Original Research Article

Newer trends in management of haemorrhoids

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Abstract

World wide the prevalence of symptomatic hemorrhoids is estimated at 4.4% in the general population. Since ages hemorrhoid management, appears easy job for everyone as it is treated from self-management by patient, quacks, GPs to experts like general surgeon and Coloproctologist management is done from simple laxatives to difficult stapler surgery. But doing all this not enough what I feel, as recurrence is possible in 40 -45% of patients in long period of time as we are treating the effect which has happened due to constipation, and basic cause for constipation is not taken care of, as it is a lifelong management, patient compliance is very poor in this the era of Junk food enjoyment and stressful life.
Keywords: Haemorrhoid, stapler haemorrhodectomy, per rectal bleeding.

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INTRODUCTION

Hemorrhoidal venous cushions are normal structures of the anorectum and are universally present unless a previous intervention has taken place. Hemorrhoidal cushions are present in healthy individuals. In fact, hemorrhoidal columns exist in utero.Evidence indicates that hemorrhoidal bleeding is arterial and not venous. This evidence is supported by the bright red color and arterial pH of the blood. Hemorrhoids are not varicosities; they are clusters of vascular tissue (eg, arterioles, venules, arteriolar-venular connections), smooth muscle (eg, Treitz muscle), and connective tissue lined by the normal epithelium of the anal canal.When these vascular cushions produce symptoms, they are referred to as hemorrhoids. Hemorrhoids generally cause symptoms when they become enlarged, inflamed, thrombosed, or prolapsed. Newer trends from concept of development of hemorrhoid to classification of hemorrhoids and recent advances in medical management and surgical management. Why hemorrhoids develop? It is now clearly understood by sliding theory of perks. Anal cushions are fixed in their proper sites within anal canal by sub mucosal smooth muscle and elastic fibres (Treitz ligament), these fibres get fragmented by prolonged downward stress due to straining, during defecation. Newer trends in management like Recto anal repair or stapler surgery are based on repositioning of these anal cushions. Considering classification as we know previous was grade I to grade IV Depending on prolapse but new classification is based on bleeding, prolapse, and complications

Table 1: Amended anatomical classification of haemorrhoids

Grade I	Intact an canal
Grade II	Patient denies manual reduction but examination reveals muchohaemorrhoidal prolapsed
Grade III	Patients gives positive history of manual reduction of muchohaemorrhoidal prolapse
External Component	A. No external component B. One or more soft skin folds C. Circumferential tags and anodermal polyps

Traditional grade IV has been replaced by a grading of the external component that is its main feature. Patients a IIC or grade IIC depending on their history of manual reduction. The following is a quick summary of treatment for internal hemorrhoids by Grade I - hemorrhoids are treated with conservative medical therapy and avoidance of nonsteroidals drug. Grade II or III - hemorrhoids are initially treated with nonsurgical procedures. Symptomatic grade III and grade IV hemorrhoids are best

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treated with surgical hemorrhoidectomy. Treatment of grade IV internal hemorrhoids or any incarcerated or gangrenous tissue requires prompt surgical consultation. Grade III and grade IV with or without complications are managed by surgical line of treatment but it should be on patient demand as recurrence is possible in 30-40% of cases. When considering about conservative therapy, laxatives play key role for effective and smooth evacuation of bowel. The medical treatment for hemorrhoids has undergone significant changes on introduction of new pharmaceutical agents in the last decade.Laxitol, lactitol, lactulose and picosulphate, like so many newer molecules and their combination with bulk laxatives are available. Tranexemic acid, ethamsylate, euphorbia prostrata are agents which are used to stop bleeding. Euphorbia Prostrata is a new molecule used for grade I and II hemorrhoids. Beneficial effects of the Euphorbia prostrata in hemorrhoids have multiple mechanisms that are due to its active constituents flavonoids, tannins and phenolic acid. In Newer methods of surgical treatment painless surgery is the main goal as all old methods are painful in post op. period. In spite of newer advances, according to complications and economical status of patient we may have to adopt standard method of haemorrhiodectomy some time. There are three new procedures

1. Haemorrhoidal artery ligation alone or RAR (recto anal repair)
2. Stapler haemorrhiodectomy
3. Transanal suture anopexy invented by an Indian surgeon and is alteration of above two methods

