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A Clinical Study on Etiopathogenesis and Management in Haemorrhoids

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ABSTRACT

Background; Haemorrhoidal disease is one of the most common anorectal disorders affecting adults worldwide. It significantly impacts quality of life due to symptoms such as bleeding, pain, prolapse, and discomfort. The present study was conducted to evaluate the etiopathogenesis, clinical presentation, grading, and management outcomes of haemorrhoidal disease.

Materials and Methods; This hospital-based prospective observational study was conducted in the Department of General Surgery, Smt. N.H.L. Municipal Medical College and associated tertiary care hospital from December 2023 to December 2025. A total of 100 patients diagnosed with haemorrhoids were included. Patients were evaluated clinically and graded according to Goligher's classification and BPRST classification. Management modalities included conservative treatment, rubber band ligation, sclerotherapy, stapled haemorrhoidopexy, open haemorrhoidectomy, and closed haemorrhoidectomy. Postoperative pain, complications, recurrence, and patient satisfaction were assessed during follow-up.

Results; The majority of patients belonged to the 31–40 years age group (25%), with a male predominance (66%). Bleeding per rectum was the most common presenting symptom (63%). Grade II haemorrhoids were the most frequent clinical grade (52%). Surgical management was required in 69% of patients, while 31% were managed conservatively. Open haemorrhoidectomy was the most commonly performed procedure (60.9%). Postoperative pain was highest following open haemorrhoidectomy, whereas minimally invasive procedures such as stapled haemorrhoidopexy and sclerotherapy were associated with less postoperative discomfort. Postoperative bleeding occurred in 15.9% of operated cases. The overall patient satisfaction rate was 87%, with the highest satisfaction observed after stapled haemorrhoidopexy.

Conclusion; Haemorrhoidal disease commonly affects middle-aged males and most frequently presents with bleeding per rectum. Conservative management is effective in early-stage disease, whereas advanced grades require surgical intervention. Open haemorrhoidectomy remains the most commonly used and effective procedure, though minimally invasive techniques offer better postoperative comfort and patient satisfaction. Early diagnosis and individualized treatment selection are essential for optimal outcomes.

Keywords*: Haemorrhoids, Haemorrhoidal disease, Goligher classification, BPRST classification, Open haemorrhoidectomy, Stapled haemorrhoidopexy, Rubber band ligation, Sclerotherapy, Postoperative pain, Surgical management.*

INTRODUCTION

Haemorrhoidal disease is one of the most common anorectal disorders encountered in surgical practice and has been recognized since ancient times. The term "haemorrhoids" refers to the symptomatic enlargement and distal displacement of the normal anal cushions, which are vascular structures composed of connective tissue, smooth muscle, arteriovenous

channels, and venous plexuses located within the anal canal. These vascular cushions contribute to fine continence and help maintain anal closure; however, pathological changes in their supporting structures and vascular components lead to the development of symptomatic haemorrhoids (1).

Haemorrhoids affect a substantial proportion of the adult population worldwide and are associated with significant morbidity and impaired quality of life. The disease commonly presents during the middle decades of life and affects both genders, although several studies have demonstrated a male predominance (2). The prevalence of haemorrhoidal disease varies widely due to differences in dietary habits, bowel patterns, healthcare-seeking behavior, and diagnostic methods. It has been estimated that nearly 50% of individuals over the age of 50 years experience symptoms related to haemorrhoids at some point in their lifetime (3).

The etiopathogenesis of haemorrhoidal disease is multifactorial and remains an area of ongoing research. Traditionally, haemorrhoids were considered varicosities of the haemorrhoidal venous plexus; however, contemporary understanding emphasizes the role of degeneration of the supporting connective tissue, sliding anal canal theory, vascular hyperplasia, and increased anal canal pressure (4). Chronic constipation, prolonged straining during defecation, sedentary lifestyle, low-fiber diet, obesity, pregnancy, and occupational factors have all been implicated as important risk factors contributing to the development and progression of haemorrhoidal disease (5).

Clinically, haemorrhoids are broadly classified as internal or external depending on their relation to the dentate line. Internal haemorrhoids are further graded according to Goligher's classification into four grades based on the degree of prolapse. Grade I haemorrhoids present with bleeding without prolapse, whereas Grade IV haemorrhoids are irreducibly prolapsed and often associated with complications (6). Although Goligher's classification remains widely used, newer systems such as the BPRST classification have been introduced to provide a more comprehensive assessment by incorporating bleeding, prolapse, reducibility, skin tags, and thrombosis (7).

