NHS
Cheshire and Merseyside

Clinical Commissioning Policy

Haemorrhoids, surgical management

Category 2 Intervention - Only routinely commissioned when specific criteria are met -

Ref:	CMICB_Clin024
Version:	2
Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
Supersedes:	CMICB_Clin024 version 1
Author (inc Job Title):	
Ratified by: (Name of responsible Committee)	ICB Clinical Effectiveness Group
Cross reference to other Policies/Guidance	
Date Ratified:	9th April 2026
Date Published and where (Intranet or Website):	8th July 2026 (Website)
Review date:	July 2031
Target audience:	All Cheshire & Merseyside ICB Staff and Provider organisations

This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

Document control:		
Date:	**Version Number:**	**Section and Description of Change**
April 2023	1	Policy ratified by Cheshire & Merseyside ICB
April 2026	2	Policy wording updated and ratified by ICB Clinical Effectiveness Group

1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

1.4 This policy is based on NHS England's Evidence-Based Interventions (EBI) recommendations see link to programme below - accurate at the point of publication https://www.aomrc.org.uk/ebi/clinicians/haemorrhoid-surgery/.

2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Summary of Intervention

3.1 This procedure involves surgery for haemorrhoids (piles).

3.2 Often haemorrhoids (especially early-stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient, non-surgical treatments such as banding or injection.

The following policy statement describes the circumstances patients should be offered surgical interventions.

Commented [KS1]: Does there need to be a final point here that states that this policy outlines in what circumstances patients should be offered surgical interventions for haemorrhoids, because 3.2 is about all of the other interventions?

4. Policy statement

4.1 All patients with haemorrhoids should be provided with dietary and lifestyle advice

4.2 Surgical management of haemorrhoids is also routinely commissioned in the following circumstances:

4.2.1 Persistent grade 1 (rare) or grade 2 haemorrhoids that have not responded to non-operative measures including dietary and lifestyle changes and non-surgical procedures, such as rubber band ligation, injection sclerotherapy, and infrared coagulation, as appropriate. Surgical management and approach to be clinically determined after considering response to conservative options.

OR

4.2.2 Grade 3, grade 4 or combined internal/external haemorrhoids causing persistent pain or bleeding which are recurrent or which are not suitable for non-surgical procedures.

OR

4.2.3 Large, irreducible external haemorrhoids.

4.3 In cases where there is significant rectal bleeding the patient should be examined internally by a specialist

4.4 When a patient meets the criteria for haemorrhoid surgery, there should be a shared decision-making process to decide what specific surgical procedure is used, taking into account patient choice, haemorrhoid severity, medical comorbidities and local availability

5. Exclusions

5.1 None

6. Rationale

6.1 Early stage haemorrhoids can often be treated through conservative measures such as dietary changes. If these measures are not effective then outpatient non-surgical interventions such as rubber band ligation or injections can be used.

6.2 Surgery should be performed, according to patient choice, and only in cases of persistent grade 1 (rare) or 2 haemorrhoids that have not improved with dietary changes or non-surgical treatments, in cases of symptomatic grade 3, grade 4 or combined internal/external haemorrhoids which are recurrent or not suitable for non-surgical interventions, or in cases of large, irreducible external haemorrhoids.

7. Underpinning evidence

7.1 National Institute for Health and Care Excellence. NICE CKS Haemorrhoids Management. 2021 07/2021 [cited 2024 May]; Available from: https://cks.nice.org.uk/topics/haemorrhoids/management/management/.

7.2 England, N., Haemorrhoid Surgery. Evidence-Based Interventions: Guidance for CCGs 2019: https://ebi.aomrc.org.uk/resources/. p. 28-29

7.3 Watson, A.J., et al., A pragmatic, multicentre, randomised controlled trial comparing stapled haemorrhoidopexy to traditional excisional surgery for haemorrhoidal disease (eTHoS): study protocol for a randomised controlled trial. Trials, 2014. 15: p. 439

7.4 Watson, A.J., et al., Comparison of stapled haemorrhoidopexy with traditional excisional surgery for haemorrhoidal disease (eTHoS): a pragmatic, multicentre, randomised controlled trial. Lancet, 2016. 388(10058): p. 2375-2385.

