

The Clinical Blueprint: Hemorrhoids & Anal Fissures

An evidence-based diagnostic and stepped-care algorithm for primary care.

Based on Med2Date Clinical Guidelines (Updated May 2026)

A Massive Primary Care Burden

500,000+

GP consultations annually in Australia
for anorectal conditions

25–40%

Prevalence in adults over 50 years of age



Despite their benign nature, these conditions severely impair quality of life and trigger acute patient anxiety over rectal bleeding. The true prevalence is obscured by high rates of unmonitored self-management.

Triage Protocol: Exclude Proximal Pathology First

Presentation: New Rectal Bleeding

Is the patient ≥ 50 years?

YES

Urgent Colonoscopy

NO

Red Flags: Iron-deficiency anaemia (ferritin $<30 \mu\text{g/L}$)? Change in bowel habit (>6 weeks)?
Unintentional weight loss ($>5\%$ in 6 mo)? Family history of CRC in 1st-degree relative <55 years?
Dark/mixed bleeding (melaena)? Palpable mass?

Any YES

Urgent Colonoscopy / Specialist Referral

(Colorectal cancer screening mandate per RACGP Red Book)

All NO

Proceed to Primary Care
Anorectal Assessment.

! Clinical Pearl: Up to 10% of 'haemorrhoidal' bleeding presentations reveal significant endoscopic pathology.

Structured Investigation Pathways

[Essential]

FBC & Iron Studies

Assess for anemia (Hb, MCV, ferritin). Low ferritin ($<30 \mu\text{g/L}$) mandates colonoscopy. (MBS: 65070, 65145).

[Primary Care]

Proctoscopy / Anoscopy

Visualizes internal hemorrhoids and mucosal pathology. Perform where trained. (MBS: 30230).

[Endoscopy]

Flexible Sigmoidoscopy

First-line for patients <50 with red flags or diagnostic uncertainty. (MBS: 32222).

[Referral]

Colonoscopy

Mandatory for age ≥ 50 with new bleeding, anemia, habit change, or family history. (MBS: 32224).



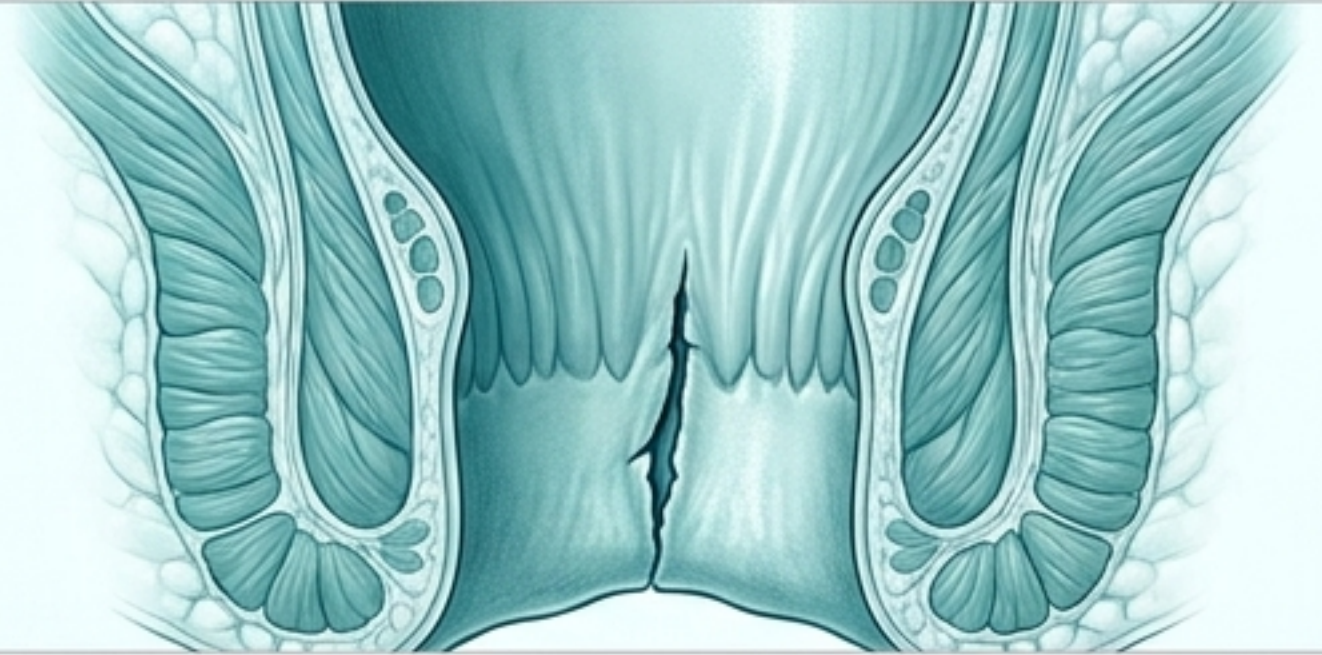
iFOBT is for **screening** (NBCSP from age 45) and **MUST NOT** replace **endoscopy** when symptomatic bleeding is present.

