Personal Experience of Stapled Haemorrhoidectomy

[redacted] Mander

Background

I trained as a colorectal surgeon in London and South West Thames between 1996 and 2002. I undertook a one year fellowship in colorectal surgery at Concord Hospital Sydney under Professor L Bokey in 2001.

I was appointed to the colorectal unit in Edinburgh in April 2002. The unit provides a comprehensive colorectal service to a population of approximately 900,000 within Edinburgh and East and West Lothian. It also provides a tertiary referral practice to a much larger population . The unit is staffed by nine consultants (2 academics and 7 NHS staff). I have been lead clinician of the unit since December 2004.

Exposure to Stapled Haemorrhoidectomy (SH)

I was exposed to the procedure sporadically during my training in London and South West Thames. I attended a Stapled Haemorrhoidectomy Masterclass in Sydney in 2001 where 14 procedures were performed by Professor F Seow-Chen (Singapore) and I had the opportunity to look after the patients in the early post-operative period and to follow their clinical course.

Since 2002 approximately 90 SH procedures have been performed in Edinburgh. I have performed 22 of these. This equates to approximately 8% of all the haemorrhoidectomy procedures performed in Edinburgh during this time.

The following statement is based on my personal experience and on the cumulative experience of my colleagues unless specifically stated.

Indications for Stapled Haemorrhoidectomy (stapled anopexy)

1. Treatment Of Haemorrhoids

Traditionally haemorrhoids have been graded (1-4) depending on their degree of prolapse with grades 3 and 4 being considered for surgical treatment. In my experience it is more informative to discuss the internal and external components of haemorrhoids and their contribution to patients symptoms. If the external components (usually skin tags but occasionally grade 4 haemorrhoids) are the major cause of the symptoms then a formal excision haemorrhoidectomy is indicated.

With regard to patients with prolapsing internal components I would favour excisional surgery if there was only one haemorrhoid causing symptoms. In symptomatic patients, who had not experienced relief with conservative measures or banding, with 2 or more pedicles and particularly in patients with circumferential internal haemorrhoids I would consider a stapled procedure ahead of excisional surgery.

2. Treatment of Mucosal Prolapse

I have undertaken 5 SH procedures in patients (largely multiparous women aged >50) with anterior or circumferential mucosal prolapse. Such patients frequently describe symptoms of obstructive defaecation, mucous leakage and bleeding. I would consider a stapled anopexy in such patients after they had failed a course of banding and conservative treatment.

I would not perform the procedure in patients with continence problems or inflammatory bowel disease

Technical Issues

When consenting patients for the procedure I will warn them of the common well documented complications, of bleeding, early post-operative pain, minor disturbances

of continence and urgency. In addition I advise them of the isolated case reports of fistula formation, rectal obstruction and pelvic sepsis which although exceptionally uncommon may result in serious sequelae and / or the need for a defunctioning stoma. I will spend approximately twice as long consenting a patient for stapled haemorrhoidectomy as for a standard Milligan-Morgan procedure.

My preference is to perform the procedure in the prone position (assuming no anaesthetic contraindications) to facilitate placing of the pursestring suture. This position is also ideal for supervising training surgeons. I perform the procedure in the standard fashion recommended by the manufactures of the PPH gun (Ethicon). In males with a small diameter pelvis it is frequently not possible to fully insert the obdurator because its diameter is greater than that distance between the ischial tuberosities. If the pursestring is then placed the tendency is to place it too low. It my practice to abandon the obdurator and apply the pursestring using the supplied retractor alone to ensure that it is sited sufficiently proximal, 4-5cm form the anal verge. I am happy to perform the procedure as a daycase.

Outcome

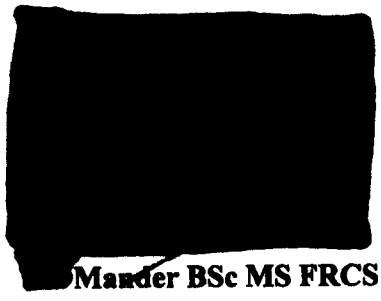
In my experience patients have the same degree of post-operative pain for the first week as patients undergoing standard surgery. The major advantage of the procedure is that this level of pain rapidly subsides and is usually resolved by the end of the second week. There are of course no slow or non-healing anal wounds. The majority of my patients experience a degree of rectal urgency which is usually resolved by four weeks. This symptom is often advantageous in patients with circumferential mucosal prolapse when obstipation is a significant pre-operative symptom.

The consensus of the consultants in the Edinburgh colorectal unit is that this is an excellent procedure if performed carefully in appropriately selected patients. I find it especially good in patients with symptomatic prolapse. To date (with a follow-up period of approximately 2 years) I have no patients returning with symptomatic disease although I have one patient who has developed a small asymptomatic prolapse. I have not had to take any patients back to theatre for bleeding although one patient developed a pararectal haematoma. In the unit we have not seen any

rectovaginal fistulas or anastomotic strictures and no major complications with continence. A small number of patients have experienced external haemorrhoid thrombosis which usually resolves quickly. One patient within the unit developed acute rectal obstruction which was quickly identified and simply resolved. There have been no episodes of significant pelvic sepsis or rectal perforation although I know via anecdote of two unpublished episodes in the UK which both resulted in the patient requiring a stoma

Summary

I think that stapled haemorrhoidectomy is an excellent procedure for the small group of patients with prolapsing haemorrhoids, resistant to simple treatments, who have no external components or in patients with circumferential mucosal prolapse. It is a procedure that need to be performed carefully by trained surgeons aware of the small risk of potentially serious complications. The Edinburgh Colorectal Unit's results mirror the published data in terms of efficacy and complications.



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Competing Interests

I was taken to Hamburg in 2003 to the Laparoscopic Colorectal Training course as a guest of Ethicon and my expenses were paid by them. Ethicon Regularly sponsors educational meetings in Edinburgh and hosts dinners at these meetings which I attend intermittently