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Prolapsing Thrombosed Haemorrhoids: Outcome of Conservative Management

Prolapsed thrombosed haemorrhoids are a common and painful surgical emergency. Though emergency haemorrhoidectomy was discussed as early as 1914¹ the usual treatment in the United Kingdom is non-operative. The natural history of thrombosed haemorrhoids managed conservatively, however, is not known and there are no reports on whether patients continue to have symptoms. We report here the incidence of continuing symptoms after recovery from an acute episode and the incidence of subsequent elective haemorrhoidectomy.

Methods and Results

The records of all patients attending St. Mark's Hospital from 1962 to 1967 with prolapsed thrombosed haemorrhoids were studied. Basic information was extracted and several patients examined.

Altogether 117 patients presented in this period; all were managed conservatively. Four patients had died, 21 could not be traced, and further information was available about 92. At the time of their original presentation 47 (40.2%) patients had had their symptoms for more than three years and 10 (8.5%) for more than 10 years. More patients (69) complained of prolapse than complained of rectal bleeding (62); 47 complained of both. Six patients had had a previous episode of thrombosis. Nineteen patients denied having previous symptoms. Despite these symptoms only 10 (8.5%) patients had had previous treatment; seven had had their haemorrhoids injected while three had had a haemorrhoidectomy performed elsewhere. After treatment at St. Mark's 80 (68.4%) of the 117 patients continued to complain of symptoms. Only 12 (13.0%) of the 92 patients traced had had no further trouble and five of these had had no symptoms before the acute episode. More patients (58) continued to complain of prolapse than complained of rectal bleeding (51); 39 had both. Ten patients had a further episode of thrombosis. Only 27 (23.1%) patients had no further treatment, 45 (38.5%) had their haemorrhoids injected, and 64 (54.7%) were advised to undergo a haemorrhoidectomy because of continuing symptoms. Of the 24 patients with a previous history of less than three years only eight (33%) were advised to undergo a haemorrhoidectomy. In contrast, 35 (74.5%) of the 47 patients with a history of longer than three years were advised to undergo haemorrhoidectomy ($P < 0.05$). Only 13 (35.1%) of the 37 patients who did not complain of prolapse were advised to undergo a haemorrhoidectomy compared with 46 (66.7%) of the 69 patients with prolapse ($P < 0.05$). Thirty-three of the 42 patients whose history was longer than three years and included prolapse but only eight (42.1%) of the 19 patients with prolapse but a history of under three years were advised to undergo haemorrhoidectomy ($P < 0.05$). None of the five patients with symptoms but no prolapse and a history of under three years were advised to undergo haemorrhoidectomy ($P < 0.05$), and only six (31.6%) of the 19 patients who had no previous symptoms were so advised ($P < 0.001$).

Discussion

There has been no review of the long-term results of conservative management of acutely prolapsing thrombosed haemorrhoids. Our results have shown that thrombosis is merely an episode in the natural history of the disease and does not influence subsequent symptoms.

Two factors in the patient's history are particularly important when assessing the probability of symptoms after the acute episode:

a history of more than three years and one which includes a story of prolapse. Several small series have suggested that the incidence of complications after emergency haemorrhoidectomy is no higher than that after routine haemorrhoidectomy;²⁻⁴ in particular the incidence of ascending portal infection has been exaggerated.⁵

The incidence of complications after emergency haemorrhoidectomy needs to be properly assessed in a prospective study. As our results have shown that there is a high incidence of continuing symptoms in patients treated conservatively a previous history of prolapse and a history of longer than three years or both are strong indications for emergency haemorrhoidectomy.

We thank the surgeons of St. Mark's Hospital for allowing us to study patients under their care, and Mr. Broughton and Fison's Pharmaceutical Company for financial assistance. We are particularly grateful to Mrs. Green for her help in tracing the patients.

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Infantile Kala-azar in Britain

With increased travel and immigration protozoal infections are being diagnosed more often outside endemic areas.¹ We have seen two British children who developed kala-azar after holidays in Mediterranean countries.

Case Reports

Case 1.—A 15-month-old girl was admitted to hospital with a seven-week history of increasing lethargy, anorexia, and intermittent fever with associated rigors at night. The family had been on holiday in Corfu six months earlier. She was found to have hepatosplenomegaly and slight lymphadenopathy. Since it was feared she might have an underlying malignancy she was transferred to the Hospital for Sick Children. Investigations showed haemoglobin 8.0 g/dl, white blood count (W.B.C.) $2.5 \times 10^9/l$ (neutrophils $0.3 \times 10^9/l$), and platelets $50 \times 10^9/l$. Tests for salmonella, brucella, and tuberculosis and blood cultures were negative, and serum electrophoresis showed diffusely raised γ -globulin. A hypercellular marrow aspirate showed increased granulopoiesis, and after much searching we found a few reticulum cells containing Leishman-Donovan bodies. Leptomonads were isolated from cultured aspirated marrow, and the Leishmania fluorescent antibody test gave a positive result. After transfusion she was treated with intravenous sodium stibogluconate (Pentostam) 10 mg/kg body weight⁻¹ day⁻¹ for three weeks. She responded dramatically, becoming afebrile within 24 hours (see fig.). The hepatosplenomegaly receded over the first 10 days of treatment.

