Hemorrhoids

A Complete Guide to Prevention and Treatment

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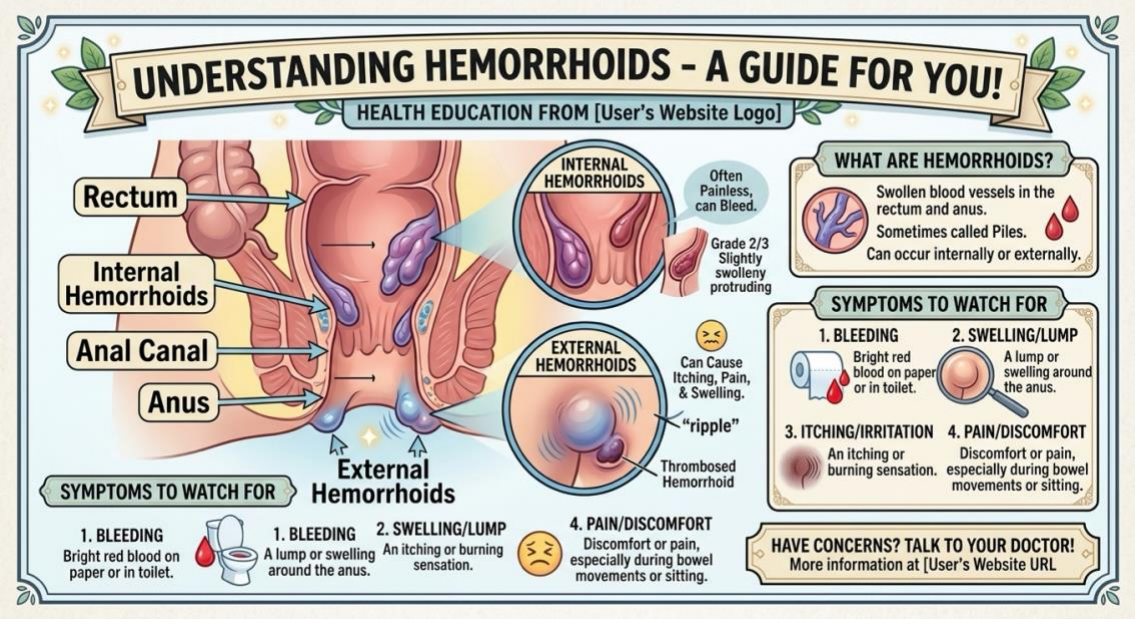

Hemorrhoids are one of the most common conditions in medicine, and one of the least discussed. When they flare, most people are not interested in the anatomy lesson first. They want the pain to stop, the lump and swelling to go down, bowel movements to stop hurting, the bleeding to stop, and the area to feel clean again. This guide begins with those concerns, then shows you how to prevent the next episode.

If you are in the middle of a flare, begin with Part One and the Jumpstart Plan. Once you are comfortable again, use Part Two to address the bowel and bathroom habits that allow hemorrhoids to keep returning.

> *Before you read further: do not automatically blame rectal bleeding on hemorrhoids. Hemorrhoids are common, but bleeding can also come from a fissure, inflammation, a polyp, or colorectal cancer. New, recurrent, unexplained, heavy, or persistent bleeding deserves medical evaluation. Being current with colorectal cancer screening does not make every episode harmless, but it does make the conversation much safer and clearer.*

Understanding What You Are Dealing With

Hemorrhoids Are Normal Anatomy Behaving Badly

Everyone has hemorrhoids. That surprises most people. The anal canal is lined with three small cushions of tissue packed with blood vessels, and those cushions are part of the normal equipment. They seal the anal canal, they help you distinguish gas from stool, and they cushion the passage of a bowel movement. Think of them as the weather stripping around a door: soft, springy, and doing quiet work you never notice.

The word hemorrhoid only becomes a diagnosis when those cushions become engorged, stretched, and inflamed. Picture an inner tube that has been overinflated one too many times. The rubber stretches, loses its recoil, and starts to bulge where it used to sit flat. That is a hemorrhoid. Almost everything in this guide is aimed at one goal: taking pressure off that inner tube.

Internal Versus External

Internal hemorrhoids- sit above the anal opening, where there are relatively few pain fibers. They most often cause bright-red bleeding or prolapse rather than sharp pain. Prolapsed tissue can create pressure, a persistent feeling that something is still there, mucus leakage, underwear staining, and difficulty getting clean after a bowel movement.

External hemorrhoids- sit at and just below the anal opening, in skin rich in pain fibers. These are the hemorrhoids most likely to hurt with sitting, walking, wiping, or passing stool. They can cause a tender lump, swelling, burning, itching, and raw skin. If a clot forms inside one, the result is a thrombosed external hemorrhoid: a sudden, firm, blue or purple lump that can be intensely painful.

Many people have internal and external disease at the same time. That is why one person may be worried mainly about pain, while another is bothered more by bleeding, prolapse, mucus, or repeated difficulty getting clean.

How Internal Hemorrhoids Are Graded

If you see a specialist, you will hear grades. They are simply a description of how far the tissue has slipped.

- **Grade I:** they bleed but do not come out.
- **Grade II:** they come out during a bowel movement and go back on their own.
- **Grade III:** they come out and have to be pushed back in by hand.
- **Grade IV:** they stay out and cannot be pushed back.

