Homoeopathic Perspective on Haemorrhoids: A Holistic View

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***Abstract*- Hemorrhoids, also known as piles, are swollen veins in the lower rectum and anus, causing discomfort, pain, and bleeding. They are a common anorectal disorder affecting a large portion of the adult population. Homoeopathy offers a holistic, individualized approach to treating hemorrhoids, aiming to relieve symptoms and address the root cause. This article discusses the pathology, risk factors, and treatment options with emphasis on key homoeopathic remedies and their indications.**

***Index Terms*— Hemorrhoids, Homoeopathy, Piles, Rectal bleeding, Constitutional treatment**

I. INTRODUCTION

Hemorrhoids are vascular structures in the anal canal that help with stool control. They become pathological when swollen or inflamed. Increased intra-abdominal pressure, constipation, sedentary lifestyle, and pregnancy are common causes. Homoeopathy, with its individualized approach, can provide significant relief from the symptoms and recurrence of hemorrhoids.

II. DEFINITION

Haemorrhoids, also known as piles, are swollen and inflamed vascular structures in the anal canal that act as cushions to help with stool control. When they become enlarged, they can cause symptoms such as bleeding, pain, itching, and prolapse.

III. CAUSES

Causes of Hemorrhoids (Piles)
Hemorrhoids develop due to increased pressure in the rectal and anal veins, which causes them to swell, stretch, and sometimes bleed. The following are the primary causes and contributing factors:

1. Chronic Constipation
Frequent straining during bowel movements increases venous pressure.
Hard stools irritate the anal lining, causing inflammation.
2. Chronic Diarrhea
Repeated bowel movements can irritate and inflame the anal canal.
3. Prolonged Sitting
Sitting for long periods, especially on the toilet, leads to pooling of blood in rectal veins.
4. Low-Fiber Diet
Insufficient dietary fiber leads to hard stools and constipation.
5. Obesity
Excess body weight increases abdominal pressure, especially in the pelvic region.
6. Pregnancy
The growing uterus compresses veins, increasing venous pressure.
Hormonal changes also relax vein walls.

7. Sedentary Lifestyle
Lack of physical activity impairs blood circulation, contributing to vein congestion.
8. Heavy Lifting
Repeated heavy lifting can strain abdominal and rectal muscles, increasing pressure in the veins.
9. Aging
With age, the tissues supporting the veins in the rectum and anus may weaken and stretch.
10. Hereditary Factors
Family history of hemorrhoids can increase susceptibility.
11.Portal Hypertension
Seen in liver diseases, it increases pressure in the rectal venous plexus

IV. RISK FACTORS

- Chronic constipation or diarrhea
- Low-fiber diet
- Obesity and sedentary lifestyle
- Pregnancy
- Prolonged sitting or straining during bowel movements

V. ETIOLOGY

1. Anatomical Factors
The anal canal contains vascular cushions made of blood vessels, connective tissue, and muscle.
These cushions normally assist in stool control.
When these cushions become engorged or displaced, hemorrhoids result.
2. Increased Intra-abdominal Pressure
Pressure on the inferior rectal veins impairs venous return, causing venous stasis and dilation of hemorrhoidal veins.
Common causes include:
Straining during defecation
Chronic constipation
Pregnancy
Ascites or abdominal tumors
3. Venous Insufficiency and Valve Incompetence
Weakening of the venous walls and valves leads to varicosities in the anal venous plexus.
Common in people with varicose veins or portal hypertension.
4. Mechanical and Traumatic Causes
Prolonged sitting, particularly on the toilet, causes continuous pressure.
Heavy lifting increases abdominal pressure.
Anal intercourse and frequent enema usage can irritate and traumatize the anal canal.
5. Dietary and Bowel Habits
Low fiber intake leads to hard stools and increased straining.
Spicy foods and alcohol may cause vascular congestion.
6. Hereditary and Constitutional Factors
A family history of hemorrhoids suggests a genetic predisposition to weak venous structures or poor connective tissue support.
7. Hormonal Influence
Especially in pregnant women, increased progesterone levels relax the smooth muscle, including venous walls, contributing to hemorrhoid formation.
8. Aging
With advancing age, the connective tissue supporting hemorrhoidal veins becomes weaker, leading to prolapse and inflammation.

