Tech Coloproctol (2006) 10:71
DOI 10.1007/s10151-006-0256-3

Section Editor: Luigi Basso

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Mucosal flap excision for treatment of remnant prolapsed hemorrhoids or skin tags after stapled hemorrhoidopexy

Dis Colon Rectum 2005; 48:1660–1662

Stapled hemorrhoidopexy may leave residual skin tags or external components following its use in large prolapsed piles. Excision of redundant mucosa above the dentate line and reconstitution to the staple line reduces these prolapsed elements. We describe a novel technique that removes residual skin tags and piles while remaining true to the spirit of stapled hemorrhoidopexy.

Invited comment

The report by Koh and Seow-Choen about a new technique to treat redundant skin tags after stapled hemorrhoidopexy is very interesting. The presence of big external components or skin tags is considered by many colorectal surgeons a contraindication to stapled hemorrhoidopexy. Their surgical removal can lead to the same postoperative pain of a conventional haemorrhoidectomy. The excision of a mucosal flap proximally to the dentate line and the subsequent suture of the external components to the previous circular suture of the haemorrhoidopexy possibly solves the problem of the pain. On the other hand the procedure does not seem to be easy to perform; at the end of the procedure the new suture is probably circular in most cases, under tension and with a certain risk of rupture. In our experience, the addition of this surgical step has not increased the number of complications of conventional hemorrhoidopexy. It should be interesting to know the long-term results of the technique, particularly as regards possible stenosis and recurrence of the external components.

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Reply from the authors

Sir,

I appreciate the thoughts of Dr. Trompetto. This technique had indeed saved many of our patients with fourth-degree piles from unneeded pain and prolonged recovery, as these patients could undergo the normal PPH procedure with the need for skin excision. I stress that not all patients need to have excess mucosa excised after PPH. Many patients with fourth-degree piles are able to get a large proportion of their external pile component reduced during surgery after anaesthesia following skillful reduction by the surgeon. Small skin components which are deemed insignificant can be left alone, but large remnant prolapse should be dealt with by our method. I almost never use conventional excisional hemorrhoidectomy now, and certainly not as a salvage procedure following PPH.

Additionally, I must stress that I have not seen any case of stricture of the anastomosis following the use of the additional technique after PPH. I am not talking here just of no increased incidence but actually not seeing a single case of stricture with this technique, which is remarkable. Recurrence of the tags does happen and is more so if inadequate suturing was performed. I now over-sew generously; Vicryl sutures are prone to disentanglement. Furthermore, I always use interrupted sutures. A continuous suture will lead to recurrence if the suture slips or dissolves before adequate healing and then out pops the prolapse.

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