Frequently Asked Questions

CRH O'Regan System®
Non-Surgical Hemorrhoid Treatment
Fast. Painless. Proven.

Q: Which patients can be "ligated"?

A: The vast majority of patients with hemorrhoidal disease are excellent candidates for the procedure. The CRH-O'Regan Disposable Hemorrhoid Banding System is suitable for virtually ALL patients with Grades I – III disease, and many to most of the Grade IV patients. If you can reduce a Grade IV patient, then you will convert them to a Grade II or III, and they will be wonderful candidates for the procedure.

Q: Can you REALLY band patients with Grade III or IV disease?

A: Yes you REALLY can! Other technologies state that Grade III patients should be taken to the operating room… and we have a wonderful track record treating these patients with our Technology.

Q: How about patients with only mild to moderate disease?

A: Other techniques are reserved only for the most severely symptomatic patients, asthose treatments are associated with significant pain and disability. The CRH O'Regan Ligator is not accompanied by any of these problems, and so is perfectly suited to the recurrent-mildly symptomatic patients, as well as those with moderate to severe problems.

Q: I'm afraid that I'm not grabbing enough tissue in my band to afford the patient any relief . .. is there a minimum size to the "pile" that is banded using your Ligator?

A: The techniques that we espouse allow for an excellent clinical response without trapping a tremendous amount of tissue in the band. The band works in two ways . . both to help cut off some of the "feeders" to the pile, as well as to create a scarring that occurs in the submucosa, helping to re-establish some of the suspensory connections between the mucosa and the muscularis that are broken down in patients with hemorrhoids. The facts that less tissue is required, and that the band is placed a bit more proximal than with other techniques as well restricting treatment to one column of hemorrhoids at a setting allows for our technique to be more effective with less associated problems than other treatments available.

That being said, it IS possible to have too little tissue in the band. As a general rule of thumb, you should have a "tuft" of tissue in the band, the size of which depends in large part on how much loose and redundant tissue is present. If the banded tissue feels like a pencil eraser or less . . . you will need to get additional tissue banded. If the tuft is similar in size to the tip of your little finger… you are probably fine.

Q: What do I do if the patient complains of pain after a band?

A: Typically, the patient complains of a "pinching" pain when too much tissue is trapped within the band, or some excess surrounding mucosa, or tissue which is too close to (or distal to) the dentate line. Trapping of the muscularis is also a possibility. Perform a digital rectal exam, and manipulate the banded pile to make certain that the tuft is "standing straight up", is not tethered to any other mucosa, and moves freely (so not adherent to the muscularis). If the patient still has a pinching pain, simply roll up the band a mm or two. If that is not sufficient, you can pop the band off with your finger, and then reapply a band a bit more proximally than you placed originally.

Q: What about patient complaints after leaving the office?

A: Minimize these by asking the patient to remain in the exam room for a few minutes after being banded. If the patient only experiences a "pressure" sensation without a "pinch", then they are unlikely to have problems. If the patient does complain in the first few hours, ask the patient to return, and try to manipulate the band in order to relieve the patient's symptoms. Patient complaints after this are usually due to either a localized thrombosis or pelvic floor spasm. Treatment with topical nitroglycerin is usually quite helpful. If the patient has no contraindications, then a NSAI and/or some topical anesthetic can be used.

Q: What about sepsis?

A: Utilizing our Technology and techniques, with approximately 60,000 applications, we have not seen a case of sepsis. Much of the credit for this goes to the Ligator, which makes it difficult to pick up tissue that is too deep, and to the technique of manipulating the pile, and making certain that it is mobile. That being said, if the patient experiences fever, malaise, tachycardia, pain, urinary retention, etc., sepsis must be considered. The patient should have intravenous fluids started along with broad-spectrum antibiotics and a thorough evaluation.

Q: My patient called after a banding, and stated that they found a rubber band floating in the commode after their first bowel movement. What should I do?

A: Reassure the patient, and see him/her at their next scheduled appointment. Even though the band usually doesn't fall off until days 2 – 5, periodically it will come off earlier; yet still achieve the desired result. It is possible that the band came off prematurely, but this should be evident at the next visit.

