INCONTINENCE & DEFAECATORY DISORDERS AFTER HAEMORRHOIDECTOMY

- MINIMISING THE RISK

SURGICAL CONTROVERSIES SYMPOSIUM OCTOBER 2015

Stephen Grobler

Bloemfontein



Haemorrhoidal Disease

- One of the most common ailments to afflict mankind
- Burden to health service enormous
- Symptoms common and cause anxiety
- Management of haemorrhoids slowly evolving
 - Rubber band ligation office procedure of choice
 - Traditional excisional haemorrhoidectomy still most common surgical procedure
 - Stapled haemorrhoidopexy
 - Haemorrhoidal artery ligation



Haemorrhoidal Disease - key concepts

- Not haemorrhoidal pathology until YOU make the diagnosis
- Every patient will benefit from supplemental fibre and education on proper bowel habits
- Colonoscopy not for diagnosing haemorrhoids
 - at-risk patients, concerning findings and those without resolution of symptoms
- Surgical options understand risks and benefits



Haemorrhoidal Disease

- 21 000 patients University of Minnesota experience (1992 Bleday)
 - 45% conservative therapy
 - 45% rubber band ligation
 - -9.3 % operation

Only 10% of patients require more than lifestyle modification &/or RBL



Operative Approach to Haemorrhoidal Disease

- Proper patient selection
 - Age
 - Gender
 - Continence
 - Comorbidities
 - Expected survival
- Must be aware that postoperative complications may result in permanent quality of life consequences

Choice of operative intervention

Surgeon-related	Patient-related
Prior education and training	Age, gender, medications
Operative experience	Bowel and sphincter function
Local resources	Patient travel resources
Product availability	Patient work and family preferences
Confidence of diagnosis of isolated hemorrhoidal disease (i.e., concurrent pelvic floor dysfunction, fecal incontinence, IBD)	Red flag comorbidities: portal hypertension, Crohn, pregnancy, hx pelvic radiotherapy/radiation proctitis, immunosuppression/ immunocompromised, bleeding diatheses, poor functional status, limited life expectancy, others
Magnitude of hemorrhoidal disease burden (i.e., how big are they?)	Magnitude of the hemorrhoidal disease on the patient's daily quality of life (i.e., how bad is it?)

Long-term manometric study anal sphincter function after Milligan-Morgan haemorrhoidectomy

- 20 patients with haemorrhoids of 3rd & 4th degree
- Anorectal manometry preop, d5 & 1, 6, & 12 months
- Squeeze pressures not significantly different to baseline values



Patti et al. Int J Colorectal Dis (2007) 22:253–257

Long-term manometric study anal sphincter function after Milligan-Morgan haemorrhoidectomy



Fig. 3 Maximum resting pressure (MRP) of the anal canal before and after hemorrhoidectomy. Data are expressed as mean±SD. Significant differences vs preoperative values: *p=0.007; **p=0.014; ***p=0.016. Student's *t* test was used to compare among means

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Long-term manometric study anal sphincter function after Milligan-Morgan haemorrhoidectomy

- Squeeze pressures not significantly different to baseline
- After 6 and 12 months, resting pressures significantly lower than preop



differences vs preoperative values: *p=0.007; **p=0.014; **p=0.016. Student's *t* test was used to compare among means

- M-M haemorrhoidectomy induces complete resolution of typical manometric alterations of disease
- Excision of anal cushions mild and transient alteration of anal continence

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Complications of Haemorrhoidectomy

- Key Concept:
- Haemorrhoidectomy typically goes very well, but it is not a benign operation
 - -Avoid complications
 - -Manage complications



Complications of Haemorrhoidectomy

- from the University of Minnesota experience in over 21,000 patients
 – small percentage developed a complication
- 700 Russian pts complications in 23.3%
 - ¼ occult concomitant anorectal pathology
 - $-\frac{1}{3}$ attributable to the excision
 - 36 % attributable to systemic disease



Frank faecal incontinence after haemorrhoidectomy rare

- Continence alteration may be relatively common (2–12 %)
- Likely due to pre-existing incontinence
 - Older or female patients with altered pelvic floor
- Anal retraction / dilatation
- Surgeon damage to sphincter





Preventing Complications

- GA plus local / regional block / optimal analgesia
- Avoid inadvertent excessive excision
- Reduce the risk of intraoperative bleeding
- Avoid sphincter injury
- Lateral internal sphincterotomy not recommended



Prone jack-knife position





Loco-regional analgesia





Loco-regional analgesia



Figure 13.32 Infiltration of (a) perianal skin and (b) anal submucosa with 1:300 000 adrenaline-saline solution.



Adequate lighting & anal retraction





Adequate lighting & anal retraction



Hill-Ferguson





Adequate lighting & anal retraction







Adequate lighting & anal retraction









THE BEAK DIAGNOSTIC



Adequate lighting & anal retraction











Adequate lighting & anal retraction



Lone Star



Ferguson closed haemorrhoidectomy





Ferguson closed haemorrhoidectomy





Ferguson closed haemorrhoidectomy





























Preventing Complications

- GA plus local / regional block / optimal analgesia
- Avoid inadvertent excessive excision
- Reduce the risk of intraoperative bleeding
- Avoid sphincter injury
- Lateral internal sphincterotomy not recommended
- Electrosurgical devices (LigaSureTM, Harmonic ScalpelTM) may decrease operative time and blood loss, but increased cost without decrease in postoperative pain



Haemorrhoidal crisis





Haemorrhoidal crisis



Cryo-thermal anal dilators





Haemorrhoidal crisis

- Key Concept: not the time to be overly aggressive surgically
 - conservatively with analgesics, ice
 - anatomic distortion and gangrenous changes
 - basic principles of preserving anoderm
 - relieve the inflammation and clot
 - intervene selectively in single or multiple quadrants
 - do not damage the underlying sphincter



Haemorrhoidal crisis





Summary Pearls

- Complications and recurrence common
- Proper patient selection, preoperative optimization and tailored interventions
- Complications can result in permanent negative impact on patient quality of life
- Imperative that you as the surgeon be competent, aware of technical nuances of procedures you offer and familiar with frequency and management of proceduralspecific complications



