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Partial Stapled Hemorrhoidopexy Versus Circular Stapled Hemorrhoidopexy

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A stapled hemorrhoidopexy (SH) is a recently rising therapy and is widely performed. Side effects, such as anal stenosis, rectal stenosis, and fecal urgency, have been continuously associated with the practical uses of the SH, despite its having many advantages [1-4], including remarkably decreased anal pain after surgery, shortened recovery periods, and faster resumption of normal activities, compared to the previously used conventional hemorrhoidectomy [5-7]. On this point, this essay, which is the subject of this editorial, has great meaning in its reporting of initial results on the use of a partial stapled hemorrhoidopexy (PSH), which is a new version of the SH that was designed to reduce, and hopefully eliminate, the disadvantages associated with the old version of the SH [8-12].

In the PSH procedure, a selective purse-string suturing of prolapsed hemorrhoid tissues is performed using a specifically produced window connected to an anoscope, after which the hemorrhoids are removed with the same auto-suturing device as that used in the old version of the SH, and normal mucosa is supplied to the excision sites [13]. Also, the PSH is known thought to have few side effects, such as stenosis and fecal urgency, because of its using fewer staples than the SH, but this has yet to be confirmed but none is yet certainly identified for it. Most SH practitioners report that side effects hardly occur when the basic principles of SH surgery are followed: for example, not positioning the stapling lines in the anal canal, not excising excessive anal mucosa from the lower rectum, and proper anastomosis except for muscle layers [1, 3, 4]. Therefore, surgeons must have basic technical expertise with the use of a SH before performing a PSH.

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Because of the lack of a consensus concerning the specific name to be used when referring to the PSH, each essay uses a different term when referring to the PSH, even though the meanings are similar. During the early period of its use, the SH was referred to as the norm of circular stapled hemorrhoidectomy; later that changed to the SH, which is the term currently used in many discussions [12, 14]. Likewise, the surgical method using a tissue-selective stapler is also referred to by various names: a PSH, a tissue-selective technique (TST), a tissue-selecting therapy, etc. Also, whether the procedure should be called a hemorrhoidectomy or a hemorrhoidopexy based on the excision amount and the location of the excision has not been discussed. Thus, further in-depth discussions are required so that the terms used in this area of surgery are properly defined. Also, as this essay pointed out, few long-term follow-up and comparative studies have been done on the disadvantages of a PSH, including recurrence and hemorrhage, or, especially, on the methods for processing the dog-ear that is formed after mucosal bridge dissociation [8, 9, 11-13]. Thus, further prospective studies comparing the SH to the PSH are needed.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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