

Management of Internal Hemorrhoids by Elastic Ligature in Brazzaville

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1. Abstract

1.1. Patients and Methods

This was a retrospective, descriptive multicenter study on 132 patients treated with ligation of hemorrhoids. The study took place from January 2015 to July 2020 at the Medico-Social Center of the Schnell Foundation and at the Brazzaville University Hospital. Study variables were epidemiological, clinical and therapeutic. Microsoft Excel version 20016 software for the compilation of the database and the development of graphs as well as the SPSS.07 software for data processing. The quantitative variables will be expressed as an average, the qualitative variables as a percentage.

1.2. Results

The mean age of the patients was 48.76 ± 11.04 . There were 13 women and 119 men, respectively 9.85% and 90.15% of men, or a sex ratio of 9.15. Management of hemorrhoidal disease was the most dominant indication (47.73%) followed by rectal bleeding (45, 45%). Proctologic examination revealed grade III hemorrhoidal disease in 65.15% of cases. In the majority of cases, a single session was sufficient to achieve healing. There were no notable complications in our series.

1.3. Conclusion

Rubber band ligation is an effective treatment for hemorrhoidal disease II and III. Rubber band ligation is an effective treatment for

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2. Introduction

Hemorrhoidal disease is the first cause of consultation in proctology, it is one of the most common causes of consultation in gastroenterology [1,2]. It is defined as the set of pathological manifestations related to changes in the hemorrhoidal vascular network and supporting tissues, which are naturally present from birth [3]. The treatment of HD involves many medical, instrumental and surgical methods, the choice of which must be adapted to each patient according to the stage and the symptoms expressed [1]. Instrumental treatment uses several methods, applying a chemical or physical process to treat internal hemorrhoids responsible for rectal bleeding or grade 2 or 3 prolapse; it currently occupies an important place in the management of hemorrhoidal disease [2,3]. The purpose of instrumental treatments (IT) is not to remove the hemorrhoidal tissue but to fix the hemorrhoids in a normal anatomical position, and to reduce vascularization [3]. Rubber band ligation of hemorrhoids is one of the most effective methods for first, second and third degree hemorrhoids [4]. The purpose of this work is to report on the experience of Congo in the management of internal hemorrhoids by rubber band ligation.

3. Materials and Methods

This was a descriptive retrospective study from January 2015 to July 2020, i.e. a period of 5 years. The study took place in the Gastroenter-

ology and Internal Medicine Department of the University Hospital of Brazzaville and at the Schnell Foundation Medico-Social Center. The study population consisted of all patients who had undergone hemorrhoid ligation. The reports of proctologic examinations of patients were the source of information. We included all patients over 18 years old who underwent anoscopy and rubber band ligation of the hemorrhoids. Patients who underwent anoscopy without rubber band ligation of the hemorrhoids were not included in the study. Patients who underwent proctologic examination without rubber band ligation of the hemorrhoids were excluded from the survey. The study variables were epidemiological (age, sex), clinical (hematochezia, pruritus, proctalgia, oozing, anal swelling, grade of hemorrhoids), therapeutic (number of sessions, number of rubber bands per session, complications). Evolution had not been studied. The survey data was entered on a pre-established survey sheet. Each patient receives a normacol® enema two hours before rubber band ligation of the hemorrhoids. The purpose of rubber band ligation is to achieve a “sclerosis nail” fixing the mucous membrane with free fibers. The method consists of placing an elastic ring in the suprapectin insensitive cylindrical zone. The suction device is preferred to the claw device because it does not cause mucosal breakthrough and allows better visual control. The device comprises two cylinders, the exterior of which is movable. An elastic band (or vinyl ring in case of latex allergy) is placed using an introduction cone on the inner cylinder. The device is connected to a suction. The mucosa is sucked into the inner cylinder. The outer cylinder is mobilized forwards sliding on the inside and pushes back the elastic at the base of the aspirated pedicle. The ligated tissues become necrotic forming a scab which heals in three weeks. The ligation material consisted of a single or multiple use anoscope, sterilizable, a ring ligator, autoclavable, a cone, rubber bands, a tampon, a suction system. There was no pre-medication. After rubber band ligation of the hemorrhoids, each patient receives transit-regulating treatment depending on the context (diarrhea or constipation), hygiene rules and analgesic and/or anti-inflammatory treatment if necessary. The Microsoft Excel version 20016 software is used for the creation of the database, the development of the graphs and the SPSS.07 software for the data processing. Quantitative variables will be expressed as an average, qualitative variables as percentages.

Table I: Distribution of patients according to the circumstances of discovery of the hemorrhoidal disease.