Bleeding per rectum is the most common presenting symptom of haemorrhoidal disease and is often painless in uncomplicated cases. Other symptoms include prolapse, pain, pruritus, mucus discharge, discomfort, and thrombosis. Severe or neglected cases may lead to anemia, strangulation, thrombosis, and impaired daily functioning (8). Early diagnosis and timely intervention are therefore essential to prevent disease progression and improve patient outcomes.

Management of haemorrhoids depends on the severity of symptoms, degree of prolapse, and patient preference. Conservative treatment remains the first-line approach for early-stage haemorrhoids and includes dietary modification, increased fiber intake, stool softeners, topical medications, and lifestyle changes (9). Office-based procedures such as rubber band ligation and injection sclerotherapy are commonly employed in Grade I and Grade II haemorrhoids and provide satisfactory outcomes with minimal morbidity (10).

Surgical intervention is generally reserved for symptomatic Grade II haemorrhoids refractory to conservative treatment and for advanced Grade III and Grade IV disease. Conventional excisional haemorrhoidectomy, including the Milligan–Morgan and Ferguson techniques, continues to be regarded as the gold standard treatment due to its low recurrence rate and definitive symptom control (11). Stapled haemorrhoidopexy has emerged as an alternative technique associated with reduced postoperative pain and earlier recovery, although concerns regarding recurrence remain (12).

Despite the availability of multiple treatment modalities, the optimal management strategy for haemorrhoidal disease continues to be debated. Each technique has its own advantages, limitations, complication profile, and patient satisfaction outcomes. Therefore, evaluating the clinical presentation, grading, management approaches, postoperative complications, and patient-reported outcomes is essential for improving treatment selection and overall care.

The present study was undertaken to evaluate the etiopathogenesis, clinical presentation, grading, and management outcomes of haemorrhoidal disease in patients attending a tertiary care hospital. The study also aimed to assess postoperative complications, treatment effectiveness, and patient satisfaction associated with various conservative, office-based, and surgical treatment modalities.

MATERIALS AND METHODS

Study Design

This hospital-based prospective observational study was conducted to evaluate the etiopathogenesis, clinical presentation, grading, and management outcomes of haemorrhoidal disease. The study aimed to analyse demographic characteristics, associated risk factors, clinical grading, and outcomes of various conservative, office-based, and surgical treatment modalities.

Study Setting
The study was carried out in the Department of General Surgery at Smt. N.H.L. Municipal Medical College and its associated tertiary care hospital. Patients were recruited from the Surgical Outpatient Department (OPD) as well as emergency admissions whenever applicable. All procedures and interventions were performed in the operating theatres of the institution.

Study Duration
The study was conducted over a period of 24 months from December 2023 to December 2025, ensuring adequate patient recruitment, treatment, and follow-up.

Sample Size
A total of 100 patients clinically diagnosed with haemorrhoids were included in the study. The sample size was considered adequate to evaluate clinical presentation, grading, treatment outcomes, and postoperative complications associated with different management modalities.

Study Population
All patients presenting with clinically diagnosed haemorrhoids and fulfilling the inclusion and exclusion criteria were enrolled after obtaining written informed consent.

Inclusion Criteria
1. Patients aged 18 years and above.
2. Patients clinically diagnosed with internal and/or external haemorrhoids.
3. Patients presenting with any grade (Grade I–IV) of haemorrhoids.
4. Patients willing to undergo conservative or surgical management as indicated.
5. Patients providing written informed consent for participation in the study.

Exclusion Criteria
1. Patients with other anorectal diseases such as fissure-in-ano, fistula-in-ano, perianal abscess, or anorectal malignancy.
2. Patients with haemorrhoids secondary to portal hypertension.
3. Patients with inflammatory bowel disease involving the anorectal region.
4. Pregnant women.
5. Patients with bleeding disorders or on long-term anticoagulant therapy.
6. Patients unfit for surgery or refusing treatment.
7. Patients unwilling to provide written informed consent.

Method of Management Allocation
Patients were categorised according to the clinical grade of haemorrhoids and severity of symptoms.
Conservative Management Group
- Grade I and early Grade II haemorrhoids
- Patients with mild symptoms

Surgical/Interventional Management Group
- Symptomatic Grade II haemorrhoids
- Grade III and Grade IV haemorrhoids
- Patients with failed conservative therapy

Preoperative Evaluation
All patients underwent a standardised preoperative assessment to confirm diagnosis, evaluate surgical fitness, and document baseline clinical findings.

