Research Paper

Volume : 4 | Issue : 8 | Aug 2015 • ISSN No 2277 - 8179

Comparative Study of Management of Prolapsed Thrombosed Haemorrhoids by Lord's Dilatation Followed by Haemorrhoidectomy Later on Vs. Primary Haemorrhoidectomy

Medical Science

KEYWORDS : Attitudes, Customer Service, Taxi Driver, Taxi Services, Factors

Dr Ravi V. Satasia	Associate Professor, Department of General Surgery, AMC MET Medical College, L.G. Hospital, Ahmedabad
DrDhruven M. Desai	Senior Resident, Department of General Surgery, AMC MET Medical College, L.G. Hospital, Ahmedabad
DrKrunal D. Chandana	Assistant Professor, Department of General Surgery, AMC MET Medical College, L.G. Hospital, Ahmedabad

AIMS AND OBJECTIVES

The present description is a comparative study of management of prolapsed, thrombosed haemorrhoids by lord's dilatation followed by haemorrhoidectomy later on vs. primary haemorrhoidectomy in 20 cases at V.S. General hospital, Ahmedabad.

1. To know pathology and sequel of the disease
2. To know the out come of the disease with treatment by two different ways we have chosen
3. To observe the complications of primary haemorrhoidectomy in thrombosed prolapsed piles.

TREATMENT

Goals of treatment:

1. To correct dietetic factors to avoid straining during defecation and to stimulate production of large, bulky and soft stools.
2. To decrease the reduction of sphincter spasm and intra abdominal pressure.
3. To avoid recurrence.
4. To avoid various sequence of natural cause of disease.
5. To reconstruct normal anatomy and physiology of anal canal.
6. To treat any concomitant lesion.

Active or surgical treatment :

1. **Haemorrhoidectomy**
2. **Injection treatment or sclerotherapy**
3. **Rubber Band ligation**
4. **Manual dilatation of anus (lord's)**
5. **Cryotherapy**
6. **Photocoagulation**
7. **Bipolar diathermy**

MATERIALS AND METHODS

Source of data:

This study consists of 20 consecutive patients of thrombosed prolapsed haemorrhoids treated at VS General Hospital during 2 years period between Dec 2012-Dec 2014.

Method of data collection:

At the initial attendance a proforma was completed recording age, sex, diet, family history, presence or absence of various symptoms with its duration and associated disease. Per rectal digital and proctoscopy examination was performed on all patients and the presence of anal pathology was recorded. Systemic examination and basic investigations done. Follow up of patients after treatment is done by history , per rectal examination and proctoscopy to assess patient's response and rate of complications like pain , retention of urine , bleeding , recurrence , stenosis and discharge per rectum.

Inclusion criteria :

All the patients who are diagnosed to be having thrombosed and prolapsed internal haemorrhoids.

Exclusion criteria :

Patients suffering from portal hypertension and liver cirrhosis are excluded from my study.

The patients were assigned to one of the treatment modalities.

1. Lord's dilatation followed by haemorrhoidectomy later on and 2. Primary haemorrhoidectomy in patients having thrombosed and prolapsed hemorrhoids. The techniques adopted by us are described above:

1. Lord's dilatation followed by haemorrhoidectomy later on

Lord's dilatation is followed by haemorrhoidectomy in the next operative setting at 4-6 weeks.

It is the treatment of choice by surgeons at various levels.

2. Primary haemorrhoidectomy

Lord's dilatation and haemorrhoidectomy in the same operative setting.

Which is not usually done at different levels.

Follow up period:

All the patients are followed up at seventh post operative day then once a week for two weeks and then 3 months period after the treatment.

The following post operative complications were assessed:

1. Post operative bleeding categorized as:

(a) Primary bleeding (p): occurring during the procedure.
(b)Reactionary bleeding(r): occurring within 24 hours of procedure
(c) Secondary bleeding(s): occurring after 24 hours but within 10 days of procedure.

This in turn were subdivided in mild and severe:

(a) Mild bleeding: Those controlled with local pressure only.
(b) Severe bleeding: Those which required surgical intervention for control and with or without blood transfusion.

2. Post operative pain was divided into 3 grades:

(a) No pain (-)
(b) Mild pain (+) – Those requiring oral analgesic for relief.
(c) Severe pain (++) – Those not relieved by oral analgesic alone.

