(e) ISSN Online: 2321-9599

(p) ISSN Print: 2348-6805

Original Article

Assessment of outcome of haemorrhoidectomy among 58 patients

Harpinder Singh

Assistant Professor, Department of General Surgery, Adesh Institute of Medical Sciences & Research, Bathinda, Punjab, India

ABSTRACT:

Background: Symptomatic haemorrhoids are common, and affect about 4% of the western population each year. The present studyassessedoutcome of Haemorrhoidectomy patients. **Materials & Methods:** 58 patients of haemorrhoids of both genders were selected. Type of haemorrhoidectomy, type of surgery performed and type of haemorrhoids was recorded. **Results:** Age group 18-28 years had 4 patients, 38-48 years had 10, 48-58 years had 16 and 58-68 years had 28 patients. Type of haemorrhoids was internal in 28, external in 20 and strangulated in 10. Clinical symptoms seen were cough in 45, pain in 56, constipation in 32, straining in 40, bleeding from rectum in 15 and mass through rectum in 28 cases. Type of surgery performed was open haemorrhoidectomy in 34, closed haemorrhoidectomy in 14 and lateral internal sphincterotomy with haemorrhoidectomy in 10 cases. The difference was significant (P< 0.05). **Conclusion:** Open haemorrhoidectomy was performed in maximum cases. Maximum cases were seen in advanced age**.**

Key words: Bleeding, haemorrhoidectomy, Pain

Corresponding author: Harpinder Singh, Assistant Professor, Department of General Surgery, Adesh Institute of Medical Sciences & Research, Bathinda, Punjab, India

This article may be cited as: Singh H. Assessment of outcome of haemorrhoidectomy among 58 patients. J Adv Med Dent Scie Res 2014;2(3):317-319.

INTRODUCTION

Symptomatic haemorrhoids are common, and affect about 4% of the western population each year. The aetiology and pathogenesis are not clear, despite a number of theories.[1] Some evidence supports age-related deterioration of anal supportive connective tissue. With an abundance of non-operative treatments, only about 10% of the patients who attend physicians require operative treatment. The most widely accepted theory attributes this disorder to the prolapse of the anal cushions.[2] 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.[3]

Haemorrhoidectomy is considered the gold standard, and Milligan-Morgan's and Ferguson's procedures are the most widely used techniques throughout the world.[4] Although these techniques have yielded excellent results and low complication rates, they are usually associated with postoperative pain.[5] Compared with haemorrhoidopexy, haemorrhoidectomy is the most effective long- term treatment but complications have been reported to be not uncommon.[6] Many proctologists in their daily clinical practice would feel that morbidity after haemorrhoidectomy is lower than reported.[7] The present study was conducted to assess outcome of Haemorrhoidectomy among 58 patients.

MATERIALS & METHODS

The present study comprised of 58 patients of haemorrhoids of both genders. The study was approved from the institutional ethical committee. All patients were informed regarding about the study and their written consent was obtained.

Demographic data was recorded. A thorough clinical examination was carried out. Type of haemorrhoidectomy, type of surgery performed and type of haemorrhoids was recorded. Results of the study was tabulated and analysed statistically. The p value less than 0.05 was considered significant.