Grades I and II almost always respond to the measures in this guide. Grades III and IV usually need a procedure in addition to them.

What Actually Causes Them

Nearly every case traces back to one of two things: too much pressure in the pelvis, or too much time straining on the toilet. The usual suspects are constipation and hard stool, straining and pushing, sitting on the toilet for long stretches, prolonged sitting in general, low fiber intake, poor hydration, pregnancy and childbirth, heavy lifting with a held breath, chronic coughing, chronic diarrhea, obesity, and simple aging of the supporting tissue.

Notice how many of those you can change. That is the good news, and it is what the prevention section in Part Two is about.

Part One: Relief During an Active Flare

During a flare, your goals are practical: control pain, reduce swelling, make the next bowel movement easy, stop irritation and leakage, and know whether the symptoms are safe to manage at home. Shrinking the hemorrhoid is useful, but it is not the goal by itself; the goal is to restore comfort, cleanliness, and confidence while the tissue heals.

Most uncomplicated flares improve noticeably within several days and settle over one to two weeks. A thrombosed external hemorrhoid often hurts most during the first two or three days. Symptoms that are severe, worsening, unusual, or not improving deserve an examination.

Start With the Problem Bothering You Most

-Pain and tenderness. Warm sitz baths, topical lidocaine or pramoxine for a short period, an appropriate oral pain reliever, and softer stool usually matter most. Sudden severe pain with a firm lump may be a thrombosed external hemorrhoid and is worth prompt evaluation.

-A swollen external lump. Cold packs can ease acute swelling, while time and protection from further trauma do most of the healing. A shrinking lump is reassuring, but pain relief and improving function are better measures of progress.

-Pain or fear with bowel movements. Make the stool soft enough to pass without straining, lubricate the opening with Preparation H, petrolatum or zinc oxide, use a footstool, and do not remain on the toilet trying to force completion. One good strategy is to insert a Preparation H suppository in the rectum at night before bed. This melts overnight, and then creates excellent lubrication the next day when you have a bowel movement. Alternatively, you can insert Preparation H ointment into the anal canal right before a bowel movement if needed.

-Bleeding. Avoid straining and correct constipation, but do not assume the blood is harmless. New, recurrent, persistent, or substantial bleeding should be evaluated.

-Itching, burning, or raw skin. Rinse rather than scrub, pat dry, avoid fragranced wipes and soaps, and protect the skin with petrolatum or zinc oxide. More wiping usually makes this problem worse. If you have access to a bidet, this can be an excellent way to clean the area without irritating the tissues. A soothing ointment to the area after cleaning, such as a preparation agent ointment, may also be helpful.

-Mucus, staining, or difficulty getting clean. This often reflects prolapsing internal tissue or irritated skin rather than true loss of bowel control. Water cleansing and a barrier ointment help, but persistent leakage, new fecal incontinence, or prolapse should be examined. Once again, a bidet may be an excellent solution for cleaning in the presence of hemorrhoids.

Step 1: Make the Next Bowel Movement Easy

Every hard or strained bowel movement re-injures swollen tissue. The immediate target is a soft, formed stool that passes without pushing—not diarrhea, and not simply a bowel movement every day.

- Increase water intake immediately and deliberately. Caution: If you are in a water restriction due to other health concerns, please consult your provider before increasing your water intake.
- Continue or start psyllium, start with one tablespoon daily with plenty of water. Then eventually ramp up to two tablespoons per day.
- Ground flax and chia seeds are another excellent source of added fiber.
- Add magnesium citrate, two hundred to four hundred milligrams at bedtime, if stools are at all hard.
- If fiber is not enough or tends to cause bloating, polyethylene glycol (MiraLAX or a generic), commonly seventeen grams in water daily, is a reasonable over-the-counter option. Adjust the amount to avoid loose stools. Docusate is widely used, but evidence that it meaningfully softens stool is limited.
- The goal for the next two weeks is stool that requires no effort at all. If you are pushing, you are not there yet.

Step 2: Calm Pain and Spasm With Warm Water

A warm sitz bath does not cure the hemorrhoid, but many patients find that it relaxes the anal muscles, cleans without rubbing, and gives meaningful short-term relief from aching, burning, and spasm.

How To Do It Properly

- Use a plastic sitz basin that sits on the toilet rim, available at any drug store, or simply sit in three to four inches of water in a clean bathtub.
- The water should be comfortably warm, not hot enough to burn or irritate the skin.
- Soak for ten to fifteen minutes.
- Do this two to three times daily, and additionally after every bowel movement, which is when it helps most.
- Plain warm water is sufficient and is what the evidence supports. If you prefer, a few tablespoons of Epsom salts may add some soothing effect. Skip bubble bath, scented oils, baking soda, and antiseptics, all of which irritate.
- Afterward, pat dry gently or use a hair dryer on the cool setting. Leaving the area damp invites itching.
- Relax the muscles while you soak rather than clenching. Slow breathing helps the sphincter let go.

Step 3: Protect the Skin and Reduce Friction

A bowel movement and repeated wiping can keep the area raw. A thin layer of Preparation H ointment, plain petroleum jelly or zinc oxide before a bowel movement reduces friction; another thin layer afterward protects irritated skin from moisture and minor leakage.