VI. PATHOPHYSIOLOGY

1. Venous Hypertension and Stasis
Increased intra-abdominal pressure (due to straining, constipation, pregnancy, etc.) causes venous engorgement.
The superior, middle, and inferior rectal veins become dilated, leading to swelling of the hemorrhoidal plexus.
2. Connective Tissue Degeneration
With age or chronic strain, supporting connective tissues (e.g., collagen, elastic fibers) deteriorate.
The vascular cushions descend or prolapse into the anal canal.
3. Disruption of Treitz's Muscle
Treitz’s muscle holds hemorrhoidal cushions in place.
Weakening or rupture leads to prolapse of internal hemorrhoids.
4. Mucosal Prolapse and Ischemia
The prolapsed hemorrhoid is exposed to friction, trauma, and irritation, especially during defecation.
This leads to inflammation, pain, and bleeding.
In severe cases, thrombosis (clot formation) within the hemorrhoid causes extreme pain and swelling.
5. Secondary Inflammatory Changes
Local irritation results in edema, ulceration, itching, and mucous discharge.
Chronic cases may show fibrosis and skin tags.

VII. SIGNS AND SYMPTOMS

Rectal Bleeding
Bright red blood seen on toilet paper, stool surface, or dripping into the toilet.
Typically painless (especially in internal hemorrhoids).
Pain or Discomfort

More common in external or thrombosed hemorrhoids.
Sharp, stabbing, or aching pain, especially during or after defecation.
Swelling or Lump near the Anus
A palpable mass, especially in external hemorrhoids.
Soft or hard lump depending on thrombosis.
Itching or Irritation
Due to mucous discharge and poor hygiene.
Common in prolapsed internal hemorrhoids.
Feeling of Incomplete Evacuation
Sensation that something remains in the rectum even after bowel movement.
Caused by prolapsed internal hemorrhoid.
Mucous Discharge
Slimy or sticky discharge, leading to local irritation and pruritus.

VIII. INVESTIGATIONS

A. Inspection
Visual examination of the anal region.
Useful for identifying external hemorrhoids, prolapse, or thrombosis.
B. Digital Rectal Examination (DRE)
Gloved finger inserted into the rectum to palpate internal masses, tenderness, and tone of the sphincter.
C. Proctoscopy / Anoscopy

Short tube inserted into the anal canal.

Allows direct visualization of internal hemorrhoids.
Helps assess degree (Grade I–IV) of prolapse and inflammation.
2. Laboratory Investigations
Test Purpose
Complete Blood Count (CBC):
To check for anemia due to chronic blood loss
Stool Occult Blood Test:
Detect hidden blood in stool when overt bleeding absent
Prothrombin Time (PT)/INR:
If bleeding is persistent or patient is on anticoagulants
3. Imaging & Endoscopy (if needed)
Sigmoidoscopy: Evaluate rectum and lower sigmoid colon; rule out polyps, malignancy
Colonoscopy: Indicated in >50 years old, or with family history of colorectal cancer
CT Colonography: Alternative to colonoscopy in some cases
Pelvic Ultrasound: In females, to assess for other pelvic pathology if symptoms are vague
4. Special Tests (Selective Use)
MRI/CT pelvis: In rare cases of complex perianal disease.
Manometry: To assess sphincter function if continence is affected.

