DIANE'S NGN NCLEX 2026 STUDY SERIES · GASTROINTESTINAL / SURGICAL

Hemorrhoids

Types · Pathophysiology · Pharmacology · Procedures · Complications · Patient Teaching

High-Yield NCLEX Topic | Internal vs External | Grades I–IV | Pre/Post-Op Care | Conservative + Surgical Mgmt

1 Definition & Overview

Dilated, swollen, engorged veins (varicosities) in the lower rectum and anus — extremely common, but a frequent NCLEX topic for surgical, GI, and patient-education prioritization.

What they are

Pathologic enlargement of the normal anal vascular cushions caused by sustained increases in venous pressure. May bleed, prolapse, thrombose, or strangulate.

Why it matters

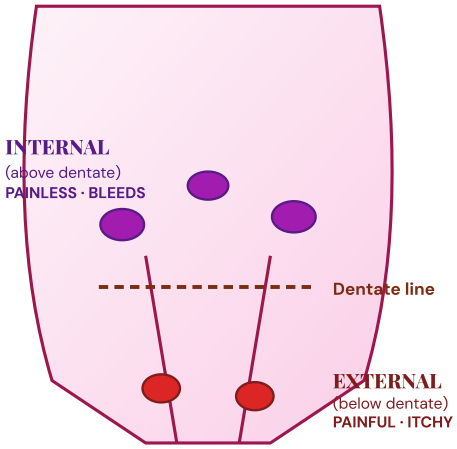
Affects ~50% of adults by age 50. Bright-red rectal bleeding is the cardinal sign — but bleeding must always be investigated to rule out malignancy.

Key risk factors

- Chronic constipation, straining
- Pregnancy & vaginal delivery
- Obesity, prolonged sitting/standing
- Low-fiber diet, dehydration
- Heavy lifting, portal hypertension

2 Types & Grading (Critical for NCLEX)

Location relative to the **dentate (pectinate) line** determines whether a hemorrhoid is internal or external — and whether it hurts.



Internal = above dentate line (visceral nerves → painless). External = below (somatic nerves → painful).

Quick clinical contrast

Feature	Internal	External
Location	Above dentate line	Below dentate line
Innervation	Visceral (no pain fibers)	Somatic (pain fibers)
Pain	**Painless** (unless prolapsed/strangulated)	**Painful**, especially if thrombosed
Hallmark sign	Bright red bleeding on stool/TP	Palpable lump, itching, pain
Visibility	Not visible (unless prolapsed)	Visible at anal verge

Grade I

Bleeding, **no prolapse**. Bulge into canal only.

Grade II

Prolapse with straining → **reduces spontaneously**.

Grade III

Prolapse → requires **manual reduction**.

Grade IV

Cannot be reduced. Risk of strangulation. Often surgical.

Thrombosed external hemorrhoid

RED FLAG Sudden, severe, **throbbing perianal pain** with a tense, blue-purple lump. Most painful in the first 48–72 hours; conservative care after that, surgical excision if severe.

Strangulated hemorrhoid

EMERGENCY Prolapsed internal hemorrhoid with sphincter spasm cutting off blood supply → ischemia, gangrene risk. Severe pain, swelling — **urgent surgical referral**.

3 Pathophysiology (Simplified)

Sustained pressure overwhelms the supportive connective tissue of the anal cushions → veins dilate, slide downward, and become symptomatic.

↑ Intra-abdominal & venous pressure (straining, pregnancy, portal HTN) → Venous engorgement of anal cushions → Weakening of supporting connective tissue →

Vein dilation, prolapse, friable mucosa → Bleeding · pain · itching · thrombosis

Why bleeding is bright red

Hemorrhoidal blood is **arterio-venous** and exits a low-pressure, well-oxygenated environment near the anal verge — so it appears bright red on toilet paper or coating the stool, **not** mixed throughout it.

Why internal don't hurt

Above the dentate line, tissue is innervated by **visceral autonomic nerves** (no pain receptors). Below it, somatic **pudendal nerve** branches supply pain sensation — that's why external/thrombosed hemorrhoids hurt so much.

4 Signs & Symptoms

Pattern recognition is the NCLEX skill: **painless bright-red bleeding** = internal; **painful perianal lump** = external/thrombosed.

