



## RARE CASE OF CONSERVATIVE MANAGEMENT OF POST STAPLED HAEMORRHOIDOPEXY PERFORATION

### Surgery

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### KEYWORDS

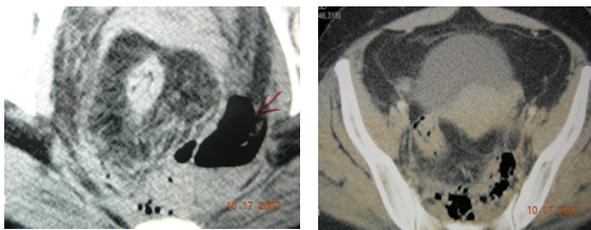
#### INTRODUCTION

Stapled haemorrhoidectomy has become increasingly popular over the past 10 years for the treatment of third degree haemorrhoids. Most studies have shown stapled haemorrhoidectomy to be associated with reduced postoperative pain, less bleeding, shorter hospital stay and earlier return to normal activities (1). Complication rates reported in literature after stapled haemorrhoidectomy range between 20% and 36% (2). Major complications can be rectal bleeding, rectal perforation, rectal obliteration and rectovaginal fistula, often requiring emergency surgical exploration and sometimes faecal diversion (3). We are presenting a unique case of rectal perforation following stapled haemorrhoidectomy which was managed conservatively.

#### CASE REPORT

A previously healthy 38 year female presented to the emergency department of our hospital with sudden onset diffuse abdominal pain. She had undergone stapled hemorrhoidectomy 8 days earlier at another hospital and was discharged after an uneventful post-operative course. On examination she was vitally stable, afebrile and abdomen was soft. Digital rectal examination revealed hematochezia. Laboratory findings were unremarkable. Computed Tomography revealed rectal perforation 4 cm from the anal verge with minimal contamination in the retroperitoneal space. Decision was taken to conservatively manage the patient in view of stable vitals and minimal contamination.

Patient was kept nil by mouth for 5 days and CT scan was repeated again. Repeat CT scan showed no air leak and the contamination seen on previous scan had subsided. The patient was started on liquids orally and kept on all liquids for 5 days. The patient passed stools and no hematochezia was seen. The patient was discharged 12 days after admission on full diet and was asymptomatic on follow-up for 3 months.



(CT SHOWING RECTAL PERFORATION)

#### DISCUSSION

Stapled haemorrhoidectomy has gained wide acceptance in the treatment of haemorrhoids because of many reasons. It is easier to perform and has a shorter operating time with advantages like less post operative pain and earlier return to normal activity than conventional haemorrhoidectomy. Reported complication rates after stapled haemorrhoidectomy range from 20-36% (4). These complications are often minor such as external thrombosis, persistent pain, bleeding, severe chronic pain, abscess, fissure and faecal urgency. Studies have reported major complications such as retroperitoneal sepsis and intra-peritoneal rectal perforation which require exploration and faecal

diversion (5).

Faucheron et. al, in their review found that many surgeons performed open laparotomy and created diverting stoma in cases of rectal perforation following stapled haemorrhoidectomy (6). With the advent of laparoscopic surgery, surgeons may attempt laparoscopic management of colorectal perforation (7, 8, 9). The SCANDIV trial showed that laparoscopic lavage did not reduce morbidity and had higher re-operation rate (10). Lee et al reported that laparoscopic intervention for rectal perforation had shorter hospital stay and fewer complications (11). Factors favouring this approach are early surgery, young age, sufficient irrigation and meticulous primary closure.

The cases of conservative treatment that are described in the literature are few. It seems that non-operative management could be undertaken in a highly selected group of patients who do not exhibit signs of peritoneal contamination or abdominal sepsis (12).

There are cases of rectal perforation managed conservatively following stapled haemorrhoidectomy and diagnostic procedures (13,14). Studies have shown that fecal diversion is not always necessary following extraperitoneal rectal injuries (15).

Conservative management was successful in this case as the perforation was small and occurred below the pelvic peritoneal reflection, so there was no peritoneal contamination. So the choice of treatment should be determined after considering the patient's parameters and location of rectal perforation.

#### CONCLUSION

Any patient operated for stapled haemorrhoidectomy with unexpected abdominal pain should be investigated with suspicion of perforation. We strongly recommend that decision of management of this perforation should be taken depending on the site of perforation along with patient's clinical parameters and conservative management can be done in selected cases.

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