INFRARED COAGULATION OF INTERNAL HEMORRHOIDS

Please report to the office on:_____@_____

Your physician has recommended that you undergo a treatment called Infrared Coagulation of Internal Hemorrhoids (IRC). IRC is the most widely used treatment for internal hemorrhoids and is performed in our office. A small probe contacts the area above the hemorrhoid, exposing the tissue to a burst of infrared light for about one second. This coagulates the veins above the hemorrhoid causing it to shrink and recede. Patients may feel a sensation of heat very briefly, but it is generally not painful. No anesthesia is required for this treatment. Many patients have more than one hemorrhoid; therefore, two to three treatments may be required.

Most patients return to their normal routine the day of the procedure. There may be some slight spot bleeding a few days after the procedure. Heavy lifting and straining should be avoided and your physician may ask that you avoid aspirin and other blood thinning medications for a few days afterward. Please make sure to advise the physician if you are on any blood thinning medications. Other side effects of the procedure include possible infection, bleeding, and temporary inability to urinate although these are extremely rare. Please contact our office immediately should you have any problems after your treatment at (301) 695-6800.

PREPARATION:

1. There are no dietary restrictions for this test. You may take your usual medications UNLESS you have been directed to stop blood thinner medications.

2. You will need to **purchase 2 plain Fleet enemas** over the counter at the drug store to be used 2 hours before coming to the office for your treatment. You will use one enema, hold for 2-3 minutes and expel. Then do second enema and hold for 2-3 minutes as tolerated and expel.

I, _____, give my consent for IRC (infrared coagulation of internal hemorrhoids) to be performed by Dr._____. The procedure and possible complications have been explained to me. I understand the risks and benefits and agree to undergo the treatment.

_____/_____/_____/_____
Patient Signature DOB Date Witness

Revised 8/14/14