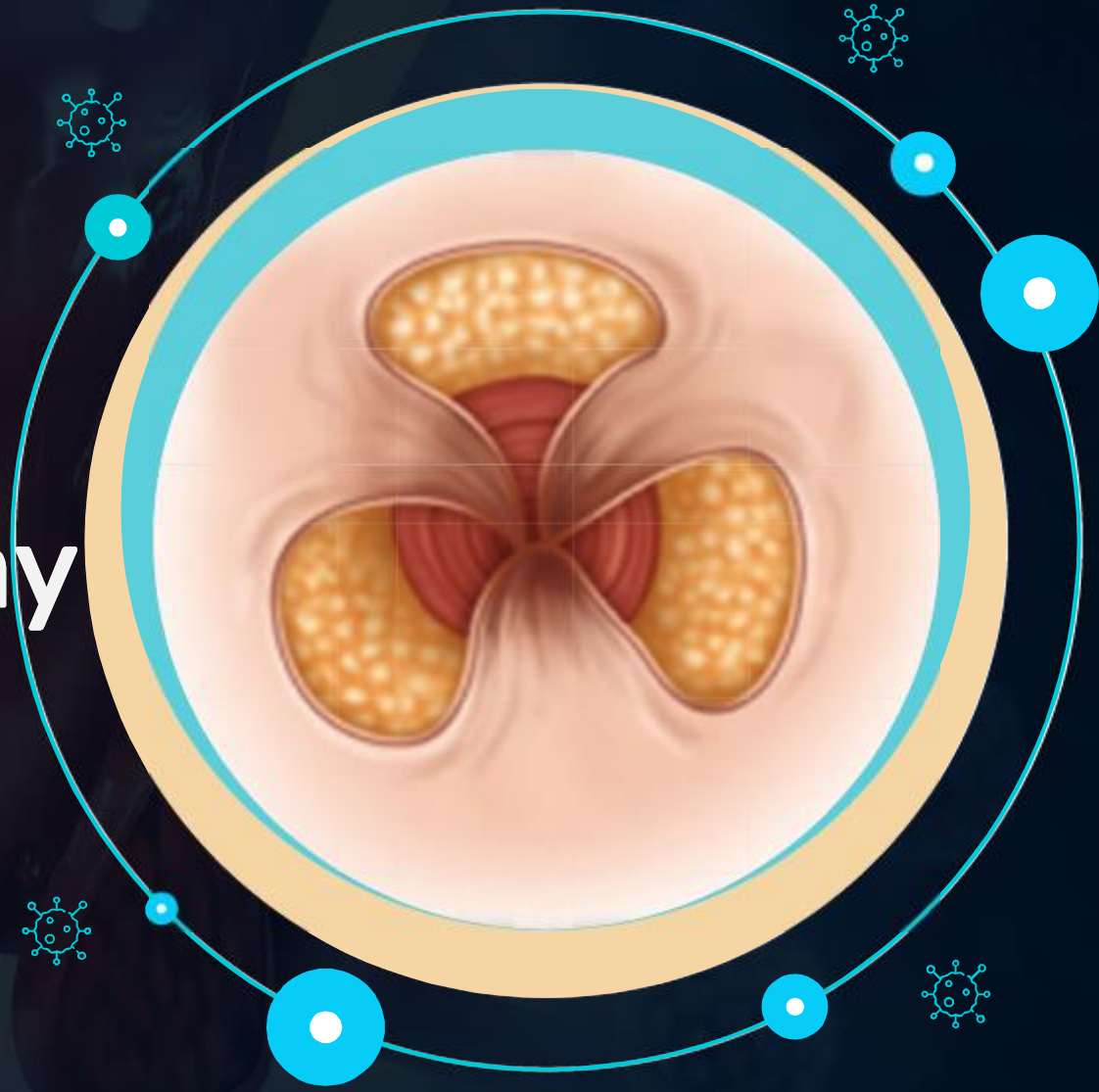
2023

Is Milligan–Morgan Open Hemorrhoidectomy obsolete ?!



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Master's degree of surgery

ADDRESSES AND ORIGINAL ARTICLES

SURGICAL ANATOMY OF THE ANAL CANAL, AND THE OPERATIVE TREATMENT OF HÆMORRHOIDS

BY

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IT is the main purpose of this paper to describe an operation for the removal of hæmorrhoids based on anatomical study of the component parts of a hæmorrhoid and of the related muscles.

