

## Thrombosed Internal Hemorrhoid: Case Report

Bangda Ekanga Yannick<sup>1\*</sup>, Ayee Afetane Stephane<sup>2</sup>, Boubker Idrissi Kaitouni<sup>2</sup>, Mohamed Najih<sup>2</sup>, Hicham Laraqui<sup>2</sup>, Mohamed Tariq Tajdine<sup>2</sup>

<sup>1</sup>Department of Gastroenterology I, Mohammed V Military Teaching Hospital, Faculty of Medicine and Pharmacy, Mohammed V University, 10100, Rabat, Morocco

<sup>2</sup>Proctology Department, Mohammed V Military Teaching Hospital, Faculty of Medicine and Pharmacy, Mohammed V University, 10100, Rabat, Morocco

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\*Corresponding author: Bangda Ekanga Yannick

Department of Gastroenterology I, Mohammed V Military Teaching Hospital, Faculty of Medicine and Pharmacy, Mohammed V University, 10100, Rabat, Morocco

### Abstract

### Case Report

Hemorrhoids are vascular structures essential for maintaining anal continence. Their dysfunction can lead to symptomatic hemorrhoidal disease, a common condition in adults. Hemorrhoidal thrombosis is an acute complication that requires specific management, which differs depending on whether the thrombosis is external or internal. We report the case of a 43-year-old man, a former smoker, presenting with a thrombosed grade IV internal hemorrhoidal prolapse, diagnosed clinically based on acute anal pain and inflammatory edema. Initial conservative management, including analgesics, corticosteroids, venotonics, and laxatives, led to a gradual improvement in symptoms. This was followed by a Milligan-Morgan hemorrhoidectomy performed after resolution of the inflammatory phase, resulting in complete healing within three months. This case highlights the relevance of a stepwise therapeutic strategy in the management of internal hemorrhoidal thrombosis, starting with medical treatment to control symptoms and optimally prepare for delayed surgery if necessary, in accordance with current guidelines.

**Keywords:** internal hemorrhoidal thrombosis, Milligan-Morgan hemorrhoidectomy, Grade IV hemorrhoidal prolapse.

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## INTRODUCTION

Hemorrhoids are normal vascular plexuses located within the anal canal, playing a crucial role in fecal continence by contributing to anal canal volume. Hemorrhoids are classified into four grades, ranging from simple bulges within the canal to irreducible prolapses. However, dysfunction or prolapse of these hemorrhoidal cushions can lead to symptomatic hemorrhoidal disease, which affects a significant portion of the adult population. The prevalence of hemorrhoids is estimated at around 11% in adults, though this may underestimate the true figure due to underreporting and asymptomatic cases.

Among the various clinical presentations, hemorrhoidal thrombosis represents an acute complication and a proctological emergency. It involves the formation of a blood clot within a hemorrhoidal bundle, leading to severe anal pain, localized edema, and sometimes bleeding. Although the clinical presentation and initial medical management (analgesics, anti-inflammatories, topical treatments) may appear similar

between internal and external hemorrhoidal thrombosis, their emergency management differs significantly due to anatomical considerations and accessibility. For external hemorrhoidal thrombosis, a simple clot excision under local anesthesia is often sufficient for rapid and effective pain relief. In contrast, internal hemorrhoidal thrombosis is rarer and more complex to access. Initial treatment is conservative, and surgical intervention remains exceptional, requiring specialized equipment such as an anoscope.

This distinction underscores the importance of accurately identifying the type of thrombosis, as the timing and nature of the intervention vary considerably: excision is the treatment of choice for external thrombosis, while medical management is the cornerstone for internal cases, with surgery reserved for refractory situations.

### Relevance of the Topic

Publishing on thrombosed internal hemorrhoids is essential due to the crucial differences in management compared to external thrombosis. Internal thrombosis

requires a distinct approach due to complex anatomy and limited access, making initial medical treatment critical and surgical intervention exceptional. Understanding these nuances is vital for providing appropriate care and preventing potential complications.