3. Retention of urine was classified into 3 grades:
(a) No difficulty (-)
(b) Required hot water bag fomentation (+)
(c) Required catherization (++)

The patient were asked about loss of time from work, the recurrence of symptoms and complications in their follow up and lastly patients were asked regarding their assessment of the different treatment modalities and categorized them as:

(a) excellent/cured (A)
(b) satisfactory (B)
(c) little or no improvement (C)

PROFORMA
A) DEMOGRAPHIC DATA:
Name: _____ Date of admission:_____
Age/Sex: _____ Date of discharge:_____

Race: _____ Date of operation:_____
Occupation: _____
Outdoor Registration Number: _____
Indoor Registration Number: _____

B) CHIEF COMPLAINTS AND IT'S DURATION:
Bleeding: _____
Pain: _____
Constipation: _____
Discharge: _____
Something coming out of P/R (Prolapse): _____

C) PAST HISTORY:
Haematemesis: _____
Melena: _____
Diabetes: _____
Hypertension: _____
Operations: _____
Portal Hypertension_____
Pregnancy: _____
Varicose Veins: _____
Major Illnesses: _____
Cardiac/Respiratory_____
Treatment for perianal conditions:_____
Others: _____

D) FAMILY HISTORY:
Similar Complaints: _____
Varicose Veins: _____

E) PERSONAL HISTORY:
Loss of Weight: _____
Loss of Appetite: _____
Diet: _____

F) GENERAL CONDITION:
Pulse: _____ Respiratory rate:_____
Anaemia: _____ Palmar Erythema: _____
Pedal Edema: _____ Gynecomastia: _____
Jaundice: _____ Spider Nevi: _____
Varicose Veins: _____ Lymphadenopathy: _____
Heart: _____
Lungs: _____

Abdomen: CaputMedusae/Ascites/Splenomegaly/Testicular Atrophy/ Varicocele /Others: _____

G) LOCAL EXAMINATION:

P/R and Proctoscopy:

Degree: _____
Position: _____

Associated Anorectal Condition: Fissures/Fistula/Skin tags/ Others: _____

H) INVESTIGATIONS:
Hemoglobin: _____ gm%
Others: Blood sugar/Blood Urea/Blood Grouping
Liver Function Test/Others: _____
_____
Chest X-Ray/ECG
Sigmoidoscopy and Barium Enema/ Upper G.I. Scopy

I) DIAGNOSIS: _____
J) TREATMENT:
Lord's Dilatation followed by Haemorrhoidectomy later on/Cryosurgery/Rubber Band Ligation/ Primary Haemorrhoidectomy:

K) POST OPERATIVE COMPLICATIONS:
Post Op. Pain: No Pain/Mild Pain/Severe Pain

Post Op Bleeding: Primary/Reactionary/Secondary

Retention of Urine: No difficulty/Hot water bag fomentation/ Catheterization

Others: _____

L) HOSPITAL STAY: _____
M) FOLLOW UP:
1) SUBJECTIVE ASSESSMENT:

Recurrence of Symptoms: Bleeding/Prolapse/Pain/

Others: _____

Assessment by Patients:
a) Excellent/Cured
b) Satisfactory
c) Little/No improvement

Time off work: _____

2) OBJECTIVE ASSESSMENT:
Local Examination:
Fissure/Fistula/Anal Narrowing/Skin Tags/
Others: _____
Proctoscopy: Degree: _____ Position: _____
N) REMARKS: _____
_____

OBSERVATION AND DISCUSSION
Results of our study of 20 patients are detailed below:
Table 1: Age incidence

Age(in years)	NOP 20	Percentage
Upto 30	6	30%
30-50	12	60%
Above 50	2	10%

Approximately half of our patients (60%) were middle aged (30-50 years) individuals. There was no case below the age of 20 years.

Table 2: Sex incidence

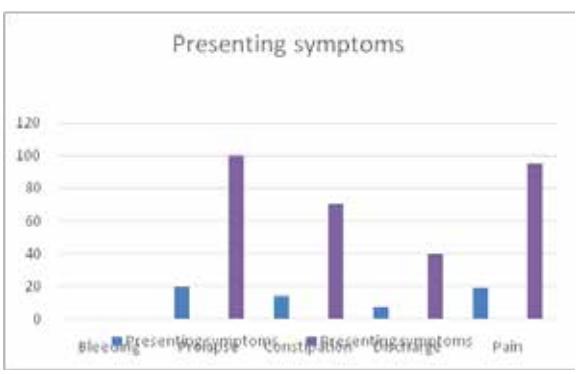
Volume : 4 | Issue : 8 | Aug 2015 • ISSN No 2277 - 8179

Sex	NOP 20	Percentage
Male	18	90%
Female	2	10%

In our study, the incidence was found to be more in male than female because most of the Indian women lead a sedentary life style.

