Norwest PRIVATE HOSPITAL

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IS THERE AN ALTERNATIVE TO PAINFUL HAEMORRHOIDECTOMY?

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Introduction

Haemorrhoid is a common health problem, estimated to affect 4-5% of the population. However, only one-third seek medical advice. It usually affects people in the age group 45-65 years and decreases after 65. It rarely affects people <20 years old.

Haemorrhoids are associated with straining and constipation. Hormonal changes during pregnancy also predisposes to the development of haemorrhoids or exacerbation of pre-existing haemorrhoids. The pathophysiology of haemorrhoidal disease remains controversial. It is said to be related to vascular hyperplasia, internal anal sphincter tone, degeneration of connective tissue, sliding of the haemorrhoidal cushions, impaired venous drainage and malfunction of the arterio-venous shunts within the haemorrhoidal plexus. Perhaps all the above factors are contributory to the development of haemorrhoids and its symptoms.

Haemorrhoidal symptoms may include bright red PR bleeding, prolapse that may/may not require manual reduction, anal pain/discomfort, pruritus ani and anaemia.

Treatment of haemorrhoids can be non-operative or operative. The aim of non-operative treatment is to avoid straining and/or constipation. This can be carried out by taking a high fibre diet, drink plenty of fluids, exercise and take fibre supplements if necessary.

Operative treatment can be minor procedures such as banding of haemorrhoids or sclerotherapy or operations such as open haemorrhoid-ectomy, stapled anopexy (stapled haemorrhoidectomy) or transanal haemorrhoid dearterialisation (THD - relatively new procedure). The following provides overview of operations for haemorrhoids.

1. Open Haemorrhoidectomy (conventional)

- Necessary for large or complicated haemorrhoids
- Performed under anaesthetic in a hospital or Day Surgery Centre
- It involves the cutting out of the haemorrhoids. A maximum of 3 haemorrhoids can be removed at any one time with careful preservation of the mucosal bridges (to prevent anal stenosis) and the identification and preservation of internal anal sphincters (to prevent faecal incontinence).
- Main disadvantage is significant anal pain for at least 2 weeks despite laxatives, analgesia, oral Metronidazole and warm bath. It may also need to be performed in 2 stages if the haemorrhoids are large and circumferential
- Risks: <5% risk of bleeding requiring hospitalisation or intervention, delayed wound healing acting like an anal fissure, faecal incontinence (uncommon) and rare anal stenosis

2. Stapled Haemorrhoidectomy

- Involves the use of a stapled gun inserted through the anus to cut the internal hemorrhoids out. There is no external wound.
- It gives minimal pain after the operation, does not need to be performed in stages and it also allows patients to return to work or normal activity in a significantly shorter time compared to open haemorrhoidectomy.
- It removes internal haemorrhoids very well but it does not remove the external haemorrhoids or anal skin tags. Therefore, it is not suitable for patients with fourth degree haemorrhoids or in patients who would like to have their skin tags removed. The literature also indicates a higher recurrence rate especially for prolapse.
- Risk: 1. Bleeding <5%, 2. Anal pain - minimal unless the stapled line is too close to dentate line, 3. Faecal urgency 20%, 4. Stapled line leak - Rare, 5. Pelvic abscess - Rare.

3. Transanal Haemorrhoid Dearterialisation (THD)

THD, also known as Doppler-guided haemorrhoid artery ligation or haemorrhoid artery ligation and rectoanal repair – HAL RAR, is a relatively new innovation based on a different principle from conventional open haemorrhoidectomy.

The operation involves the use of a specifically designed proctoscope together with a Doppler transducer. With the rotation of the proctoscope, the Doppler probe allows for the accurate localisation of the terminal branches of haemorrhoidal arteries which are then ligated with sutures.

(Cont. p.2)

DR SIMON CHEW

Colorectal Surgeon

Dr Simon Chew obtained his MBBS (Honours Class 1) in 1992 from the University of NSW and gained the Fellowship of the Royal Australasian College of Surgeons in 2001. He was then selected by The Colorectal Surgical Society of Australia and New Zealand (CSSANZ) into the colorectal training programme for 2 years (2001-2002).

Dr Chew has been a Clinical Lecturer and Clinical Senior Lecturer at the University of NSW and the University of Sydney respectively. He has been a practising Colorectal Surgeon for the last 9 years and currently operates at Norwest Private Hospital, Castle Hill Hospital, Nepean Private Hospital and Strathfield Private Hospital.

Dr Chew designed his own hand-assisted laparoscopic colectomy techniques in 2004. He has been invited to teach the techniques at interstate educational workshops for Colorectal Surgeons held in Melbourne and Perth. He has also been an invited speaker at various conferences on this topic. Dr Chew has published 21 peer-reviewed journal articles and 2 book chapters.

Dr Chew recently built his new practice premises at 69 Showground Road Castle Hill. This new location provides an enhanced colorectal surgical service with the set-up of an anorectal physiology assessment facility, addition of a dietitian and a pelvic floor physiotherapist.

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(Cont. from p.1)

The reduced blood flow should lead to the shrinkage of haemorrhoids. The haemorrhoids were also reduced into the anal canal via a continuous stitch to compress the haemorrhoids tightly. In fact, the compression actually makes the haemorrhoids ischaemic and therefore the internal haemorrhoids are removed by making them "die inside". The external haemorrhoids were reduced into the anal canal to a certain extent via the pulling action by the same stitch.

The postoperative pain from this operation is minimal because the technique avoids suturing the sensitive anoderm below the dentate line. It also avoids any external wound. The main advantages are minimal postoperative pain, minimal analgesic use, no need to use warm/Sitz bath, a safe operation and quicker recovery (compared to open haemorrhoidectomy). The disadvantages are that it is not suitable for fourth degree haemorrhoids or in patients who would like to have their skin tags removed. A combination of THD and excision of certain skin tags may be carried out for those with prolapsed haemorrhoids and large skin tags to minimize their postoperative pain.

In a systematic review published in Diseases of the Colon & Rectum in 2009 (DCR 52 (9): 1665-71), the overall recurrence rate was 9.0% for prolapse, 7.8% for bleeding and 4.7% for pain at defaecation. The recurrence rate at one year or more was 10.8% for prolapse, 9.7% for bleeding and 8.7% for pain at defecation. The operative risks are bleeding and anal pain (especially if the suture is too close to dentate line).

Conclusion

THD is effective in controlling symptoms of PR bleeding and prolapse with minimal morbidities. I perform THD for second and third degree haemorrhoids and in my opinion, open haemorrhoidectomy is still a better option for fourth degree haemorrhoids. The pain from open haemorrhoidectomy may be reduced with the use of an instrument known as ligasure Small Jaw. However, this instrument is not readily available in many hospitals due to the cost of the instrument. Finally, there is an alternative to painful haemorrhoidectomy and it is important to be able to provide different modality of treatment for different types and sizes of haemorrhoids.