

## A Study On Clinical Profile Of Patients With Haemorrhoids

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### Abstract

Haemorrhoids can be categorized by their location as well as by the size and degree of prolapse of the involved tissue. Internal haemorrhoids are located proximal to the dentate line, external haemorrhoids are distal to it, and 'mixed' haemorrhoids arise from both the internal and external plexi along with their anastomotic connections. A detailed history was taken and all patients were subjected to clinical examination including per rectal and proctoscopic examination. Routine lab investigations like blood and urine examination and screening of chest was done. In our study, the patients were in the age range of 21-84 years. Most of the patients in the stapler group were in the age group of 41- 50 years, while in the open group, the majority were in the range of 21-40 years.

**Keyword:** Haemorrhoids, Mucosal prolapse, Internal haemorrhoids

### Introduction

The pathogenesis of 'hemorrhoids' is not completely clear, but contributing factors have been suggested, including a lack of dietary fiber, chronic straining, spending too much time on the commode, constipation, diarrhea, pregnancy, and family history <sup>[1]</sup>. The underlying problem behind the development of hemorrhoids seems to be the breakdown of the underlying support structure of the cushions, leading to venous distension, dilation of the arteriovenous junctions, progressive prolapse of the involved tissue, mucous deposition on the perianal skin (and, thus, itching), friability, bleeding, and, sometimes, fecal soiling. Internal hemorrhoidal tissue is covered by rectal mucosa (proximal to the dentate line) and so is insensate <sup>[2]</sup>.

Haemorrhoids can be categorized by their location as well as by the size and degree of prolapse of the involved tissue. Internal haemorrhoids are located proximal to the dentate

line, external haemorrhoids are distal to it, and 'mixed' haemorrhoids arise from both the internal and external plexi along with their anastomotic connections [3].

There is a broad correlation between symptoms and grades of haemorrhoids typically there is bright red blood drips into the pan and is generally painless. Patient is aware of "something coming down". Sometimes it may associate with pain if thrombosed or acutely prolapsed. Prolapse of haemorrhoidal cushions and mucosal diarrhoea results in soiling of perianal skin, intern, results in pruritus [4].

Polyp, adenomas and carcinomas, which are easily palpated, should be differentiated from haemorrhoidal tissue. An anoscopy will clarify hypertrophied anal papilla.

Mucosal prolapse (rectal) is a close differential diagnosis. Complete rectal prolapse is distinguished by its concentrically arranged mucosal folds, when pain is the chief complaints, fissures, anal ulcer, and herpes needs to be ruled [5].

The need for investigations is guided by the risk profile of the patient, if low risk profile, it is reasonable to confine to clinical examination that is, digital rectal examination, proctoscopy, sigmoidoscopy, colonoscopy is strongly recommended in case of high risk profile patient (age >45 years, present with bleeding per rectum, positive family history of colorectal cancer) [6].

## **Methodology**

**Study design:** Prospective Observational study

**Study population:** Patients admitted in surgical wards in the period of study

**Study period:** One year

**Sample size:** 77 consecutive patients undergoing haemorrhoidectomy

## **Study subjects**

### **Inclusion criteria**

- Patients who are posted for open hemorrhoidectomy and stapler hemorrhoidectomy
- Age more than 18 years

### **Exclusion criteria**

1. Haemorrhoids with fissure in ano
2. Haemorrhoids with fistula in ano
3. Prior hemorrhoidectomy
4. All patients who are not willing to give consent.

A detailed history was taken and all patients were subjected to clinical examination including per rectal and proctoscopic examination. Routine lab investigations like blood and urine examination and screening of chest was done.

## **Results**

A total of 77 consecutive patients were included in this study who fulfilled the preset inclusion criterion. Out of these, 36 opted for stapler haemorrhoidectomy and 41 patients underwent open haemorrhoidectomy.

In our study, the patients were in the age range of 21-84 years. Most of the patients in the stapler group were in the age group of 41- 50 years, while in the open group, the majority were in the range of 21-40 years.