7.5 Brown, S., et al., The HubBLe Trial: haemorrhoidal artery ligation (HAL) versus rubber band ligation (RBL) for symptomatic second- and third-degree haemorrhoids: a multicentre randomised controlled trial and health-economic evaluation. Health Technol Assess, 2016. 20(88): p. 1-150 .

7.6 Academy of Medical Royal Colleges. Haemorrhoid surgery. 2024 [cited 2024; Available from: https://ebi.aomrc.org.uk/interventions/haemorrhoid-surgery/.

7.7 Academy of Medical Royal Colleges. Haemorrhoid surgery. 2024 [cited 2024; Available from: https://ebi.aomrc.org.uk/interventions/haemorrhoid-surgery/.

7.8 Thaha, M.A. and R.J.C. Steele, BMJ Best Practice Haemorrhoids. 2022: https://bestpractice.bmj.com/topics/en-gb/181/pdf/181/Haemorrhoids.pdf.

7.9 van Tol, R.R., et al., European Society of ColoProctology: guideline for haemorrhoidal disease. Colorectal Dis, 2020. 22(6): p. 650-662.

7.10 Hawkins, A.T., et al., The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for the Management of Hemorrhoids. Dis Colon Rectum, 2024. 67(5): p. 614-623.

7.11 El-Kelani, M.Z., et al., Recommendations and best practice on the management of hemorrhoidal disease in Saudi Arabia. Hospital Practice, 2022. 50(2): p. 104-109.

7.12 De Schepper, H., et al., Belgian consensus guideline on the management of hemorrhoidal disease. Acta Gastroenterol Belg, 2021. 84(1): p. 101-120.

7.13 Gallo, G., et al., Consensus statement of the Italian society of colorectal surgery (SICCR): management and treatment of hemorrhoidal disease. Techniques in Coloproctology, 2020. 24(2): p. 145-164.

7.14 National Institute for Health and Care Excellence, IPG627 Superior rectal artery embolisation for haemorrhoids. 2018: https://www.nice.org.uk/guidance/ipg627/resources/superior-rectal-artery-embolisation-for-haemorrhoids-pdf-1899873987681733.

7.15 National Institute for Health and Care Excellence, IPG589 Radiofrequency treatment for haemorrhoids. 2017: https://www.nice.org.uk/guidance/ipg589/resources/radiofrequency-treatment-for-haemorrhoids-pdf-1899872177055685.

7.16 National Institute for Health and Care Excellence, IPG525 Electrotherapy for the treatment of haemorrhoids. 2015: https://www.nice.org.uk/guidance/ipg525/resources/electrotherapy-for-the-treatment-of-haemorrhoids-pdf-1899871807540165.

7.17 National Institute for Health and Care Excellence, MIB201 eXroid for internal heamorrhoids. 2019: https://www.nice.org.uk/advice/mib201/resources/exroid-for-internal-haemorrhoids-pdf-2285965386043333.

7.18 National Institute for Health and Care Excellence, IPG342 Haemorrhoidal artery ligation. 2010: https://www.nice.org.uk/guidance/ipg342/resources/haemorrhoidal-artery-ligation-pdf-1899867569868997.

7.19 National Institute for Health and Care Excellence, TA128 Stapled haemorrhoidopexy for the treatment of haemorrhoids. 2007: https://www.nice.org.uk/guidance/ta128/resources/stapled-haemorrhoidopexy-for-the-treatment-of-haemorrhoids-pdf-82598140063429.

7.20 National Institute for Health and Care Excellence, IPG34 Circular stapled haemorrhoidectomy. 2003: https://www.nice.org.uk/guidance/ipg34/resources/circular-stapled-haemorrhoidectomy-pdf-52774099025605.

7.21 Gallo, G., et al., Sclerotherapy for hemorrhoidal disease: systematic review and meta-analysis. Tech Coloproctol, 2024. 28(1): p. 28.