IX. CONVENTIONAL TREATMENT

1. Lifestyle and Dietary Modifications (First Line for All Grades):
High-fiber diet (fruits, vegetables, whole grains)
Adequate fluid intake
Avoid straining during defecation
Regular physical activity
Use of sitz baths – warm water baths for 10–15 minutes, 2–3 times daily
2. Pharmacological (Medicinal) Treatment:
Topical analgesics: Lidocaine, Pramoxine
Relieve pain and itching
Topical corticosteroids: Hydrocortisone cream
Reduce inflammation and itching
Astringents: Witch hazel, zinc oxide Shrink tissues, dry weeping lesions
Vasoconstrictors: Phenylephrine
Reduce swelling by constricting blood vessels
Laxatives/Stool softeners: Docusate sodium, Psyllium husk.
Prevent straining during bowel movement
Oral painkillers: Paracetamol, Ibuprofen
For pain relief in external or thrombosed piles
3. Non-Surgical Office Procedures (for Internal Hemorrhoids Grades I–III)
Rubber Band Ligation:
Bands applied to base of hemorrhoid; cuts off blood supply Most common OPD treatment
Sclerotherapy:
Injection of sclerosing agent to shrink vessels
For Grade I and II hemorrhoids
Infrared Coagulation:
Coagulates vessels causing hemorrhoid to shrink
Minimally invasive
Cryotherapy: Freezes hemorrhoidal tissue
Less commonly used today
Electrocoagulation:
Uses electric current to cut off blood supply
Alternative to rubber band ligation

4. Surgical Treatment (for Grade III/IV or complicated hemorrhoids)
Hemorrhoidectomy:
Excision of hemorrhoids: gold standard for severe or thrombosed hemorrhoids
Stapled Hemorrhoidopexy (PPH):
Staples prolapsed tissue back inside – less painful, faster recovery
Doppler-Guided Hemorrhoidal Artery Ligation (DGHAL):
Identifies and ligates arteries supplying hemorrhoids

5. Management of Thrombosed External Hemorrhoids:
Conservative: Painkillers, sitz bath, topical agents
Surgical: Excision of clot within 72 hours of onset if pain is severe

X. HOMOEOPATHIC MANAGEMENT

Homeopathic medicines for hemorrhoids are selected based on a holistic totality of symptoms including type of piles (bleeding/non-bleeding), associated complaints, modalities, constitution, and miasmatic background.
Key Remedies:
. Aesculus hippocastanum Dry, non-bleeding piles; burning, fullness; marked backache
Hamamelis virginiana Profuse, painless bleeding; sore bruised feeling; venous congestion
Nux vomica Hemorrhoids with constipation, ineffectual urging; sedentary life; irritable
Aloe socotrina Protruding piles like grapes, mucus discharge, worse in the morning
RatanhiaSplinter-like pain in anus after stool; fissures with hemorrhoids
Sulphur Itching, burning piles; early morning diarrhea; unclean feeling

Collinsonia canadensis Piles with pelvic congestion; during pregnancy; obstinate constipation
Muriatic acid Bluish, extremely painful piles; difficult to sit; worse during delivery
Lycopodium Right-sided piles; associated with bloating and liver complaints
Graphites Bleeding piles with fissures and burning; constipation with large, knotty stools

XI. MIASMATIC CLEAVAGE

Psora : Functional piles, itching, burning, dryness; often without bleeding
Sulphur, Nux vomica, Aesculus
Sycosis : Engorged, swollen, prolapsed, bluish piles; with mucous discharge
Aloe, Hamamelis, Thuja, Lycopodium
Syphilis: Painful, ulcerated, bleeding, offensive piles; fissures, destruction
Ratanhia, Muriatic acid, Nitric acid, Merc sol

Correct identification of dominant miasm aids in selecting a deep-acting constitutional remedy.

XII. REPORTORIAL APPROACH

Repertorial Approach in Hemorrhoids (Piles)
– A Structured Guide Using Homoeopathic Repertories

The repertorial approach involves using a repertory to analyze symptoms and select the simillimum remedy for a case of hemorrhoids. It is based on repertorization of totality including local, general, mental, and miasmatic symptoms.