## CASE REPORT

We report the case of a 43-year-old man, a former smoker, with a history of untreated hemorrhoidal disease. He had no prior surgical history. He presented to the emergency department with sudden onset of severe anal pain.

The patient complained of sudden, intense, constant, non-pulsatile anal pain (VAS 7/10) without significant rectal bleeding. On proctological examination, a tense, edematous, and painful swelling was observed, with a violaceous central area surrounded by inflammatory borders. Hemodynamically, the patient was stable (BP: 126/84 mmHg), tachycardic (HR: 104 bpm), and afebrile (T: 37.1°C).

The diagnosis was mainly clinical, based on the patient's history and a detailed proctological examination. Findings confirmed a grade IV thrombosed internal hemorrhoidal prolapse.

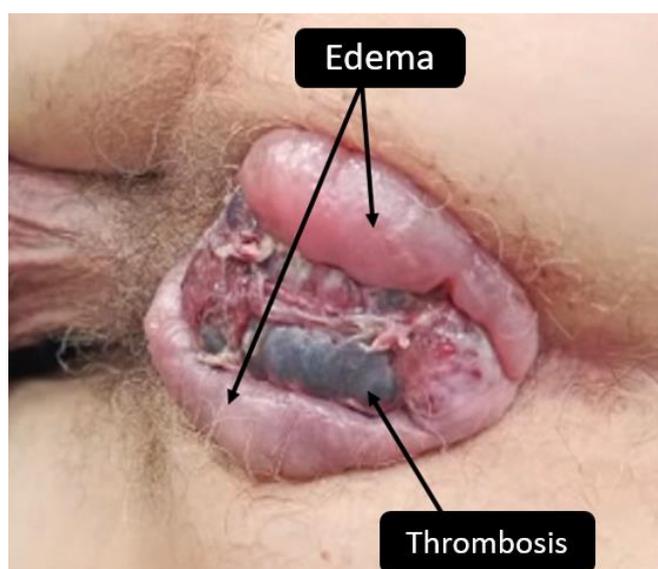


Figure n°1: Thrombosed grade IV internal hemorrhoids

## TREATMENT APPROACH AND OUTCOMES

Given the relative pain control and the absence of immediate complications such as bleeding, necrosis, or local infection, conservative medical management was initiated. The treatment plan included:

- **Analgesics:** Paracetamol 1000 mg IV every 8 hours for 3 days, then switched to oral administration.
- **Venotonic treatment:** Daflon 1000 mg every 8 hours for the first 5 days, then every 12 hours for 10 days.
- **Anti-inflammatory corticosteroids:** Prednisolone 20 mg twice daily for 5 days.
- **Laxative:** Osmosine, 1 tablespoon every 8 hours.

Hospital admission and close monitoring were warranted.

During the first few days of medical management, progressive symptom improvement was observed:

- Anal pain (VAS 7/10 initially) significantly decreased, with complete resolution by day 5.
- Anal edema and inflammatory swelling gradually regressed, with notable improvement by day 6.

No serious complications (heavy bleeding, infection, necrosis) occurred during the observation period. The patient tolerated the treatment well, and no clinical deterioration was noted.

After complete resolution of pain and edema, a Milligan-Morgan hemorrhoidectomy was scheduled two weeks later. This procedure aims to excise the internal hemorrhoidal bundles responsible for the grade IV prolapse, providing definitive symptom resolution. The Milligan-Morgan technique involves pedicular resection of the hemorrhoidal bundles with careful dissection to preserve the intersphincteric mucosa and the anal sphincter, ensuring anal patency. The procedure is performed under general or regional anesthesia and leaves multiple open wounds that heal progressively.

The postoperative course was uneventful. The patient was followed in outpatient consultation, and complete healing was achieved within three months.