Though embryologically the rectum and anal

Since the composite portions of a hæmorrhoid lie subjacent to the rectal mucosa and to the various linings of the anal canal, a description of these coverings is necessary for the identification of the underlying component parts of the hæmorrhoid (Figs. 1 and 2).

Rectal mucosa. — This is columnar,

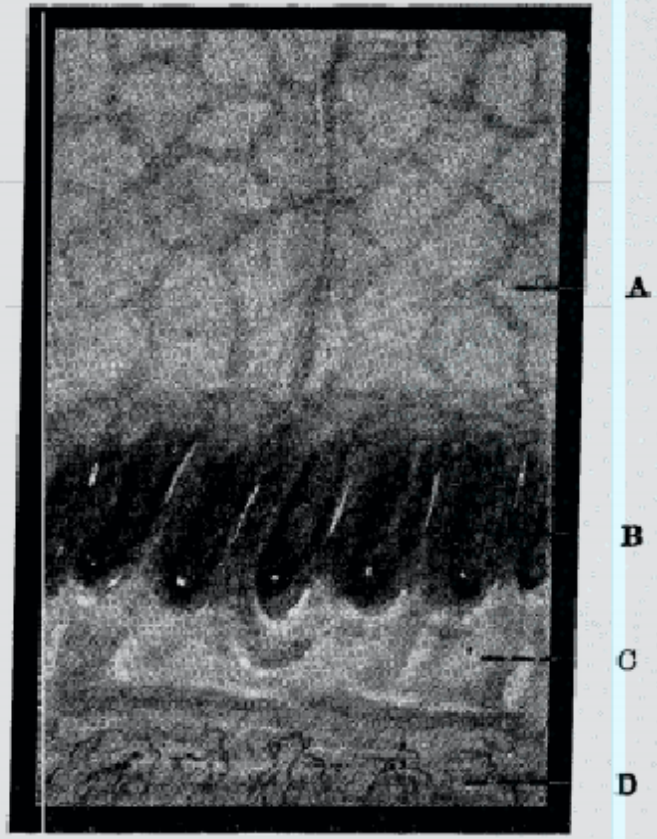


FIG. 1.—Drawing of linings of rectum and anal canal, showing (A) rectal mucosa; (B) plum-coloured anal mucosa; (C) anal canal skin; (D) skin of anus.

HISTORY

COMMENT

The advantages claimed for the removal of hæmorrhoids by the method described are :

1. The ligature is definitely applied above the hæmorrhoid and therefore the whole is removed—a distinct safeguard against recurrence.

2. The ligature is held down by being applied round both the longitudinal muscle and the pile pedicle, below the internal sphincter. This avoids retraction of the pedicle upwards with resulting extensive "raw" areas in the anal canal which may lead to stricture formation at the site of the ano-rectal ring.

3. Areas of anal mucosa and skin are left intact between each wound from which regeneration successfully takes place. This is essential in order to prevent the more painful and difficult stricture formation at the anus.