Internal hemorrhoid clues

- **Painless** bright-red rectal bleeding
- Blood on toilet tissue or coating stool
- Mucus discharge, anal moisture/itching
- Sensation of incomplete evacuation
- If prolapsed: visible bulge, soiling, urgency

External / thrombosed clues

- **Sudden severe perianal pain**
- Tender bluish-purple lump at anal verge
- Itching, burning, swelling
- Pain worse with sitting & defecation
- Possible scant bleeding if thrombus erodes

🚨 RED FLAGS — Escalate / report

STRANGULATION Severe pain + irreducible prolapse

HEMORRHAGE Heavy persistent bleeding · ↓Hgb · tachycardia · hypotension

INFECTION / SEPSIS Fever, perianal cellulitis, foul drainage

ANEMIA Fatigue + chronic occult blood loss

ATYPICAL BLEEDING Dark/tarry stool, weight loss, change in caliber → r/o cancer

URINARY RETENTION Common post-hemorrhoidectomy

5 Priority Nursing Interventions

Frame interventions through ABCs → Safety → Comfort → Education. Most acute hemorrhoid care is comfort-focused; post-op adds bleeding and elimination priorities.

Conservative / outpatient

- **Assess** bleeding amount, pain, bowel pattern, hydration
- **Sitz bath** warm water 15–20 min, 3–4×/day & after each BM
- **Apply** topical anesthetics, witch hazel pads, hydrocortisone (short-term)
- **Promote** high-fiber diet (25–30 g/day) + 2–3 L fluids
- **Administer** stool softeners (docusate); avoid straining
- **Cold packs** for acute thrombosis × first 24 hr
- Discourage prolonged sitting on toilet (≤5 min); avoid heavy lifting

Post-hemorrhoidectomy

- PRIORITY **Monitor for bleeding** — first 24 hr; check dressing, vital signs, Hgb
- Position **side-lying** (NOT supine — pressure on suture line)
- Ice pack first 12–24 hr → then warm **sitz baths**
- Administer scheduled analgesics **before** first BM & sitz bath
- Stool softener + bulk laxative — **first BM is most painful**
- Assess for **urinary retention** — common post-op (sphincter spasm)
- Encourage early ambulation; teach to splint perianal area when coughing
- Notify HCP: bright red bleeding, fever, no BM by day 3, unable to void

6 Pharmacology

Most pharm is symptomatic. Know mechanism, side effects, and the **nursing teaching point** for each.

STOOL SOFTENER

Docusate sodium (Colace)

- **Mechanism:** ↓ surface tension → water/fat enter stool
- **Side effects:** mild cramping, throat irritation (liquid)
- **Teaching:** Take with full glass of water; takes 1–3 days

BULK-FORMING LAXATIVE

Psyllium (Metamucil)

- **Mechanism:** Absorbs water → bulkier, softer stool
- **Side effects:** Gas, bloating, **esophageal obstruction if taken dry**
- **Teaching:** Mix in 8 oz fluid + extra glass of water; not bedridden pts

TOPICAL CORTICOSTEROID

Hydrocortisone cream / suppository

- **Mechanism:** ↓ inflammation, swelling, itching
- **Side effects:** Skin thinning with prolonged use
- **Teaching:** Short-term only (≤7 days); avoid open wounds

TOPICAL ANESTHETIC

Dibucaine / pramoxine / lidocaine

- **Mechanism:** Numbs sensory nerve endings
- **Side effects:** Local irritation, contact dermatitis
- **Teaching:** Apply after sitz bath/cleansing; not on broken skin

ASTRINGENT

Witch hazel pads (Tucks)

- **Mechanism:** Tightens tissue, soothes itching
- **Side effects:** Minor stinging
- **Teaching:** Pat (don't rub) after each BM/sitz bath

VASOCONSTRICTOR (TOPICAL)

Phenylephrine (Preparation H)

- **Mechanism:** Constricts vessels → ↓ swelling
- **Side effects:** ↑BP, palpitations (rare systemic)
- **Teaching:** Use cautiously in HTN, CAD, hyperthyroid, BPH, DM

ANALGESIC

Acetaminophen / opioids post-op

- **Mechanism:** Pain relief; opioids slow gut
- **Side effects:** Constipation (opioids) — *worst possible*
- **Teaching:** Pair every opioid dose with a stool softener

7 Procedures & Surgical Management

Office procedures handle most internal Grade I–III. Hemorrhoidectomy is reserved for Grade IV, thrombosed external, or failed conservative care.