Suppositories are intended primarily for internal symptoms. They may temporarily soothe or lubricate, but they do not treat an external lump and are not necessary for everyone. However, they may ease the passage of the stool since it makes the tissues slippery.

Before a bowel movement: apply a small amount of Preparation ointment, petroleum jelly, zinc oxide, or an appropriate hemorrhoid ointment to the anal opening. Do not force an applicator into a painful or swollen canal.

Afterward: rinse gently with water, pat dry or use a hair dryer on the cool setting, and reapply a thin barrier if the skin is irritated or moist.

If hard stool is already lodged at the outlet, an occasional glycerin suppository may lubricate and stimulate evacuation. Stop if insertion is painful, and do not use repeated rectal products to compensate for ongoing constipation.

Products containing phenylephrine are marketed to temporarily shrink swollen tissue. The benefit is usually modest and temporary. Ask your provider or pharmacist before using one if you have cardiovascular disease, high blood pressure, thyroid disease, diabetes, urinary retention, or potentially interacting medication.

Step 4: Reduce Acute External Swelling

Warmth relaxes, and cold reduces swelling. There is no contradiction in using both, and alternating them is often the most comfortable approach in the first two or three days.

Apply a cloth-wrapped cold pack to the outside for ten to fifteen minutes, up to three or four times daily, particularly for a sudden, tense, painful external swelling. Never apply ice directly to the skin. A useful routine during the acute phase is a warm sitz bath, followed by gentle drying, followed by a cold pack, followed by ointment.

Step 5: Match the Topical Product to the Symptom

The drugstore shelf is crowded. Choose by symptom, use the fewest products necessary, and stop anything that causes more burning or rash.

Witch hazel pads. These may temporarily soothe itching or irritation, but they can sting or dry the skin in some people. Stop if symptoms worsen.

Barrier ointments. Preparation age ointment, petrolatum and zinc oxide are often the simplest choices for raw skin, moisture, minor mucus leakage, and difficult cleanup. They can be used longer than steroid or anesthetic products.

Local anesthetics. Lidocaine or pramoxine can provide short-term relief of external pain and itching. Use only as directed and generally for no more than about a week unless your clinician advises otherwise; prolonged use can cause contact dermatitis.

Vasoconstrictors. Phenylephrine may temporarily reduce swelling and discomfort, but it does not remove the hemorrhoid or correct the cause.

Hydrocortisone one percent. Available over the counter, this reduces inflammation and itching. Limit it to one to two weeks, for the reasons described below.

Step 6: Prescription Options

When over-the-counter measures are not enough, a short course of a prescription combination product usually settles things quickly. These are prescription-only in the United States, so they require a conversation with your provider.

Anusol-HC suppositories, twenty-five milligrams. Insert one suppository rectally at bedtime for one week. This combines the lubricating benefit of a suppository with hydrocortisone to reduce inflammation, and it is particularly useful for internal hemorrhoids that bleed.

Anusol-HC cream. Apply two to four times daily for one to two weeks. This is the better choice for external symptoms, itching, and irritated skin.

Why the one to two week limit matters. Topical steroids thin the skin with prolonged use, and the skin around the anus is already thin. Months of steroid cream produce fragile, easily torn skin, and sometimes a stubborn steroid-related dermatitis. Use it hard for a week or two, then stop and continue with the non-steroid measures. If you still need a steroid after two weeks, that is a reason to be seen rather than to refill.

Other prescriptions your provider may consider. Compounded nifedipine or diltiazem ointment relaxes sphincter spasm and is especially helpful when an anal fissure accompanies the hemorrhoids. Compounded combinations of a local anesthetic with a calcium channel blocker are also used. Nitroglycerin ointment works but frequently causes headaches. There are also other types of prescription steroid topical agents that your doctor may prescribe.

Step 7: Oral Flavonoids

This is the treatment most patients in the United States have never heard of, and it deserves a wider audience. Flavonoids are plant compounds that strengthen vein walls, reduce capillary leakiness, and improve venous tone. In Europe they are standard therapy for hemorrhoids, and the evidence for reducing bleeding, itching, and recurrence is reasonably good.

Diosmin with hesperidin. Often labeled micronized purified flavonoid fraction or sold under the brand name Daflon outside the United States. A typical maintenance dose is five hundred milligrams twice daily, and higher short-term dosing is often used during an acute flare. This is the best-studied of the group and is available as a supplement in the United States.

Horse chestnut seed extract. Standardized to sixteen to twenty percent aescin, roughly fifty milligrams of aescin twice daily. Long used for venous insufficiency and reasonable for hemorrhoids. Use a standardized extract rather than the raw seed, which is not safe.

Rutin and troxerutin. Related flavonoids with similar effects, sometimes included in combination products.

Cautions. *Discuss these with your provider if you take a blood thinner, and avoid them in pregnancy and breastfeeding unless your obstetric provider approves. As with all supplements, quality varies considerably between manufacturers, so look for third-party testing.*

Step 8: Pain Control

Acetaminophen is the preferred first choice, up to three thousand milligrams daily in divided doses for a healthy adult, and less if you have liver disease or drink alcohol regularly.

