

AN EXPERIENCE OF OPERATING 115 CASES OF PROLAPSING HAEMORRHOIDS

Waqar Alam Jan, Azra A. Ghani, Kifayat Khan,
Mohammad Ismail Khan, Nisar Ali, Israr

*Department of Surgery and
Department of Paediatric Surgery,
Postgraduate Medical Institute,
Lady Reading Hospital,
Peshawar.*

ABSTRACT

Objective: To assess the safety, cost affectivity and outcome of surgical treatment of prolapsing haemorrhoids, in terms of improving the quality of life.

Material and Methods: This observational, study was conducted in Saidu group of teaching hospital Swat, and PGMI/Lady Reading Hospital (NWFP) from April 2000 to January 2003. One hundred and fifteen patients with prolapsing haemorrhoids were included in the study. Patients with 1st degree and 4th degree complicated haemorrhoids were excluded from the study. All the patients were fully evaluated by complete history, clinical examination and proctosigmoidoscopy.

Results: The male to female ratio was 2.84:1. The mean age was 45 years and majority of the patients were in the 4th and 5th decade of life. The most frequent symptoms were bleeding and prolapse and the most frequently found haemorrhoids was the left lateral one. All the patients were operated upon by low excision and ligation method. Postoperative complications were bleeding (reactionary) in 2.6% of the patients and secondary haemorrhage in 1.73% of the patients.

Conclusion: Surgery should be considered the treatment of choice in case of prolapsed haemorrhoids, when performed skillfully, having good long-term results.

Key words: Prolapsed Haemorrhoids, Surgery.

INTRODUCTION

Haemorrhoids are dilated veins that lie beneath the anal canal mucosal lining and

peri anal skin.¹ Haemorrhoids is one of the most common diseases of the mankind, and the commonest anorectal condition in surgical practice. Men knew about this since early

ages, and its surgical history extends over centuries. Hippocrates (400 B.C) recognized that burning could cure haemorrhoids.² Morgan first practiced injection therapy, but the great practical advancement was made by Salmon, who showed that the main blood supply of the anal canal is derived from the superior haemorrhoidal artery and that the haemorrhoids covered with the sensitive epithelium could be severed from its bed.³ He introduced the first form of ligation and excision operation for piles. Haemorrhoids can present at any age, but very rare in the first two decades of life. The condition is more common in men than women at the ratio of 3:2.^{4,5} Not all the Haemorrhoids are symptomatic, some patients have very little symptoms, hardly compelling them to seek medical advice. Majority of cases have distressing symptoms, interfering much with the quality of life. Treatment of haemorrhoids may be either surgical or non-surgical. Operative treatment is still the best treatment modality especially for the prolapsing piles. It gives excellent long term results.

MATERIAL AND METHODS

One hundred and fifteen patients with prolapsing haemorrhoids were included in the study. All the patients were selected irrespective of their ages and sex. The duration of the study extended from April 2000 to January 2003. All of the patients were admitted through our out patient department. Patients with either 1st degree, 4th degree and complicated haemorrhoids were excluded from the study. Patients were inquired fully about their symptoms, duration of their symptoms and bowel habits by taking careful history. Examination including general physical examination, digital rectal examination, proctosigmoidoscopy was performed and routine investigations including X-ray chest and E.C.G were done in the elderly patients as part of pre-op workup. All the patients were administered with dis-

able kleen enema in the evening before surgery, and repeated the next morning some three to four hours before shifting the patient to theatre. In cases where necessary, the area was shaved on the table just before surgery, prophylactic antibiotics (first generation cephalosporine) with metronidazol infusion were injected at the time of induction of anaesthesia. Patients were operated upon by low excision ligation method. Majority of the patients were discharged after their first bowel action.

OPERATIVE TECHNIQUE

All the patients were operated by Milligan -Morgan method (low ligation and excision), under general anesthesia, in lithotomy trendlenberg position. After cleaning and draping, digital rectal examination was performed and in case of tight sphincter, gentle stretch of two to four fingers made. In elderly patients, with lax sphincter, this part of the procedure was omitted. Haemostats were applied over the three primary haemorrhoidal cushions. Gentle traction was made to display the pedicle. A second haemostat was applied to the haemorrhoidal tissue. Holding the pair of the artery forceps, applied to the left lateral one, in the palm of left hand, the pedicle was pressed out ward with the extended left index finger. A "V" shaped cut, out side the mucocutaneous junction was made with blunt pointed scissors and deepened to reach the lower border of the internal sphincter. Submucosal dissection extended to reach the pedicle of the pile. The pedicle was transfixed with No. 1 chromic catgut, placing the knots on the luminal side. The pile distal to the ligation was cut. Rest of the haemorrhoids dealt with in the same manner. Mucocutaneous bridges were preserved, in between the dissection sites. Haemostasis secured either with diathermy or ligatures. Anal canal was gently packed and dressing maintained with T-bandage.