Divergent Pathophysiology: Vascular vs. Mucosal



Hemorrhoids

- **Anatomy:** Vascular cushions (left lateral, right anterior, right posterior) composed of AV channels, Treitz's muscle, connective tissue.
- **Mechanism:** 'Sliding anal lining' and hyperperfusion. Engorgement and deterioration of connective tissue leads to prolapse.
- **Sensory:** Internal (columnar epithelium) = insensate. External (squamous) = somatic innervation (painful if thrombosed).



Anal Fissure

- **Anatomy:** Linear ulcers in squamous epithelium, 80-90% at the posterior midline due to poor vascular supply.
- **Mechanism:** Mechanical trauma (hard stool) leading to internal sphincter spasm and focal ischemia.

The Diagnostic Matrix: Differentiating Benign Presentations

Symptom Domain	Hemorrhoids	Anal Fissure
Bleeding	Painless, bright red , dripping into pan, coats stool	Small amount, bright red , on paper or stool surface
Pain	Usually absent (unless thrombosed external)	Sharp, tearing during defecation; persists for hours post-defecation
Prolapse	Reducible/irreducible lump at anal verge	Sentinel skin tag at verge; no true prolapse
Itching	Perianal pruritus common	Less common
Discharge	Mucoid discharge (internal)	Rarely significant

Systematic Examination Protocol (Left Lateral Position)

1

Inspection

Part buttocks to examine perianal skin.

Look for bluish swellings (external hemorrhoids), firm/tender blue nodules (thrombosed), sentinel tags (fissures), excoriation, or abscesses.



2

Digital Rectal Exam

Assess resting/squeeze tone, palpate for masses or induration.

Caution: Posterior midline may be exquisitely tender in acute fissures.



3

Proctoscopy

Visualize internal canal. Look for the chronic fissure triad: visible internal sphincter fibers, sentinel tag, hypertrophied anal papilla.

Step 1: The Conservative Foundation (Trial for 4–6 Weeks)

Dietary Fiber

Psyllium Husk (Ispaghula). 3.5g **PO BD** with meals + 250mL water. Target 25–30g daily fiber to reduce intra-abdominal pressure.

Fluid Intake

≥1.5 L (8 glasses) daily. Vital for fiber efficacy; without fluid, bulk-forming agents worsen constipation.