Q: How do you handle a patient with a post-band bleed?

A: Most patients stop bleeding when lying down, applying ice and drinking fluids. For those that do not, or for those with a substantial bleed, instruct the patient to come to the emergency room. Multiple treatments are available for this type of bleeding, from re-ligating the bleeding site, to cauterizing it with a silver nitrate stick, to applying an endoscopic clip. Each of these maneuvers typically takes care of the patient's problem immediately.

Q: How do you deal with patients on anticoagulants?

A: Patients on anticoagulants are said to have an increased risk of bleeding in the postbanding period. These patients should have their Coumadin or Plavix stopped on the day of the banding session (if safe and appropriate to do so) and withheld for 5 days following the procedure in order to minimize that risk. Aspirin products are accompanied by a caution, as there can be bleeding issues arise, but these are not terribly common. We do NOT recommend banding a patient with portal hypertension.

Q: I've had terrible problems using nitroglycerin in the past, and I see that you use this quite often.

A: The vast majority of the problems associated with topical nitroglycerin utilized in perianal situations is due to either using too potent a formulation of NTG, or using too much of it (or both!). We recommend using 0.125% nitroglycerin ointment*, and using a "pea-sized" drop placed inside the anus 2 -3 times per day. In patients with fissures, the treatment must be continued for 3 months after the fissure is healed, in order to minimize the risk of recurrence.

Q: Who should be treated with NTG?

A: At a minimum, the patients with the following problems should be treated with topical NTG:

- Anal Fissures
- Anal Spasm
- Perianal pain
- Thrombosed Hemorrhoids (Int or Ext)
- "Double Sphincter Sign"
- Patients with incomplete evacuation symptoms
- "Tight Sphincter"

Dr. Cleator recommends using NTG on the vast majority of patients, as he sees a more rapid healing of the post-banding ulcer, and sees fewer complaints of pain with its use.

Q: What do I do for a patient when NTG is not effective?

A: If 0.125% NTG* administered as recommended is not sufficient, then the frequency or amount of the medication can be increased. If that is not effective, AND if the patient is not having headaches, then you can advance to a 0.2% NTG* formulation. If the patient IS having headaches, then topical Nifedipine or Diltiazem can be tried. In the event that all of the above has failed, botulinum toxin can be administered, 10 units into each side of the internal sphincter. If this fails, then a repeat treatment with 20 units per side may be tried. This strategy results in the healing of 80-85% of the patients with virtually no long-term problems (such as incontinence) If all of the above has failed, then consideration should be given to a surgical procedure (Lateral Internal Sphincterotomy).

Q: **My patient presented with a thrombosed external hemorrhoid that occurred 3 days ago. What should I do?**

A: Thrombosed external hemorrhoids can be treated conservatively, but often, if treated acutely with an incision and evacuation within the first 24-48 hours of its onset, relief will be more immediate and more complete. If more than 48 hours has passed, then the thrombosis typically begins the "organization" process, and becomes much more difficult to evacuate with a simple incision. In fact, incising these patients' thromboses may well lead to a DELAY in their improvement. In most circumstances, topical anesthetics, nitroglycerin and sitz baths are very helpful. A notable exception to this is for the patient with a several day old thrombosis, and an ulceration with a visible clot. Evacuating the clot can help these patients, and this can be done by topically applying anesthetic cream or ointment and then manually decompressing the thrombosis.

Q: Can I band someone that has a coexistent thrombosis or fissure?

A: If the patient is very symptomatic from a thrombosis or fissure, then treatment for the fissure or thrombosis should be instituted, and the ligation of the hemorrhoids can commence at their next clinic visit. If the patient is only mildly symptomatic from either of the conditions, then it is perfectly acceptable to begin ligations. These patients benefit tremendously by banding using the "touch technique" (without an anoscope), as the treatment is much less traumatic to the patient.

* "off-label" usage. Reference: Guttenplan, Mitchel. Anorectal Topicals – White Paper. January 2015