

Assessment of Patients Undergoing Haemorrhoid Surgery

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Abstract

Background: Aim: To assess outcome of Haemorrhoidectomy patients. **Subjects and Methods:** Ninety- two patients with Haemorrhoidectomy were included in the study. In all dietary habits, bowel habits, physical activity, smoking, alcohol, family history and clinical features were assessed. Patients underwent open haemorrhoidectomy, closed haemorrhoidectomy and Lateral internal sphincterotomy with haemorrhoidectomy. Type of haemorrhoids was also recorded. **Results:** Age group 18-28 years had 4 males and 2 females, 38-48 years had 8 males and 5 females, 48-58 years had 12 males and 10 females and 58-68 years had 38 males and 13 females. Physical activity was present among 16, 44 were vegetarian and 48 were on mixed diet, positive family history was seen in 32, smoking was seen in 56 and alcoholism in 50. A significant difference was observed ($P < 0.05$). Type of haemorrhoids was internal in 52, external in 25 and strangulated in 25. Clinical features seen were cough in 83, straining in 54, constipation in 70, bleeding from rectum in 65, mass through rectum in 22 and pain in 92. Surgery performed was open haemorrhoidectomy in 65, closed haemorrhoidectomy in 10 and lateral internal sphincterotomy with haemorrhoidectomy in 17 cases. A significant difference was observed ($P < 0.05$). **Conclusion:** Maximum cases were seen in advanced age. open haemorrhoidectomy was performed in maximum cases.

Keywords: Open haemorrhoidectomy, Smoking, Cough, Bleeding.

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Introduction

Haemorrhoidal disease is a common disorder, affecting 4% of the world population. The most widely accepted theory attributes this disorder to the prolapse of the anal cushions. Haemorrhoids are not varicose veins, but rather vascular cushions composed of fibroelastic tissue, muscle fibers, and vascular plexuses with arteriovenous anastomoses.^[1] 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.^[2]

Haemorrhoids are a common problem, but incidence data are difficult to collect, and the available information varies greatly. It has been stated, for example, that 4.4% of the total population in the United States have haemorrhoids at some time in their lives, compared with 36.4% of people in the UK.^[3]

Internal haemorrhoids are covered in mucous membrane and originate from above the dentate line, which marks the junction between the upper and lower anal canals.^[4] On proctoscopy it is possible to see the change from columnar epithelial tissue, which occurs above the dentate line, to the squamous epithelium below.^[5] External haemorrhoids originate from below the dentate line and are covered in skin.^[6] Strangulated haemorrhoids are haemorrhoids that have prolapsed and their blood flow is restricted by the ana

sphincter. Thrombosed haemorrhoids are external haemorrhoids that are full of clotted blood.^[7] Haemorrhoidectomy is considered the gold standard, and Milligan-Morgan's and Ferguson's procedures are the most widely used techniques throughout the world. Although these techniques have yielded excellent results and low complication rates, they are usually associated with postoperative pain.^{8,9} Considering this, we selected present study with the aim to assess outcome of Haemorrhoidectomy patients.

Subjects and Methods

A total of ninety- two patients with Haemorrhoidectomy were included in the study. The study was approved from the institutional ethical committee. All enrolled patients were informed regarding about the study and their written consent was obtained.

Demographic data of patients was recorded. In all dietary habits, bowel habits, physical activity, smoking, alcohol, family history and clinical features were assessed. Patients underwent open haemorrhoidectomy, closed haemorrhoidectomy and Lateral internal sphincterotomy with haemorrhoidectomy. Type of haemorrhoids was also recorded. Results of the study was tabulated and subjected to statistical inference, where level of significance was set significant below 0.05.

Results

Table 1: Age and gender wise distribution of cases

Age group (Years)	Male	Female	Total
18-28	4	2	6
38-48	8	5	13
48-58	12	10	22
58-68	38	13	51
Total	62	30	92

Age group 18-28 years had 4 males and 2 females, 38-48 years had 8 males and 5 females, 48-58 years had 12 males and 10 females and 58-68 years had 38 males and 13 females [Table 1].

Table 2: Patients characteristics

Parameters	Variables	Number	P value
Physical activity	Yes	16	<0.05
	No	76	
Diet	Vegetarian	44	>0.05
	Mixed	48	
	Positive	32	
Family history	Negative	60	<0.05
	Yes	56	
Smoking	No	36	<0.05
	Yes	50	
Alcoholism	Yes	50	>0.05
	No	42	

Physical activity was present among 16, 44 were vegetarian and 48 were on mixed diet, positive family history was seen in 32, smoking was seen in 56 and alcoholism in 50. A significant difference was observed (P< 0.05) [Table 2, Figure 1].