Rubber band ligation

Most common in-office Tx for Grade I–III internal. Band cuts off blood supply → necrosis → falls off in 5–7 days.

TEACH Mild discomfort, possible bleeding day 7–10 when band sloughs.

Sclerotherapy

Injection of sclerosing agent → fibrosis. Useful for small bleeding internal hemorrhoids; multiple sessions may be needed.

Infrared coagulation

Heat creates a small burn → scar tissue → shrinkage. Quick, minimal pain; for Grade I–II.

Cryotherapy

Freezes hemorrhoidal tissue. Less commonly used today.

Hemorrhoidectomy (surgical)

Excision under anesthesia for Grade IV, thrombosed, or refractory disease. Most painful but most definitive.

WATCH Bleeding, urinary retention, infection.

Stapled hemorrhoidopexy (PPH)

Circular stapler removes excess tissue & lifts prolapsed cushions. Less post-op pain than excisional surgery; possible recurrence.

8 Potential Complications

Know which complication to watch for at which point in care — pre-op, intra-procedure, and post-op timelines are tested.

Thrombosis

Acute clot in external hemorrhoid → severe sudden pain & tense bluish lump. Surgical excision within 48–72 hr most effective.

Strangulation

Irreducible prolapse + sphincter spasm → ischemia → gangrene risk. **Emergency**.

Iron-deficiency anemia

Chronic occult bleeding. Monitor Hgb/Hct & ferritin; teach iron-rich diet.

Post-op hemorrhage

Bright red bleeding, ↓BP, ↑HR — assess perineum & under buttocks (blood pools).

Urinary retention

Reflex sphincter spasm. Encourage voiding within 6 hr; may need straight cath.

Fecal impaction

From pain-related stool retention. Prevent with stool softeners + scheduled analgesia *before* first BM.

Anal stricture

Late post-op narrowing → painful, narrow stools. May need dilation.

Infection / abscess

Fever, increasing pain, purulent drainage. Cultures + antibiotics.

Recurrence

Most common after stapled or band Tx; reinforce lifestyle teaching.

9 NCLEX Test Traps ⚠

High-yield wrong-answer patterns the NGN loves to test:

WRONG: "Place the post-hemorrhoidectomy patient in supine position to relieve pain."	**RIGHT:** Position **side-lying**. Supine puts pressure on the suture line and increases pain & bleeding risk.
WRONG: "Apply a warm sitz bath immediately after surgery to reduce swelling."	**RIGHT: Ice/cold packs first 12–24 hr** for vasoconstriction & ↓ swelling, **then** warm sitz baths beginning POD 1.
WRONG: "Bright red rectal bleeding always indicates hemorrhoids."	**RIGHT:** Bright red blood = lower GI source — could be hemorrhoids, polyps, or **colorectal cancer**. Always evaluate before assuming hemorrhoids.
WRONG: "Internal hemorrhoids cause severe pain — give opioids."	**RIGHT:** Internal hemorrhoids are typically **painless** (above dentate line). Severe pain points to **thrombosed external** or strangulated prolapse.
WRONG: "Hold stool softeners post-op until bowel sounds return."	**RIGHT:** Start stool softeners **early**. The first post-op BM is the most painful — preventing constipation prevents straining, bleeding, and impaction.
WRONG: "Encourage the patient to remain on the toilet until completely empty."	**RIGHT:** Limit toilet time to **≤5 min**. Prolonged sitting + straining ↑ venous pressure and worsens hemorrhoids.
WRONG: "Patient hasn't voided 8 hr post-op — wait another 4 hr."	**RIGHT:** Urinary retention is common post-hemorrhoidectomy. Assess bladder, encourage voiding, **straight cath if needed by 6–8 hr**.

10 Patient & Family Education

Hemorrhoid prevention & recurrence reduction live in the **bathroom + diet**. Teaching is heavily tested.