Baseline Management

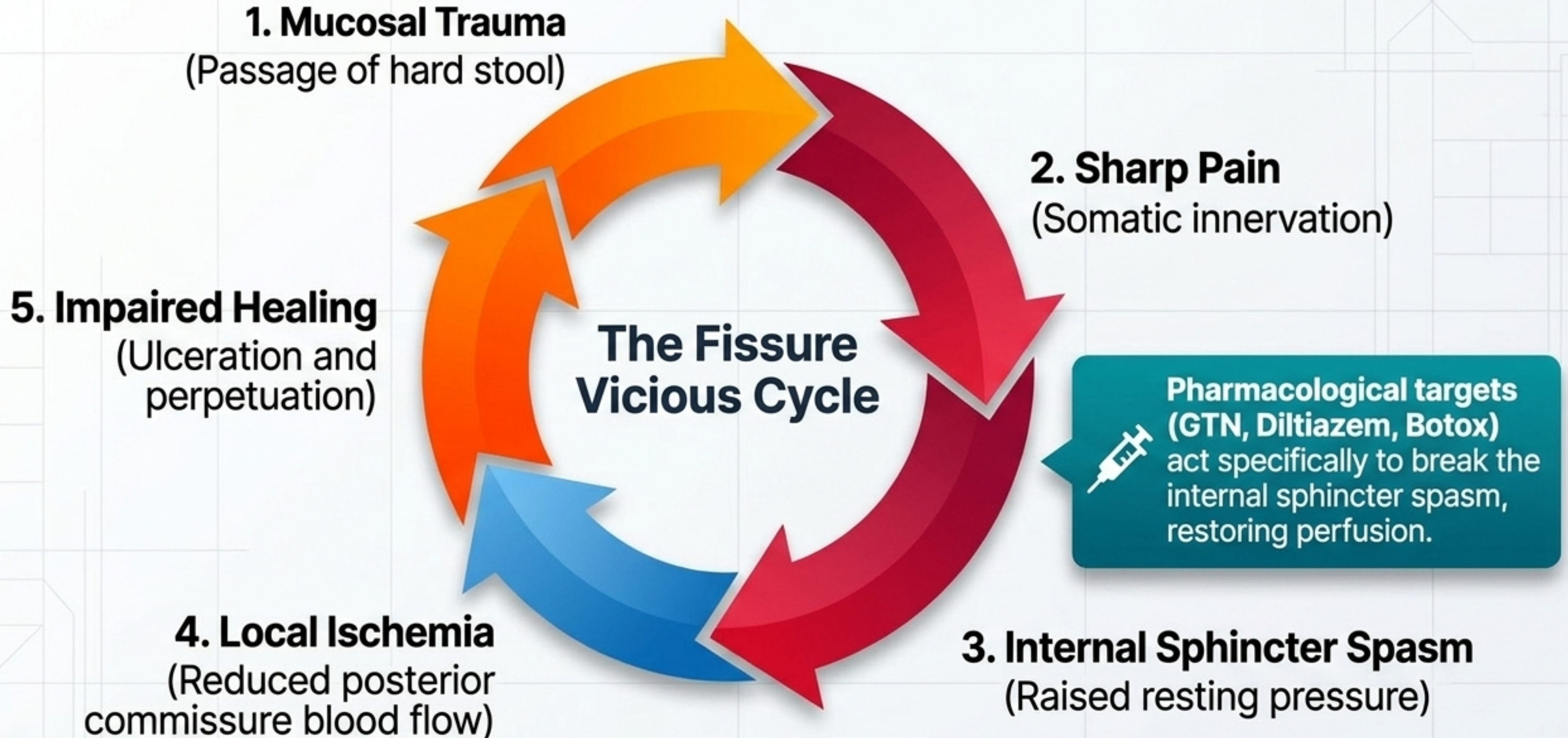
Sitz Baths

Warm plain water (37–40°C), 10–15 mins, 2–3x daily. Provides analgesic and muscle-relaxant effects. No additives needed.

Toilet Habit

Limit sitting to <5 mins (no phones). Avoid straining. Use a footstool to straighten anorectal angle. Avoid forceful wiping.

The Mechanics of Chronic Fissures



Fissure Progression: Acute vs. Chronic

6
Weeks

Acute Fissure (<6 weeks)

Appearance: Clean, **linear mucosal tear**.

Pain: **Brief, during defecation only**.

Prognosis: 50–60% **heal spontaneously**.

Treatment: **Conservative measures**.

Chronic Fissure (≥ 6 weeks)

Appearance: **Deep ulcer**, visible **internal sphincter fibers**, **sentinel tag**, **hypertrophied papilla**.

Pain: Severe, lasting **hours** post-defecation.

Prognosis: **Spontaneous healing rare**.

Treatment: **Targeted sphincter relaxants** (GTN/Diltiazem).

Step 2: Fissure Pharmacotherapy (Sphincter Relaxants)

Glyceryl Trinitrate (GTN) 0.4% Ointment (Rectogesic®)

Dose: 2.5 cm intra-anally BD for minimum 8 weeks.

Counseling: **Headache** in 30-50%. Advise **Paracetamol 1g pre-dose**; start half-dose for 3 days. **Avoid PDE-5 inhibitors.**

PBS Status: General Benefit.