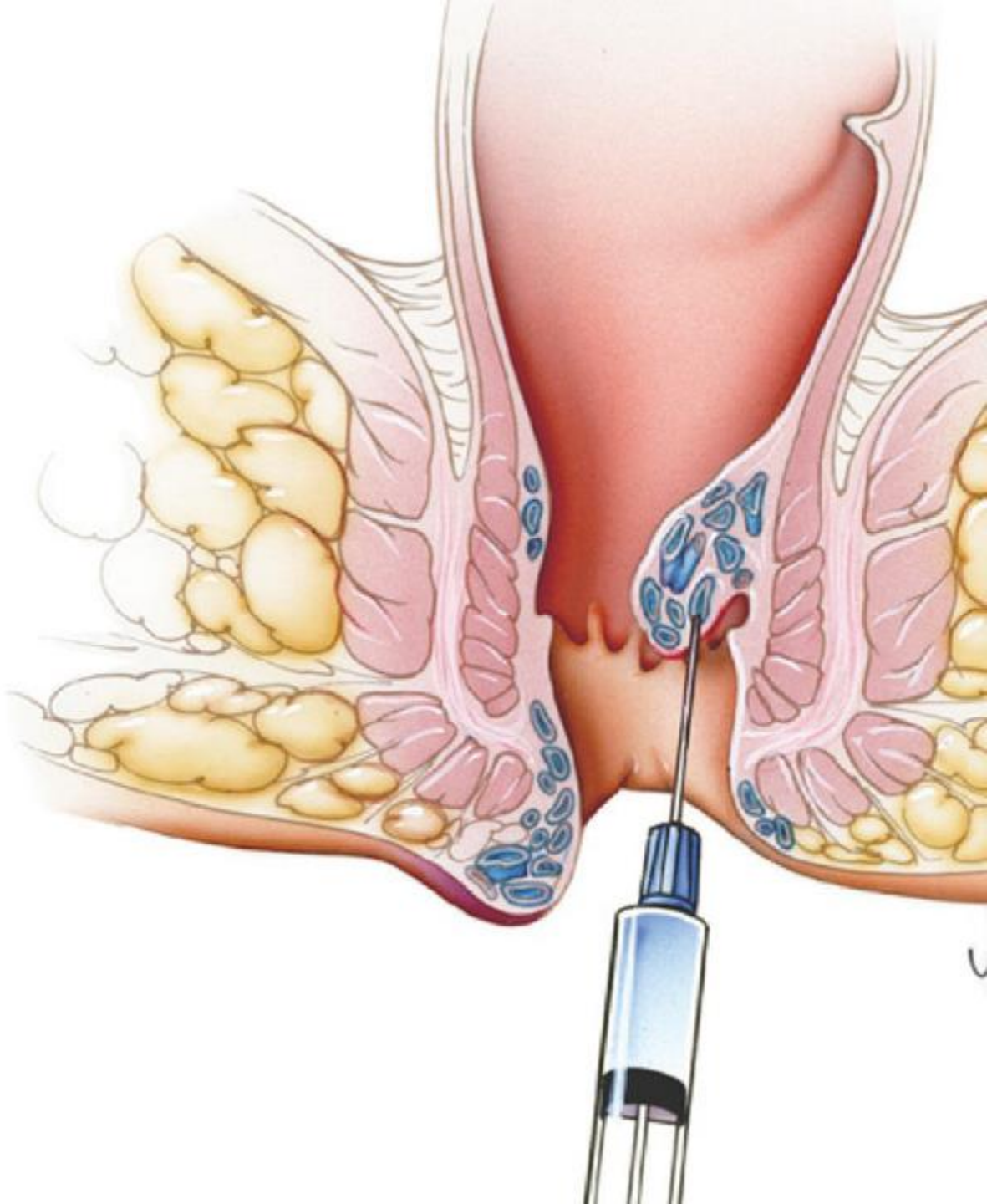
4. Accurate removal of portions of the external hæmorrhoidal plexus, together with trimming of the resulting wounds, considerably minimises post-operative skin œdema and the formation of skin tags (Fig. 16).


01 Option
02 Option
03 Option
04 Option
Options

Other modalities

Sclerotherapy

Injection sclerotherapy was first attempted by **John Morgan** in **1869**



Office Ligation Treatment Of Hemorrhoids

James Barron M.D.**

Detroit, Michigan

* Read at the meeting of the American Proctologic Society, Miami Beach, Florida, April 30 to May 3, 1962.

** Surgeon-in-Charge of Division III, Department of General Surgery, Henry Ford Hospital.

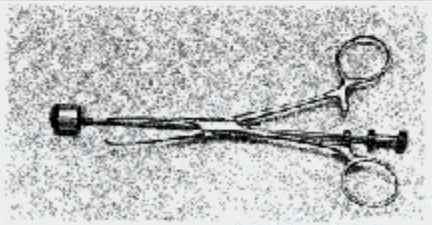


FIG. 1. The Blaisdell ligator.

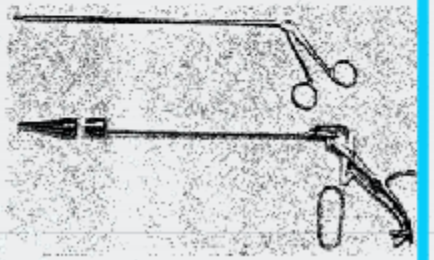


FIG. 3. Modified Blaisdell instrument and grasping forceps.

