

Assessment of Outcome of Hemorrhoidectomy in Adult Population

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Abstract

Background: To assess outcome of hemorrhoidectomy in adult population. **Subjects and Methods:** One hundred five adult population with hemorrhoids of both genders were included and parameters such as symptoms, type of hemorrhoids and complications were recorded. Operating time (mins), first bowel movement (hours), return to normal daily activities (days) and VAS was also recorded. **Results:** Out of 105 patients, males were 60 (57.7%) and females were 55 (52.3%). The mean operating time was 25.3 minutes, first bowel movement was 18.2 hours, return to normal daily activities was 6.7 days and VAS was 4.2. Common symptoms were pruritis in 68, mass through rectum in 32, bleeding through rectum in 14, soiling of clothes in 12 and pain during defecation in 40. Type of haemorrhoids was internal in 38, external in 38 and strangulated in 22 cases. The difference was significant ($P < 0.05$). Complications was bleeding seen in 1, urinary retention in 2 and both bleeding and urinary retention in 4 patients. The difference was significant ($P < 0.05$). **Conclusion:** Common symptoms were pruritis, mass through rectum, bleeding through rectum, soiling of clothes and pain during defecation. Complications were bleeding and urinary retention.

Keywords: bleeding, hemorrhoids, strangulated.

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Introduction

Hemorrhoidal illness is a common anorectal ailment occurring in about 5% and more often in people who are more established than 40 years.^[1] Hemorrhoids, also called piles are masses or clumps of tissues which consist of muscle and elastic fibers with enlarged, bulging blood vessels and surrounding supporting tissues present in the anal canal of an individual. It is a condition characterized by the prolapsed of an anal cushion that may result in bleeding and pain. This condition is a common ailment among the adults.^[4]

Hemorrhoids are cushion sinusoids thought to function as part of the continence mechanism and aid in complete closure of the anal canal at rest.^[5] The main cushions lie at the left lateral, right anterior and right postero-lateral portions of the anal canal. Secondary cushions may be present. Bleeding and thrombosis of the pre-sinusoidal arterioles may occur in association with prolapse.^[6] There are different systems utilized in the careful treatment of hemorrhoidal ailment. Ordinary strategies incorporate Fergusons shut hemorrhoidectomy and Milligan–Morgans open hemorrhoidectomy, which can be performed with surgical blade or electrocautery. Also, an assortment of gadgets and techniques have been acquainted with assistance encourage the system and limit persistent inconvenience in the postoperative period.^[7]

Compared with haemorrhoidopexy, haemorrhoidectomy is

the most effective long-term treatment but complications have been reported to be not uncommon.^[6] Many proctologists in their daily clinical practice would feel that morbidity after haemorrhoidectomy is lower than reported.⁸ Considering this, we performed this prospective observational study to assess outcome of hemorrhoidectomy in adult population.

Subjects and Methods

After considering the utility of the study and obtaining approval from ethical review committee of the institute, we selected one hundred five adult population with hemorrhoids of both genders. All agreed to participate in the study with their written consent.

A thorough clinical examination was performed. The percent of time the person had to strain during the bowel movement, had a feeling of incomplete bowel evacuation, or had hard or lumpy stools was also noted. Symptoms, type of hemorrhoids and complications were recorded. Operating time (mins), first bowel movement (hours), return to normal daily activities (days) and VAS was recorded. Patients were managed with stapler hemorrhoidectomy group (SH) and Open (Milligan Morgan) hemorrhoidectomy group (OH). The results were compiled and subjected for statistical analysis using Mann Whitney U test. P value less than 0.05 was set significant.

Results

Table I Patients distribution

Total- 105		
Gender	Male	Female
Number (%)	60 (57.7%)	55 (52.3%)

Out of 105 patients, males were 60 (57.7%) and females were 55 (52.3%) (Table I).

Table II Assessment of parameters

Parameters	Variables	Mean	P value
Operating time (mins)		25.3	-
first bowel movement (hours)		18.2	-
return to normal daily activities (days)		6.7	-
VAS (mean)		4.2	-
Symptoms	Pruritis	68	0.05
	Mass through rectum	32	
	Bleeding through rectum	14	
	Soiling of clothes	12	
	Pain during defecation	40	
Type of haemorrhoids	internal	45	0.04
	external	38	
	strangulated	22	

The mean operating time was 25.3 minutes, first bowel movement was 18.2 hours, return to normal daily activities was 6.7 days and VAS was 4.2. Common symptoms were pruritis in 68, mass through rectum in 32, bleeding through rectum in 14, soiling of clothes in 12 and pain during defecation in 40. Type of haemorrhoids was internal in 38, external in 38 and strangulated in 22 cases. The difference was significant ($P < 0.05$) (Table II).