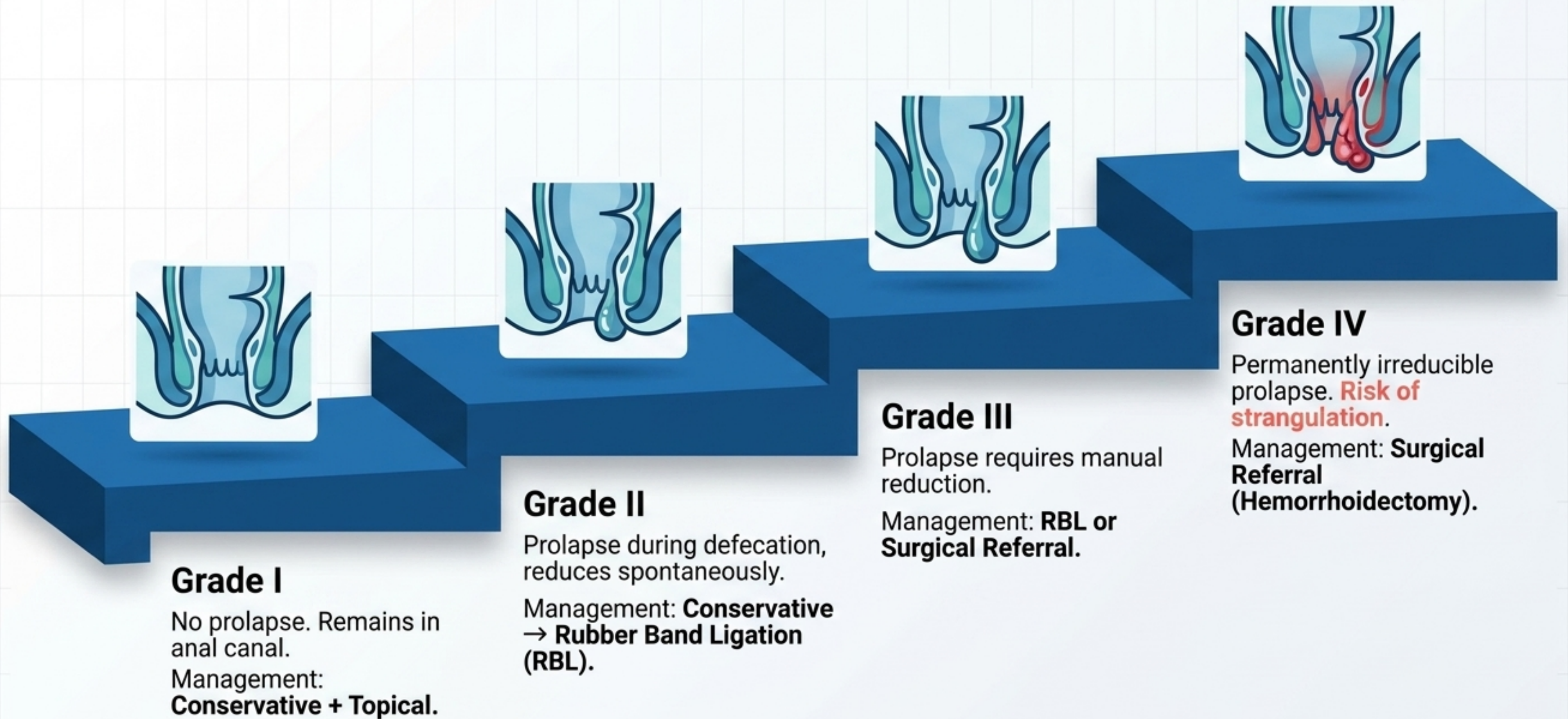
Diltiazem 2% Ointment (Compounded)

Dose: 2.5 cm intra-anally BD for 8-12 weeks.

Counseling: **Lower headache rate** (~10%). Less **systemic absorption**. Requires **compounding pharmacy.**

PBS Status: Authority Required (Private/Compound).

The Goligher Escalator: Staging Internal Hemorrhoids



Step 2: Hemorrhoid Pharmacotherapy (Symptomatic Relief)

Hydrocortisone + Cinchocaine (Proctosedyl®)

MAXIMUM 5-7 DAYS.

Dose: Apply BD and post-defecation.

Duration Warning: Prolonged use causes perianal skin atrophy, striae, and contact dermatitis.

PBS Status: General Benefit.