RESULTS

dalities.[13] Rubber band ligation has also been directly compared with excisional hemorrhoidectomy for grade III hemorrhoids. A systematic review of randomized controlled trials found that, overall, it was less effective and more likely to require multiple procedures than surgical excision. However, rubber band ligation was associated with less pain and fewer complications than the operative approach.[16] A recent Cochrane review by the same group reported that band ligation may be the preferred choice for grade II hemorrhoids, and even considered for first-line therapy in grade III hemorrhoids, whereas surgical excision may be more appropriately reserved for grade III or rubber band treatment failures.[17]

Comparison of Hemorrhoidal Treatment Modalities.

A Meta-Analysis

Helen M. MacRae, M.D., FR.CS.C., Robin S. McLeod, M.D.

From the Department of Surgery and Samuel Lunenfeld Research Unit, Mount Sinai Hospital and University of Toronto, Toronto, Ontario, Canada

Dr. MacRae was supported in part by the Wigston Foundation, Toronto, Ontario, Canada.

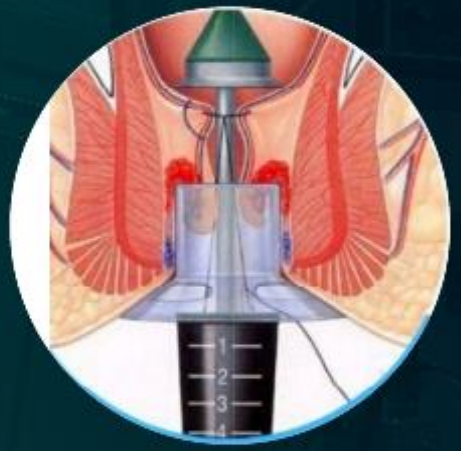
Poster presentation at the meeting of The American Society of Colon and Rectal Surgeons, Montreal, Quebec, Canada, May 7 to 12, 1995.

No reprints are available.

Hemorrhoidectomy was found to be significantly more effective

hemorrhoids (# = 0.0017), with less need for further therapy (P = 0.034), no significant dif erence in complications (although there was a trend toward an in-