1. Case Taking Essentials
Local symptoms: bleeding, pain, itching, prolapse, discharge
Modalities: aggravation and amelioration (e.g., worse after stool, better from cold)
Associated complaints: constipation, fissures, varicose veins
General symptoms: thermal state, cravings, thirst, sleep
Mental state: irritability, anxiety, oversensitivity
Miasmatic traits: recurrence, destruction, venous stasis
2. Useful Repertories
Repertory Usefulness
Kent's Repertory Well-structured; useful for general, mental, and physical generals
Boenninghausen's TPB Emphasis on modalities and concomitants; ideal for incomplete local symptoms
Synthesis Repertory Rich rubrics with sub-rubrics; integrates Kent, Boenninghausen, and others
Murphy's Repertory Clinically oriented; good for practical rubric selection
3. Important Rubrics in Repertories
From Synthesis / Kent:
Rectum – Hemorrhoids – bleeding
Rectum – Hemorrhoids – protruding
Rectum – Hemorrhoids – painful – after stool

Rectum – Hemorrhoids – burning

Rectum – Constipation – with hemorrhoids

Rectum – Fissure – with hemorrhoids

Generalities – Sedentary habits – agg.

Mind – Irritability
From Boenninghausen's Therapeutic Pocket Book:
Anus – Piles – protruding
Anus – Piles – bleeding
Stool – Constipation – with piles
Concomitants: Back pain, rectal fullness, itching, burning
Modalities: After stool, walking, sitting, pregnancy
4. Repertorization Strategy
Identify key symptoms (especially peculiar, characteristic ones)

Select rubrics from multiple sections (local + generals + mind)

Repertorize using software (RADAR Opus, Hompath, etc.)

Apply remedy differentiation based on materia medica

Confirm with miasmatic background and constitution

- Rest aggravates (Bryonia)
- Pain; wandering; changing location (Pulsatilla)
Remedy selection is aided by computer repertorization tools like RADAR and Complete Dynamics.

XIII. MATERIA MEDICA VIEW

AESCULUS HIPPOCASTANUM
• Hemorrhoids without bleeding (blind piles).
• Marked dryness and burning in rectum.
• Sensation of fullness, as if full of small sticks.
• Intense low back pain accompanying piles.
• Worse: standing, after stool. Better: cold applications.
HAMAMELIS VIRGINIANA
• Profuse, passive bleeding from hemorrhoids.
• Soreness in rectum, bruised feeling.
• Acts on venous system – useful in varicose veins.

• Hemorrhoids during pregnancy or after delivery.
• Better from cold, worse from warmth and motion.
NUX VOMICA
• Hemorrhoids with frequent, ineffectual urging for stool.
• Associated with constipation, sedentary lifestyle, stress.
• Hemorrhoids bleed slightly and burn.
• Mental irritability and oversensitivity present.
• Worse in morning, after eating; better with warmth.
ALOE SOCOTRINA
• Hemorrhoids protrude like bunch of grapes.
• Burning, soreness, and heaviness in rectum.
• Involuntary stool with flatus, mucus discharge.
• Worse in the morning and after eating.
• Sudden urge for stool, cannot control.
RATANHIA
• Fissure with hemorrhoids; severe burning pain after stool.
• Pain lasts for hours after defecation.
• Sensation of broken glass or splinters in the rectum.
• Better from hot applications.
• Often needed in cases with anal fissures and painful piles.
SULPHUR
• Hemorrhoids with itching, burning, oozing moisture.
• Early morning diarrhea drives the patient out of bed.
• Dirty, philosophical, warm-blooded constitution.
• Neglect of hygiene and disheveled appearance.
• Worse from heat, bathing; better with cold.
COLLINSONIA CANADENSIS
• Hemorrhoids in pregnant women or after labor.
• Obstinate constipation, sensation of weight in rectum.
• Hard, knotty stool with rectal fullness.
• Congestion of pelvic organs.
• Especially useful in females with hemorrhoidal complaints.
MURIATIC ACID
• Extremely painful, bluish, swollen hemorrhoids.
• Pain worse during and after stool.
• Too weak to sit up in bed; sensitive piles.
• Used in low vitality cases.
• Worse from touch, motion, after stool.
LYCOPODIUM
• Right-sided piles with bloating and flatulence.
• Constipation with small, difficult stool.
• Craves sweets and warm food; irritable, anxious.
• Worse 4–8 PM; better with warm drinks and movement.
• Hemorrhoids with liver dysfunction.
GRAPHITES
• Bleeding piles with fissures and constipation.
• Hard, knotty stools that stick to anus.
• Moist skin, tendency to obesity, chilly patient.
• Burning and soreness after stool.
• Useful in obese, anemic individuals.