Clinical Assessment
A detailed history was obtained regarding:
- Bleeding per rectum
- Pain during defecation
- Prolapse
- Pruritus
- Duration of symptoms
- Bowel habits and dietary pattern
- Constipation and straining during defecation
- Associated comorbidities and previous treatment history

Physical Examination
All patients underwent:

- General physical examination
- Inspection of the anal region
- Digital rectal examination
- Proctoscopic examination

Laboratory Investigations
Routine investigations included:

- Complete blood count (CBC)
- Blood sugar levels (RBS/FBS)
- Renal function tests (RFT)
- Coagulation profile (PT/INR)
- Viral markers (HIV and HBsAg) as per institutional protocol

Additional Investigations
Additional investigations, such as colonoscopy and imaging studies, were performed in selected cases, especially in patients with atypical bleeding, suspicion of malignancy, or the elderly age group.

Pre-anesthetic Evaluation
All patients underwent pre-anaesthetic check-up (PAC) and were graded according to the American Society of Anesthesiologists (ASA) physical status classification before intervention.

Classification
Haemorrhoids were graded according to Goligher's classification:

- Grade I: Bleeding without prolapse
- Grade II: Prolapse with spontaneous reduction
- Grade III: Prolapse requiring manual reduction
- Grade IV: Irreducible prolapse

Treatment Modalities
Open Haemorrhoidectomy (Milligan–Morgan Technique)
Open haemorrhoidectomy was performed under spinal or general anaesthesia with the patient in the lithotomy position. Haemorrhoidal cushions at the classical 3, 7, and 11 o'clock positions were identified. A V-shaped incision was made over the haemorrhoidal tissue, followed by careful dissection from the sphincter complex. The vascular pedicle was ligated using absorbable sutures, and the haemorrhoidal tissue was excised. The wound was left open for secondary healing while preserving adequate mucocutaneous bridges to prevent anal stenosis.

Closed Haemorrhoidectomy (Ferguson Technique)
Closed haemorrhoidectomy was performed similarly to the open technique. After ligation and excision of the haemorrhoidal tissue, the mucosal and skin edges were approximated using absorbable sutures. This technique aimed to reduce postoperative pain and facilitate faster wound healing.

Stapled Haemorrhoidopexy
Stapled haemorrhoidopexy was performed under spinal or general anesthesia. A circular anal dilator was introduced, and a circumferential purse-string suture was placed approximately 3–4 cm above the dentate line. A circular stapling device was inserted and fired, excising a circumferential ring of mucosa and submucosa. This repositioned the prolapsed haemorrhoidal tissue and interrupted its blood supply. The staple line was inspected for hemostasis.

Rubber Band Ligation
Rubber band ligation was performed using a proctoscope and ligator device. The haemorrhoidal tissue was grasped or suctioned into the ligator, and a rubber band was applied at its base above the dentate line. This resulted in ischemic necrosis and subsequent sloughing of the haemorrhoidal tissue.

Injection Sclerotherapy
Injection sclerotherapy was performed by injecting a sclerosant agent such as polidocanol into the submucosal plane above the dentate line at the base of the haemorrhoid. The procedure caused fibrosis and obliteration of vascular channels, resulting in reduction of bleeding and haemorrhoidal size.

Intraoperative Parameters
The following intraoperative parameters were recorded:

- Type of procedure performed
- Indication for intervention based on haemorrhoid grade
- Type of anesthesia used
- Operative time (minutes)
- Number and position of haemorrhoidal cushions
- Associated findings such as thrombosis, skin tags, or fissure
- Estimated blood loss
- Adequacy of hemostasis
- Intraoperative complications including bleeding, mucosal tear, and sphincter injury
- Need for modification of surgical technique

Postoperative Care

Postoperative management was standardized and included:

- Monitoring of vital parameters and operative site
- Adequate analgesia according to institutional protocol
- Stool softeners and high-fiber dietary advice
- Sitz bath for local hygiene and pain relief

Postoperative Assessment and Follow-Up

Patients were evaluated postoperatively for:

- Pain using the Visual Analogue Scale (VAS) at 12 hours, 24 hours, and during follow-up
- Bleeding, urinary retention, wound infection, and severe pain
- Late complications such as anal stenosis, incontinence, persistent pain, and recurrence

The duration of hospital stay and time required to resume normal daily activities were recorded.