Indications	Effective
Anal bleeding	69
Management of hemorrhoidal disease	62
Evaluation of a hemorrhoidal disease	9
Proctalgia	9
Constipation	3
Management of a polypoid lesion	2

4. Results

During the study, 132 patients underwent rubber band ligation of the hemorrhoids. The age of the patients varied between 24 and 74 years with an average of 48.76 ± 11.04 . There were 119 men and 13 women, respectively 90.15% and 9.85% with a sex ratio of 9.15 in favor of men. The prevalence of hemorrhoidal disease was 23.2%. anal bleeding was the first THE Anal bleeding the first circumstance of discovery of the hemorrhoidal disease in 69 patients followed by Management of hemorrhoidal disease in 62 cases. Table I Distribution of patients according to the circumstances of discovery of the hemorrhoidal disease. It was grade III hemorrhoidal disease in 65.15% (n=86) of cases, grade II in 32.58% (n=43) of cases, grade I in 2.27% (n=3) cases. The number of sessions needed to achieve healing was one session for 90.15% (n=119) of cases, two sessions in 9.1% (n=12) cases and three sessions in 0.75% (n=1) cases. In the majority (98.48%) of cases there were no complications, two patients (1.52%) had anal bleeding. The need to treat hemorrhoids is based on the severity of the symptoms, but the type of treatment is based on the traditional classification of hemorrhoids.

5. Discussion

The need to treat hemorrhoids is based on the severity of the symptoms, but the type of treatment is based on the traditional classification of hemorrhoids. Rubber band ligation of hemorrhoids has been practiced for about forty years, for grade 1, 2 and 3 hemorrhoids [6]. Rubber band ligation of hemorrhoids is an effective alternative to surgery for the same indications; it is less expensive and has the advantage of being performed on an outpatient basis [7]. The male sex is the most affected by hemorrhoidal disease in our study. Other authors make the same observation [1, 4, 6,7]. In our series, anal bleeding was the first circumstance of discovery of hemorrhoidal disease that was the subject of an indication for rubber band ligation of hemorrhoids. Our results corroborate those of Traoré and Abid, in whom rectal bleeding was the first indication for rubber band ligation of hemorrhoids [1,7]. The proctologic examination reports a grade III hemorrhoidal disease in the majority of cases. Abid and Traoré report the same result in their series, although the sample sizes differ from one study to another [1,7]. In almost all of the patients in our series, a single ligation session was sufficient to achieve healing. In Abid et al as well as in Traoré et al, it took two sessions to obtain a cure [1,7]. The difference is explained by the indications, in fact, rectal bleeding was the second indication in our series while it was the first indication in Abid and Traoré. We noted two cases of anal bleeding during ligation. It is a benign complication whose treatment is most often simple and safe. Abid et al report a similar result [1]. However, the patient must be informed of the complications inherent in rubber band ligation after the intervention, in particular bleeding which may be severe within two weeks following the ligation [8]. Anal pain as well as perianal abscesses are also observed. Antibiotic prophylaxis with metronidazole as well as analgesic treatment with class 1 and 2 analgesics are recommended [9]. Sometimes, discomfort

can be felt by the patient after the ligation, some authors suggest performing the ligation in a single session with material that does not require reloading, thus reducing the duration of the procedure and the patient's discomfort [6].

6. Conclusion

Rubber band ligation of hemorrhoids is an effective technique for grade 2 and 3 internal hemorrhoids, performed on an outpatient basis with few complications and without hospitalization. The results of our series are encouraging and encourage the promotion of this technique in Congo because surgery is an expensive method, requiring a pre-therapeutic assessment and hospitalization.

References

1. H Abid, G Ousseur, R Benjira. The Elastic Ligation of Internal Hemorrhoids: Where Are We Now? .Open Journal of Gastroenterology. 2019; 1: 28-35
2. Zeitoun JD, Lehur PA, Atienza P, De Parades V. Hemorrhoidal pathology: where are we in 2011?. Hepato Gastro. 2011; 18: 177-192
3. S Seok-Gyu, K Soung-Ho. Optimal Treatment of Symptomatic Hemorrhoids. J Korean Soc Coloproctol. 2011 ; 27(6): 277-281
4. Coulibaly A, Kafando R, Somda KS. The Haemorrhoid's pathology: Epidemiological, Diagnostic, Therapeutic and Evolutionary Aspects. Open Journal of Gastroenterology. 2016; 6(12): 343-52.
5. Cazemier M, Felt-Bersma RJJ, Cuesta MA, Mulder CJJ. Elastic band ligation of hemorrhoids: Flexible gastroscope or rigid proctoscope? World J Gastroenterol. 2007; 13(4): 585-587.
6. Alubaidi K, Clarke G, Jamil A, Ghareeb E. Single Session, Multiple Band Ligation for Haemorrhoids. Surgical Science. 2016 ; 7 : 230-234
7. Traoré O, Diarra AS, Kassogué O, Abu T, Guindo S. Rubber band ligation in the management of symptomatic hemorrhoidal pathology after failure of traditional treatment at the Sikasso hospital in Mali. J Liver Res Disord Ther. 2018; 4(4): 153-155.
8. Jutabha R, Jensen D M, Chavalitdhamrong D. Randomised Prospective Study of Endoscopic Rubber Band Ligation Compared with Bipolar Coagulation for Chronical Bleeding Internal Hemorrhoids. American Journal of Gastroenterology. 2009; 104: 2057-2064.
9. Abramowitz L. Recommendations for clinical practice on the treatment of hemorrhoidal disease. Gastroenterol Clin and Biol. 2001; 25: 674-702.