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Editorial

Surgical Haemorrhoidectomy is Still the Gold Standard Treatment for Prolapsing Hemorrhoids

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There has been a recent surge in upper and lower gastrointestinal diseases in the last two years, probably secondary to COVID-19 infection and the recent tight social restrictions. Many of these diseases are limited to the anorectal area, specifically anal pain and bleeding secondary to anal fissures and haemorrhoids [1].

Haemorrhoidal disease can be treated conservatively in most cases. Complicated haemorrhoids can present with either prolapse, bleeding or with varying degrees of incontinence. Bleeding haemorrhoids can be treated with ligation or banding of haemorrhoids and ligation of the feeding haemorrhoidal arteries. This relatively new and moderately effective technique does not fully remove the causing pathology, the haemorrhoids. Drs. Milligan and Morgan developed the open hemorrhoidectomy technique in the UK in 1937. This surgical procedure was invented mostly for second, third- and fourth-degree hemorrhoids. The most common postoperative complication in the postsurgical-hemorrhoidectomy patients is severe throbbing pain. Closed hemorrhoidectomy was developed in the United States by Drs. Ferguson and Heaton in 1952 as a modification of the Milligan-Morgan procedure. The closed technique is similar to the open technique but the wounds are closed with absorbable sutures. A recent meta-analysis showed that the closed technique (Ferguson's) is superior to the open hemorrhoidectomy operation (Milligan-Morgan) in terms of reducing post-operative complications like bleeding, severe pain. The Ferguson's technique was also proven to be associated with faster wound healing [2].

Anatomically, the surgical hemorrhoidectomy procedures remove the excess prolapsing tissue which revert the anorectal area back to its almost normal anatomical structure. Thorough knowledge of the anatomy of the anal canal and sphincters is vital. This is important in order to avoid anal sphincter damage which can lead to fecal incontinence. Another crucial point is the consent procedure for hemorrhoidectomy procedures. Fecal incontinence and anal stenosis, though rare in the experienced hands, have to be well documented in the signed consent form.

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