Zinc Oxide + Bismuth Subgallate (Anusol®)

Role: Barrier + mild astringent.

Dose: Apply BD and post-defecation.

Duration: Up to 7 days, longer if corticosteroid-free formulation.

PBS Status: OTC (Not listed).

Triage Callout: Acute Thrombosed External Hemorrhoids <72 hrs with moderate/severe pain may require urgent ED/Surgical excision.

Step 3: Procedural Escalation for Chronic Fissures

Procedure	Setting / Indication	Success Rate	Key Risks
Botulinum Toxin A (Botox®)	Second-line. 20-50 units injected locally.	60-80% at 8 weeks.	Transient flatus incontinence (5-15%). Not PBS-listed.
Lateral Internal Sphincterotomy (LIS)	Gold standard surgical treatment after 8 weeks failed medical Rx.	90-95% healing.	Permanent incontinence risk (solid stool <2%, flatus 5-10%). Higher risk in women/elderly.
Advancement Flap	Patients with pre-existing sphincter weakness.	80-90%.	Sphincter-sparing, longer operative time.

Step 3: Procedural Escalation for Hemorrhoids

Procedure	Setting / Indication	Success Rate
Rubber Band Ligation (RBL)	Grade II–III. Office-based. Mild discomfort expected.	70-80% success per session.
Injection Sclerotherapy	Grade I–II. Office-based. Phenol-in-almond-oil. Useful if anticoagulated.	Lower recurrence for Grade I.
Excisional Hemorrhoidectomy	Grade III–IV. Hospital setting. Significant post-op pain (2-4 weeks recovery).	>95% cure rate (gold standard).



CLINICAL ALERT (Pelvic Sepsis): Post-RBL fever, urinary retention, and severe perianal pain within 3-7 days is a life-threatening emergency requiring urgent surgical assessment and IV antibiotics.

Specialist Referral Triaging Timelines

Urgent

(Category 1 / <7 Days)

Strangulated Grade IV hemorrhoid, extensive thrombosis, suspected pelvic sepsis, iron-deficiency anemia, new rectal bleeding age ≥ 50 .

Semi-Urgent

(Category 2 / <30 Days)

Persistent symptoms after 8 weeks optimal management, severe impact on QOL, chronic fissure, Grade III hemorrhoids.

Routine

(Category 3 / Await Outpatient)

Symptomatic, stable, managed conservatively for ≥ 6 weeks with no red flags.

Preparation Note: Document conservative compliance, forward FBC/Iron studies, and manage expectations regarding procedural pain/recovery.

Special Populations: Pregnancy & Paediatrics

Pregnancy

Prevalence: 25-35%, mostly 3rd trimester/postpartum.

✅ **Safe:** Psyllium, Lactulose, brief hydrocortisone (≤ 5 days), Paracetamol.

❌ **Avoid:** GTN (hypotension), NSAIDs (ductus arteriosus), Diltiazem. Defer RBL until postpartum.

Paediatrics

Context: Hemorrhoids are extremely rare. Fissures (constipation-driven) are the primary cause of bleeding.

✅ **Treatment:** Osmotic laxatives (Macrogol 3350 first-line), barrier creams.

❌ **Avoid:** GTN and Diltiazem.

⚠️ **Red Flags:** Chronic/bloody diarrhea, weight loss, unexplained trauma.

Systemic Constraints: Age, Renal, and Hepatic Function

Elderly (≥ 65)

Lower colonoscopy threshold for bleeding. **Avoid GTN** (hypotension/falls); **prefer Diltiazem**. **Caution** with **LIS** due to baseline sphincter weakness. **Review polypharmacy** constipators (opioids, anticholinergics).

Renal Impairment

Avoid magnesium laxatives and **ibuprofen** (AKI risk). **Macrogol** requires **electrolyte monitoring** if eGFR < 30 . **Topical relaxants are safe** (no dose adjustment).

Hepatic Impairment

Rule out portal hypertension (rectal varices mimic hemorrhoids—biopsy/injection causes **life-threatening hemorrhage**). **Max paracetamol 2g/24hrs**.



