

STAPLER HAEMORRHOIDPEXY FOR 3rd & 4th DEGREE HAEMORRHOID OUR EXPERIENCE

Arvind Baghel¹, Anil Haripriya², Vibha Haripriya³

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ABSTRACT: Haemorrhoid is most commonly and frequently presented in the surgical OPD as benign anorectal pathology. The main complains of Haemorrhoid are bleeding and protrusion. Haemorrhoid are painless but are painful when thrombosed and infected. It has been seen that about 70% of population above the age of 30 years are affected with this disease. We here by present our study and experience done on 80 patients treating them with the newer method that is stapler Haemorrhoidopexy in the patients who were having third degree and four degree Haemorrhoid. All the patients were done under spinal anesthesia and the average time taken by the surgery was about 40 minute. We have found stapler Haemorrhoidopexy was a safe and effective technique for the treatment of third and for degree Haemorrhoid. It associated with less post-operative complication such as pain, bleeding, hospital stay early recovery and can be done as a day care surgery. As compare to excision Haemorrhoidectomy.

KEYWORD: Haemorrhoids, Staperhaemorrhoidopexy.

INTRODUCTION: Haemorrhoid has been a cause of human discomfort for many years. Now a day's many people suffer from this disease. Patients with hemorrhoid mostly complain of bleeding, itching, burning, mass sensation and pain. These symptoms may be due to other causes, such as benign and malignant anorectal tumors, mostly identifiable with a simple digital rectal examination. These are different medical and surgical therapeutic modalities in the treatment of hemorrhoids which can be performed through an outpatient or inpatient approach.

In different trials the stapler hemorrhoid-dopexy compared and evaluated with other surgical techniques, as well as Dia-thermy and Harmonic Scalpel.^(1,2,3) stapled hemorrhoidectomy (S.H.) is a new procedure described primarily by Antonio Longo in 1998.⁽⁴⁾ Circular Staplers are being used for Hem-orrhoidopexy. The device excises a ring of mucosa from upper and canal and lower rectum and disrupts artery of piles, reduces inflow to hemorrhoid and re-store the anatomy of the hemorrhoidcushions.⁽⁵⁾ Several published reports, indicate that staple-used hemprrhoidopexy is a safe and effective procedure recommended because of its shorter operation time and lesser postoperative pain. It also has a shorter period of convalescence and earlier return to social activity in comparison with conventional hemorrhoidectomy.^(3,4,5) As piles are not excised in the stapling procedure, recurrence might be a problem in this technique.^(3,4,5)

MATERIAL METHODS: Our studies were done between 1st Nov. 2010 to Oct. 2012. The patient selected work of 3rd degree & 4th degree haemorrhoids according to grading of Miles.

We took about 80 cases, out of which 8 cases were females and mean age was 50 years, the age ranged between 38 years & 60 years.

The complete clinical history taking & examination was done of the patient such as inspection per rectal examination & proctoscopy.

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All the basic & necessary investigations were done such as complete blood picture B.T.C.T. urine routine microscopic blood sugar, fasting & post prandial, blood urea, ECG & exr.

After the pre anesthetic checkup fitness was taken prior to surgery, written consent, enema & required pre-operative preparations were done.

All the cases were done under spinal anesthesia, patients were put in lithotomy position.

In the procedure we did stapler haemorrhoidectomy, for that we had PPH03 proximate haemorrhoid stapler (Ethicon endo surgery).

PPH kit included 33mm haemorrhoid circular stapler 9PPH03, Suture Threader (ST 100) Circular Anal Dilater (CAD33) Purse String Suture Anoscope (PSA33).

PROCEDURE: After applying a lubricant lignocaine jelly, a circular and anal dilator was introduced to reduce the prolapsed of the anoderm and parts of the anal mucous membrane. After removal of the obturator, the prolapsed mucous membrane falls into the lumen of the circular anal dilator. Thus, a purse string suture, non-absorbable surgical, of 2-0 polypropylene 9 Prolene; Ethicon NW824PPH) was placed circumferentially 3 to 5 cm above the dentate line through the window of the purse – string suture anoscope. Subsequently, a haemorrhoidal circular stapler was positioned and fired. Finally a gauze pack soaked with betadine and xylocaine was applied endoanally. The operative time was defined as the time from the beginning of the operation until the application of the endoanal dressing.

