Conservative Treatment of Hemorrhoids in Pregnant Women and Postpartum Patients

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Abstract: Hemorrhoids are one of the most common proctological diseases in pregnant women and postpartum patients, significantly impairing quality of life.The aim of this study was to evaluate the specific features of treatment strategies for hemorrhoids during pregnancy and in the postpartum period, taking into account safety for both mother and fetus. Clinical manifestations, the effectiveness of various therapeutic approaches, and the incidence of complications were analyzed. The study included 60 patients who received комплекс therapy using outpatient methods. The results demonstrated high effectiveness of conservative treatment in the early stages of the disease. Optimal treatment strategies are discussed considering the trimester of pregnancy and the condition of postpartum patients.

Keywords: hemorrhoids; pregnancy; postpartum women; proctology; therapy; conservative treatment

Introduction

Hemorrhoids are a pathological enlargement of hemorrhoidal nodes manifested by periodic bleeding, prolapse of nodes from the anal canal, and frequent inflammation. The condition is based on cavernous formations located as internal nodes within the anal canal and as external nodes under the perineal skin in close proximity to the anal opening[1].

The main factor in hemorrhoid development is impaired venous outflow from the cavernous bodies of the rectum and their subsequent hyperplasia in its distal part and anal canal. Anatomically, cavernous bodies are characterized by numerous direct arteriovenous anastomoses. Therefore, bleeding in hemorrhoidal disease is arterial in nature and may pose a risk to the patient[2].

Hemorrhoids are among the most common conditions during pregnancy and the postpartum period. The disease may occur in acute or chronic forms, presenting as thrombosis, inflammation, and bleeding. The incidence of hemorrhoids during pregnancy ranges from 25% to 40%, depending on age and lifestyle. Increased intra-abdominal pressure, hormonal relaxation of venous walls, constipation, and prolonged straining during labor are key risk factors for the development and progression of hemorrhoids during this period[3].

Despite its high prevalence, the optimal treatment strategy in pregnant and postpartum women remains controversial due to the need to balance therapeutic effectiveness and maternal–fetal safety.

The purpose of this study was to develop a justified treatment strategy for hemorrhoids in pregnant and postpartum women, taking into account disease stage, gestational age, and associated risk factors[4].

1. To assess clinical manifestations of hemorrhoids at different stages of pregnancy and in the postpartum period.
2. To evaluate the effectiveness of conservative therapy in pregnant women with hemorrhoids.
3. To assess the efficacy of minimally invasive methods in patients unresponsive to conservative therapy.
4. To determine complication rates and factors influencing treatment outcomes.

Materials and Methods

A clinical observational study was conducted involving 60 women aged 19–42 years diagnosed with hemorrhoids:

- 45 pregnant women (I trimester — 10%, II trimester — 30%, III trimester — 60%);
- 15 postpartum women within the first 6 weeks after delivery.

Exclusion criteria: acute thrombosis of hemorrhoidal nodes, inflammatory bowel diseases, malignant neoplasms, and severe somatic disorders.

Clinical and instrumental methods included detailed medical history, objective examination, digital rectal examination, anoscopy, and, when indicated, fibrokolonoscopy to assess the stage of hemorrhoids.

All patients underwent stepwise treatment including:

- Conservative therapy:
- dietary and lifestyle modification;
- increased intake of fiber and fluids;
- mild laxatives when necessary;
- topical preparations (ointments/suppositories with anesthetics and venotonics approved for pregnancy);
- systemic venotonics when indicated (after safety evaluation).

The choice of method depended on the stage of hemorrhoids and gestational age.

Criteria for Treatment Effectiveness

- relief of pain;
- reduction of bleeding;
- regression of nodes;
- absence of disease progression;
- safety and tolerability of therapy.

Results

Stage II hemorrhoids were diagnosed in 65% of patients, stage III in 25%, and stage I in 10%. Stage II predominated among pregnant women, while stage III was more common among postpartum patients[5].

Conservative therapy was effective in 70% of women with stage I–II hemorrhoids[6]:

- pain reduction in 85%;
- bleeding regression in 72%;
- 88% reported sustained symptom relief, with a low recurrence rate (8%) at 6-week postpartum follow-up.