New Era



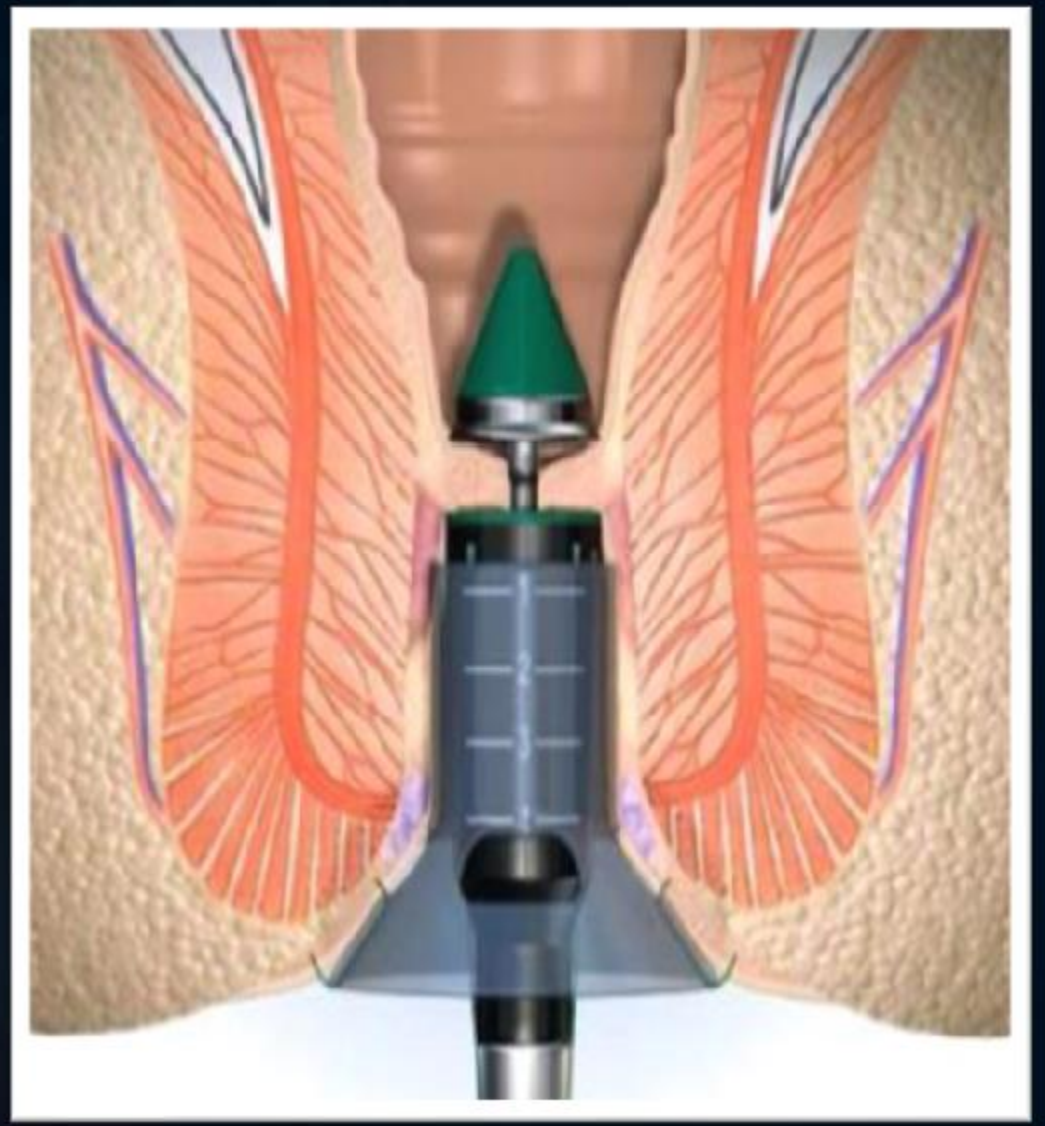
Stapler Surgery

Infrared Coagulation

Laser Treatment

Stapled Hemorrhoidopexy

Stapled Hemorrhoidopexy was developed in Italy as an alternative form of operative therapy for hemorrhoids in ۱۹۹۸



Stapled haemorrhoidopexy vs. *Milligan-Morgan* haemorrhoidectomy for grade III haemorrhoids: a randomized clinical trial

AMMATURO, C.; TUFANO, A.; SPINIELLO, E.; SODANO, B.; IERVOLINO, E. M.; BRILLANTINO, A.; BRACCIO, B.

Author Information®

Il Giornale di Chirurgia - Journal of the Italian Association of Hospital Surgeons (١٠)٣٣:p ٣٥١-٣٤٦, October ٢٠١٢.

Patients undergoing the SH procedure showed greater short term advantages than MMH group with reduced pain, shorter length of hospital stay, earlier return to work and high patient satisfaction. Longterm follow-up has indicated more favourable results in MMH group in terms of resumption of symptoms with absence of residual prolapse and risk of recurrence of prolapse. At two years follow-up recurrent prolapse was confirmed in six patients of SH group (13%) whereas in none of the MMH group. At six months follow-up there weren't significant difference in the mean satisfaction score for the two groups. At two years the mean satisfaction score was higher in the MMH group vs SH group. Seven patients in the SH group needed a reoperation whereas none in MMH group.

