circumferential haemorrhoids

CURRENT OPTIONS

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Most patients with symptomatic haemorrhoids do not require surgical intervention and are adequately treated without having to excise haemorrhoidal tissue. The remainder will need surgical management due to severity of prolapse. Thus third and fourth degree haemorrhoids are more appropriately treated by surgery which had previously been performed by excision of the three primary piles. Some patients nonetheless will have severe circumferential prolapse with massive engorgement of both internal and external haemorrhoidal plexuses. Such large haemorrhoids require extensive ablation to ensure adequate treatment in order to prevent residual or recurrent symptoms. In the past such haemorrhoids had been dealt with either standard haemorrhoidectomy plus excision of the largest secondary pile with subsequent mucocutaneous reconstruction or a modification of the whitehead or radical haemorrhoidectomy.

These techniques however are not entirely satisfactory. Patients with large third- or fourth- degree circumferential prolapsed haemorrhoids deemed not suitable for conventional three piles haemorrhoidectomy, admitted between January 1992 and June 1993 under the care of one surgeon, were prospectively randomized to undergo either radical haemorrhoidectomy (group 1) or four piles haemorrhoidectomy (group 2) by opening sealed envelopes in the operating theatre.

In group 1, patients had diathermy excision of the three primary piles. The largest remaining pile bearing mucocutaneous bridge was then brought down by incising the proximal end of the bridge and dissecting it from the underlying circular sphincter muscle. Haemorrhoidal tissue and excess mucosa were excised. The mucocutaneous bridge was then reconstructed with 00 polyglactin interrupted sutures.

In group 2, the anorectal mucosa was divided into thirds circumferentially and each third was dealt with in turn. Two pairs of artery forceps were used to cause further prolapse of the normal rectal mucosa above the pile-bearing area and to put this third of the anorectal circumference at a stretch. A suitable point above the dentate line was chosen and an incision made along this line for one-third of the circumference of the anal canal. The mucosal flap was then raised free from the underlying circular internal anal sphincter. Grossly evident haemorrhoidal tissue and excess mucosa were then removed. Devascularization of the flap by overenthusiastic removal of haemorrhoidal tissue was carefully avoided. The flap was then stitched to the proximal divided edge of the rectal mucosa and circular internal sphincter at that point with interrupted 00 polyglactin, thereby pulling the anal skin and mucosa upwards into the anal canal. This level was always at, or above that, of the previous dentate line. This procedure was repeated for the remaining two-thirds of the anal canal and haemorrhoids. Occasionally, when flap tension was excessive as a result of too much skin or mucosa, circumferential release incisions were made as required.

The results are not entirely satisfactory (Table 1). At 6 months, two patients with radical haemorrhoidectomy were disappointed with their outcome, ten were satisfied and two thought they had excellent surgery. In the four piles haemorrhoidectomy group, one patient was disappointed, seven satisfied and six had excellent results. Hence we concluded that four piles haemorrhoidectomy was significantly easier to perform and although residual tags and piles are left behind, the operation was preferred to radical haemorrhoidectomy. Currently however this discussion is immaterial as stapled haemorrhoidectomy adequately deals with most cases of circumferential prolapse.

Conventional surgical haemorrhoidectomy moreover is not based on a correction of pathophysiology but on ablation of symptoms. Hence if prolapsed piles are bleeding, painful or otherwise symptomatic, these piles are excised. Piles by themselves are normal vascular cushions and are not pathological. Prolapsed haemorrhoids are therefore not pathological unless symptomatic. Totally asymptomatic individuals can be made to totally asymptomatic by stapled haemorrhoidectomy. Occasionally, when flap tension was excessive as a result of too much skin or mucosa, circumferential release incisions were made as required.