**Table 1:** Age distribution

Age	Open Hemorrhoidectomy		Stapler Hemorrhoidectomy		Total	
	N	%	N	%	N	%
<40	17	41.5	11	30.6	28	36.4
40-50	8	19.5	12	33.3	20	26.0
50-60	10	24.4	7	19.4	17	22.1
>60	6	14.6	6	16.7	12	15.6
Total	41	100.0	36	100.0	77	100.0

**Table 2:** Mean Age

	N	Mean	sd
Open Hemorrhoidectomy	41	43.7	14.8
Stapler Hemorrhoidectomy	36	46.0	12.7
Total	77	44.8	13.8

The mean age of open haemorrhoidectomy group was 43.7±14.8 and 46.0±12.7 for stapler haemorrhoidectomy group

**Table 3:** Frequency of male and female distribution in the study

Sex	Frequency	Percent
Male	66	85.7
Female	11	14.3
Total	77	100.0

The male: female ratio was 4.98:1 for the stapler group and 7.1:1 for the open group. There was no statistically significant variation in gender distribution between the two groups.

**Table 4:** Gender distribution in both group

Sex	Open Hemorrhoidectomy		Stapler Hemorrhoidectomy		Total	
	N	%	N	%	N	%
Male	36	87.8	30	83.3	66	85.7
Female	5	12.2	6	16.7	11	14.3
Total	41	100.0	36	100.0	77	100.0

$\chi^2 = 0.313$ ,  $df=3$ ,  $p=0.576$

**Table 5:** The socioeconomic distribution

Socio economic status	Open Hemorrhoidectomy		Stapler Hemorrhoidectomy		Total	
	N	%	N	%	N	%
APL	11	26.8	20	55.6	31	40.3
BPL	30	73.2	16	44.4	46	59.7

Total	41	100.0	36	100.0	7 7	100. 0
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$\chi^2 = 6.577$ ,  $df=1$ ,  $p=0.01$

The APL: BPL ratio was 1:2.72 for the open group and 1:0.8 for the stapler group. Hence significant (P-0.01)

### Discussion

Haemorrhoidectomy is the accepted method for the treatment of large symptomatic haemorrhoids, in fact considered as gold standard; however, the problem of postoperative pain has never been satisfactorily addressed. The postoperative pain related to haemorrhoidectomy is well known. Patients will frequently avoid or postpone definitive treatment for many years so as to avoid this very problem. Also, the high postoperative morbidity and long recovery time has prompted the need for an alternative procedure. Several techniques, including laser haemorrhoidectomy, diathermy haemorrhoidectomy, sclerotherapy, dilatation with banding and cryohaemorrhoidectomy, have been attempted [7, 8]. Stapler haemorrhoidectomy offers a significantly less painful alternative definitive treatment for this disease. Stapler haemorrhoidectomy was introduced in 1995 by Longo; a novel technique in the management of haemorrhoidal disease, it has emerged as an alternative to open haemorrhoidectomy, longo considered it the “gold standard”. It corrects the mucosal prolapse, with simultaneous disruption of blood supply to haemorrhoidal tissue. This now considered as a standard technique. Several randomized trials have shown the efficacy and safety of procedure. Various controlled studies have indicated that stapler haemorrhoidectomy is associated with minimal postoperative pain and early recovery. Right from the earliest research, there has been a high patient satisfaction rate [9].

However, most of these studies were conducted in highly specialized centers, and the present study was designed to compare the short-term results of stapler haemorrhoidectomy with the Milligan–Morgan haemorrhoidectomy. Our aim was to ascertain if the stapler haemorrhoidectomy performs similarly as is reported in the literature when the procedure was conducted at independent centers. 77 patients who underwent surgery for haemorrhoids in Government medical college hospital, Trivandrum who fulfilled the criteria were included in this study. Thirty-six (36) underwent the Longo technique of stapler haemorrhoidectomy and forty-one (41) had the Milligan Morgan technique of open Haemorrhoidectomy [10].

In our study, the patients were in the age range of 21-84 years. Most of the patients in the stapler group were in the age group of 41- 50 years, while in the open group, the majority were in the range of 21-40 years. The mean age of open haemorrhoidectomy group was  $43.7 \pm 14.8$  and  $46.0 \pm 12.7$  for stapler haemorrhoidectomy group. (P value=0.759). In our study, 30 patients (83.3%) were male and 6 patients (16.7%) were females in the stapler group, while 36 patients (87.8%) were males and 5 (12.2%) were females in the open group. The difference was statistically insignificant.

### Conclusion

The mean age of open haemorrhoidectomy group was  $43.7 \pm 14.8$  and  $46.0 \pm 12.7$  for stapler haemorrhoidectomy group. The male: female ratio was 4.98:1 for the stapler group and 7.1:1 for the open group.

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