Post-Operative Follow up: Post-Operative sequel such as pain, bleeding, urine retention, edema of anal and perianal region were managed accordingly.

All patients were given appropriate antibiotic, analgesics, stool softener and normal diet type for five days.

Patients came for follow up examination after one week and fourth week.

RESULTS: Hour duration of Surgery was between 30 minute and 60 minute. Mean duration of surgery was 32 minutes.

We used to check the suture line after removal of stapler and the line was complete and no discontinuity was observed.

In five of the case there was bleeding from the suture line which was managed by putting additional hemostatic suture over the side.

A patient was discharge from the hospital after the 24 hours.

No post-operative bleeding was seen in all cases.

Two of the case had recurrence which was managed by open Haemorrhoidectomy, milligan morgana technique.

Thirteen patients complained of post-operative pain which was managed by giving anal gesic for two weeks.

Five cases reported to have increased frequency of defecation and gas incontinence which was managed by giving probiotics for a month.

Urinary retention was seen in one case which was managed by foleys catheterization.

Improvement in terms of bleeding prolapse pain was seen in all patients after one month follow up and patients were satisfied.

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DISCUSSION: Haemorrhoid is the most common benign colorectal disease in modern surgical practice. The disease management depends upon the degree of Haemorrhoid.

First degree and second degree of Haemorrhoid are often managed conservatively.

Third degree and fourth degree of Haemorrhoid surgery is required for its treatment.

Nowadays we have a better knowledge of anatomy pathophysiological and microbiological features of anus and rectum due to this knowledge there is evolution of better and newer surgical techniques.

Milligan-Morgan, Parks, Ferguson, techniques which are being practicing since 75 years are still a gold standard. Other procedures are commonly practiced for the Haemorrhoid treatment are sclerotherapy, band ligation, cryotherapy and infrared coagulation which have their own advantages and disadvantages.

In concern with modern Haemorrhoid surgery which has been developed since last ten years are Doppler guided ligation of the Haemorrhoid artery branches, Haemorrhoidectomy with ultrasound dissector and stapler and Haemorrhoidectomy.

According to the literature, stapler Haemorrhoidectomy is less risky procedure as it enables conservation of a larger mucosal portion. The pathophysiologic background of the treatment of Haemorrhoid disease by stapler is different than the pathophysiologic basis for excision Haemorrhoidectomy. The complete circular mucosa cranial to the Haemorrhoidal plexus is resected, allowing reduction of mucosa lifting and by fixing the prolapsed mucosa at the rectum wall. The reduction of arterial blood flow and reduction of the prolapsed mucosa and thereby the improvement of the venous reflux may be the key of the treatment, but further evaluation is necessary. Stapler Haemorrhoidectomy is associated with less pain post operatively, shorter wound healing time, short hospital stay and requires less operative care.

CONCLUSION: Through our study and experiences we thus conclude that the stapler haemorrhoidectomy is simple and safe procedure. It is a minimally invasive procedure and it is less associated with post-operative pain bleeding and prolapse. It can be done as the day care surgery.

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AUTHORS:

1. Arvind Baghel
2. Anil Haripriya
3. Vibha Haripriya

PARTICULARS OF CONTRIBUTORS:

1. Assistant Professor, Department of General Surgery, Neta Ji Subhash Chandra Bosh Medical College, Jabalpur, Madhya Pradesh.
2. Assistant Professor, Department of General Surgery, Chhattisgarh Institute of Medical Sciences, Bilaspur, Chhattisgarh.

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3. Assistant Professor, Department of Gynaecology, Chhattisgarh Institute of Medical Sciences, Bilaspur, Chhattisgarh.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Arvind Baghel,
Assistant Professor,
Department of General Surgery,
Neta Ji Subhash Chandra Bosh Medical College,
Jabalpur, Madhya Pradesh.
E-mail: anilharipriya@gmail.com

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