

ORIGINAL RESEARCH

To Study the Quality of Life of the Patients after following Stapled Haemorrhoidectomy

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ABSTRACT

Background: Background Haemorrhoidal disease is ranked first among diseases of rectum and large intestine and estimated worldwide prevalence ranges from 2.9% to 27% of which more than 4% are symptomatic. Haemorrhoidal disease is a frequent disease of the anal canal. It is downward sliding of Anal Cushions. Haemorrhoids are important vascular cushions located in the anal canal as part of the normal anatomy. These cushions are composed of arteries, veins, smooth muscle fibers and connective tissue embedded in thickened submucosa. Since Longo first described Stapled Haemorrhoidectomy (SH) in 1998, it has been emerging as the procedure of choice for symptomatic haemorrhoids. The success and efficacy of haemorrhoidectomy procedures can be evaluated based on postoperative healing duration, complications, recurrence as well as questionnaires that reveal patient's perspective, Therefore it has been proposed to assess the quality of life following stapled haemorrhoidectomy using SF-36 questionnaire.

Materials and Methods: This prospective studies for evaluation of quality of life and functional outcome following stapler haemorrhoidectomy was conducted in the post graduate department of surgery ASCOMS, Jammu for the period of one year to study the clinical outcome following stapled haemorrhoidectomy.

Results: The age of the patient ranged from 18 to 78 years of age with an average age of 45.73 years. Majority of patients in this study were males 60% whereas females were 40%. 21 (70%) of the patients had Grade III haemorrhoids and 9 (30%) patients had Grade II haemorrhoids. Post-operative pain was assessed by Visual analogue score at 6, 12, 24 hours. In our study, no patient complained of Urinary retention, post-operative bleeding, anal incontinence, mucosal discharge, anal stenosis or constipation.

Conclusion: Keeping all the benefits of stapled harmorrhoidectomy the clinical outcome in patients treated with this method is definitely better and clinical outcome in these patients is excellent.

Keywords: ?

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INTRODUCTION

Haemorrhoids are one of the common condition encountered in general surgical clinic. Large numbers of patients are asymptomatic; bleeding during defecation is the most common

presenting symptom. Haemorrhoids are highly vascular submucosal cushions that generally lie along the anal canal in three columns—the left lateral, right anterior, and right posterior positions. These vascular cushions are made up of elastic connective tissue and smooth muscle, but because some do not contain muscular walls, these cushions may be considered sinusoids instead of arteries or veins. Clinically evident bleeding arises from the per-sinusoidal arterioles and is therefore arterial in nature. Haemorrhoids play a significant physiologic role in protecting the anal sphincter muscles and augment closure of the anal canal during moments of increased abdominal pressure (e.g., coughing, sneezing) to prevent incontinence and contribute 15 to 20% of the resting anal canal pressure. Increases in abdominal pressure increase the pressure in the inferior vena cava that cause these vascular cushions to engorge and prevent leakage. This tissue is also thought to help differentiate stool, liquid, and gas in the anal canal. The etiology is not clear, with some factors or gravity, straining, irregular bowel habits. Other causes are pregnancy, birth, spicy food, chronic cough, obesity, alcohol, benign prostate hyperplasia cirrhosis; intra-abdominal tumors are some activities that require long period of immobility.^[3]In both sexes, a peak in prevalence was noted from age 45-65 years, with a subsequent decrease after age 65 years. The development of haemorrhoids before age 20 years was unusual. The dentate line differentiates external and internal Haemorrhoids. External Haemorrhoids are located below the dentate line and drain via the inferior rectal veins into the pudendal vessels and then into the internal iliac vein. These vessels are covered by anoderm that is comprised of modified squamous epithelium. As a result, these tissues contain pain fibers and affect how patients present and are treated. Internal Haemorrhoids lie above the dentate line and are covered by columnar cells that have visceral innervations. These drain via the middle rectal veins into the internal iliac vessels.^[3] Hence the present study was conducted to study the clinical outcome following stapled haemorrhoidectomy.

MATERIALS & METHODS

This prospective study in 30 patients was conducted for evaluation of clinical outcome following stapler haemorrhoidectomy in the post graduate department of surgery ASCOMS, Jammu for the period of one year to study the clinical outcome following stapled haemorrhoidectomy. Inclusion criteria all the patients with symptomatic II and III degree haemorrhoids with or without concomitant external haemorrhoids. Exclusion criteria Thrombosed haemorrhoids, Concomitant perianal abscess / fistula, Patients with I and IV degree haemorrhoids, Patients with portal hypertension, Patients not fit for anaesthesia. Equipment used was PPH-03 set (Procedure for prolapse and haemorrhoids set) it consists 33 mm Endo surgical circular stapler, Circular Anal Dilator, Purse String Suture anoscope. After all preoperative investigations, Colonoscopy (Age > 50 yrs) and informed consent, the Patients were kept on light low residual diet a day before surgery and kept fasting overnight. They were give Sodium Phosphate Enema night before surgery. They were operated under spinal anaesthesia. Patients were given injectable Ceftriaxone (1.5 gms) on or before surgery. Foley's Catheter in situ was place before surgery in all 30 patients. The procedure of the stapled haemorrhoidectomy was performed by same experience surgeon and same assistant team. Assessment of quality of life post stapler haemorrhoidectomy was done using SPF-36 questionnaire by the patient on 6, 12, 24 hours, 1 week and 4 week.