Stapled Hemorrhoidopexy: Results at 10-Year Follow-up

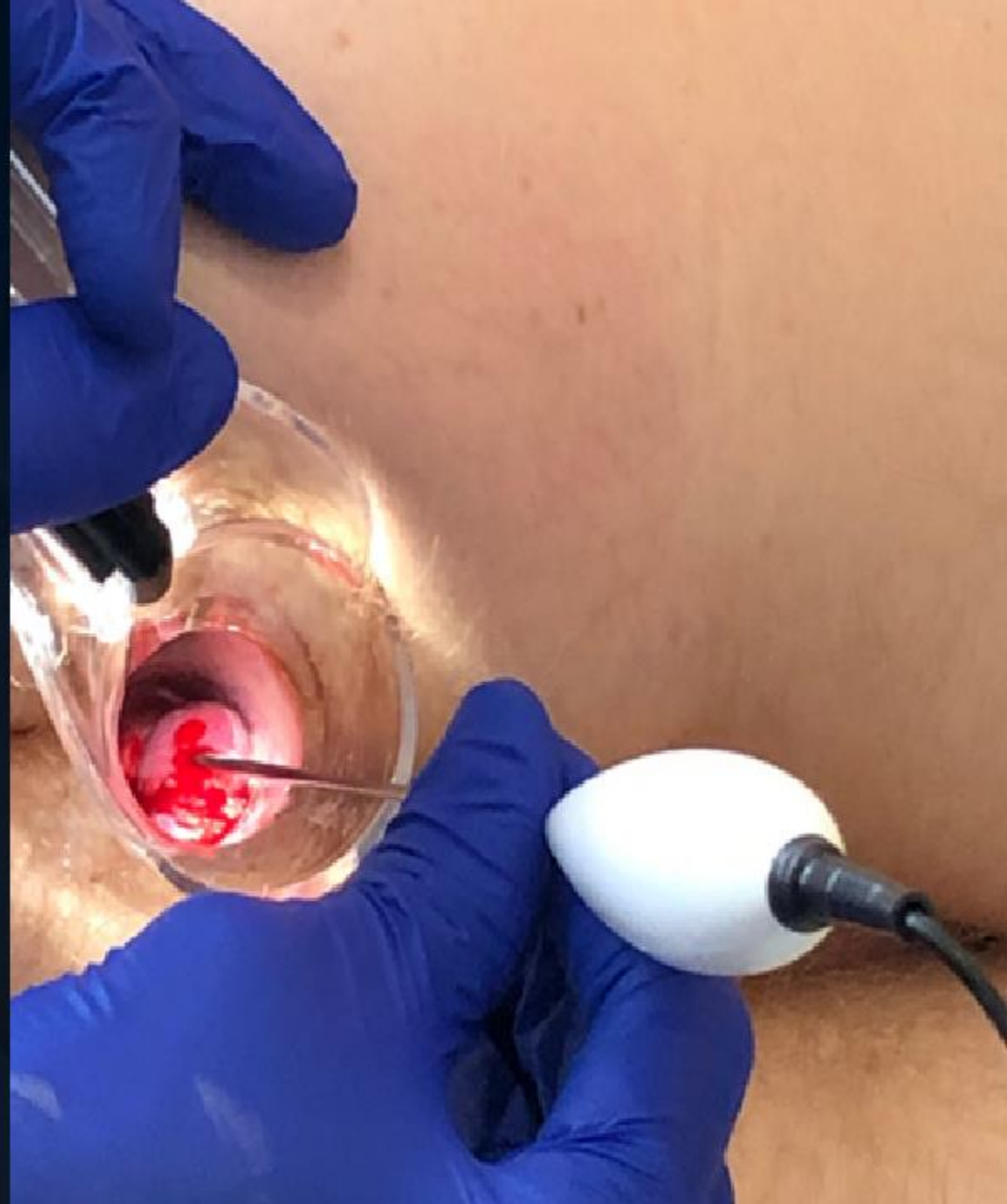
Bellio, Gabriele M.D.; Pasquali, Arianna M.D.; Schiano di Visconte, Michele M.D.

Author Information

Diseases of the Colon & Rectum 61(4):p 491-498, April 2018. | **DOI:** 10.1097/DCR.0000000000001025

Eighty-six patients (45 men and 41 women; median age, 49 y (range, 31–74 y)) underwent stapled hemorrhoidopexy. Eight patients had urinary retention during the immediate postoperative period, and 2 patients required a reoperation for suture line bleeding. The median hospital stay was 12 hours (range, 12–96 h). No suture line dehiscence, rectovaginal fistula, pelvic sepsis, anal abscess, or anal stenosis was recorded during the follow-up. Seventy-seven patients (90%) completed the expected follow-up, with a median duration of 119.0 months (range 115.4–121.8 mo). Among them, 30 patients (39%) experienced a recurrent hemorrhoidal prolapse, 8 of whom needed a reoperation. Thirty-four patients (44%) reported urge to defecate with a median visual analog scale of 1 (range, 1–7). Six patients (8%) reported gas leakage at the last follow-up visit, whereas no liquid or solid stool leakage was recorded. Satisfaction rate at 10-year follow-up was 68%.