Table III Assessment of complications

Complications	Number	P value
Bleeding	1	0.02
Urinary retention	2	
Both bleeding and urinary retention	4	

Complications was bleeding seen in 1, urinary retention in 2 and both bleeding and urinary retention in 4 patients. The difference was significant ($P < 0.05$) (Table III).

Discussion

Symptomatic haemorrhoids are common, and affect about 4% of the western population each year. The aetiology and pathogenesis are not clear, despite a number of theories.^[9] Some evidence supports age-related deterioration of anal supportive connective tissue.^[10] With an abundance of non-operative treatments, only about 10% of the patients who attend physicians require operative treatment. The most widely accepted theory attributes this disorder to the prolapse of the anal cushions.^[11] Haemorrhoids are not varicose veins, but rather vascular cushions composed of fibroelastic tissue, muscle fibers, and vascular plexuses with arteriovenous anastomoses.^[12] Haemorrhoids may be internal, external or mixed. Internal haemorrhoids are classified by the degree of prolapse of the anal canal. External may be classified as acute (hemorrhoidal thrombosis) or chronic.^[13,14] We assessed outcome of hemorrhoidectomy in adult population.

Our results revealed that Out of 105 patients, males were 60 (57.7%) and females were 55 (52.3%). D' Ugo et al^[15] in their study 86 CD patients were included; 45 were treated

for haemorrhoids and 41 presented with anal fissure. Conservative approach was initially adopted for all patients; in case of medical treatment failure, the presence of stable intestinal disease made them eligible for surgery. Fifteen patients underwent haemorrhoidectomy (open 11; closed 3; stapled 1), and two rubber band ligation. Fourteen patients required surgery for anal fissure (Botox ± fissurectomy 8; LIS 6). In both groups we observed high complication rate, 41.2% for haemorrhoids and 57.1% for anal fissure. Patients who underwent haemorrhoidectomy without certain diagnosis of CD had significantly higher risk of complications. Conservative treatment of proctologic diseases in CD patients has been advocated given the high risk of complications and the evidence that spontaneous healing may also occur.

Our results revealed that the mean operating time was 25.3 minutes, first bowel movement was 18.2 hours, return to normal daily activities was 6.7 days and VAS was 4.2. Common symptoms were pruritis in 68, mass through rectum in 32, bleeding through rectum in 14, soiling of clothes in 12 and pain during defecation in 40. Type of haemorrhoids was internal in 38, external in 38 and strangulated in 22 cases. Gravie et al^[16] included 134

patients. The patients in the SH group experienced less postoperative pain/discomfort as scored by pain during bowel movement, total analgesic requirement over the first 3 days, and per-patient consumption frequency of class III analgesics. A clear difference in morphine requirement became evident after 24 hours. Hospital stay was significantly shorter in the SH group. At 1 year, no differences in the resolution of symptoms were observed between the 2 groups, and over 2 years, the overall incidence of complications was the same, specifically fecaloma in the MM group and external hemorrhoidal thrombosis in the SH group. Impaired sphincter function was observed at 1 year with no significant difference between the groups for urgency (12%), continence problems (10%), or tenesmus (3%). No patient needed a second procedure for recurrence within 2 years, although partial residual prolapse was detected in 4 SH patients (7.5%) versus 1 MM patient (1.8%).

Complications was bleeding seen in 1, urinary retention in 2 and both bleeding and urinary retention in 4 patients. Johannsson et al^[17] assessed the long-term functional results of Milligan-Morgan haemorrhoidectomy. 507 of 556 patients who were operated on for haemorrhoids by the Milligan-Morgan technique. 418 of the 507 responded (82%). Altogether 279 patients (67%) reported a successful result, while 139 patients (33%) reported impaired anal continence. 40 of the 139 patients (29%) claimed that the incontinence was a direct result of the haemorrhoidectomy. Female sex and an operation for hygienic problems were associated with a higher risk of incontinence. Impaired anal continence is common after Milligan-Morgan haemorrhoidectomy and a large proportion of affected patients relate their problems to the operation.

Conclusion

Common symptoms were pruritis, mass through rectum, bleeding through rectum, soiling of clothes and pain during defecation. Complications were bleeding and urinary retention.

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