Haemorrhoidal artery ligation (HAL) is a novel minimallyinvasive

surgical treatment for haemorrhoids that was developed by the Japanese surgeon Morinaga in 1995. It is a technique that is based upon an understanding of the pathogenesis and arterial inflow to haemorrhoids. The procedure entails precise identification of the superior rectal arteries supplying haemorrhoids using a Doppler transducer located in the side wall of a special proctoscope. Using an applied frequency of 8.2 Mhz and an introduction angle of approximately 60° a screening depth of approximately 7mm is provided.This enables identification of the haemorrhoidal arteries which are then selectively suture ligated 2-3 cm above the dentate line through a lateral ligation window within the proctoscope (situated proximally to the transducer). Ligation of these arteries prevents inflowing blood to the haemorrhoidal venous plexi. This causes a reduction in plexi internal pressures and subsequently results in both a cessation of haemorrhoidal bleeding and shrinkage of haemorrhoidal tissues. Various centres across Europe and America have adopted this technique with minor modifications and using different names (including: Doppler guided Haemorrhoidal artery ligation (DG-HAL) and Transanal haemorrhoidal dearterialisation (THD)); however the basic principle has remained the same. Morinaga *et al*'s initial study reported promising Overall HAL has so far proven to be a painless, safe and efficacious method to treat haemorrhoids particularly if bleeding is the main complaint. The techniques effectiveness in treating prolapse symptoms is not clear. Combining HAL with a recto anal repair (HAL-RAR) potentially resolves this issue and still enables the procedure to be relatively pain free although at present there is no supporting published data. To provide the most effective surgical treatment it is necessary to choose the appropriate technique tailored to the individual patients' clinical symptoms.

Stapled hemorrhoid surgery/ procedure for prolapsing haemorrhoids (PPH)

Stapled hemorrhoid surgery, or PPH, was first described in 1997-1998 and has become prominent. This procedure is mainly used to treat internal hemorrhoids that are not amenable to conservative and nonoperative therapies. PPH is suggested for patients with large internal hemorrhoids and minimal external component. This procedure can be done in an outpatient setting with local anesthesia, similar to the protocol used for conventional hemorrhoid surgery. Narcotic use and recovery is significantly decreased compared with conventional operative hemorrhoid surgery. During this procedure, a specially designed circular stapler with smaller staples is used. The technique involves placing a suture in the mucosal and submucosal layers circumferentially, approximately 3-4 cm above the dentate line. The stapler is placed and slowly closed around the purse string. Care is taken to draw excess internal hemorrhoidal tissue into the stapler. The stapler is fired, resecting the excess tissue and placing a circular staple line above the dentate line, resulting in resection of excessive internal hemorrhoidal tissue, pexy of the internal hemorrhoidal tissue left behind, and interruption of the blood supply from above PPH does not directly affect the external tissue. Reports have described shrinking of external hemorrhoidal tissue after PPH, probably from decreased blood flow. Good results from PPH combined with judicial excision of occasional skin tags also have been reported.

Transanal suture Rectopexy

Transanal suture Rectopexy (Chivate's procedure) is a new invention by an Indian surgeon for managing all grades of haemorrhoids. It is based on the principles of plication of vessels in the rectum by double locking stitch above dentate line at two different levels by blocking of blood supply and preventing the neo vascularisation and anchoring the rectal mucosa andsub mucosa to Perks ligament .It is a minimally invasive, painless, bloodless

procedure without damaging sphincter. It is a modification of DGHAL and Stapler (MIPH) but the procedure works on same the principle. Multicentre trials at 5 hospitals in India were taken and results are published in Indian journal of surgery (Oct. 2012, issue 5) and author herself is performing this procedure since last 2 yr and her study is showing promising good results but long term follow up is awaited.

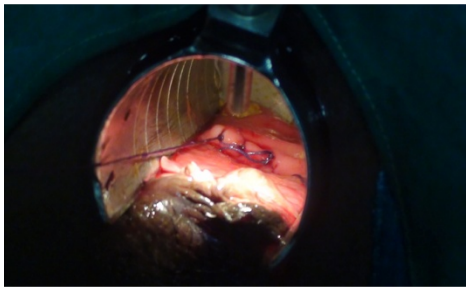

Figure 1

Attention to regular and soft bowel movements is important. Bulk agents (eg, psyllium seed) and oral fluids are important. Bathing in tubs for comfort and hygiene is part of the routine. Judicious narcotic administration relieves pain. Patients should also be advised of the following for avoiding recurrence. Avoid constipation ,Weight loss,Avoid prolonged sitting on the toilet,Avoid prolonged sitting at work,Improved anorectal hygiene. The new era is eagerly waiting for change in lifestyle in modern era and use bulk forming food containers so that patient can have spicy food without fear of constipation and haemorrhoids or fissure.

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