Ibuprofen and naproxen reduce both pain and inflammation and are helpful for a thrombosed hemorrhoid. They can increase bleeding, however, so use them cautiously if bleeding is your main symptom, and avoid them if you have kidney disease, ulcers, or take a blood thinner.

Avoid opioid pain medications if at all possible. Codeine, hydrocodone, oxycodone, and tramadol all cause constipation, which is precisely what caused the problem in the first place. Treating a hemorrhoid with an opioid is pouring gasoline on the fire.

Topical numbing usually beats an oral medication for external pain, so do not overlook Step 5.

Step 9: Toilet Discipline During a Flare

The bathroom habits described in Part Two matter even more during a flare, when the tissue is inflamed and vulnerable.

- Do not strain to chase a feeling of incomplete emptying. Swollen or prolapsed tissue itself can create the sensation that stool remains.
- Keep every visit on the toilet under three minutes.
- Use a footstool such as a Squatty Potty.
- Rinse with water rather than repeatedly wiping. This reduces pain, removes mucus or small amounts of retained stool, and protects raw skin.
- Sitz bath after each bowel movement whenever practical.
- Apply ointment before, and witch hazel after.

Reducing a Prolapsed Hemorrhoid

If internal hemorrhoid tissue has slipped out and is sitting outside the anal opening, gently returning it inside relieves a great deal of pain and prevents the tissue from becoming trapped and swollen.

- Take a warm sitz bath first to relax the sphincter and reduce swelling.
- Lubricate a gloved finger generously with petroleum jelly or the ointment you are already using.
- Lie on your side with your knees drawn up, and use steady, gentle pressure to ease the tissue back inside.
- Rest for a few minutes afterward, and avoid lifting or straining for the rest of the day.
- If it will not go back, if the attempt is severely painful, or if the tissue looks dark, dusky, or ulcerated, stop and call your provider the same day. Trapped hemorrhoid tissue can lose its blood supply, and that is an urgent problem.

The Thrombosed External Hemorrhoid

This one earns its own section because it behaves differently. A clot forms inside an external hemorrhoid, producing a sudden, firm, marble-like lump at the anal opening that is blue or purple and out of proportion in its tenderness. People often think something has ruptured.

The clot is not dangerous and the body gradually reabsorbs it. Pain commonly peaks during the first forty-eight to seventy-two hours and then improves over the following days. The lump may take several weeks to flatten and can leave a harmless skin tag. Judge recovery primarily by decreasing pain and improving function, not by whether the lump disappears immediately.

If the pain is severe and the lump appeared within the past two or three days, prompt evaluation is worthwhile. For selected patients, excision of the thrombosed hemorrhoid can provide faster relief. The decision depends on symptom severity, timing, health history, and clinician judgment—not on the clock alone.

In the meantime: cold packs, sitz baths, an anti-inflammatory such as ibuprofen if you can take it, topical numbing, stool softeners, and rest.

Do not attempt to lance or drain it yourself. Potential complications of that include serious infection and bleeding.

Things That Make It Worse

Some of the most common mistakes are worth naming plainly.

- Reading, scrolling, or lingering on the toilet.
- Straining to finish when the sensation of fullness is coming from the hemorrhoid itself.
- Aggressive or repeated dry wiping.
- Scented soaps, scented wipes, alcohol-containing wipes, and antiseptics.
- Using a topical steroid for months rather than weeks.

- Relying on stimulant laxatives to force a bowel movement.
- Adding fiber without adding water.
- Heavy lifting with a held breath.
- Sitting all day without breaks, including on a bicycle saddle.
- Alcohol, which dehydrates, and for some people spicy food and heavy caffeine, which can irritate. Watch your own pattern rather than assuming.
- Doing everything right for four days and then stopping. The tissue needs weeks, and the habits need to become permanent.

When To Call Your Provider

Self-treatment is entirely appropriate for a straightforward flare. These situations are not straightforward, and this is the most important list in the document.

Be Seen Promptly

- Any rectal bleeding that is new to you, or bleeding that persists beyond a week or two of good treatment.
- Bleeding accompanied by a change in your bowel habits, a change in the caliber or shape of the stool, unexplained weight loss, or abdominal pain.
- Blood that is mixed through the stool rather than streaked on the surface or on the paper, or stool that is black, tarry, or maroon.
- Bleeding if you are over forty-five, if you have a family history of colorectal cancer or polyps, or if you are overdue for colonoscopy. Hemorrhoids and colorectal cancer coexist all the time, and finding one does not rule out the other.
- Dizziness, unusual fatigue, shortness of breath, or paleness, which can indicate anemia from ongoing blood loss.
- Symptoms that are not improving after one to two weeks of consistent treatment, or that keep coming back.

Seek Care The Same Day Or Go To The Emergency Department

- Severe or rapidly worsening pain.
- Fever, chills, spreading redness, or drainage of pus, which suggest an abscess or infection.
- Heavy bleeding, bleeding that does not stop, or passing clots.
- Prolapsed tissue that cannot be reduced, or tissue that looks dark, black, or dusky.
- Inability to pass stool or urine.
- New fecal incontinence or a true loss of bowel control. Minor mucus or underwear staining can occur with prolapse, but new incontinence needs evaluation.

