

Retrospective Study of Immediate Post operative Complications of Conventional Haemorrhoidectomy Cases

Sukesh K S Thakur¹, Deepak Pawar², Prashant Pawar¹

ABSTRACT

Introduction: Hemorrhoids are highly vascularized cushions forming masses of thick submucosa, containing blood vessels, elastic and connective tissue within the anal canal. With patient in the lithotomy position they characteristically lie in 4, 7 and 11 o' clock positions. Hemorrhoidectomy is treatment for 3rd and 4th degree hemorrhoids. There are two methods of haemorrhoidectomy - Milligan-Morgan technique which is more common and also called as open haemorrhoidectomy in which the wound is left open and healing occurs by secondary intention. In the closed or Ferguson procedure the wound is closed with absorbable sutures. Study aimed to evaluate the course of post haemorrhoidectomy indoor cases.

Material and methods: This is a retrospective randomized clinical study of management of third and fourth degree hemorrhoids by conventional methods of haemorrhoidectomy that is, open (Milligan-Morgan)/closed (Ferguson) hemorrhoidectomy. The average hospital stay was recorded. Data so obtained was evaluated using SPSS-16 software and required values and percentage was obtained accordingly.

Results: Out of 40 patients 30 patients were male, suggesting higher male prevalence. Constipation was present in 60% of cases. Mean hospital stay was 4 days. Post operative pain was seen in 30% Post operative urinary retention was observed in 10% patients. Bleeding was observed in 70% cases on post operative day 1, 30% cases on 2nd and 10% on 3rd day. Discharge was found in very few number of patients with <5% incidence. 20% cases developed fever on 1st post operative day and 5% on 2nd day.

Conclusion: Conventional haemorrhoidectomy is safe and effective procedure for three/four degree haemorrhoids.

Keywords: Hemorrhoidectomy, Complications, Technique

INTRODUCTION

Haemorrhoids are one of the commonest diseases.¹ They are dilated veins in relation to anal canal. Hemorrhoids play a significant physiologic role in protecting the anal sphincter muscles and augment closure of the anal canal during moments of increased abdominal pressure.² It is common disease affecting people of all ages and both sexes.³ It has been estimated that 50% of the population has haemorrhoids by the age of 50 years⁴ and these are supposed to be the commonest cause of rectal bleeding.⁵

It is more common in the affluent people, perhaps related to exercise; diet and bowel habits.⁶ Hemorrhoids present symptoms similar to other diseases and the differential diagnosis should include abscesses and fistulas, rectal prolapsed, anal fissures, inflammatory bowel disease and neoplasia. The clinical history is important to identify the etiology. Hemorrhoidal bleeding is common, however in patients with anemia, it is less common.^{7,8} Due to the wide array of pathology, a thorough examination including anoscopy is required.

Clinically internal haemorrhoids can be classified into four degrees.² First and second degree haemorrhoids usually respond to outdoor measures including dietary modifications, injection sclerotherapy, rubber band ligation and medications etc. Surgical treatment is regarded as the best therapeutic approach for third and fourth degree haemorrhoidal disease.⁷ Haemorrhoidectomy can be performed by various techniques including open (Milligan Morgan), sub mucous resection (Park), closed (Ferguson) or by stapled techniques. Closed haemorrhoidectomy is the one in which excision of the haemorrhoids is followed by primary suturing of the mucosal and skin edges. This approach is considered as better in terms of postoperative pain, healing time and other postoperative complications.⁹⁻¹¹ Open haemorrhoidectomy is traditional treatment of haemorrhoids. In this technique haemorrhoidal tissue is excised and wound is left open to heal by secondary intention. This study was undertaken to analyze the postoperative outcome following traditional method of haemorrhoidectomy by the open and the closed methods.

MATERIAL AND METHODS

This is a retrospective randomized clinical study of management of third and fourth degree hemorrhoids by conventional methods of hemorrhoidectomy that is, open (Milligan-Morgan)/closed (Ferguson) hemorrhoidectomy. The aim is to record the immediate post-operative sequel during hospital stay of the patient. This study was carried over a period of one year from March 2015 to March 2016. Forty (40) patients with symptomatic and confirmed third/fourth degree hemorrhoids were admitted and operated under spinal anesthesia in the surgical unit at New Noor Multi Specialty Hospital, Mumbai were selected for the study. All patients operated for third/ fourth degree hemorrhoids by conventional method of hemorrhoidectomy were included in the study. Patients with anal fissure, inflammatory bowel diseases and anorectal malignancy; portal hypertension were excluded from the study. The selected patients underwent open and closed haemorrhoidectomy. Post-Operatively patients were treated with analgesics, antibiotics and laxatives. Patients were observed for pain, discharge, bleeding, urinary retention postoperatively and were discharged according to wound condition. The average hospital stay was recorded. Data so obtained was evaluated using SPSS-16 software and required

¹Assistant Professor, ²Associate Professor, Department of Surgery, Rajiv Gandhi Medical College, Thane, Mumbai, India

Corresponding author: Dr. Sukesh K S Thakur, Assistant Professor, Department of Surgery, Rajiv Gandhi Medical College, Thane, Mumbai, India

How to cite this article: Sukesh K S Thakur, Deepak Pawar, Prashant Pawar. Retrospective Study of Immediate Post operative Complications of Conventional Haemorrhoidectomy Cases. International Journal of Contemporary Medical Research 2016;3(9):2630-2632.

values and percentage was obtained accordingly.