Diagnostic Alert Tromhest Card: The Immunocompromised & Atypical Pathologies



Atypical Fissures: If fissures are off-midline, multiple, deep, or non-healing despite optimal therapy, **STOP treatment and investigate.**



Differentials to Exclude: Crohn's disease, HIV/AIDS, Syphilis, Tuberculosis, CMV, HSV, or Anal Malignancy.



Procedural Caution in Immunocompromised: Increased risk of poor wound healing and sepsis. Avoid sphincterotomy/hemorrhoidectomy where possible. Use lowest effective dose of topical corticosteroids to prevent perianal fungal superinfections.

Aboriginal & Torres Strait Islander Health Context

Epidemiology

Disproportionately **higher burden** of anorectal disease, **late-stage presentation**, and **higher CRC incidence** (lower NBCSP participation at 27%).

Clinical Approach

Ensure **same-sex practitioners** where possible. Engage Aboriginal Health Workers/Liaison Officers. **Opportunistic iFOBT screening** (45-74 yrs).

Culturally Safe Care

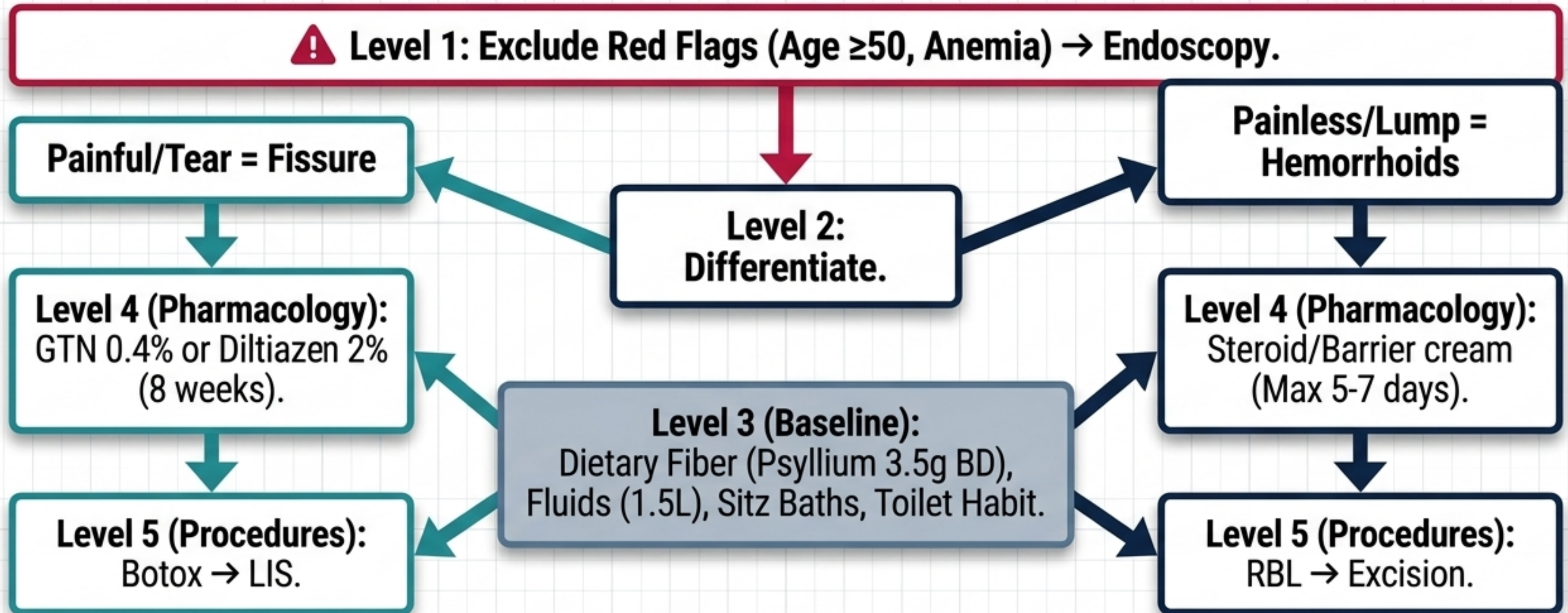
Access & Environment

Food insecurity drives a high-fat/low-fiber diet. **Remote access** relies on **RFDS** and **S100 pharmacy programs**.

Traditional Medicine

Check for interactions with traditional bush medicines.

Symptom to System: The Unified Management Pathway



Print and retain as a clinical quick-reference guide.