
- Calm and quiet environment was maintained
- Prescribed analgesics administered.
- Patient was reassured

Evaluation

Patient was able to sleep within 2 hours of nursing intervention

Postoperative nursing care

The patient underwent surgery on the 07/06/2025.

After assessment, the following nursing diagnoses were derived.

Nursing diagnosis 1

Acute pain related to surgical incision

Intervention

- Pain was evaluated, noting the characteristics and intensity using the Paon rating scale
- Vital signs were assessed T 37.2, R 18, P 68, BP130/80
- Patient was assessed for other possible causes of discomfort
- He was assisted on lateral position with legs abducted
- He was encouraged and assisted with sitz bath.
- Prescribed analgesic was administered as prescribed and documented.
- Patient was reassured

Evaluation

Patient verbalized relief of pain, appeared relaxed, and was able to sleep within 30 minutes of nursing intervention

Diagnosis 2

- Impaired skin integrity related to haemorrhoidectomy, evidenced by disruption of skin tissue on the incision site.
- Incision site was regularly inspected, noting characteristics and integrity.
- The amount and characteristics of drainage were noted
- Patient was educated on the importance of not touching the incision site
- He was encouraged and assisted with a sitz bath
- Patient and significant others were educated on the diet that promotes wound healing

Evaluation

Skin integrity restored within 2 weeks of nursing management

Other nursing diagnosis

- Impaired setting related to surgery
- Risk for infection related to exposure tissue during surgery
- Risk for fluid volume and electrolyte deficit related to losses during surgery

Discharge

Patient was discharged on 12/06/2025. Proper health education was given. Patient left the hospital same day in the company of his relatives with his take home medications.

Home visit

There was no home visit as patient was referred to the nearest primary health centre for further management

CONCLUSION

Haemorrhoids, also called "piles," are swollen tissues that contain veins. They are located in the wall of the rectum and anus and may cause minor bleeding or develop small blood clots. Haemorrhoids occur when the tissues enlarge, weaken, or loosen out of their supporting structure. This results in a sac-like bulge that extends into the anal area. It is difficult to determine ascertain the statistics of persons living with haemorrhoids, as majority of persons with haemorrhoid do not consult healthcare providers. About 5% of the population is affected at any given time. Both sexes experience about the same incidence of the condition, with rates peaking between 45 and 65 years. Haemorrhoids can be prevented through lifestyle modifications.

Recommendation

There should be health enlightenment programs on lifestyle changes to prevent the incidence of haemorrhoids. Healthy habits can prevent haemorrhoids or keep haemorrhoids from getting worse. People should be encouraged to consult healthcare providers when signs and symptoms of haemorrhoids are noticed.

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