RESULTS

Age of the patients ranged from 18-78 years with maximum patients in the range of 29-38 years with mean age was 45.73 years.

Table 1: Distribution of Patients according to age

Age Group (in years)	No. of Patients (n)	Percentage
18-28	4	13.33%
29-38	8	26.66%
39-48	5	16.66%
49-58	6	20%
59-68	3	10%
69-78	4	13.33%
Total	30	100%

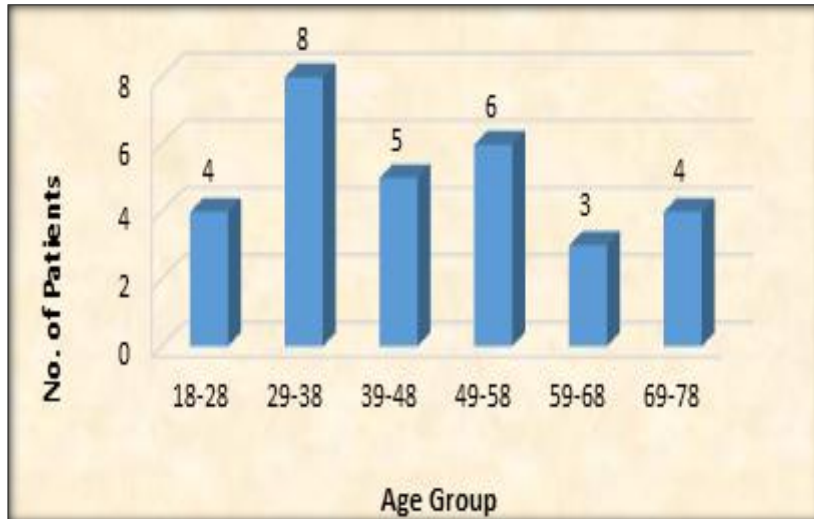


Figure: 1 ?

Table 2: Distribution of Patients according to gender

Gender	No. of Patients (n)	Percentage
Male	18	60%
Female	12	40%
Total	30	100%

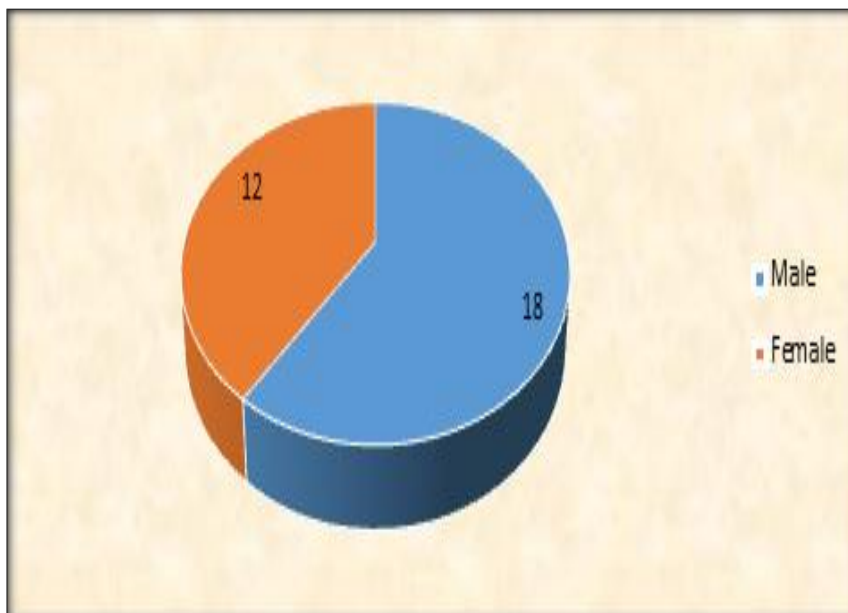


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Table 3: Distribution of Patients according to grade of haemorrhoids

Grade	No. of Patients (n)	Percentage
Grade-II	9	30%
Grade-III	21	70%
Total	30	100%

Post-Operative Quality of Life Assessment Following Stapler Haemorrhoidectomy Using Sf-36 Questionnaire