Case 2.—This girl was well until the age of 8 months, when she developed a fever and on admission to hospital was found to have hepatosplenomegaly and lymphadenopathy. Investigations showed haemoglobin 7.9 g/dl, W.B.C. $8 \times 10^9/l$ (neutrophils $2.66 \times 10^9/l$, and platelets $53 \times 10^9/l$). Marrow aspiration yielded a normocellular sample showing erythroid hyperplasia and plentiful megakaryocytes. Investigations for bacterial and viral infections were negative; serum γ -globulin was raised; Rose-Waaler and latex tests for rheumatoid factor were positive. Her haemoglobin fell to 6.4 g/dl and she was transfused. She was discharged with a tentative diagnosis of Still's disease. She appeared well for almost six weeks but then intermittent fever recurred, and she was admitted to the Hospital for Sick Children, aged 11 months, for further investigation. She had hepatosplenomegaly, lymphadenopathy,

FIG.—Case 1. Four-hourly temperature chart.

pathy, and a striking pancytopenia (haemoglobin 5.6 g/dl, W.B.C. $2.3 \times 10^9/l$ (neutrophils $0.5 \times 10^9/l$), platelets $29 \times 10^9/l$). The Rose-Waaler test was positive, and the serum γ -globulin raised. Bone marrow examination showed numerous Leishman-Donovan bodies. Close questioning of the parents revealed that the baby had been taken to Alicante, Spain, at the age of 6 weeks. Positive serological tests for Leishmania antibody and the culture of leptomonads from the aspirated marrow confirmed the diagnosis of kala-azar. She was treated with sodium stibogluconate 10 mg/kg of body weight⁻¹ day⁻¹ for 10 days. Her fever subsided slowly and her blood count gradually returned to normal. Her spleen and liver shrank rapidly but about five weeks after finishing treatment she relapsed with fever and recurrent splenomegaly. Another 10-day course was given, and after that she remained well.

Discussion

If fever, splenomegaly, and pancytopenia are present in a child who has been in an area where leishmaniasis is endemic visceral leishmaniasis should be considered. The diagnosis may be confirmed by finding Leishman-Donovan bodies in the bone marrow^{2,3} and by serological tests and culture of leptomonads from the aspirated marrow. The incubation period is variable and related to the number of protozoa inoculated by the sandfly.

It is not widely appreciated that leishmaniasis is endemic in most areas bordering the Mediterranean, where it mainly affects young children.² As increasing numbers of British people are taking holidays in Mediterranean countries we draw attention to these cases of infantile kala-azar so that a potentially curable disease may be recognized and treated appropriately.

We thank Professor O. H. Wolff and Dr. J. M. Chessells for permission to report these cases, Professor R. M. Hardisty for helpful advice, and the staff of the Hospital for Tropical Diseases, London, for help with the investigations and advice on treatment.

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Necrotizing Fasciitis with Polymyositis

Necrotizing fasciitis is a little-known but serious and often fatal disease. Unusually, the mortality rate seems to be rising, probably because of failure in diagnosis and over-reliance on medical treatment. The condition therefore deserves emphasis. We present here a case of necrotizing fasciitis with polymyositis, a previously unreported association.

Case Report

A 46-year-old woman presented with swelling of the eyelids which had lasted for 24 hours. The swelling had spread down her face and neck and was

accompanied by severe pain. Two weeks earlier she had had an influenza-like illness, but had been otherwise well apart from a benign gastric ulcer treated by a Bilroth I gastrectomy in 1969.

When first seen she was severely prostrated, with a temperature of 39.4°C and a pulse rate of 104/minute. There was gross swelling of the face and neck, most pronounced around both eyes; otherwise, examination was unremarkable. Investigations, including sterile cultures from both eyes, showed nothing abnormal. Treatment was started with parenteral cephaloridine (500 mg) and hydrocortisone (100 mg) every six hours.

Over the next few days a dusky erythema appeared over the lids followed by ulceration in the tarsal folds of both eyes. The bases of the ulcers liquified and necrotic material was discharged. The facial oedema slowly settled leaving periorbital oedema and the discharging lid lesions. We then noticed that the necrotic material in the discharge seemed to be coming down from the temporal areas to the communicating ulcers on the lids (see fig.) and, as the discharge slowed, these areas were left depressed.

Left eye three weeks after the onset of illness showing depressed frontotemporal area draining through lid ulcers.

As her clinical condition improved mild proximal muscle weakness was noticed and electromyography showed a fibrillary pattern characteristic of polymyositis. This responded to an increased dose of steroids but relapsed more severely later when the dosage was being reduced.

Cultures of the discharge from the left eye persistently grew group A beta-haemolytic streptococcus and *Staphylococcus pyogenes*, but the right eye remained sterile. Other extensive investigations, including a search for the cause of her polymyositis, showed nothing abnormal.

Comment

Necrotizing fasciitis presents a characteristic and easily recognizable clinical picture.¹ Gross swelling of the affected part, usually a limb or the trunk, is accompanied by severe prostration and fever. After one or two days a dark patch appears in the overlying skin which soon breaks down and large amounts of necrotic material are discharged. Surgical exploration of the ulcer will show that it extends along the fascial planes a long way from the immediately obvious site. It is thought to be due to a bacterial infection which, for some reason, spreads rapidly through the tissues, causing vessel thrombosis and, therefore, necrosis.

The important treatment is early surgical intervention, debriding the wound and laying open the extent of the necrotic process; rarely, patients may recover without surgery when the process is limited, as in our patient. Meleney,¹ working in China in the pre-antibiotic era, had a mortality rate of 20% (4 out of 20 cases), whereas more recently Fallahzadeh *et al.*² reported a 63% mortality rate (7 out of 13 cases), and this percentage reflects those in other recent reports. Fallahzadeh *et al.* attributed high mortality rates to delayed surgical intervention, which in turn was due to unwarranted reliance on antibiotics and delayed diagnosis.

Only two cases of periorbital necrotizing fasciitis have been reported,^{3,4} and the association with polymyositis has never been reported and may, therefore, be fortuitous, though one or two possible links with the fasciitis exist. Immunosuppression associated with the