7.22 Ding, Z., et al., Rubber band ligation versus coagulation for the treatment of haemorrhoids: a meta-analysis of randomised controlled trials. Postgraduate Medical Journal, 2023. 99(1175): p. 946-953.

7.23 Yuan, X.G., et al., Comparison of the efficacy and safety of different surgical procedures for patients with hemorrhoids: a network meta-analysis. Tech Coloproctol, 2023. 27(10): p. 799-811.

7.24 Patel, J., et al., HEmoRhoidal disease management with Band ligation versus polidocanol Sclerotherapy: a systematic review and meta-analysis (the HerBS Review). Int J Colorectal Dis, 2023. 38(1): p. 112.

7.25 Lohsiriwat, V., et al., Recurrence Rates and Pharmacological Treatment for Hemorrhoidal Disease: A Systematic Review. Advances in Therapy, 2023. 40(1): p. 117-132.

7.26 Tan, V.Z.Z., et al., Systematic review and meta-analysis of postoperative pain and symptoms control following laser haemorrhoidoplasty versus Milligan-Morgan haemorrhoidectomy for symptomatic haemorrhoids: a new standard. Int J Colorectal Dis, 2022. 37(8): p. 1759-1771.

7.27 Grossi, U., et al. Surgical Management of Hemorrhoidal Disease in Inflammatory Bowel Disease: A Systematic Review with Proportional Meta-Analysis. Journal of Clinical Medicine, 2022. 11, DOI: 10.3390/jcm11030709.

7.28 Trigui, A., et al., Laser utility in the treatment of hemorrhoidal pathology: a review of literature. Lasers in Medical Science, 2022. 37(2): p. 693-699.

7.29 Aibuedefe, B., et al., An update on surgical treatment of hemorrhoidal disease: a systematic review and meta-analysis. International Journal of Colorectal Disease, 2021. 36(9): p. 2041-2049.

7.30 Ruan, Q.Z., et al., A systematic review of the literature assessing the outcomes of stapled haemorrhoidopexy versus open haemorrhoidectomy. Tech Coloproctol, 2021. 25(1): p. 19-33.

7.31 Longchamp, G., et al., Non-excisional laser therapies for hemorrhoidal disease: a systematic review of the literature. Lasers in Medical Science, 2021. 36(3): p. 485-496.
Sheikh, P., V. Lohsiriwat, and Y. Shelygin, Micronized Purified Flavonoid Fraction in Hemorrhoid Disease: A Systematic Review and Meta-Analysis. Advances in Therapy, 2020. 37(6): p. 2792-2812
Zhang, G., et al., Network meta-analysis of randomized controlled trials comparing the procedure for prolapse and hemorrhoids, Milligan-Morgan hemorrhoidectomy and tissue-selecting therapy stapler in the treatment of grade III and IV internal hemorrhoids(Meta-analysis). International Journal of Surgery, 2020. 74: p. 53-60.

7.32 Du, T., et al., Comparison of surgical procedures implemented in recent years for patients with grade III and IV hemorrhoids: a network meta-analysis. International Journal of Colorectal Disease, 2019. 34(6): p. 1001-1012

8. Force

8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

9. Coding

SQL code

```
WHEN left(der.Spell_Dominant_Procedure,4)  IN ('H511','H512','H513','H518','H519')
AND APCS.Admission_Method  not like ('2%')
THEN 'I_haemmor'
```

Global cancer exclusion

```
APC
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (apcs.der_diagnosis_all not like '%C[0-9][0-9]%'
AND apcs.der_diagnosis_all not like '%D0%'
AND apcs.der_diagnosis_all not like '%D3[789]%'
AND apcs.der_diagnosis_all not like '%D4[012345678]%'
OR apcs.der_diagnosis_all IS NULL)
```

10. Monitoring And Review

10.1 This policy may be subject to continued monitoring using a mix of the following approaches:

- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

10.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix 1 - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:
- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:
- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:
- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.