> **One more point worth repeating.** A great many things in this region are mistaken for hemorrhoids: anal fissures, abscesses and fistulas, pruritus ani, skin tags, condyloma, inflammatory bowel disease, and, uncommonly but importantly, anal and rectal cancer. If

> your symptoms are not behaving the way this guide describes, get an examination. It takes a few minutes and it settles the question.

Procedures, If You Need Them

If you have done the work in this guide faithfully and are still bleeding, still prolapsing, or still miserable, there are excellent office-based options, and they are far less dramatic than most people fear.

Rubber band ligation. The workhorse. A tiny band is placed at the base of an internal hemorrhoid, cutting off its blood supply so it shrinks and falls away within a week or two. It is done in the office in a few minutes, requires no anesthesia, and is highly effective for grades I through III. Expect a few days of dull pressure.

Sclerotherapy. A solution is injected into the hemorrhoid to scar and shrink it. Useful for small, bleeding internal hemorrhoids and for patients on blood thinners.

Infrared coagulation. A brief pulse of infrared light causes the tissue to scar and retract. Well tolerated, best for smaller hemorrhoids.

Hemorrhoidal artery ligation and stapled hemorrhoidopexy. Operating-room procedures that reduce blood flow or reposition the tissue rather than removing it, with less pain than a traditional hemorrhoidectomy.

Excisional hemorrhoidectomy. The definitive surgical removal, reserved mainly for grade IV disease, large mixed hemorrhoids, or cases that have failed everything else. It is the most effective and the most uncomfortable, with a recovery of two to four weeks.

Whichever route you take, continue the prevention habits in Part Two. Procedures treat the hemorrhoids you have; habits reduce the likelihood of the next flare.

The One-Week Jumpstart Plan

If you are uncomfortable right now, this is the shortest practical plan. It targets what patients care about most: less pain and swelling, an easy bowel movement, clean and comfortable skin, and confidence that the problem is improving safely.

If you do nothing else, do the first three.

1. Make stool easy to pass. Start psyllium gradually with plenty of water. If stool remains hard—or fiber worsens bloating—consider polyethylene glycol as directed on the label. The target is a soft, formed stool that passes without pushing. Avoid diarrhea, which can be just as irritating.

2. Hydrate consistently. Drink enough that you are not thirsty and your urine is generally pale, unless a clinician has restricted your fluids. Increase fluid as you increase fiber.

3. Change what happens on the toilet. Leave your phone outside the bathroom. Keep every visit under three minutes. Do not push, strain, or bear down, even if it feels unfinished, because

an inflamed hemorrhoid creates a false sense of incomplete emptying and chasing it is what prolongs a flare. Put a footstool under your feet so your knees sit above your hips.

4. Use warm water for pain and cleaning. Soak in comfortably warm water for ten to fifteen minutes two or three times daily if it helps, especially after a bowel movement. Pat dry; do not scrub.

5. Protect before and after. Apply a thin layer of Preparation H ointment. petroleum jelly or zinc oxide before a bowel movement to reduce friction. Rinse afterward, dry gently, and reapply a barrier if the skin is raw, damp, or irritated by mucus or minor staining.

6. Treat the symptom that is actually bothering you. Use a cloth-wrapped cold pack for a tense external swelling and acetaminophen for pain when appropriate. A short course of topical lidocaine or pramoxine may help external pain or itching. Avoid opioid pain medication because it worsens constipation.

7. Rinse instead of repeatedly wiping. A bidet attachment, peri bottle, handheld sprayer, or shower is gentler and cleans mucus and retained stool better than dry paper. Minor staining can accompany prolapse; true new loss of bowel control is not typical and should be evaluated.

8. Reassess at one week. You should be clearly trending better. If you are not, let a clinician confirm the diagnosis and discuss prescription or office-based treatment rather than continuing to cycle through over-the-counter products.

Call Your Provider Sooner Than Later If

- You have rectal bleeding that has never been evaluated, or you are over forty-five and overdue for a colonoscopy.
- The pain is severe, or a sudden hard painful lump has appeared, which is worth being seen for within two or three days.
- You have fever, chills, spreading redness, or drainage.
- Bleeding is heavy, will not stop, or comes with dizziness or unusual fatigue.
- Tissue has come out and will not go back in, or looks dark or dusky.

What To Buy

A practical shopping list: Preparation H suppositories and ointment (or petroleum jelly or zinc oxide ointment), psyllium, polyethylene glycol if needed, a footstool,- such as a Squatty Potty, a peri bottle or bidet attachment, a cloth-covered cold pack, and—if symptoms call for it—a short-term topical anesthetic. A plastic sitz basin is optional if a bathtub is inconvenient.

Most uncomplicated flares improve within several days and settle over one to two weeks. Pain should improve before every trace of the lump disappears. Once you are comfortable, continue the prevention habits in Part Two so the same episode is less likely to return.

Part Two: Preventing the Next Flare

Once the pain, swelling, bleeding, or irritation is settling, prevention becomes the priority: keep stool soft and formed, shorten toilet time, avoid straining, protect the skin, and address persistent constipation or diarrhea.

1. Hydration Comes First

This is the step people skip, and it is the one that makes everything else work. Fiber without water is a mistake. Fiber is a sponge, and a sponge with nothing to absorb becomes a plug — which is exactly the opposite of what you want. Adding fiber to a dehydrated system can make constipation worse, not better.