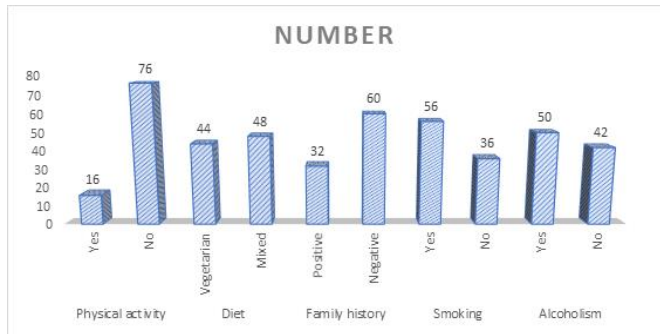
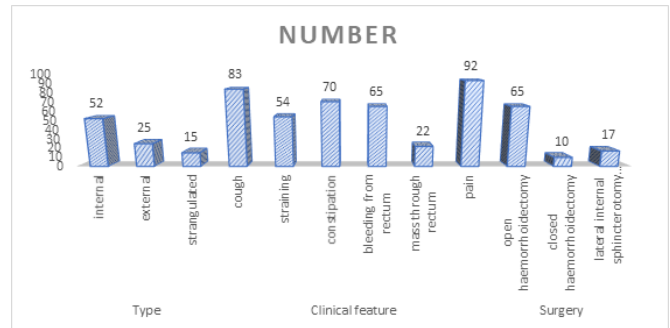


Figure 1: ?

Table 3: Patients parameters

Parameters	Variables	Number	P value
Type	internal	52	<0.05
	external	25	
	strangulated	15	
Clinical feature	cough	83	>0.05
	straining	54	
	constipation	70	
	bleeding from rectum	65	
	mass through rectum	22	
	pain	92	
Surgery	open haemorrhoidectomy	65	<0.05
	closed haemorrhoidectomy	10	
	lateral internal sphincterotomy with haemorrhoidectomy	17	

Type of haemorrhoids was internal in 52, external in 25 and strangulated in 25. Clinical features seen were cough in 83, straining in 54, constipation in 70, bleeding from rectum in 65, mass through rectum in 22 and pain in 92. Surgery performed was open haemorrhoidectomy in 65, closed haemorrhoidectomy in 10 and lateral internal sphincterotomy with haemorrhoidectomy in 17 cases. A significant difference was observed (P< 0.05) [Table 3, Figure 2].



Discussion

Haemorrhoid disease is one of the most common diseases of the lowest part of the gastrointestinal tract, and related complications are often the cause of the provision of medical advice.^[10,11] Symptoms associated with haemorrhoids are experienced by 5% to 50% of the adult population.^[12] The common goal of all operative methods is to reduce the blood flow to the piles, partial obliteration of the haemorrhoidal plexus and formation of a connective tissue scar which attaches the piles to the ground (underlying tissue) to prevent them from moving downwards.^[13] Patients with haemorrhoids often seek treatment because of painless bleeding, prolapse, pain associated with hemorrhoidal thrombosis or itching. Conservative medical treatment, which is initially indicated in most cases, includes increased dietary fiber and fluid intake and use of topical agents. When there is no initial clinical improvement, more invasive treatment methods are warranted, such as rubber band ligation, infrared coagulation and sclerotherapy.^[14,15] We selected present study with the aim to assess outcome of Haemorrhoidectomy patients.

Our results showed that age group 18-28 years had 4 males and 2 females, 38-48 years had 8 males and 5 females, 48-58 years had 12 males and 10 females and 58-68 years had 38 males and 13 females. Szyca et al,^[16] assess treatment and satisfaction in particular life domains after haemorrhoidectomy among 50 patients treated due to haemorrhoids and operated on in the period 2007–2008. The study evaluated quality of patients’ life after haemorrhoidectomy by Ferguson’s method using a LigaSure appliance. The study investigated whether patients perceived a difference before and after surgery. The research proved that patients can describe disease symptoms and know the risk factors for haemorrhoids. In the studied group patients are able to describe characteristic signs of haemorrhoidal disease and also indicate differences in everyday life before and after the surgery. They can also describe and classify the pain before and 1 year after the haemorrhoidectomy, which was statistically significantly lower already 3 months after the

operation. Conducted examinations showed that sick people in the precise way were able to determine manifestations and know risk factors of the prevalence of disease hemorrhoidal. Operated sick people indicated the difference in quality of the life both before, as well as after the undergone treatment. After the operation of the haemorrhoids with method of Ferguson using LigaSure apparatus operated sick persons could distinguish and classify pain before the treatment as well as in a year after which was statistically characteristically lower already after three months from treatment.

Ravindranath et al,^[17] conducted a study and found that out of the 63 patients under study, 66.67% were males and 33.33% were females, with the most common age group affected was below 40 years of age. Less than 40% of the patients were vegetarians, with more than half of the patients having a mixed diet. More number of women history of haemorrhoids in their family (47.6%), while the history in the males was only 26.2%. Straining and constipation was seen in majority of the patients while many of them also had chronic cough. Bleeding and mass through the rectum was seen in majority of the patients (96.8% and 93.7% respectively) while 76.2% of them had pain during defecation. Few of the patients (33.3%) soiled their clothes. Cerato et al,^[18] found that currently available surgical treatment options include procedure for prolapse and hemorrhoids (PPH), transanal hemorrhoidal dearterialization (THD), and conventional hemorrhoidectomy techniques. Excisional techniques showed similar results regarding pain, time to return to normal activities, and complication rates. PPH and THD were associated with less postoperative pain and lower complication rates; however, both had higher postoperative recurrence rates.

Conclusion

Maximum cases were seen in advanced age. open haemorrhoidectomy was performed in maximum cases.

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