Patients were followed up on:

- Postoperative day 7
- One month
- Three months or longer when required

Outcome Measures

Primary Outcome Measures

1. Symptomatic improvement, including reduction or cessation of bleeding, relief from pain, prolapse, pruritus, and discomfort.
2. Clinical grading outcome and resolution of prolapse during follow-up.
3. Effectiveness of conservative, office-based, and surgical management.
4. Post-treatment complications including pain, bleeding, urinary retention, infection, anal stenosis, and incontinence.

Secondary Outcome Measures

1. Postoperative pain assessed using VAS score.
2. Duration of hospital stay.
3. Time required to return to normal daily activities.
4. Recurrence of haemorrhoidal symptoms during follow-up.
5. Patient satisfaction regarding symptom relief and overall comfort.

Data Collection

Data were collected using a structured case record proforma. Parameters recorded included:

- Age and sex
- Occupation and socioeconomic status
- Presenting complaints and duration of symptoms
- Dietary habits and bowel pattern
- Personal and family history
- Clinical findings and investigation reports
- Treatment modality used
- Postoperative outcomes and complications

Ethical Considerations

Approval for the study was obtained from the Institutional Ethics Committee before commencement of the study. Written informed consent was obtained from all participants after explaining the nature of the disease, proposed treatment, possible benefits, and complications in a language understandable to them.

Strict confidentiality of patient identity and clinical data was maintained throughout the study. Participation was voluntary, and patients were informed that they could withdraw from the study at any stage without affecting their treatment.

Patients were also informed about potential risks, including postoperative pain, bleeding, infection, urinary retention, and recurrence, as well as expected benefits, such as symptomatic relief, improved quality of life, and effective management of haemorrhoidal disease.

RESULT AND OBSERVATIONS

The present study included 100 patients diagnosed with haemorrhoidal disease. Analysis of demographic variables revealed that the disease predominantly affected middle-aged individuals, with a clear male predominance.

Table 1: Age-wise and Gender-wise Distribution of Patients

Variable	Category	Frequency (n)	Percentage (%)
Age Group (Years)	21–30	18	18%
	31–40	25	25%
	41–50	24	24%
	51–60	20	20%
	>60	13	13%
	Total	100	100%
Gender	Male	66	66%
	Female	34	34%
	Total	100	100%

Table2 :Distribution of Presenting Symptoms and Clinical Grading of Haemorrhoids

Variable	Category	Frequency (n)	Percentage (%)
Presenting Symptoms	Bleeding per rectum	63	63%
	Pain during defecation	22	22%
	Prolapse	15	15%
	Total	100	100%
Clinical Grade (Goligher Classification)	Grade I	18	18%
	Grade II	52	52%
	Grade III	26	26%
	Grade IV	4	4%
	Total	100	100%

Table 3 Distribution of BPRST Classification Parameters and BPRST Staging

Parameter	Category	Frequency (n)
Bleeding (B)	B0 – No bleeding	23
	B1 – Bleeding	77
Prolapse (P)	P0 – No prolapse	53
	P1 – Prolapse of one pile	28
	P2 – Prolapse of two or more piles	19
Reduction (R)	R0 – Spontaneous reduction	70
	R1 – Manual reduction	26
	R2 – Irreducible prolapse	4
Skin Tag (S)	S0 – No skin tags	71
	S1 – Symptomatic skin tags	29
Thrombosis (T)	T0 – No thrombosis	98
	T1 – Acute thrombosis	2
BPRST Staging	Stage I	35
	Stage II	36
	Stage III	29

Table 4 : Demographic Characteristics and Comorbidities According to Treatment Modality

Variables	Surgical Group (n=69)	Conservative Group (n=31)	P value
Age (years), mean ± SD	44.5 ± 13.5	43.8 ± 12.9	0.78
Gender, n (%)			0.82
Male	46 (66.7%)	20 (64.5%)	
Female	23 (33.3%)	11 (35.5%)	
Comorbidities, n (%)			
Hypertension (HTN)	16 (23.2%)	10 (32.3%)	0.34
Diabetes Mellitus (DM)	8 (11.6%)	4 (12.9%)	0.85

Table 5: Distribution of Management Modalities and Surgical Procedures Performed in Haemorrhoidal Disease