Aim for two to three liters of fluid daily, which is roughly eight to twelve cups, and more in the A summer or if you exercise, sweat heavily, or drink alcohol. Water is the mainstay. Herbal tea, mineral water, broth, and water-rich foods such as melon, cucumber, and citrus all count. Coffee and alcohol are mildly dehydrating, so drink extra water alongside them rather than counting them.

The easiest way to check: look at your urine. Pale straw means you are well hydrated. Dark yellow means you are behind. A tall glass of water first thing in the morning, before coffee, is one of the highest-return habits in this entire document.

2. Build the Foundation With Food Fiber

Most Americans take in about fifteen grams of fiber daily. Aim for thirty to forty grams. Fiber does two jobs at once: soluble fiber holds water and turns stool into something soft and slick, while insoluble fiber adds bulk so the stool passes with a gentle push rather than a strain. You want both, and whole foods give you both.

- **Vegetables:** aim for volume and variety. Broccoli, Brussels sprouts, carrots, artichokes, sweet potatoes, winter squash, okra, greens, and cabbage are all strong choices.
- **Legumes:** the single most fiber-dense food group there is. Black beans, lentils, chickpeas, and split peas deliver twelve to sixteen grams per cup. Introduce them gradually if you are not used to them.
- **Fruit:** berries, pears and apples with the skin on, and avocado. Two green kiwifruit daily has held up well in studies of constipation. Five or six prunes, or a small glass of prune juice, is an old remedy that genuinely works.
- **Whole grains:** oats, barley, quinoa, and steel-cut oatmeal. Oats in particular are rich in the soluble fiber beta-glucan.
- **Nuts and seeds:** almonds, walnuts, pumpkin seeds, and sunflower seeds.

> **Go slowly.** Jumping from fifteen grams of fiber to forty overnight produces gas, bloating, and cramping, and most people quit. Add about five grams per week and give your microbiome two to three weeks to adapt at each step. Increase your water at the same time.

3. Then Add a Fiber Supplement

Food should carry most of the load, but a targeted supplement is where hemorrhoid patients often see the difference. Fiber supplements are among the best-studied interventions for hemorrhoid bleeding and symptoms, and they are inexpensive and safe.

Psyllium

Psyllium husk is my first choice for hemorrhoids. It is a gel-forming soluble fiber that pulls water into the stool and holds it there, producing a stool that is soft, bulky, and easy to pass without straining. Metamucil is the familiar brand, but the better option is pure psyllium without added sugar, sweeteners, or dyes. Konsyl makes a one hundred percent psyllium product available at most drug stores and online.

- Start with one teaspoon in eight to twelve ounces of water once daily.
- Build up over two to three weeks to one to two tablespoons daily, taken in one or two doses.
- Always take it with a full glass of water, and drink another glass afterward.
- Drink it promptly, because it thickens quickly in the glass.
- Separate psyllium from prescription medications by about two hours, since it can slow their absorption.

Ground Flaxseed

One to two tablespoons of ground flaxseed daily. Flax adds soluble fiber, mucilage that lubricates, and omega-3 fatty acids as a bonus. Whole flaxseed passes through undigested, so it must be ground. Keep ground flax in the refrigerator or freezer, because the oils go rancid at room temperature within a few weeks. It stirs easily into yogurt, oatmeal, smoothies, or applesauce. You may also sprinkle it on salads, or add it to baked goods.

Chia Seeds

One to two tablespoons daily. Chia forms a soft gel when it meets liquid, which is exactly the texture you want inside the digestive tract. Unlike flax, chia does not need grinding, but it does need liquid. Soak it for ten to fifteen minutes in water, milk, or yogurt before eating, and never take it dry with only a sip of water.

> **A practical combination:** one tablespoon of ground flax and one tablespoon of chia stirred into yogurt or oatmeal in the morning, and one teaspoon to one tablespoon of psyllium in a large glass of water in the evening. Adjust up or down based on one single measure — whether your stool is soft, formed, and passes without effort.

4. Gentle Reinforcements

Magnesium citrate. Two hundred to four hundred milligrams at bedtime draws water into the bowel and relaxes smooth muscle. The form matters here, and citrate is the one to buy. Magnesium glycinate is absorbed efficiently in the small intestine, which makes it a fine choice for sleep and muscle relaxation but a poor one for this purpose, because it leaves the digestive tract rather than staying behind to hold water in the stool. Many people are low in magnesium to

begin with, so citrate often solves two problems at once. Back off the dose if stools become loose, and check with your provider first if you have kidney disease.

Glycerin suppositories. Available over the counter and genuinely useful, though for a narrower problem than most people realize. Glycerin is hyperosmotic, meaning it pulls water into the rectum, softens the stool that is already sitting there, lubricates the canal, and gives a gentle signal to evacuate, usually within fifteen to thirty minutes. That makes it the right tool when the stool is soft enough upstream but hard, dry, and stuck in the last few inches — a very common pattern in people who have been putting off the urge. Insert one in the morning, ideally after breakfast, and lubricate it before insertion during a flare. Two caveats: frequent use can irritate the lining of the rectum, and glycerin addresses the exit rather than the transit, so treat it as a bridge while fiber, fluid, and magnesium do the real work rather than as a daily fixture.