Table 3: Presenting symptoms

Symptoms	Number of patients 20	Percentage
Bleeding	0	0%
Prolapse	20	100%
Constipation	14	70%
Discharge	8	40%
Pain	19	95%



In our study, amongst 20 patients with thrombosed and prolapsed piles, none of the patient presented with bleeding per rectum. Constipation (70%) was found to be one of the most important predisposing factors. 95% of the patients presented with pain interfering with daily activities. 40% of patients presented with discharge per rectum.

Thrombosed hemorrhoids present with a history of prolapse complicated by intense pain , swelling and surrounding edema. And the haemorrhoid itself is hard and without bleeding as a result of venous thrombosis.[11]

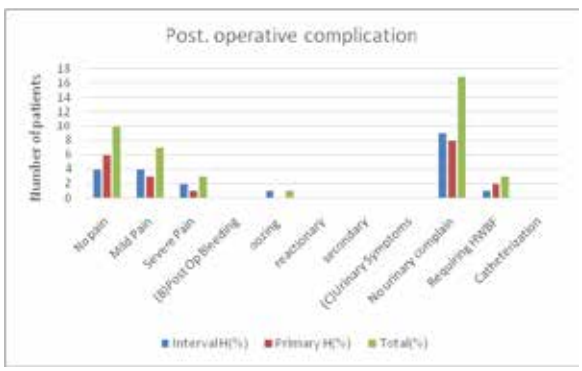
Table 4: Diet history

	Veg. diet (NOP =20) %	Mixed diet (NOP=20)%	Total
Diet	3(15%)	17(85%)	20

In our study, Amongst the patients, 85% consumes mixed vegetarian and non-veg diet containing less amount of fibers. Thus diet habit have significant role in development of haemorrhoids.

Table 5: Post operative complications

Complications	Interval H.(%) NOP 10	Primary H.(%) NOP 10	Total NOP 20(%)
(A)Post Op. Pain			
No pain	4(40%)	6(60%)	10(50%)
Mild Pain	4(40%)	3(30%)	7(35%)
Severe Pain	2(20%)	1(10%)	3(15%)
(B)Post Op. Bleeding			
Oozing	1(10%)	0(0%)	1(5%)
Reactionary	0(0%)	0(0%)	0(0%)
Secondary	0(0%)	0(0%)	0(0%)
(C)Urinary Symptoms			
No urinary complain	9(90%)	8(80%)	17(85%)
Requiring HWBF	1(10%)	2(20%)	3(15%)
Catheterization	0(0%)	0(0%)	0(0%)



In our study, patients treated with lord's dilatation followed by haemorrhoidectomy later on (interval haemorrhoidectomy) showed total relief of pain symptoms amongst 40% , mild pain amongst 40% and had severe pain in 20% post operatively with no significant urinary complains. Post operatively oozing from raw area was found in 10% of the patients which did not require any intervention.

Patients treated with primary haemorrhoidectomy showed better relief of pain , total pain relief in 60% patients, mild pain in 30% and 10% had severe pain post operatively. Urinary complains were not significant. Without any post operative bleeding.

Ligation of the sensitive epithelium below the dentate line in the course of excision ligation operation. Spasm of the sphincter or exposed raw area of anal canal.[5]

Table 6: Hospital stay

Hospital stay			
Duration (days)	Interval H.(%) NOP 10	Primary H.(%) NOP 10	Total NOP 20(%)
3 to 5	1(10%)	7(70%)	8(40%)
6 to 8	7(70%)	3(30%)	10(50%)
9 to 11	2(20%)	0(0%)	2(10%)

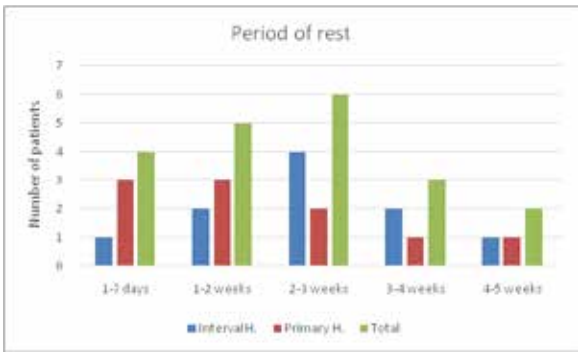
In our study 70% patients following interval haemorrhoidectomy have total hospital stay around 6 to 8 days. Whereas 70% patients following primary haemorrhoidectomy have hospital stay around 3 to 5 days.