Variable	Category	Frequency (n)	Percentage (%)
Type of Management	Conservative	31	31%
	Surgical	69	69%
	Total	100	100%
Surgical Procedures Performed	Open Haemorrhoidectomy	42	60.9%
	Closed Haemorrhoidectomy	7	10.1%
	Stapled Haemorrhoidopexy	9	13.0%
	Rubber Band Ligation	6	8.7%
	Sclerotherapy	5	7.2%
	Total Interventions	69	100%

Table 6: Association of Disease Grade with Treatment Modality and Distribution of Management Techniques

Disease Grade	Conservative	Banding	Closed Haemorrhoidectomy	Open Haemorrhoidectomy	Sclerotherapy	Stapled Haemorrhoidopexy	Total Cases	Surgical Rate (%)
Grade I	18	0	0	0	0	0	18	0%
Grade II	13	5	3	24	5	2	52	75%
Grade III	0	1	3	16	0	6	26	100%
Grade IV	0	0	1	2	0	1	4	100%
Total	31	6	7	42	5	9	100	69%

Table; 7 Distribution of Postoperative Pain Severity and Postoperative Bleeding According to Surgical Procedures

Surgical Procedure	Mild Pain n (%)	Moderate Pain n (%)	Severe Pain n (%)	Bleeding (n)	No Bleeding (n)	Total Cases (n)	Bleeding Rate (%)
Open Haemorrhoidectomy	20 (47.6%)	16 (38.1%)	6 (14.3%)	7	35	42	16.7%
Closed Haemorrhoidectomy	4 (57.1%)	2 (28.6%)	1 (14.3%)	1	6	7	14.3%
Stapled Haemorrhoidopexy	7 (77.8%)	2 (22.2%)	0 (0%)	1	8	9	11.1%
Rubber Band Ligation	5 (83.3%)	1 (16.7%)	0 (0%)	2	4	6	33.3%
Sclerotherapy	5 (100%)	0 (0%)	0 (0%)	0	5	5	0.0%
Total	—	—	—	11	58	69	15.9%

Table 8 : Patient Satisfaction According to Different Treatment Procedures

Procedure	Excellent (n)	Good (n)	Poor (n)	Total (n)	Success Rate (%)
Open Haemorrhoidectomy	8	29	5	42	88.1%
Rubber Band Ligation (Banding)	1	3	2	6	66.7%
Closed Haemorrhoidectomy	2	4	1	7	85.7%
Stapled Haemorrhoidopexy	5	4	0	9	100.0%
Sclerotherapy	1	3	1	5	80.0%

Total	**17**	**43**	**9**	**69**	**87.0%**

DISCUSSION

Haemorrhoidal disease remains one of the most frequently encountered anorectal disorders in general surgical practice and continues to represent a significant clinical and socioeconomic burden. The present prospective observational study evaluated the etiopathogenesis, clinical profile, grading, and management outcomes of haemorrhoidal disease in 100 patients treated at a tertiary care center.

In the present study, the majority of patients belonged to the 31–40 years (25%) and 41–50 years (24%) age groups, indicating that haemorrhoidal disease predominantly affects middle-aged individuals. Similar observations have been reported by Johanson and Sonnenberg, who demonstrated a peak prevalence in adults between the fourth and sixth decades of life (13). This age distribution may be explained by prolonged exposure to etiological factors such as constipation, straining, sedentary lifestyle, and occupational stress. The lower frequency observed in elderly individuals may be related to underreporting or adaptation to chronic symptoms.

A male predominance was observed in the present study, with males accounting for 66% of cases and a male-to-female ratio of approximately 1.9:1. Similar male predominance has been reported in previous studies by Haas et al. and Acheson et al. (14,15). Increased exposure of males to occupational strain, prolonged sitting, smoking, and dietary risk factors may explain this finding. However, haemorrhoids also remain a clinically important problem in females, particularly in relation to pregnancy and constipation.

Bleeding per rectum was the most common presenting symptom in the present study, observed in 63% of patients. This finding is consistent with earlier studies, which have identified painless rectal bleeding as the hallmark symptom of internal haemorrhoids (16). Pain during defecation was present in 22% of cases, likely reflecting associated inflammation, thrombosis, or concomitant anorectal pathology. Prolapse was observed in 15% of patients and was mainly associated with advanced grades of haemorrhoids.

