Introduction and Aim of Essay

The term haemorrhoids or "Piles" means different things to different people and patient will use these words to describe a wide variety of anorectal conditions. To the surgeon however, it refers to varicose veins that occur inside, or just outside the anus. ***(Cuschieri et al., 2002)***.

The anal canal is well adapted to its function, being able to accommodate the passage of large formed stool yet able to form a complete seal to prevent the unwanted egress of gas and liquid. Three cushions, composed of blood filled spaces supported by a matrix of fibrous tissue and smooth muscle aid the anus in this adaptablity. ***(Loder, 2001)***.

Haemorrhoids are the most prevalent anorectal disorder. The incidence of haemorrhoids is 1 in 25 in developing countries, being increased dramatically to reach up to 2 in 3 58% in the developed community ***(Dennison et al., 2002)***.

The incidence of haemorrhoids increases with age. At least it reaches 50% in people over the age of fifty years ***(Cuscheri et al., 2002)***.

Many theories have been postulated to explain the nature and pathogenesis of piles including; varicose veins theory, vascular hyperplasia theory and mucosal cushion sliding theory ***(Jensen et al., 1988)***.

Haemorrhiods may be: a) external: which are covered with skin only and usually require no treatment unless become irritated or inflamed b) internal: these are essentially varicosities of venous plexuses in the wall of the anal canal and lower most part of the rectum. These form swellings covered with mucosa which bulge into the lumen of the anal canal, especially when the portal venous pressure is raised and the sphincter relaxed during defecation and straining. ***(Goligher, 1984)***.

Bleeding, prolapse discharge, itching and pain or discomfort are the main local symptoms of haemorrhoids ***(Smith, 1992)***.

To establish diagnosis of haemorrhoids, clinical examination (including both inspection and digital examination), proctoscopy, sigmoidoscopy and even anorectal manometry may be required ***(Keighly and Williams, 1993)***.

Profuse hemorrhage anaemia, thrombosed prolapsed haemorrhoids, ulceration, gangrene, suppuration, portal pyaemia and fibrosis are the main complications of haemorrhoids ***(Smith 1992)***.

The treatment is essentially medical for the 1st and 2nd degree of haemorrhoids, uncomplicated and in pregnant females. Whiles the surgical therapy is still useful & preferred for the patient with large 3rd and 4th degree haemorrhoids ***(Goligher, 1984)***.

The new trends in haemorrhoids management include injection treatment, rubber band ligation, cryotherapy, infrared photocoagulation, galvanic generator and probe and bipolar diathermy coagulation, manual dilatation, laser treatment and Doppler guided haemorrhoidal artery ligation ***(Smith, 1992)***.