Patients treated with Interval haemorrhoidectomy have longer hospital stay than those patients treated with primary haemorrhoidectomy.

Table 7: Period of rest

Duration	Interval H(%) NOP 10	Primary H(%) NOP 10	Total NOP 20
Nil			

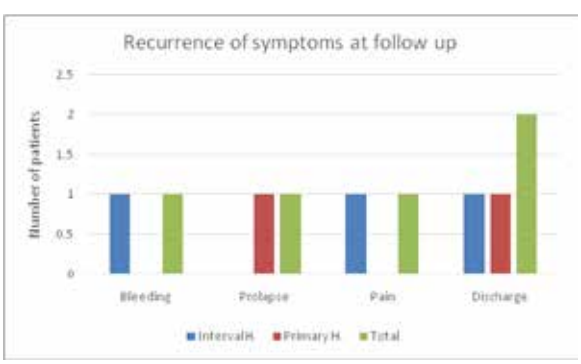
1-7 days	1(10%)	3(30%)	4(20%)
1-2 weeks	2(20%)	3(30%)	5(25%)
2-3 weeks	4(40%)	2(20%)	6(30%)
3-4 weeks	2(20%)	1(10%)	3(15%)
4-5 weeks	1(10%)	1(10%)	2(10%)



In our study, 70% patients returned to their work following interval haemorrhoidectomy and 80% patients returned to their work following primary haemorhhoidectomy within 3 weeks.

Table 8: Recurrence of symptoms at follow up

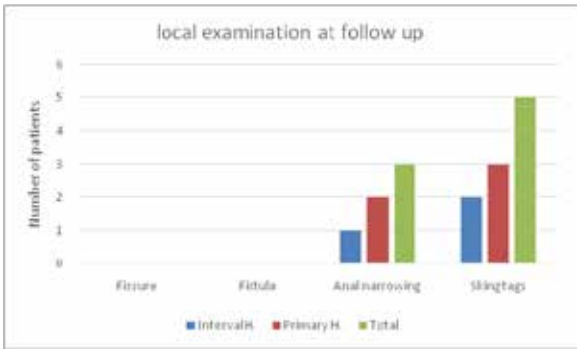
Symptoms	Interval H.(%) NOP 10	Primary H.(%) NOP 10	Total NOP 20(%)
Bleeding	1(10%)	0(0%)	1(5%)
Prolapse	0(0%)	1(10%)	1(5%)
Pain	1(10%)	0(0%)	1(5%)
Discharge	1(10%)	1(10%)	2(10%)



In our study , 10% patients had bleeding , pain and discharge per rectum following interval haemrrhoidectomy . Whereas , 10% had prolapse and discharge per rectum , Whereas none of the patient had complain of pain , bleeding following primary haemorrhoidectomy at follow up.

Table 9 : local examination at follow up

Findings	Interval H(%) NOP 10	Primary H(%) NOP 10	Total NOP 20 (%)
Fissure	0(0%)	0(0%)	0(0%)
Fistula	0(0%)	0(0%)	0(0%)
Anal narrowing	1(10%)	2(20%)	3(15%)
Sking tags	2(20%)	3(30%)	5(25%)



In our study only 10% patients had anal narrowing and 20% had external skin tags following interval haemorrhoidectomy . while 20% patients had anal narrowing , 30% had external skin tags following primary haemorrhoidectomy. None of the patients had developed fissure or fistula.

In primary haemorrhoidectmy because of gross edema , more tissue will be excised than is necessary resulting in stenosis or less tissue will be excised than is necessary resulting in sking tags.[5]

Table 10 : Patient's response to the treatment

Grading	Interval H(%) NOP 10	Primary H(%) NOP 10	Total NOP 20(%)
Excellent/ complain free	7(70%)	8(80%)	15(75%)
Satisfactory	3(30%)	2(20%)	5(25%)
Little/no improvement	0(0%)	0(0%)	0(0%)

In our study , 70 % of the patients had excellent response and 30 % had satisfactory response following interval haemorrhoidectomy , whereas 80% had excellent response and 20% had satisfactory response following primary haemorrhoidectomy.

