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Research Article

Thrombectomy for Acute Treatment of Trombosed Hemorrhoids

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Abstract: Hemorrhoidal disease is a common anorectal disorder characterized by the symptomatic enlargement and distal displacement of the hemorrhoids, which are the normal anal cushions. The main symptoms of hemorrhoidal disease include rectal bleeding, prolapse, pain, thrombosis, mucus discharge, and pruritus. Hemorrhoids are classified based on their location and the degree of prolapse. Clinical management of hemorrhoidal disease is based on severity. While conservative strategies are used for Patients with grades I or II disease, radical surgery is recommended for patients with grades III or IV hemorrhoids. Hereby we present our results of thrombectomy on acute treatment in patients with acute thrombosed hemorrhoids. 54 consecutive cases included this study. The mean age of the Patients was 38.5(+/-4.1), 22 patients were male, 32 patients were female. All patients underwent thrombectomy procedure and 8th hour 12th hour, 24th hour and 3rd day VAS scores were (4.1; 3.4; 5.8; 2.1) consecutively. 1 patient had developed intraoperative bleeding which controlled with monopolar electrocautery application, no postoperative bleeding has seen. 1 patient developed slight infection which controlled with simple antibiotics. No other complication has seen after procedure. Our study's the results were similar with literature and as conclusion we believe thrombectomy is a very safe and effective method of management of acute hemorrhoidal crisis in patients with thrombosed hemorrhoids.

Keywords: hemorrhoidal disease, management, thrombectomy.

INTRODUCTION

Hemorrhoidal disease is a common anorectal disorder characterized by the symptomatic enlargement and distal displacement of the hemorrhoids, which are the normal anal cushions [1-3]. The main symptoms of hemorrhoidal disease include rectal bleeding, prolapse, pain, thrombosis, mucus discharge, and pruritus [1,4]. Hemorrhoids are classified based on their location and the degree of prolapse. Clinical management of hemorrhoidal disease is based on severity. While conservative strategies are used for Patients with grades I or II disease [1,5,6], radical surgery is recommended for patients with grades III or IV hemorrhoids. Hereby we present our results of thrombectomy on acute treatment in patients with acute thrombosed hemorrhoids.

PATIENTS AND METHODS

54 consecutive cases included this study. The Patients admitted to proctology department with anal pain which revealed trombosed hemorrhoids in proctologic examination. The patients with bleeding disorders, immunedefficiency syndromes and unregulated systemic diseases excluded from study. All 54 patients underwent trombectomy with same technique performed by same surgeon. After cleaning the area with an alcohol swab, local anesthetic had locally injected approximately 2-6 mL of at the base of the thrombosed hemorrhoid, then approximately 1-2 mL of the local anesthetic had injected within the hemorrhoid. An elliptical incision had made in the roof of the hemorrhoid, taking care to avoid the anal sphincter muscle radially from the anal orifice. The blood clot had removed from the elliptical opening; if multiple clots are present; all clots had removed. A packing material made of oxidized regenerated

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cellulose (Oxicel®, Betatech Medical, Istanbul/Turkey) had used to pack the space left by the removal of the clot. After 12 hours of hospitalisation the patients had discharged with oral ciprofloxacin 500 mg 2*1 (Cipro®, Biofarma Drug Inc. Istanbul/Turkey) and diclofenac potassium 2*1 (Dolorex ®, Abdi Ibrahim Drug Inc. Istanbul/Turkey) and invited to outpatient clinic for follow-up daily. The pain scores (according to VAS system), bleeding (perioperative) and infection rates has evaluated.

RESULTS

The mean age of the Patients was 38.5(+/-4.1), 22 patients were male, 32 patients were female. All patients underwent thrombectomy procedure and 8th hour 12th hour, 24th hour and 3rd day VAS scores were (4.1; 3.4; 5.8; 2.1) consecutively. 1 patient had developed intraoperative bleeding which controlled with monopolar electrocautery application, no postoperative bleeding has seen. 1 patient developed slight infection which controlled with simple antibiotics. No other complication has seen after procedure.

DISCUSSION

Hemorrhoids develop when the venous drainage of the anus is altered, causing the venous plexus and connecting tissue to dilate, creating an outgrowth of anal mucosa from the rectal wall. However, the exact pathophysiology is unknown. Hemorrhoids occur above or below the dentate line where the proximal columnar transitions to the distal squamous epithelium[7]. The anus is approximately 4 cm long in adults, with the dentate line located roughly at the midpoint[7,8]. Hemorrhoids developing above the dentate line are internal. They are painless because they are viscerally innervated. External hemorrhoids develop below the dentate line and can become painful when swollen. The extent of prolapse of internal hemorrhoids can be graded on a scale from I to IV, which guides effective treatment[7]. This grading system is incomplete, however, because it focuses exclusively on the extent of prolapse and does not consider other clinical factors, such as size and number of hem-orrhoids, amount of pain and bleeding, and patient comorbidities and preferences[7,9]. Therefore the management of the disease varies. While hemorrhoid disease is one of the most common proctologic conditions affecting large numbers of people in the world and is one of the principal reasons that patients seek consultation from a colorectal surgeon, treatments include conservative medical management, office procedures, and surgical approaches in an operating room[10]. The Initial treatment of the hemorrhoidal illness consists of general conservative measures (hygienicdietetic, life style changes, and symptomatic treatment) to restore the intestinal habit and to diminish the local symptoms. Although several medicines have been tested, significant benefits have not been obtained to control this condition and very seldom do these procedures come from randomized, controlled clinical trials[10]. In this study we focused on the acute treatment of thrombosed hemorrhoids, which is a very safe and effective method for acute relief. Thrombosed hemorrhoids if seen within the first 24–48 hours, evacuation of the clot under local anaesthesia is recommended[11]. Care should be taken to remove all of the visible clot. A circumferential rather than a radial incision may help prevent a skin tag forming after healing. A large retrospective study describes evacuation of thrombosed perianal varices under local anaesthesia in 340 patients[11,12]. Operative indications were severe pain, necrosis or perforation of the underlying skin. Bleedingvoccurred in one patient (0.3%) and seven patients (2.1%) developed a fistula or abscess. Our study's the results were similar with literature and as conclusion we believe thrombectomy is a very safe and effective method of management of acute hemorrhoidal crisis in patients with thrombosed hemorrhoids.

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