Adverse effects included transient pain (12%) and local edema (7%), not requiring surgical intervention. Thrombosis developed in 3 patients, requiring more intensive management[7].

Thirty-five postpartum women with signs of acute hemorrhoids were observed. Thirteen had pronounced pain syndrome with intermittent bleeding, usually associated with defecation[8].

Average labor duration was 9 hours 45 minutes. Premature rupture of membranes occurred in 45% of mothers, with an average anhydrous interval of 4 hours 10 minutes. All observed women experienced chronic constipation during pregnancy. Predisposing factors included iron supplementation for anemia (25.7%), biliary dyskinesia (11.4%), and chronic gastritis (8.6%)[9].

Treatment included Relief (“standard”) and Relief Advance administered 2–3 times daily for 5–6 days. Postpartum women with severe pain and bleeding additionally received Relief ointment applied to external nodes three times daily until healing[10].

All women reported pain and burning reduction within 1–2 days. Treatment duration varied:

- up to 3 weeks in 48.5% of cases;
- 2 weeks in 34.3%;
- 7–10 days in 20.5%.

Eight postpartum women who received Relief Advance suppositories during pregnancy and postpartum showed significant improvement without complications such as strangulation or bleeding of external nodes[11].

Approximately half of women with hemorrhoids during pregnancy experience exacerbation after childbirth. Severe straining during the second stage of labor may lead to rupture of hemorrhoidal nodes or even anal sphincter injury, requiring surgical repair. In the early postpartum period, internal nodes often reduce spontaneously; however, rapid sphincter contraction may cause strangulation and acute hemorrhoids[12].

Exacerbation of hemorrhoids, especially combined with perineal trauma, significantly affects postpartum recovery. The use of Relief group medications облегчает symptoms, accelerates healing, supports mother–newborn bonding, and carries a low risk of adverse effects[13].

The findings confirm that hemorrhoids in pregnant and postpartum women are common and require an individualized approach[14]. Conservative therapy remains the cornerstone of treatment in early stages, ensuring high effectiveness and safety. Dietary recommendations and correction of bowel habits contribute significantly to symptom reduction and prevention of complications[15].

Conclusion

Treatment of hemorrhoids in pregnant and postpartum women should be comprehensive, safe, and stage-oriented, considering the physiological changes that occur during pregnancy and the postpartum period. Hormonal effects, increased intra-abdominal pressure, venous congestion, and constipation contribute significantly to the development and exacerbation of hemorrhoids. Therefore, therapeutic management must focus not only on symptom relief but also on preventing progression while ensuring the safety of both mother and child.

For stage I–II hemorrhoids, conservative therapy remains the first-line treatment. The primary goals are to reduce pain, itching, inflammation, and bleeding, as well as to normalize bowel function. Dietary modification plays a central role in management. A fiber-rich diet including vegetables, fruits, whole grains, and legumes helps soften stool and decrease straining during defecation. Adequate fluid intake is essential to support bowel motility. Moderate physical activity, such as daily walking, also improves venous return and reduces pelvic congestion.

Regulation of bowel movements is particularly important. Safe bulk-forming agents or mild osmotic laxatives may be prescribed under medical supervision to prevent constipation. Patients should be educated about avoiding prolonged sitting on the toilet and excessive straining, which can worsen symptoms. Topical therapy is widely used for symptomatic relief. Suppositories and ointments containing anti-inflammatory and mild anesthetic components help decrease swelling and discomfort. In selected cases, short-term use of topical corticosteroids may be recommended under strict medical supervision. Warm sitz baths and careful perianal hygiene further support recovery.In more advanced cases (stage III–IV) or when complications such as thrombosis or persistent bleeding occur, additional interventions may be necessary. However, invasive procedures during pregnancy are generally avoided unless absolutely indicated. After delivery, if conservative therapy is ineffective, minimally invasive techniques may be considered. Overall, management requires a multidisciplinary approach involving both an obstetrician-gynecologist and a proctologist. Such collaboration ensures appropriate disease assessment, safe treatment selection, and prevention of complications during pregnancy and the postpartum period.

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