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## Original Article

# Stapled hemorrhoidopexy – Initial experience from a general surgery center

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## ABSTRACT

**Background:** Stapled hemorrhoidopexy is gaining popularity as a relatively painless alternative to conventional excisional hemorrhoidectomy. The initial experience from a service hospital is presented along with review of literature.

**Methods:** 40 cases were managed by stapled hemorrhoidopexy (SH) over a period of two and half years. The primary outcome measures assessed were the analgesic requirement in the post-operative period and the time taken to resume Activities of Daily Living (ADL). Additional outcome measures studied were; presence of bleeding per rectum, prolapse of mass per rectum, incontinence to flatus/stool, post-operative urinary retention, requirement of a repeat procedure, presence of post-operative anal stenosis, and residual external haemorrhoids at 1 week, 1, 3 and 6 months and 1 year after surgery.

**Results:** 40 patients with grade II, III and IV hemorrhoids underwent SH under spinal anesthesia. In the first 24 h 17 patients required a single dose of Injection Diclofenac Sodium while 19 patients required two doses and 4 patients had to be given three doses. 14 patients (35%) achieved Katz Index of Independence in Activities of Daily Living score of 6 on the first post-operative day and another 17 (42.5%) on the second post-operative day. By the fourth post-operative day all patients had achieved a score of 6. One patient had a rectal perforation as a complication of the procedure and another required a second procedure for excision of thrombosed external hemorrhoids.

**Conclusion:** Stapled hemorrhoidopexy is associated with less post-operative pain and early resumption of ADL. Although the procedure appears simple to perform, it can be associated with serious complications and still cannot be considered the standard of care for the operative treatment of internal hemorrhoids.

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## Introduction

Hemorrhoidal disease is common and symptomatic hemorrhoids affect >1 million individuals in the western

world per year.<sup>1</sup> Excisional hemorrhoidectomy (EH) is considered the most definitive treatment for both internal and external hemorrhoidal disease but since it is associated with marked post-operative pain; patients and

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surgeons were left searching for alternative treatment options.

Stapled hemorrhoidopexy (SH) represents the first dramatic change in the treatment of hemorrhoids in many years. This technique was introduced in 1997 by Sir Antonio Longo.<sup>2</sup> A modified circular stapler is inserted across the anus, and used to excise a circular ring of mucosal tissue from the anal canal, well above the dentate line. A stapled anastomosis is created, thus lifting the redundant, prolapsing mucosa back into the anal canal. The name of this procedure has undergone many changes. The operation is essentially a procedure of fixation; therefore the name Stapled Hemorrhoidopexy was accepted by an international working committee, and subsequently this has been the name most commonly used.<sup>3</sup>

SH is reported to be effective in the treatment of second and third-degree hemorrhoids with low morbidity, high patient satisfaction and good long-term control of hemorrhoidal symptoms.<sup>4</sup> It is not routinely performed in AFMS hospitals and hence this study was undertaken to evaluate the efficacy of this modality in our set-up.

## Materials and methods

This study was conducted over a period of two and a half years, from Sep 2009 to Feb 2012, at a referral and teaching hospital of the Armed Forces. Adult patients undergoing elective surgery for symptomatic hemorrhoidal disease (Grades II, III and IV) were included in the study. Patients with thrombosed/gangrenous internal or external haemorrhoids, those with presence of anal stenosis, perianal abscess and full thickness rectal prolapse and those who had undergone previous anorectal surgery/injection sclerotherapy with resultant scarring of the anal canal were excluded from the study. A total of 40 patients were treated with SH. The procedure was performed by the first author and by final year residents in General Surgery with assistance by the former.