According to Goligher's classification, Grade II haemorrhoids constituted the majority of cases (52%), followed by Grade III (26%), Grade I (18%), and Grade IV (4%). Similar distributions have been reported in studies evaluating haemorrhoidal grading patterns in tertiary care settings (17). The predominance of Grade II disease suggests that many patients seek medical attention after the onset of prolapse and persistent bleeding but before development of advanced irreducible disease.

The present study also evaluated haemorrhoids using the BPRST classification system. Most patients were classified as Stage II (36%) or Stage III (29%), indicating the presence of prolapse, manual reduction, skin tags, or thrombosis. The BPRST system provided a more comprehensive assessment compared to Goligher's classification by incorporating both structural and symptomatic parameters. Similar observations regarding the clinical utility of BPRST classification have been highlighted in recent literature (7).

Conservative treatment was employed in 31% of patients, predominantly those with Grade I and early Grade II disease. Surgical or interventional treatment was required in 69% of patients, indicating that a substantial proportion presented with advanced disease or persistent symptoms. Open haemorrhoidectomy was the most commonly performed procedure (60.9%), followed by stapled haemorrhoidopexy (13.0%), closed haemorrhoidectomy (10.1%), rubber band ligation (8.7%), and sclerotherapy (7.2%). Conventional open haemorrhoidectomy continues to remain the preferred surgical modality in many institutions because of its definitive results and lower recurrence rates (11).

A clear association was observed between disease grade and treatment modality. All patients with Grade I haemorrhoids were managed conservatively, whereas all Grade III and Grade IV haemorrhoids required surgical intervention. Grade II haemorrhoids demonstrated a mixed treatment pattern, with 75% requiring operative management. These findings support the widely accepted principle that treatment selection is largely dependent on disease severity and symptom burden (18).

Postoperative pain remains one of the most important determinants of patient satisfaction and recovery following haemorrhoid surgery. In the present study, open haemorrhoidectomy was associated with the highest postoperative pain intensity, with 14.3% of patients experiencing severe pain. In contrast, stapled haemorrhoidopexy, rubber band ligation, and sclerotherapy demonstrated significantly lower pain severity. Similar findings have been reported by Rowsell et al. and Mehigan et al., who observed reduced postoperative pain and earlier recovery with stapled haemorrhoidopexy compared to conventional excisional haemorrhoidectomy (19,20).

Postoperative bleeding was observed in 15.9% of operated patients. Open haemorrhoidectomy accounted for the largest number of bleeding cases, whereas no bleeding complications were observed following sclerotherapy. However, the

association between procedure type and postoperative bleeding was not statistically significant (p = 0.421). Previous studies have similarly reported postoperative bleeding as an infrequent but recognized complication of haemorrhoid surgery (21).

Patient satisfaction analysis revealed the highest success rate with stapled haemorrhoidopexy (100%), followed by open haemorrhoidectomy (88.1%) and closed haemorrhoidectomy (85.7%). Lower satisfaction rates were observed with rubber band ligation due to recurrence and persistence of symptoms in some patients. These findings suggest that although minimally invasive procedures provide superior postoperative comfort, definitive excisional procedures continue to offer excellent long-term symptom relief and patient satisfaction in advanced disease (22).

Overall, the findings of the present study emphasize that haemorrhoidal disease predominantly affects middle-aged individuals and commonly presents with bleeding per rectum. Disease grading strongly influences treatment selection, with conservative management being effective in early stages and surgical intervention necessary in advanced disease. While conventional haemorrhoidectomy remains the most widely utilised definitive treatment, minimally invasive procedures are associated with improved postoperative comfort and reduced pain. Individualised treatment planning based on disease severity, patient characteristics, and expected outcomes remains essential for achieving optimal results.

CONCLUSION

Haemorrhoidal disease commonly affects middle-aged individuals and shows male predominance. Bleeding per rectum was the most common presenting symptom, while Grade II haemorrhoids were the most frequent clinical presentation. Conservative treatment was effective in early-stage disease, whereas advanced grades required surgical intervention. Open haemorrhoidectomy was the most commonly performed procedure and provided effective symptom relief, though with higher postoperative pain. Minimally invasive procedures such as stapled haemorrhoidopexy, banding, and sclerotherapy were associated with less postoperative discomfort and good patient satisfaction. Early diagnosis, accurate grading, and individualised treatment selection are essential for optimal management and improved patient outcomes.

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