Vitamin C. At higher doses vitamin C has a mild osmotic effect. It is not a primary strategy, but it is a harmless nudge for some people.

Polyethylene glycol. Sold over the counter as Miralax and generics, seventeen grams in water daily. It is not habit-forming, it works by holding water in the stool, and it is a reasonable long-term option when fiber alone is not enough. It is often better tolerated than fiber by people who bloat.

What to avoid leaning on. Stimulant laxatives such as senna and bisacodyl are fine for occasional rescue, but they are not a long-term plan. Regular use trains the bowel to depend on them and does nothing for the underlying problem. Mineral oil is likewise best avoided as a habit, since it interferes with absorption of fat-soluble vitamins.

5. How You Use the Bathroom Matters More Than You Think

If you change only one behavior after reading this guide, change this one. Sitting on the toilet is a uniquely unfavorable position for the anal cushions: the seat opening removes the support beneath them while gravity pulls blood into them. Ten minutes of unsupported sitting engorges the tissue, and straining on top of that is what stretches it permanently.

- **Leave your phone outside the bathroom.** This is the single most common cause of hemorrhoids these days. The phone turns a two-minute errand into a twenty-minute sit, and this is a setup for Hemorrhoids.
- **Set an informal limit of three to five minutes.** If nothing has happened, get up and come back later. Nothing is gained by waiting on the toilet.
- **Do not strain, push, or bear down.** If it does not come easily, it is not ready. Straining is the mechanical act that damages the tissue.
- **Listen to your bowels and go when the urge arrives!** Ignoring the signal lets the stool sit in the rectum, where water is reabsorbed and the stool gets harder. Holding it is a habit worth breaking.
- **Breathe out, do not hold your breath.** Holding your breath and bearing down, the maneuver known as a Valsalva, spikes pressure throughout the pelvis. If you need a little help, exhale slowly through pursed lips instead.

- **Try the after-breakfast window.** Eating triggers a natural wave of colon activity. Twenty to thirty minutes after breakfast, coffee included, is the body's most cooperative moment, and using it consistently builds a reliable rhythm.

6. Change the Angle: Use a Footstool

There is a muscle called the puborectalis that loops around the rectum like a sling and holds a kink in it, which is part of what keeps you continent. Sitting upright on a standard toilet only partially releases that kink. Picture trying to run water through a garden hose that still has a bend in it: you have to turn the pressure up to get anything through. Straightening the hose lets it flow at low pressure.

Raising your knees above your hips straightens that angle. A seven to nine inch footstool under your feet accomplishes it for a few dollars. The purpose-built version, the Squatty Potty, is inexpensive, fits around the base of the toilet, and tucks out of the way, and it is the version most patients will actually keep using. A sturdy step stool, an upended shoe box, or a couple of thick books works exactly as well, so there is no reason to skip this step over the cost.

This is not merely a comfort measure. Studies have found that the knees-above-hips position widens the anorectal angle, reduces the amount of straining required, and shortens the time it takes to finish. Less straining and less time on the toilet are the two things this entire guide is trying to accomplish, and a footstool delivers both for about the price of lunch.

Lean forward slightly, rest your forearms on your thighs, relax your abdomen rather than tightening it, and let the position do the work that pushing used to do. Most patients notice a difference within the first week, and it is the change patients thank me for most often.

7. Get Off Your Seat

Prolonged sitting compresses the pelvic floor and lets blood pool in the anal cushions. If your work is sedentary, the fix is not to sit less overall but to interrupt the sitting.

- Stand and walk for two or three minutes every thirty to forty-five minutes. Set a reminder if you need one.
- Get thirty minutes of walking or other moderate exercise most days. Movement stimulates the bowel, improves venous return, and helps with weight, all of which matter here.
- Use a cushion rather than a firm chair during a flare. A soft seat cushion or a cushion with a cut-out center is more comfortable than a doughnut ring, which can actually increase pressure around the rim.
- On long flights or drives, get up hourly, or at least shift, flex your legs, and change position.
- If you cycle, look hard at your saddle. A poorly fitted or overly narrow saddle puts sustained pressure exactly where you do not want it. A wider saddle, a cut-out design, or a professional bike fit is worth the money.

8. Lift Smart

Heavy lifting with a held breath is a reliable way to produce hemorrhoids, and it is common in people who are otherwise doing everything right. Squats, deadlifts, and heavy overhead pressing all generate large spikes in abdominal pressure. You do not have to give up strength training, which is one of the best things you can do for your long-term health. You do have to breathe.

- Exhale on the effort. Breathe out as you lift, press, or push, rather than clamping down.
- Avoid maximal, breath-held attempts, particularly during an active flare.
- Keep loads moderate and the volume higher rather than chasing one-repetition maximums.
- At work or at home, ask for help with anything genuinely heavy instead of powering through it.

9. Take Care of the Digestive Tract Itself

Hemorrhoids sit at the end of a long system, and they reflect the health of everything upstream. In my practice, patients whose hemorrhoids keep returning despite good fiber and hydration almost always have something else going on in the digestive tract.

Aim for the right output. One or two soft, formed, easily passed bowel movements daily is the target. Stool that resembles a smooth sausage or soft cracked log is ideal. Hard pellets mean too little water or fiber. Loose, urgent, or frequent stools are just as damaging as hard ones, because repeated wiping and repeated urgency irritate and engorge the tissue.

