

Tips for safe stapled haemorrhoidopexy

Sir,

Stapled haemorrhoidopexy is one option for treating haemorrhoids, but it is not without complications. Rectal perforation with life-threatening peritonitis following stapled haemorrhoidopexy is a rare but known complication (Faucheron et al, 2012). The original procedure that Longo described has gone through changes and adaptations to become the present-day procedure of stapled haemorrhoidopexy.

Some important factors in reducing complications in stapled haemorrhoidopexy are selecting appropriate patients, treating the correct grade of haemorrhoids (grade 3 and 4 (Lan et al, 2006), with best results in grade 3), training clinicians to reduce the learning curve (National Institute for Health and Care Excellence, 2011), and considering the use of prophylactic antibiotics.

From the surgical perspective, recommendations include standardizing the technique of purse-string placement in the sub-mucosal plane and creating sub-mucosal anastomosis (Shanmugam et al, 2005), avoiding incorrect placement of purse-string suture leading to full thickness excision, avoiding peri-rectal fat inclusion, and ensuring that the staple line is not too close to the dentate line. Bleeding and staple-line haematoma can be prevented by

prolonged stapler compression after firing – staple gun manufacturers recommend that the stapler should be kept closed for approximately 20 seconds after firing to promote haemostasis. The staple line should be examined and absorbable sutures used if necessary; diathermy should be avoided. Giving the patient a list of do's and don'ts for the immediate postoperative period can also be helpful.

A Health Technology Assessment compared conventional haemorrhoidectomy with stapled haemorrhoidectomy and concluded that there was no clear difference in the rate or type of complications. Conventional haemorrhoidectomy and stapled haemorrhoidectomy had very similar costs and quality-adjusted life years. They concluded that the decision as to whether stapled haemorrhoidectomy or conventional haemorrhoidectomy is conducted should primarily be based on the priorities and preferences of the patient and surgeon (Burch et al, 2008).

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