Rare Case of Rectal Pocket with Ano-Rectal Stenosis in a Post-Operative Case of Stapled Haemorrhoidopexy Treated by Achalasia Balloon Dilatation

Darshan Parekh1, Mohan A. Joshi2, Samir Rambhia3, Vishwajeet Pawar4, Anoop Joshi5

1Senior Registrar, Department of General Surgery, LTMMC and LTMGH, Sion, Mumbai, Maharashtra, India. 2HOD, Department of General Surgery, LTMMC and LTMGH, Sion, Mumbai, Maharashtra, India. 3Assistant Professor, Department of General Surgery, LTMMC and LTMGH, Sion, Mumbai, Maharashtra, India. 4Assistant Professor, Department of General Surgery, LTMMC and LTMGH, Sion, Mumbai, Maharashtra, India. 5Registrar, Department of General Surgery, LTMMC and LTMGH, Sion, Mumbai, Maharashtra, India.

INTRODUCTION

Stapled haemorrhoidopexy is a convenient and safe modality with good results, but may be followed by unusual and severe postoperative complications. Formation of a rectal pocket and anorectal stenosis are rare but distressing complications. We report a case of rectal pocket formation with anorectal stenosis in a post-operative case of SH, and its management.

PRESENTATION OF CASE

A 48-year-old male patient underwent SH with 35 mm stapler, for grade III haemorrhoids. Procedure was uneventful and there were no immediate or early complications. Two months later, he presented with severe pain during defecation and difficulty in passing stools, which persisted in spite of taking stool softeners. On PR, stenosis of staple line could be felt. We did a rectosigmoidoscopy for him and noticed a rectal pouch formation just below the stapler line with ano-rectal stenosis at the staple line (Figure 1). We did a balloon dilatation with a 40 mm diameter achalasia balloon (Figure 2), of the staple line under fluoroscopy guidance (Figure 3). There were no complications, and post procedure, there was adequate dilatation and obliteration of rectal pouch. Patient was relieved of his complaints.

The incidence of rectal pocket post stapled haemorrhoidopexy (SH) is 2.5%1, and anorectal stenosis is 3-3.5%2,3. We present a rare case of both the complications together causing difficulty in passing stools and pain at defecation in a patient after two months of undergoing stapled haemorrhoidopexy. The complications were discovered on rectosigmoidoscopy. Patient underwent Rigiflex™ achalasia balloon (Diameter 40 mm) dilatation and he was relieved of the stenosis and his symptoms.
Haemorrhoids are common and >1 million individuals are affected by symptomatic haemorrhoids in the western world per year. The most definitive treatment is excisional haemorrhoidectomy (EH) but it is associated with marked post-operative pain. Hence, surgeons were required to innovate alternative treatment options. Stapled haemorrhoidopexy was a landmark change in the treatment of haemorrhoids. This method was established in 1997 by Sir Antonio Longo. A modified circular stapler is inserted through the anus, and a circular ring of mucosal tissue from the anal canal is excised, well above the dentate line. The redundant, prolapsing mucosa is lifted back into the anal canal by a stapled anastomosis.

One multicenter study has reported that 36.4% of patients had at least one adverse event following SH. A systematic review has revealed that 20.2% had postoperative complications. In another study in which PPH was done as a day case procedure, 12.7% of patients required readmission on the day of surgery, mostly due to bleeding, pain and urinary retention. It has been reported that manual haemorrhoidectomy has equal complications such as bleeding, strictures and fissures. Although unusual complications (e.g. rectal obliteration, rectal perforation with retroperitoneum and pneumomediastinum as well as chronic pain) have been reported as well following SH.

A pathological pocket in the lower rectum, resembling a diverticulum or an intramural fistula may be caused by a partial slippage of the purse string. This may lead to an intermittent collection of faecolith followed by inflammation and local sepsis similar to a perirectal or perianal abscess. This would require a lay-open of the pocket which is effective in most of the cases. The incidence of this complication is 2.5%.

Anorectal stenosis is also uncommon. Its incidence has been reported as 3% and 3.6% of the operated cases in two series. In another series, it was rare (1.2%) and mostly related to a breakdown of the anastomosis. It has been successfully managed with dilation.

There is no reported case in literature of these two complications existing together. Both complications were managed by a single endoscopic intervention of achalasia balloon dilatation without any need for resurgery. It is a simple, safe, effective and cheap innovative intervention for such a complication of SH.

**CONCLUSIONS**

SH is a widely used surgery for the management of haemorrhoids. As prevention is better than cure, the risk of adverse events may be reduced by accurate technique and meticulous selection of patients. If complications occur, they may be managed surgically and non-surgically. We reported two rare complications coexisting and their successful management with the innovative use of an achalasia balloon, without any need of hospitalization.

**REFERENCES**