RESULTS

40 patients (30 male, 10 female) were selected and the case sheets were retrospectively evaluated. The age ranged from 35 years to 55 years. Preoperatively, constipation was observed in all 40 cases. The most common complication of haemorrhoidectomy (table-1) in this study was pain seen in all cases. The pain was mild in intensity and subsided over a period of 3 days. All the patients were pain free at the time of discharge. Bleeding per rectum was observed in 70% cases on post operative day 1, 30% cases on 2nd and 10% on 3rd day Discharge was present in very few number of patients with <5% incidence. 20% cases developed fever on 1st post operative day and 5% on 2nd day. 30% patients needed catheterization for post operative retention of urine.

DISCUSSION

Conventionally haemorrhoidectomy can be done by two methods open (Milligan- Morgan) and closed (Ferguson) haemorrhoidectomy. This study was conducted to record the post operative complications (Milligan- Morgan and Ferguson techniques) with regards to post operative pain, bleeding, discharge, fever, urinary retention and hospital stay.

Haemorrhoids can occur at any age but the peak incidence is found in 5th decade of life.¹² Aroya A et al⁹ concluded that the mean age of the patients presenting with symptomatic haemorrhoids was 43.5 years. In the present study, majority of the patients were between 35-55 years of age and the mean age was 44 years. 30 patients were male and 10 were female. Although female population is equally prone to develop haemorrhoids, low hospital turn up could be due to shyness to consult physician regarding this problem.

Anal canal is richly innervated tissue in the digestive system, so pain after haemorrhoidectomy is an expected postoperative outcome. A great deal of emphasis has been applied to the management of pain after haemorrhoidectomy as it also has role in urinary symptom.¹³ The bare area of the anal canal after open haemorrhoidectomy is considered as the reason of the pain. In view of this, closed haemorrhoidectomy has been considered as better approach, even though there is no statistically significant differences between the open and closed methods of haemorrhoidectomy in terms of cost per patient and morbidity rates.¹⁴

The study of Kim SH et al¹¹ concluded that the pain score was significantly lower in closed group than in open one. In the present study the pain score after 24 hours and 48 hours of surgery was lower in open haemorrhoidectomy than the closed technique. In another randomised trial, Carapeti EA et al¹⁵ showed that there was no significant difference in the mean pain scores between the open and closed haemorrhoidectomy techniques. However, in another prospective study, Gencosmanoglu et al¹⁶ reported that the open technique is more advantageous, in that patients experience less discomfort during the early post-operative period, although the healing time was shorter with the closed technique. Postoperative bleeding was the same in both open and the closed method. Aroya A et al⁹ described that there is no difference in two techniques regarding postoperative bleeding. The over enthusiastic use of intravenous fluids during

Post –operative complications	Percentage of patients (n=40)
Pain	100%
Bleeding per rectum	70% (1 st post-op day)
	30% (2 nd post-op day)
	10% (3 rd post-op day)
Discharge	<5%
Fever	20% (1 st post-op day), 5% (2 nd post-op day)
Retention of urine	30% patients required catheterization
Table-1: Post –operative complications of conventional haemorrhoidectomy cases	

the procedure may contribute to the high incidence of urinary retention.¹⁷ In a study carried out by Chik B et al,¹⁸ the incidence of urinary retention following haemorrhoidectomy was 15.2%.

CONCLUSION

Open and closed hemorrhoidectomy are conventional approaches for hemorrhoid surgery. Both the techniques are fairly effective and having no serious drawbacks in terms of immediate. Both procedures are easy to perform without requirement of any costlier instruments and operating room setup. Though the time duration of surgery was significantly less in open hemorrhoidectomy (15- 20 minutes more intraoperative time) does not pose any significant morbidity to patient as both surgeries can be performed under spinal anaesthesia. Thus, it can be concluded that open and closed both types of hemorrhoidectomies are simple, safe and effective method for treatment of hemorrhoids and there are few post surgical complications.

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Source of Support: Nil; **Conflict of Interest:** None

Submitted: 13-08-2016; **Published online:** 27-09-2016