

James Aitken

MB, BS; LRCP, MRCS; MS; FRCS (Edin); FCS(SA); FRACS
General and Colorectal Surgery

Unit 4,
77 Grand Boulevard,
Joondalup, 6027

Suite 41
Hollywood Medical Centre,
85 Monash Avenue,
Nedlands, 6009

Tel: 6389 0244

Fax: 6389 0255

www.perthcolorectal.com.au

email: info@perthcolorectal.com.au

All correspondence to Hollywood

OPEN HAEMORRHOIDECTOMY (PILE OPERATION)

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

Pre-operative preparation.

During the week prior to surgery you should make a special effort to ensure your stools are soft. It is important that you continue to keep your stools soft for at least six weeks after your surgery. A laxative such as Lactulose or husk may be helpful. However, you must not get diarrhoea. You should drink at least 1.5 litres of fluid a day.

What is involved?

There are two options. The first option is the traditional open haemorrhoidectomy. The second option is the stapled haemorrhoidectomy. Some patients may be suitable for either technique, others only for one or other. The options will need to be discussed with you prior to your surgery. This advice sheet describes the open haemorrhoidectomy. A separate advice sheet is available for the stapled haemorrhoidectomy.

In the open haemorrhoidectomy small cuts are made around the anus and the neck of the pile is tied or burnt off. The skin is left open, but there may be a gauze or wax dressing over the wound.

Pain relief.

Open haemorrhoidectomy has a reputation for being painful, particularly when the bowels are opened the first few times after the operation. Your post-operative recovery will be slower if you do not have adequate pain relief.

Proper pain relief is very important for both holistic and physiological reasons. Patients often have an understandable reluctance to take pain relieving drugs. This is a mistake and may increase post-operative complications. The principal that underlies all methods of pain relief is that the drugs work best if you anticipate the pain. A small quantity of the drug taken regularly (even if pain free at that time) will work better than waiting for the pain to occur and then taking a larger dose.

Post-operative pain can be minimised with appropriate care. It is important that you do not let your stools become hard and you should follow the advice above, starting before your operation. Many patients find warm baths very soothing and it will do no harm if you have several baths per day. Do not put salt in the bath as this will dry the skin and may burn any open area.

Immediately after the operation you may require an injection to provide you with pain relief, but after that adequate pain relief can normally be achieved by oral medication. Regular Panadol, regardless of whether you have pain or not, is the foundation on which all pain relieving strategies are based. It should be used on a regular basis to provide background pain relief, regardless of whether you have pain or not, for a week after your surgery. Additional, stronger pain killers and/or anti-inflammatory drugs can be taken on top of the Panadol for break through pain.

Many stronger pain relieving drugs contain codeine or similar drugs and this will tend to cause constipation and a hard stool. This will make defaecation more painful. This is why you must make your stools soft prior to the surgery and continue with a laxative such as lactulose and drink plenty of water. Anti-inflammatory drugs can irritate the stomach and should be taken with food. Normally they can be stopped after seven days.

Day one.

You are encouraged to be mobile as soon as you have recovered from the anaesthetic. It is now possible to go home immediately after the operation or the next day, but you must have somebody at home when you open your bowels for the first time.

Dressing and stitches.

There may be a soft dressing around the anus. This can be gently pulled off the first day when you are in the bath. Any stitches will dissolve.

Managing perianal wounds at home.

You are encouraged to be as active as possible. There may be some bleeding with your bowel motion for up to one week. Occasionally there is a brisk, larger bleed at ten days. If this occurs you should call my rooms or the hospital.

Many perianal wounds require nothing further than regular baths or showers and the application of a light dressing to absorb any leakage from the open wound. Your main objective is to keep the wound clean rather than sterile. Leaning forward in the shower, or curling legs up in a bath will open the area and adequate washing obtained. It is not necessary to use salt; this may sting and dries out the skin.

Other cases require a daily visit from a nurse so that the wound can be dressed. In these cases it is helpful if patients have a bath and remove the dressings themselves prior to the arrival of the nurse.

Return to work and normal activities.

There is no fixed period that has to elapse before you can resume normal activities. You should be guided by your pain. Few patients will feel like returning to work within one week, but almost all will have resumed full activities by four weeks. You can resume sexual activity when you feel comfortable. For medico-legal reasons you should not drive a vehicle for at least seven days.

Large, circumferential haemorrhoids.

Some patients present with large, circumferential haemorrhoids. These sometimes require two operations. When the haemorrhoids are excised the surgical site heals by inward growth from the mucosa that is left between each raw area. If these mucosal bridges are

not preserved there will be a circumferential wound round the anus. When this heals it may cause an anal stenosis. This is a difficult problem to manage and may require a plastic procedure to correct it. It is better avoid an anal stenosis rather than to have correct it latter. This may require a conservative approach at the first operation and if there are still residual anal tags they can be excised at a second, more minor operation.

What can go wrong?

In surgical terms this is a minor operation. Although major surgical complications are a rare event other complications are possible, as after any surgical procedure. These include drug reactions, post-operative bleeding, deep vein thrombosis, heart and lung complications and wound infections. This list is not exhaustive and if you have any concerns about the possible side-effects or complications you should ask about them before you sign the consent form.

The most common complication is a sudden haemorrhage at about 7 – 10 days. This is called a secondary haemorrhage. Normally it is little more than the passage of a bright red blood clot that stops. On a few occasions this bleeding can be greater and persist. In that case you need to seek urgent advice through my rooms or attend an Emergency Department. Very occasionally a secondary haemorrhage does not stop spontaneously and an operation is required to place a suture through the bleeding artery.

There are some specific complications. Some patients (1 in 50) develop a persistent fissure. Normally this settles over three to six months. It sometime requires an examination under anaesthesia, and in some patients a lateral sphincterotomy is required. A separate advice sheet on anal fissure is available. Occasionally (less than 1 in 200), patients can develop an anal stenosis secondary to the scarring that occurs with healing. This may require a second, plastic operation to correct.