Feed the microbiome. Fermented foods such as yogurt with live cultures, kefir, sauerkraut, kimchi, and miso, along with prebiotic foods such as onions, garlic, leeks, asparagus, and slightly green bananas, support the bacteria that regulate stool consistency and transit time. Food first is the right instinct here, because fermented foods deliver both organisms and the fiber that feeds them.

Consider a probiotic supplement. A probiotic does not treat a hemorrhoid, and I want to be straightforward about that. What it can do is soften stool and speed transit, which is the entire objective of this guide. The trials are modestly positive rather than dramatic, generally showing softer stools and roughly one additional bowel movement per week. That is still worth having when the goal is never to strain again. The best-studied strains for constipation are *Bifidobacterium lactis*, particularly BB-12, HN019, and DN-173 010, along with *Lactobacillus casei* Shirota. Multi-strain formulas have the better track record in irritable bowel syndrome, where stools swing between hard and loose. Choose a product that names its specific strains rather than only the species, that guarantees the organism count through the expiration date rather than at the time of manufacture, and that comes from a company doing third-party testing. Give it four to six weeks before deciding whether it is helping. The clearest reasons to add one are a recent course of antibiotics, stools that alternate between constipated and loose, and good fiber and fluid intake that has still not produced regularity.

Address chronic diarrhea. Chronic loose stools deserve a diagnosis, not just a fiber supplement. Food sensitivities, lactose intolerance, small intestinal bacterial overgrowth,

irritable bowel syndrome, celiac disease, inflammatory bowel disease, bile acid malabsorption, and medication side effects are all common and all treatable. Talk to your provider.

Review your medications. A long list of common medications cause constipation: opioid pain medications, iron supplements, calcium supplements, calcium channel blockers such as amlodipine, anticholinergics, some antidepressants, antihistamines, and aluminum-containing antacids. Never stop a prescription on your own, but do ask your provider whether an alternative exists or whether you should be on a preventive regimen alongside it.

10. Be Kind to the Skin

The skin around the anus is thin, and a great deal of hemorrhoid misery is really irritated skin rather than the hemorrhoid itself.

- Do not wipe dry, hard, or repeatedly. Aggressive wiping with dry paper is abrasive, and over-wiping in pursuit of perfect cleanliness makes matters worse.
- Use water. A bidet, a handheld sprayer, a peri bottle, or simply rinsing in the shower is gentler and more effective than any paper. A bidet attachment is inexpensive and is one of the best investments a hemorrhoid patient can make.
- If you use wipes, choose unscented, alcohol-free wipes, or plain witch hazel pads. Scented and alcohol-containing wipes are a frequent cause of contact dermatitis in this area.
- Pat dry rather than rubbing. A hair dryer on the cool setting works beautifully.
- Keep the area dry between visits to the bathroom. Moisture breeds itching. Cotton underwear, loose clothing, and a change out of damp workout clothes all help. A dusting of cornstarch-based powder or a thin barrier ointment can help those prone to moisture.
- Resist scratching. Itching is common and scratching feels good for about four seconds, then restarts the cycle of inflammation and broken skin.

Special Situations

Pregnancy and after delivery. Hemorrhoids are extremely common in pregnancy, thanks to the pressure of the growing uterus, higher progesterone levels that slow the bowel, expanded blood volume, and then the pushing of labor itself. Prevention is the same: fiber, fluids, movement, a footstool, and left side-lying rest to take pressure off the pelvic veins. Clear every supplement and every medication, including over-the-counter products, with your obstetric provider. Most pregnancy-related hemorrhoids improve considerably in the months after delivery.

Chronic cough. A chronic cough from smoking, reflux, allergies, asthma, or an ACE inhibitor blood pressure medication produces hundreds of pressure spikes a day. Treating the cough is treating the hemorrhoids.

Weight. Excess abdominal weight raises baseline pressure in the pelvic veins continuously. Weight loss helps, and even modest loss helps.

Travel. Travel combines dehydration, disrupted routine, unfamiliar food, prolonged sitting, and a reluctance to use unfamiliar bathrooms. Pack your psyllium, carry a water bottle, walk the

aisle or the rest stop, and do not put off the urge. You can usually find small psyllium packs, which are ideal for travel.

Quick Start Plan: Prevention

If the list above feels like a lot, start with these five and add the rest later.

- Drink a large glass of water first thing every morning, and aim for two to three liters through the day.
- Take one tablespoon of ground flax or chia in the morning and psyllium in a large glass of water in the evening.
- Leave your phone outside the bathroom and keep your time on the toilet under five minutes.
- Put a footstool in front of the toilet.
- Walk for thirty minutes most days, and stand up every thirty to forty-five minutes at your desk.

The Bottom Line

Hemorrhoids are common and usually manageable. During a flare, focus first on what matters: control pain, reduce swelling, make stool easy to pass, protect the skin, and deal honestly with bleeding or leakage. Long term, soft formed stool, short toilet visits, no straining, and regular movement do more than any ointment.

The one thing worth being firm about: do not diagnose your own rectal bleeding. Get it looked at, get your colonoscopy on schedule, and then treat your hemorrhoids with confidence.

Take care and be well.

James E. McMinn, MD

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