Infrared coagulation



LASER

Hemorrhoidectomy — laser *vs.* nonlaser

Outpatient surgical experience

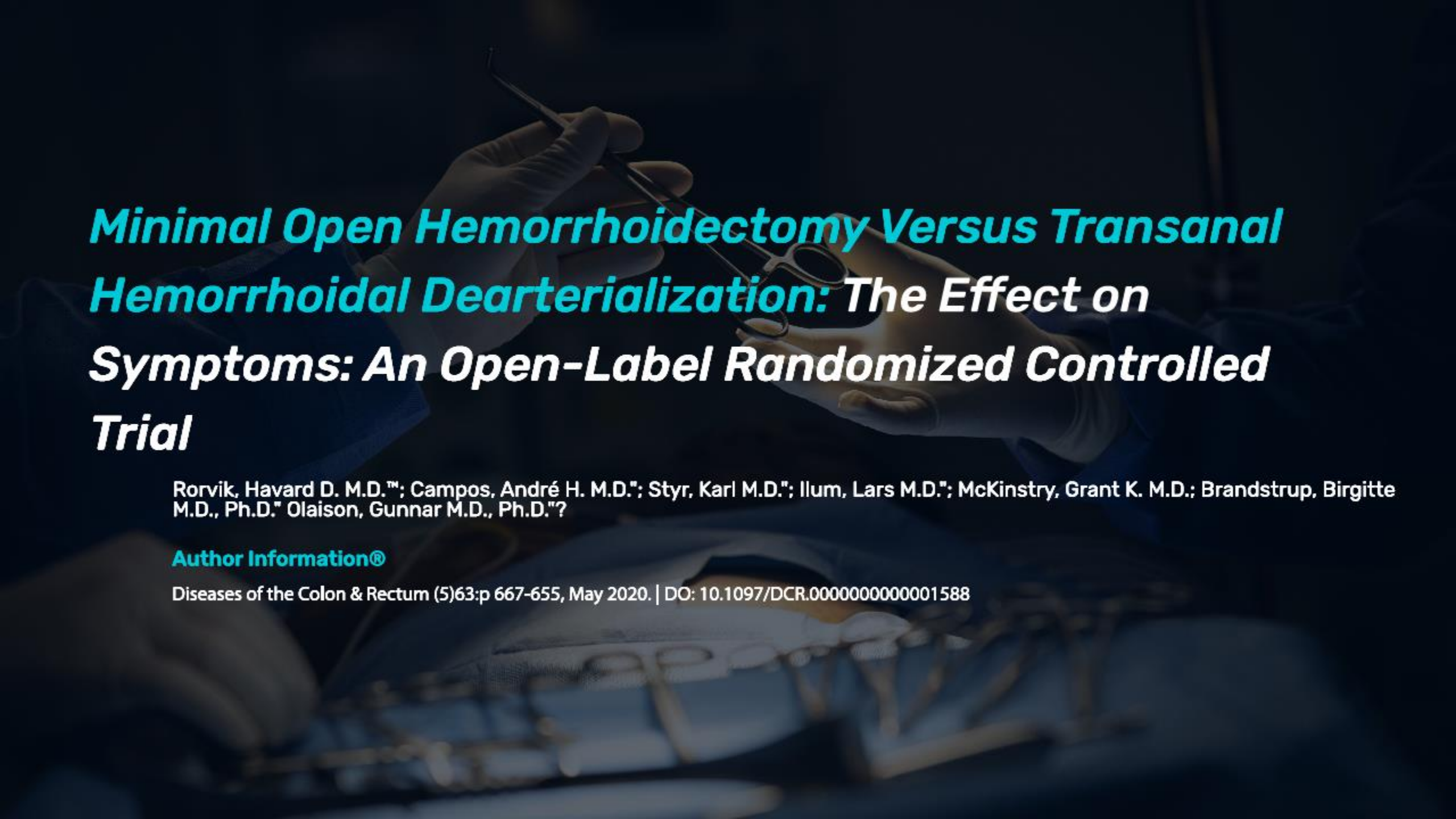
Leff, Edmund I. M.D.[1]

Author Information

Diseases of the Colon & Rectum 35(8):p 743-746, August 1992. | *DOI:* 10.1007/BF02050322

Mid-term efficacy and postoperative wound management of laser hemorrhoidoplasty (LHP) vs conventional excisional hemorrhoidectomy in grade III hemorrhoidal disease: the twisting trend

Hemorrhoidal prolapse recurrence was reported in 2 (2.7%), 6 (8.1%), and 14 (18.9%) patients in LHP group at 6 + 2 months, 12 + 3 months, and 25 + 8 months follow-up,respectively. Hemorrhoidal symptom recurrence was reported in 0 (0%), 0 (0%), and 1 (1.1%) patient in MM group at 6 + 2 months, 12 + 4 months, and 25 + 8 months follow-up, respectively. Therefore, at 25 + 8 months, the percentage of patients with hemorrhoidal prolapse recurrence was significantly higher in LHP group if compared with MM group (p