Table I Distribution of cases

Age group (Years)	Number	P value
18-28	4	0.05
38-48	10	
48-58	16	
58-68	28	

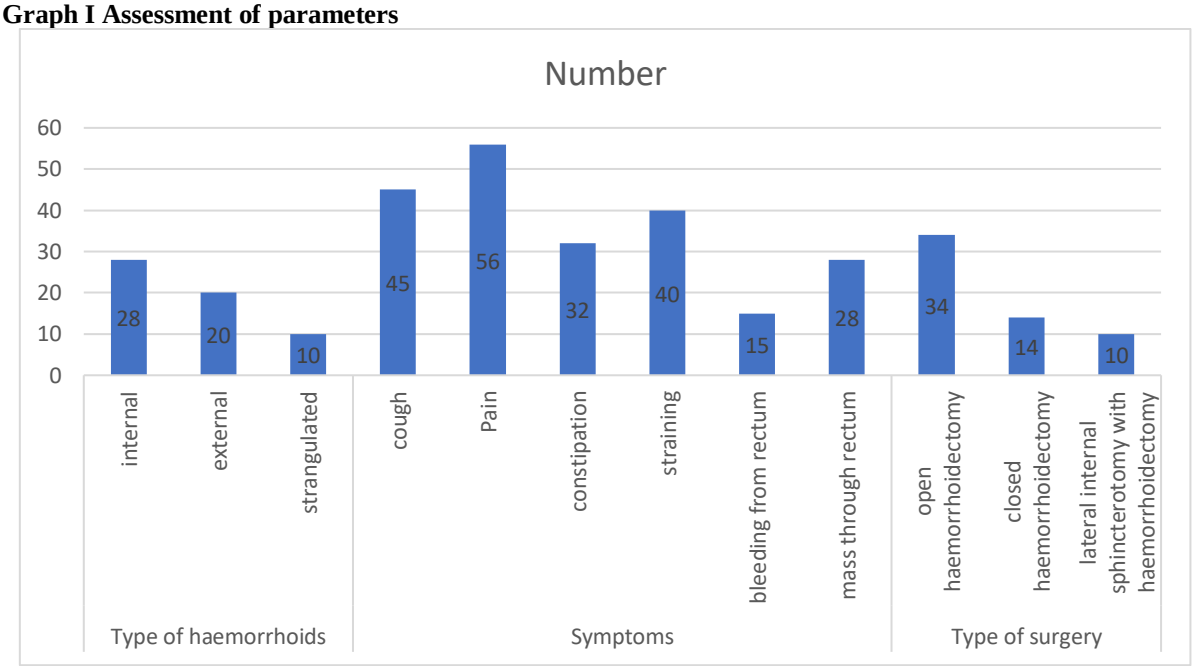
Table I shows that age group 18-28 years had 4 patients, 38-48 years had 10, 48-58 years had 16 and 58-68 years had 28 patients.The difference was significant (P< 0.05).

Table II Assessment of parameters

Parameters	Variables	Number	P value
Type of haemorrhoids	internal	28	0.81
	external	20	
	strangulated	10	
Symptoms	cough	45	0.94
	Pain	56	
	constipation	32	
	straining	40	
	bleeding from rectum	15	
	mass through rectum	28	
Type of surgery	open haemorrhoidectomy	34	0.05
	closed haemorrhoidectomy	14	
	lateral internal sphincterotomy with haemorrhoidectomy	10	

Table II, graph I shows that type of haemorrhoids was internal in 28, external in 20 and strangulated in 10. Clinical symptoms seen were cough in 45, pain in 56, constipation in 32, straining in 40, bleeding from rectum in 15 and mass through rectum in 28 cases. Type of surgery performed was open haemorrhoidectomy in 34, closed haemorrhoidectomy in 14 and lateral internal sphincterotomy with haemorrhoidectomy in 10 cases. The difference was significant(P< 0.05).

Graph I Assessment of parameters



DISCUSSION

Haemorrhoidal disease is a common disorder, affecting 4% of the world population.[8,9] Haemorrhoids are a common problem, but incidence data are difficult to collect, and the available information varies greatly.[10,11]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.[12,13] The present study was conducted to assess outcome of Haemorrhoidectomy among 58 patients.

We found that age group 18-28 years had 4 patients, 38-48 years had 10, 48-58 years had 16 and 58-68 years had 28 patients. 16. Johannsson et al[14]assessed the long-term functional results of Milligan-Morgan haemorrhoidectomy. 507 of 556 patients who were operated on for haemorrhoids by the Milligan-Morgan technique between January 1987 and December 1995.: 418 of the 507 responded (82%). Altogether 279 patients (67%) reported a successful result, while 139 patients (33%) reported impaired anal continence. 40 of the 139 patients (29%) claimed that the incontinence was a direct result of the haemorrhoidectomy. Female sex (p = 0.005) and an operation for hygienic problems (p = 0.02) were associated with a higher risk of incontinence. Impaired anal continence is common after Milligan-Morgan haemorrhoidectomy and a large proportion of affected patients relate their problems to the operation