**Figure n°2: Post-hemorrhoidectomy healing at 3 months**

## DISCUSSION

This case describes a 43-year-old man, a former smoker with a history of untreated hemorrhoidal disease, who presented with acute anal pain due to thrombosis of a grade IV internal hemorrhoidal prolapse. The acute clinical presentation, including painful, edematous swelling with a violaceous center, is typical of hemorrhoidal thrombosis, a common and painful complication in patients with advanced prolapsed hemorrhoids.

Diagnosis was clinical, based on patient history and precise proctological examination. Differential diagnoses such as other painful anorectal conditions were considered but ruled out due to the absence of significant hemorrhagic or infectious signs, allowing for initial conservative management. Literature supports medical management as first-line therapy, using analgesics, anti-inflammatory drugs, and local care, while awaiting potential delayed surgery.

In this case, the gradual resolution of pain and edema under medical treatment and close clinical monitoring validated this strategy. These findings are consistent with published data showing that well-conducted medical treatment can significantly reduce symptoms and often avoid emergency surgery, which is usually reserved for complicated cases or failure of conservative management.

The subsequent Milligan-Morgan hemorrhoidectomy, performed two weeks after inflammation subsided, aligns with the recommended approach for grade IV hemorrhoidal prolapse. This technique, involving pedicular excision while preserving the intersphincteric mucosa and anal sphincter, remains a standard for definitive management of advanced internal hemorrhoids. It provides effective treatment of prolapse and disabling symptoms while preserving sphincter function.

Compared to newer techniques such as stapled hemorrhoidopexy or laser hemorrhoidoplasty, the Milligan-Morgan method is recognized for its robustness and long-term outcomes, though it may be associated with higher postoperative morbidity, notably pain and bleeding. However, recent advances in surgical techniques aim to better control postoperative pain and reduce complications, such as stapled techniques, laser procedures, or improved suturing methods, which could become interesting alternatives in selected clinical scenarios.

The uneventful postoperative course and complete healing within three months confirm the good tolerance and efficacy of this management approach, in line with outcomes reported in the literature. Gradual recovery with progressive wound healing is typical following multiple open excisions.

### Case Limitations

The main limitation was the absence of systematic complementary imaging. While clinical examination is usually sufficient, it may be inadequate in cases of diagnostic uncertainty or early complications.

## CONCLUSION

Management of hemorrhoidal thrombosis must consider its location: for external thrombosis, simple excision under local anesthesia is widely recommended when significant pain is present. In contrast, internal thrombosis requires primarily conservative medical treatment, with surgery reserved for refractory or complicated cases.

This case illustrates the effectiveness of a stepwise strategy, starting with symptomatic treatment followed by delayed surgery. This approach provides durable symptom relief while preserving sphincter function. Such individualized management, supported by the literature, optimizes patient quality of life and lays the groundwork for future technical innovations.

## Highlights

- **The importance of accurate differential diagnosis:** Distinguishing between internal and external hemorrhoidal thrombosis is essential, as it determines the therapeutic strategy. A rigorous clinical examination enables prompt initiation of the appropriate treatment.
- **Medical management is prioritized for internal hemorrhoidal thrombosis:** Internal hemorrhoidal thrombosis is first managed medically (analgesics, anti-inflammatories, venotonics, laxatives), with close monitoring. Emergency surgery is not indicated except in case of complications.
- **Delayed surgery for advanced cases:** In the case of grade IV hemorrhoidal prolapse, a scheduled hemorrhoidectomy (here, using the Milligan-Morgan technique) after resolution of inflammatory symptoms is recommended for definitive treatment while preserving sphincter function.
- **Gradual and individualized approach:** Optimal management relies on a progressive and personalized strategy—medical treatment first, followed by surgery if necessary—thereby providing lasting symptom relief, minimizing risks, and preserving the patient's quality of life.

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## Consent

Written informed consent was obtained from the patient for publication of this case report including the images used.

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