Minimal Open Hemorrhoidectomy Versus Transanal Hemorrhoidal Dearterialization: The Effect on Symptoms: An Open-Label Randomized Controlled Trial

Rorvik, Havard D. M.D.™; Campos, André H. M.D."; Styr, Karl M.D."; Ilum, Lars M.D."; McKinstry, Grant K. M.D.; Brandstrup, Birgitte M.D., Ph.D." Olaison, Gunnar M.D., Ph.D."?

Author Information®

Diseases of the Colon & Rectum (5)63:p 667-655, May 2020. | DO: 10.1097/DCR.0000000000001588

Transanal Hemorrhoidal Dearterialization With Mucopexy Versus Vessel-Sealing Device Hemorrhoidectomy for Grade III to IV Hemorrhoids: Long-term Outcomes From the THDLIGA Randomized Controlled Trial

Trenti, Loris M.D., Ph.D.[1]; Biondo, Sebastiano M.D., Ph.D.[1]; Espin-Basany, Eloy M.D., Ph.D.[2]; Barrios, Oriana M.D.[1]; Sanchez-Garcia, Jose L. M.D., Ph.D.[2]; Landaluce-Olavarria, • Aitor M.D., Ph.D.[3]; Bermejo-Marcos, Elena M.D.[4]; Garcia-Martinez, • Maria T. M.D., Ph.D.[5]; Alias Jimenez, David M.D., Ph.D.[6]; Jimenez, Fernando M.D., Ph.D.[3]; Alonso, Adolfo M.D., Ph.D.[4]; Manso, Maria B. M.D.[6]; Kreisler, Esther M.D., Ph.D.[1]; On behalf of the THDLIGA-RCT Study Group

RESULTS:

Data from 1681 patients were analyzed. The 2 groups resulted to be comparable in terms of postoperative clinical score by multiple regression analysis and matched case-control analysis. Patients submitted to excisional hemorrhoidectomy had a significantly higher risk of postoperative complication (adjusted odds ratio=1.58; $p = 0.006$). A secondary analysis highlighted that excisional hemorrhoidectomy performed with new devices and hemorrhoidal artery ligation reported significant lower risk for complications then excisional hemorrhoidectomy performed with traditional monopolar diathermy. At the 24-month follow-up assessment, recurrence was significantly higher in hemorrhoidal artery ligation group (adjusted odds ratio=0.50; $p = 0.001$). A secondary analysis did not show a higher risk of recurrences based on the type of device.

RESULTS

CONCLUSION

The American Society of Colon and Rectal Surgeons

Clinical Practice Guidelines for the Management of Hemorrhoids

Davis, Bradley R. M.D,; Lee-Kong, Steven A. M.D; Migaly, John M.D; Feingold, Daniel L. M.D; Steele, Scott R. M.

Author Information®

Diseases of the Colon & Rectum (3)61:p 292-284, March 2018:| DOI: 10.1097/ DCR.0000000000001030

1. Hemorrhoidectomy should typically be offered to patients whose symptoms result from external hemorrhoids or combined internal and external hemorrhoids with prolapse (grades III–IV). Grade of Recommendation: Strong recommendation based on high-quality evidence, 1A.

Surgical Excision. Surgical excision of hemorrhoids remains a very effective approach. In general, it should be reserved for patients for whom office-based procedures fail or who cannot tolerate these procedures, grade III or IV hemorrhoids, or patients with substantial external skin tags. In a meta-analysis of 18 randomized prospective studies comparing hemorrhoidectomy with office-based procedures, hemorrhoidectomy was the most effective treatment for patients with grade III hemorrhoids. However, it was associated with increased pain and the highest complication rate.[13]

NO
It STILL

IMPROVING

Pain After Hemorrhoidectomy

Tarik Sammour, ER.A.C.S, Ph.D.

Colorectal Unit, Department of Surgery, Royal Adelaide Hospital, Adelaide, Australia

Dis Colon Rectum 952-951 :65 ;2022

DOI: 10.1097/DCR.0000000000002445


SPECIAL
Thank's
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