All patients were subjected to detailed pre operative evaluation including inspection during straining, digital rectal examination and anoscopy. Colonoscopy was carried out selectively in those patients who had a positive family history of colon cancer, were older than 50 years of age or had concomitant anemia. All cases were admitted on the day prior to surgery and placed on fluid diet. Oral laxative tablets were given at bedtime followed by administration of sodium phosphate (Proctoclysis) enema, on the morning of surgery. The procedure was explained to the patient and consent obtained. Similarly the Visual Analog Scale for recording post-surgical pain was explained to the patient and co-operation sought in recording it.

All patients were operated under spinal anesthesia in lithotomy position. The Proximate Hemorrhoidal Circular Stapler (HCS), manufactured by Ethicon Endo-surgery was used in all cases. Once properly positioned, the anal canal was thoroughly examined for pathology other than hemorrhoids. The sphincter was then progressively dilated digitally, to facilitate insertion of the circular anoscope. The hub of the scope was sutured to the perianal skin with silk sutures to retain it in position. Next, the purse string suture anoscope was inserted through the circular anoscope and the purse

string suture placed approximately 4 cm cephalad to the dentate line using a 2/0 polypropylene suture incorporating only the mucosa and submucosa (Fig. 1). The purse string suture anoscope was then removed and the HCS inserted, with the head of the stapler fully opened. The purse string suture was then tightened and tied around the shaft of the stapler. Thereafter, the suture threader was passed through each of the side channels on the stapler head, and the tails of the purse string suture brought out from either side of the head of the stapler. Once the tails of the suture were brought through the side channels of the stapler head, gentle traction was applied to the suture and the stapler advanced into the anal canal such that the 4 cm mark on the head of the stapler was at the level of the anal verge, and the stapler head was tightened. When fully closed, the stapler was fired (Fig. 2). After firing, the stapler was held in position for 2 min and then withdrawn after partial untwisting and the doughnut examined for completeness. The anoscope was then inserted back into the anus, and the staple line inspected for bleeding (Fig. 3). If present, it was addressed by over sewing that aspect of the staple line with an absorbable, 3/0 polyglactin, suture. Dressings were applied and operative time and blood loss were assessed and recorded.

The patient was permitted to take oral fluids after 6 h of surgery. Pain was assessed at 6 h, 12 h, 24 h and 48 h, as per the Visual Analog Scale, and requirement of analgesia (both injectable and oral) was recorded. Inj. Diclofenac Sodium, 75 mg intramuscular, was administered to all patients who had a VAS score of more than 4 and oral NSAID (combination of Ibuprofen 400 mg with Paracetamol 500 mg) was given to others with VAS scores below that. All cases also received Injection Ciprofloxacin 200 mg and Injection Metronidazole 500 mg intravenously at the commencement of the surgery followed by Tablet Ciprofloxacin 500 mg and Tablet Tinidazole 500 mg for 3 days post-operatively. The primary outcome measures assessed were the requirement of injectable analgesic in the first 48 h post-operatively and the time taken to resume Activities of Daily Living (ADLs) which was evaluated using the Katz Index of Independence in Activities of Daily Living.<sup>5</sup> The Index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring,

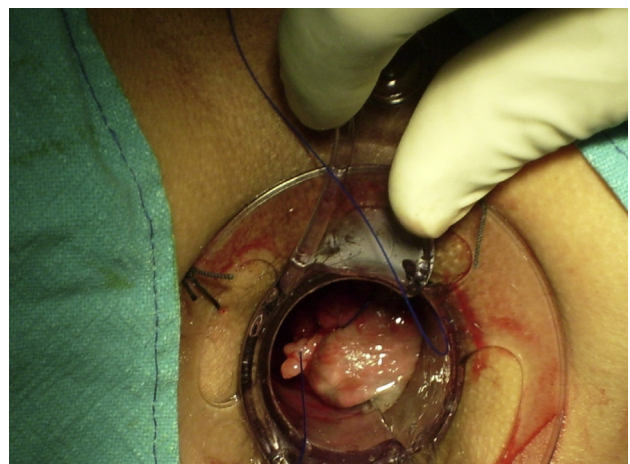


Fig. 1 – Purse string suture being placed.

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