List of abbreviations used

- Interval H. – Interval haemorrhoidectomy (lord's dilatation followed by haemorrhoidectomy later on)
- Primary H.- Primary haemorrhoidectomy
- NOP – Number of patients
- H.W.B.F. – Hot water bag fomentation

SUMMARY

- In this comparative clinical study we studied 20 patients of thrombosed and prolapsed haemorrhoids who presented to our hospital.
- Maximum patients in the study belong to 3rd to 4th decade of life (60%) with higher predominance in patients having mixed diet(85%) , in this study higher incidence was noted in males (90%) as compared to females(10%).
- Among the studied patients prolapse was noted in all the patients followed by pain (95%) and constipation (70%) . discharge per rectum was noted in 40% patients .
- Lord's dilatation followed by haemorrhoidectomy was done in half of the patients (50%) and remaining half (50%) underwent primary haemorrhoidectomy .
- In primary haemorrhoidectmy There is less incidence of post operative pain(10%) and bleeding (none) than in interval haemorrhoidectomy where post. Operative pain (20%) and oozing (10%)
- Total duration of Hospital stay and period of rest was found less in patients treated with primary haemorrhoidectomy than in interval haemorrhoidectomy.
- Amongst the patients treated with interval haemorrhoidectomy , anal narrowing was found in 10% , skin tags was found in 20% Which is less than those treated with primary

Volume : 4 | Issue : 8 | Aug 2015 • ISSN No 2277 - 8179

haemorrhoidectomy , where anal narrowing was 20% skin tags was 30% at follow up examination .

- Anal stenosis occur as a consequences of leaving inadequate skin bridges or, where retained skin bridges fibrosed because the base of the skin bridges are not wide enough .

CONCLUSION

Primary haemorrhoidectomy in acutely edematous and thrombosed haemorrhoids significantly reduce pain and bleeding .

In this procedure as haemorrhoids are thrombosed there are less chances of bleeding in acute phase and patient significantly improves symptomatically. But It should be done by expertised with sparing of skin bridge without damaging sphincter muscles.

In this procedure single anesthesia is required with less hospital stay and period of rest if done by expertised surgeon with proper care.

Given all the advantages and minimal drawback like anal narrowing , it can be concluded that primary haemorrhoidectomy has a definite edge in the management of thrombosed , prolapsed haemorrhoids when compare with interval haemorrhoidectomy.

I have not found any series study in the international literature to support my comparative study . Though study group is small to draw any definite conclusion , it is my humble attempt to compare treatment modalities for thrombosed and prolapsed haemorrhoids.

REFERENCE

1. Anderson`s pathology 10th edition pg. no. 1771 | | 2. Longo A. 6 world congress of Endoscopy Surgery. Naples: reduction of mucosa and haemorrhoidal prolapse with a circular stapling device: A new procedure; pg. 777–84. | | 3. Snell's clinical anatomy 7th edition pg.no.418-420. | | 4. British Journal of Surgery, 1999. Littunt, A.J. Luck, G. | Rudkin and P.J. Hewett day – case haemorrhoidectomy. | | 5. Michael Keighley and Norman Williams , surgery of anus , rectum and colon, 3rd edition ,volume 1 page no.321-375. | | 6. C.C. Chung, F.R.C.S.E., J.P.Y.Ha, F.R.C.S.E., Y.P. Jai, F.R.C.S.E., W.W.C, Tsang, F.R.C.S.E, M.K.W.Li, F.R.C.S. (Eng), F.R.C.S.E. Double blind, randomised trial comparingharmonic scalpel haemorrhoidectomy, and scissors excision. Disease of colon and rectum 2002; 45: 789-794. | | 7. Sabiston textbook of surgery 19th edition ch.53 anus pg.1387- | 1391 | | 8. Baily & love short practice of surgery 26th edition pg.1250-57 | | 9. Cotran, Kumar, Robbins – Pathologic basis of disease. 5th edition. | | 10. Schwartz, Principles of Surgery, 1999, 7th edition, Vol. II, P. 1296. | | 11. Fischer `s mastery of surgery 6th edition volm. 2nd pg. no. 1804 – 1810. | | 12. B.D. Chaurasia human anatomy 4th edition vol. 2nd pg. no. 381-383 | | 13. K. Sembulingam , Text book of human physiology , 3rd edition , Ch. 43 , pg. no. 215-220. | | 14. Rob and Smith , atlas of general surgery , 4th edition , Ch. 54 , pg.no. 474-485. | | 15. Inderbirsingh , Human histology , 4th edition , Ch. 15 , page no. 245 | | 16. Inderbirsingh , human embryology , 7th edition , page no. 164-184. | | 17. Primary surgery , non – trauma , volume 1 , ch. 12 – proctology.