Quality of Life according to SF36 Questionnaire	AT 1 Week		AT 4 Weeks	
1. Physical Functioning:				
Limited a Lot	17	56.66%	0	0%
Limited a Little	13	43.33%	0	0%
Not at all Limited	0	0%	30	100%
2. Role Limitation due to Physical Health:				
Yes	16	53.33%	0	0%
No	14	46.66%	30	100%
3. Role Limitation due to Emotional Health:				
Yes	9	30%	0	0%
No	21	70%	30	100%
4. Energy:				
Full of Energy all of the Time / Fatigue None of the Time	0	0%	17	56.66%
Full of Energy Most of the Time/ Fatigue Little Bit of the Time	4	13.33%	11	36.66%
Full of Energy a Good Bit of the Time/ Fatigue Some of the Time	23	76.66%	2	6.66%
Full of Energy Some of the Time/ Fatigue Good Bit of the Time	3	10%	0	0%
Full of Energy a Little Bit of the Time/ Fatigue Most of the Time	0	0%	0	0%
Full of Energy None of the Time/ Fatigue All of the Time	0	0%	0	0%
5. Emotional Well Being:				
All of the Time	18	60%	27	90%
Most of the Time	10	33.33%	3	10%
A Good Bit of the Time	2	6.66%	0	0%
Some of the Time	0	0%	0	0%
A Little Bit of the Time	0	0%	0	0%
None of the Time	0	0%	0	0%
6. Social Functioning:				
Not at all	0	0%	10	33.33%
Slightly	0	0%	20	66.66%
Moderately	11	36.66%	0	0%
Severe	13	43.33%	0	0%

Very Severe	6	20%	0	0%
7. Pain:				
None	16	53.33%	30	100%
Very Mild	14	46.66%	0	0%
Mild	0	0%	0	0%
Moderate	0	0%	0	0%
Severe	0	0%	0	0%
Very Severe	0	0%	0	0%
8. General Health:				
Excellent	13	43.33%	25	83.33%
Very Good	11	36.66%	5	16.66%
Good	5	16.66%	0	0%
Fair	1	3.33%	0	0%
Poor	0	0%	0	0%

DISCUSSION

Quality of life following stapled haemorrhoidectomy, which is being increasingly visualized as a more refined and realistic parameter of surgical procedures. Hemorrhoids may adversely affect the quality of life to varying extent depending upon the symptoms associated with them. The change in quality of life after stapled haemorrhoidectomy is reflection of two distinct elements: Allevation of symptoms of haemorrhoids following surgery and less postoperative pain and least complications following haemorrhoids Post-operative pain along with complications following haemorrhoids. We have evaluated quality of life following stapled haemorrhoidectomy through a different lens by SF 36 questionnaire which consists of eight domain i.e. physical functioning, role limitation due to physical health, role limitation due to emotional health, energy/fatigue, emotional well-being, social functioning, bodily pain and general health patients were assessed by SF 36 questionnaire at 1st & 4th week. In our study we found that quality of life following stapled haemorrhoidectomy using SF 36 questionnaire, consisting of eight domains i.e. physical functioning, role limitation due to physical health, role limitation due to emotional health, energy/fatigue, emotional well-being, social functioning, bodily pain and general health of patients, to be an excellent predictor for quality of life. The SF-36 questionnaire score for quality of life was slightly higher at 1 month as compared to 1 week time (p value < 0.001). Similar results were obtained in a clinical study conducted in 2019.^[9]

CONCLUSION

Keeping all the benefits of stapled haemorrhoidectomy, the quality of life in patients treated with this method is definitely better.

REFERENCES

1. Bhandari RS, J Lakhey P, Singh YP, Mishra PR, Singh KP. Stapled haemorrhoidectomy versus open haemorrhoidectomy: a prospective comparative study. *Journal of Chitwan Medical College*. 2014;4(4):7-11.
2. Bona S, Battafarano F, Romario UF, Zago M, Rosati R. Stapled anopexy: postoperative course and functional outcome in 400 patients. *Diseases of the colon & rectum*. 2008;51(6):950-5.
3. Cintron J, Abcarian H. Benign anorectal: hemorrhoids. *The ASCRS textbook of colon and rectal surgery*. New York: Springer-Verlag, Inc. 2007;2:156-77.
4. Faucheron JL, Voirin D, Abba J. Rectal perforation with life-threatening peritonitis following stapled haemorrhoidopexy. *Journal of British Surgery*. 2012;99(6):746-53.

5. Ommer A, Hinrichs J, Möllenberg H, Marla B, Walz MK. Long-term results after stapled haemorrhoidopexy: a prospective study with a 6-year follow-up. *Diseases of the colon & rectum*. 2011;54(5):601-8.
6. Palimento D, Picchio M, Attanasio U, Lombardi A, Bambini C, Renda A. Stapled and open haemorrhoidectomy: randomized controlled trial of early results. *World Journal of Surgery*. 2003;27(2):203-7.
7. Pavlidis T, Papaziogas B, Souparis A, Patsas A, Koutelidakis I, Papaziogas T. Modern stapled Longo procedure vs. conventional Milligan-Morgan haemorrhoidectomy: a randomized controlled trial. *International Journal of Colorectal Disease*. 2002;17(1):50-3.
8. Ram M, Khan S, Tiwari A, Sainia T, Anand K. Surgical Review: *International Journal of Surgery Trauma and Orthopedics*. 2020
9. Shabahang H, Maddah G, Mofidi A, Nooghabi MJ, Khaniki SH. A randomized clinical trial of laser hemorrhoidoplasty vs Milligan and Morgan haemorrhoidectomy. *World*. 2019;12(2):60.
10. Sultan S, Rabahi N, Etienney I, Atienza P. Stapled haemorrhoidopexy: 6 years' experience of a referral centre. *Colorectal Disease*. 2010;12(9):921-6.