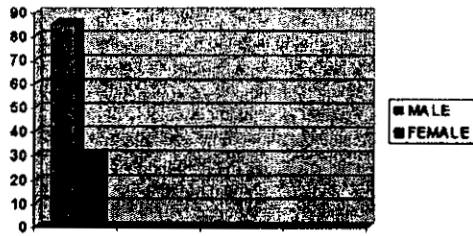


Fig. 1. Sex Distribution

Post operatively patients were given analgesics, two more doses of antibiotics, stool softener until their first bowel action. Anal pack was removed after 24-hours. At the time of discharge high residual diet and sitz bath twice a day, was advised. Patients were reviewed after a week and then after a month. Digital rectal examination performed and then called for anoscopic examination at 3 months, 6 months and a year, post operatively. In the ward as well as at each visit, the patients were inquired and examined and complications if any were recorded. All the patients were discharged on the second or third postoperative day when they had moved their bowel and the general condition were satisfactory. The mean hospital stay was 3.5 days, ranging from 2-5 days. The off work time was 2-4 weeks, mean of 20 days.

RESULTS

One hundred and fifteen patients having clinically prolapsed haemorrhoids were included in the study. Out of them 85 were males and 30 were females. The male to female ratio is 2.84: 1, shown in figure No. 1. There ages ranged from 20 to 70 years,

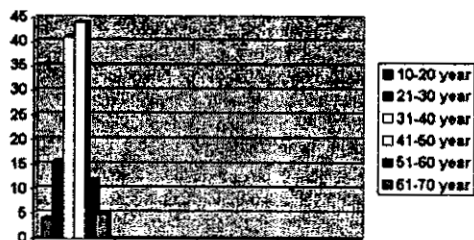


Fig. 2. Age Wise Distribution

SYMPTOMS

Symptoms	No. of patients	Percentage
Bleeding P/R	115	100%
Prolapse	115	100%
Constipation	30	26%
Discomfort at defecation	20	17.4%
Pruritis ani	8	6.95%

TABLE - 1

with mean age of 45 years. The age distribution is shown in figure No. 2, which indicates that the majority of the patients were in 4th and 5th decade of their life. The symptoms were bleeding and prolapse in all the patients. Other symptoms were constipation in 30(17.4%) patients, 8 (6.95%) patients were having pruritis ani, (table No. 1). The preoperative diagnosis was confirmed at the time of operation. 90(78.26%) patients were having 3rd degree piles while 25(21.73%) patients were found to have 2nd degree haemorrhoids. 72 (62.6%) patients found having three haemorrhoids. 34(29.5%) patients had two piles while 9 (7.5%) patients had circumferential haemorrhoids. This is shown in table No. 2. The pile most frequently found, was in the left lateral (3 o'clock) position in 80(69.56%) patients, the next common was the right posterior (7 o'clock), in 73(63.47%) patients and right anterior (11 o'clock) in 64(55.65%) patients, table No. 3.

Post operative pain was the main complaint. In majority of the patients this

MORPHOLOGY OF HAEMORRHOIDS

No. of haemorrhoids	No. of patients	Percentage
Three haemorrhoids	72	62.6%
Two haemorrhoids	34	29.5%
Circumferential	9	7.5%

TABLE - 2

POSITION OF HAEMORRHOIDS

Position of haemorrhoids	No. of patients	Percentage
Left lateral (3 O' clock)	80	69.56%
Right posterior (7 O' clock)	73	63.47%
Right anterior (11 O' clock)	64	55.65%
Circumferential	9	7.5%

TABLE - 3

required repeated doses of diclofenac sodium injection. 89(77.39%) patients remained pain free with diclofenac sodium intramuscular injections, twice a day; for 48 hours. 26(22.6%) patients needed an added dose of pentazocin, 30 mg. Three (2.6%) patients developed reactionary haemorrhage within the 1st few hours after surgery, resulting in soakage of the dressing pad. The patients were taken back to the operation theatre and examined under general anaesthesia. The bleeding points were identified and secured. The source was either bleeding from the pedicle loosened ligature or from mucosal margins. Another two (1.73%) patients presented with minor bleeding on 10th and 12th postoperative days. They were admitted to the ward and treated expectantly. 10 (8.69%) patients went in to acute urinary retention in the immediate postoperative period. All were males. 2 (1.8%) patients needed catheterization for 24-hours. The remaining patients passed water with adequate analgesia and removal of dressing pad with sitz bath. One patient developed anal stenosis with fissure at 6 o, clock position, after six months of surgery. He was treated with left lateral internal sphincterotomy. Incontinence and fistula were found in no patient. Symptomatic improvement regarding bleeding, prolapse, irritation and itching were observed in 105 patients. However 10(8.69%) patients had minor degree of discomfort at the time of defeca-

tion, for few months, postoperatively. They were reassured and advised to avoid constipation, by taking bulky foods.