XIV. STATISTICAL DATA

1. Global Prevalence

Region	Estimated Prevalence
Worldwide	~4.4% to 36% of the population (varies by region)
United States	~10–15 million people affected annually (~4.4%)
Europe	~13–20% (higher in urban, sedentary populations)
India	~25–30% in adults; more common in urban areas

2. Demographic Distribution

Parameter: Statistics
Age Group: Peak incidence between 45–65 years
Gender: Men > Women (slightly higher in men except during pregnancy)
Pregnancy: ~35–40% of pregnant women develop hemorrhoids (esp. 3rd trimester)
Occupation:
More common in sedentary workers, drivers, IT professionals
Dietary Impact:
Higher in populations with low fiber intake

3. Common Clinical Presentations (Survey-Based)

Symptom: Approximate Frequency
Rectal bleeding: 80–90%
Pain or discomfort: 60–70%
Itching and irritation:40–60%
Prolapse (internal piles):30–50%
Constipation with piles: 50–70%

4. Treatment-Seeking Behavior

Mode of Treatment: Usage Rate (India based surveys)
Allopathy (conventional): 60%
Homoeopathy: 20–25%
Ayurveda/Naturopathy: 10–15%
No treatment/self-care: 5–10%

5. Surgical Intervention Data

Type of Hemorrhoidectomy:
Usage (%) Among Surgeries
Conventional excision: 45%
Stapled hemorrhoidopexy (PPH): 35%
Rubber band ligation (OPD basis):15%
Doppler-guided hemorrhoidal ligation: 5%

XV. HUMANITARIAN VIEW

Humanitarian View of Hemorrhoids
– A Compassionate and Holistic Perspective

Hemorrhoids, though medically classified as a benign anorectal disorder, carry a significant humanitarian impact on individuals' quality of life, self-esteem, and social functioning. The humanitarian view considers not just physical symptoms but also the psychosocial, emotional, and occupational burden faced by patients.

🧍 1. Social and Emotional Impact
Stigma and Shame: Many patients feel embarrassed to discuss anal conditions, leading to delayed diagnosis and self-treatment.

Isolation: Fear of odor, bleeding, or soiling may lead to social withdrawal.

Mental Health: Chronic hemorrhoids can cause anxiety, irritability, and low mood, especially in severe or recurrent cases.

⚕️ 2. Impact on Daily Living
Aspect Impact
Work Difficulty in sitting, especially for long hours (drivers, IT workers)
Sleep Pain, itching, and urge for stool can disturb sleep cycles
Mobility Thrombosed or prolapsed piles make walking or sitting painful
Hygiene Mucous discharge and bleeding demand frequent cleaning

🧑‍⚕️ 3. Neglect and Delayed Treatment
Lack of Awareness: Many ignore early symptoms considering them minor.

Fear of Surgery: Fear of painful surgical intervention delays medical help.

Economic Constraints: In rural or low-income settings, cost of treatment is a barrier.

Gender Issues: Women may hesitate to report hemorrhoidal issues, especially during pregnancy.

🩺 4. Role of the Homoeopathic Physician
A homeopath must:

Offer a non-judgmental space for open conversation.

Understand the patient's lifestyle, fears, habits, and stressors.

Treat hemorrhoids as part of the totality of the individual, not in isolation.

Encourage early intervention, education, and prevention.

Empower patients to restore confidence in their health without fear of surgery.

🌿 5. Holistic and Preventive Outlook
Promote dietary awareness (fiber, hydration) and hygiene education.

Counsel patients on stress management, physical activity, and regular bowel habits.

Use homeopathy not just to relieve symptoms, but to strengthen the constitution and reduce recurrence.

XVI.CONCLUSION

A Humanitarian Duty
Managing hemorrhoids is not just about curing a physical ailment. It's about restoring dignity, comfort, and well-being to those silently suffering. A humanitarian approach demands compassion, education, and individualized care, values deeply aligned with homoeopathic philosophy.

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