We found that type of haemorrhoids was internal in 28, external in 20 and strangulated in 10. Clinical symptoms seen were cough in 45, pain in 56, constipation in 32, straining in 40, bleeding from rectum in 15 and mass through rectum in 28 cases. Type of surgery performed was open haemorrhoidectomy in 34, closed haemorrhoidectomy in 14 and lateral internal sphincterotomy with haemorrhoidectomy in 10 cases. Ferguson et al[15] aimed to minimise excision of anoderm thereby possibly reducing the risk of anal denervation. According to a long term follow up study after operation by the closed technique, permanent disturbance of continence was rare. There is a risk of injuries to both the internal and the external sphincter when one is operating in the vicinity of these structures. Damages to the sphincter has been seen by anal endosonography after haemorrhoidectomy. Identification of the sphincter muscles is considered important and they found a possible reduction in the risk of damage when the sphincter was identified. Some dilatation of the sphincter is often unavoidable during the operation and the sphincters can be over-distended. The use of a self-holding anal retractor reduces anal resting pressure by up to 20% and anal manipulation with instruments that pass the sphincters has a similar effect.

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.[16] On proctoscopy it is possible to see the change from columnar epithelial tissue, which occurs above the dentate line, to the squamous epithelium below. External haemorrhoids originate from below the dentate line and are covered in skin. 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.[17]

CONCLUSION

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

REFERENCES

1. Cabaj H. Hemorrhoidal disease. Health Service 2002; 15-18: 38-40.
2. Bielecki K, Cabaj H. Hemorrhoidal disease. The Progress of Medical Science 2000; 3: 35-8.
3. Krasowski G, Kruk M. Hemorrhoids. PZWL, Warsaw 2005; 11-68.
4. Dziki A, Trzciński R. Hemorrhoidal disease. Health Service 1999; 87-88: 27-31.
5. Matławska I. Plant medicines in the treatment of hemorrhoidal disease. The World of Medicine and Pharmacy 2005; 5: 27-30.
6. Godeberge P. Atlas of diseases of the blood nodules. Medical Publication Polish Server 2004; 8-97.
7. Banaszkiewicz Z, Jankowski M, Jawień A. The blood disease of the rectum. Przew Lek 2003; 10: 84-7.
8. Becker F. Venous pathology. Via Medica, Gdansk 2006; 27-139.
9. Dyczkowski K, Pawełczyk I, Starzewski J. Hemorrhoids and what's next. Primary Care Doctor 2004; 7: 100-3.
10. Trzciński R, Dziki A. If everything we already know about hemorrhoids. Proctology 2000; 1: 7-16.
11. Gaj F, Trecca A, Crispino P. Haemorrhoid disease during pregnancy: focus on delivery unit. Clin Ter 2007; 158: 285-9.
12. Johanson JF, Sonnenberg A. Constipation is not a risk factor for haemorrhoids: a case-control study of potential etiological agents. Am J Gastroenterol. 1994; 89:1981-6.
13. François Pigot, Laurent Siproudhis, François-André Allaert. Risk factors associated with hemorrhoidal symptoms in specialized consultation. 2005; 29(12):1270-1274.
14. Jóhannsson HÖ, Graf W, Påhlman L. Long-term results of haemorrhoidectomy. European Journal of Surgery. 2002 Nov;168(8-9):485-9.
15. Fergusson JA, Mazier PW, Ganchrow MI, Friend WG. The closed technique of haemorrhoidectomy. Surgery 1971; 3: 480–484.
16. Kaidar P, Person B. Hemorrhoidal Disease: A comparative study. J Am Coil Surg. 2007; 204(1):102-17.
17. Sielezneff I, Antoine K, Lecuyer J, Saisse J, Thirion X, Sarles JC. Is there a correlation between dietary habits and hemorrhoidal disease? Presse Med. 1998; 27:513-7.