DISCUSSION

Haemorrhoids is the most common ano-rectal condition encountered in general surgical practice. It significantly impairs the quality of life. The etiology remains obscure. This has been attributed to straining at stool due to constipation, diarrhoea and faulty bowel habits. Prolong standing, pregnancy, pelvic tumors, portal hypertension and heredity may play a role.⁶ It is said that erect posture of man, subject them to high pressure in the superior haemorrhoidal veins, without valves,⁷ but this is not generally accepted anatomical factor. Haemorrhoids are thought to result from degeneration of the smooth muscle and fibroelastic tissue which support the cushions, allowing them to prolapse into the anal canal.⁸

In our study we found that the mean age is 45 years, and that the majority of the patients were in the 4th and 5th decade of life. Similar observations has also been made by other studies.^{4,9,10}

Haemorrhoids are more common in males than females. We found in our study the ratio of male to female is 2.84:1. Various studies have reported different ratio, but over all males outnumber the females. In the study of Murie et al and Loder et al^{5,6} it is 2:1 and 3:2 respectively, which is comparable to our study. Another study made in 1995 reported the male to female ratio was 9:1.¹⁰ The obvious male preponderance may be due to social taboo, particularly in our set up, and secondly the men seek medical advice more readily than women. The cardinal symptoms of haemorrhoids are anorectal bleeding, prolapse, discharge, pruritis and perianal discomfort.⁶ In the present study the main symptoms were bleeding and prolapse in all the patients with

perianal discomfort. Soiling and pruritis was observed in various proportions. As we know that the disease is of obscure etiology, so the different treatment modalities available are directed towards the symptoms and efficacy of each one is judged through symptomatic improvement and minimal complications, associated with a particular procedure. Rubber band ligation has been found to be an effective way of treating prolapsing haemorrhoids. A study made in 1981 claimed that the rubber band ligation is as effective as surgery in alleviating symptoms of prolapsing haemorrhoids and its associated perianal discomfort, pruritis and soiling in majority of the patients.⁶ Similarly another study made in 1995 showed promising results for rubber band ligation by treating 200 patients with haemorrhoids.¹⁰ Ruffin and Gartell found it excellent way of treating 2nd and 3rd degree haemorrhoids.¹¹ More or less the same observation was made by Ghulam Asghar Channa, Abdul Rasheed Choudhry¹⁶ & Arshad Zafar.¹⁷ In certain conditions it is not a suitable method of treating haemorrhoids, when there is associated fissure, fistula in ano and skin tags. Similarly previous injection sclerotherapy may pose difficulty in drawing haemorrhoidal tissue into applicator and subsequent band application.

Cryo haemorrhoidectomy has also been studied much and the results have been compared with that of open haemorrhoidectomy in prolapsing piles, and this has been found that the results were no more different than that of the open haemorrhoidectomy.¹² The procedure is not suitable in patients with external haemorrhoids, in the presence of active infection, fistula, stenosis and skin tag. In addition to this, the equipment is expensive and is not available everywhere. Haemorrhoids have been extensively studied over the past so many years and different methods of treatment have been evaluated. From the various pools of treatment modalities, the one adopted should be acceptable to the patients and surgeons

in terms of symptomatic improvement, minimal hospital stay with early return to work. Equally good results have been claimed for different modalities but surgery in the form of low ligation and excision is still the method of choice of many surgeons, all over the world, particularly treating prolapsing haemorrhoids.^{6,10, 13, 15} The complications associated with surgery are bleeding, it may be reactionary or secondary. In our study we found that 3(2.6%) patients developed reactionary haemorrhage and 2(1.73%) patients presented with secondary haemorrhage. Other studies have also quoted the same proportion, 2-3% for reactionary haemorrhage and 2-5.4% for secondary haemorrhage.^{13,14} Postoperative urinary retention occurred in 10(8.69%) patients. The reported incidence in other studies is 1-50%.^{6,12,13,15} Anal stenosis has been reported in 0-5%.^{6,14} One patient developed anal stenosis in our study.

CONCLUSION

We found in our study that surgery is associated with minimal complications, short hospital stay and early return to work in the remedy of treating prolapsing/prolapsed haemorrhoids. We strongly recommend surgery for the treatment of the prolapsing/prolapsed haemorrhoids.

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Address for Correspondence:

Dr. Waqar Alam Jan,
Department of Surgery,
Lady Reading Hospital,
Peshawar.