Lifestyle & bowel habits

- **Fiber 25–30 g/day** — fruits, vegetables, whole grains, legumes
- **Fluids 2–3 L/day** unless contraindicated
- Don't ignore the urge to defecate
- Limit toilet time to ~5 min — no reading/phone scrolling
- Don't strain — exhale during effort, never hold breath (Valsalva)
- Regular exercise 30 min/day; avoid prolonged sitting
- Avoid heavy lifting; if unavoidable, exhale on lift
- Maintain healthy weight

Comfort & self-care

- **Sitz bath**: warm (NOT hot) water 15–20 min, 3–4×/day & after each BM
- Pat dry — never rub. Use moist wipes/witch hazel pads
- Topical creams **short-term only** (≤7 days)
- Avoid spicy foods, caffeine, alcohol if they trigger flare
- Donut/cushion seat for prolonged sitting

When to call the provider

- Heavy or persistent bleeding, blood clots
- Severe pain not relieved by meds
- Fever, chills, foul perianal drainage
- Cannot void within 6–8 hr post-op
- No bowel movement by post-op day 3
- Black/tarry stools, weight loss, change in stool caliber

Special populations

- **Pregnancy**: very common; fiber, fluids, sitz baths, side-lying rest, witch hazel — avoid systemic steroids
- **Older adults**: chronic constipation, polypharmacy — review med list (opioids, anticholinergics)
- **Cirrhosis / portal HTN**: hemorrhoids can bleed massively — escalate any bleeding

11 Memory Boosters & Mnemonics

"PILES" — symptom check

- **P**ain (external/thrombosed)
- **I**tching
- **L**umps (palpable or prolapsed)
- **E**vacuation feels incomplete
- **S**treaks of bright red blood

Internal vs External — pain rule

"I" can't feel them, "E" — Eww, ouch!"
Internal = above dentate = visceral nerves = painless.
External = below dentate = somatic nerves = painful.

Sitz bath rule of 3

3× a day · **15–20** min · **warm** (not hot) — and after every BM. Never use hot water (vasodilation → more bleeding/swelling).

Post-op sequence: *"Ice, then Nice"*

Ice first 12–24 hr → **Nice** warm sitz baths after. Switching too early ↑ swelling & bleeding.

Position: *"Side, never wide"*

Post-hemorrhoidectomy = **side-lying**. Supine spreads pressure across the suture line.

Bleeding color decoder

Bright red on TP/coating stool = hemorrhoid (lower GI).
Mixed in stool = polyp / colon source.
Black/tarry (melena) = upper GI — NOT hemorrhoids.

12 NCJMM Clinical Judgment Scenario

Scenario: A 58-year-old male is post-op day 1 from a hemorrhoidectomy for Grade IV internal hemorrhoids. He reports 8/10 perianal pain, has not voided in 9 hours, and you note a small amount of bright red drainage on the perianal pad. Vitals: BP 138/86, HR 96, RR 18, T 99.2°F, SpO_2 97% RA.

1 Recognize cues

8/10 pain, bright red drainage, no void × 9 hr, slightly elevated HR, low-grade temp, recent perianal surgery.

2 Analyze cues

Pain is expected POD 1 but uncontrolled at 8/10. Bright red drainage = active fresh bleeding (concerning even if small amount). No void × 9 hr exceeds 6–8 hr threshold for post-hemorrhoidectomy urinary retention. ↑HR may reflect pain, blood loss, or bladder distention.

3 Prioritize hypotheses

① Acute pain — uncontrolled. ② **Possible post-op hemorrhage** — recheck under buttocks (blood pools). ③ Acute urinary retention from sphincter spasm/anesthesia. ④ Risk for impaction once bowels resume.

4 Generate solutions

Quantify bleeding (count/weigh pads, check linen); reassess vital signs & Hgb; assess bladder (palpation/scan); administer ordered analgesic; offer voiding measures (privacy, warm water over perineum, ambulation); prepare straight cath if no void; verify stool softener is ordered & given; notify HCP if bleeding ↑, BP drops, or unable to void.

5 Take action

Priority order: ① Assess bleeding fully (under buttocks) & recheck VS · ② Bladder scan; if >500 mL or distended → notify HCP & straight cath per order · ③ Administer analgesic + reposition **side-lying** · ④ Apply ice pack if still within 24 hr window · ⑤ Confirm stool softener active · ⑥ Document & reassess in 30 min.

6 Evaluate outcomes

Effective if: pain ↓ to ≤4/10, no further bleeding, voids ≥300 mL, VS stable, patient verbalizes understanding of side-lying position, sitz bath plan for POD 1+, scheduled stool softener and timing of analgesia before first BM.