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Editorial

Adequate management of postoperative pain in surgery for hemorrhoidal disease

Importancia del adecuado tratamiento del dolor postoperatorio en la cirugía de la enfermedad hemorroidal

There is no doubt that haemorrhoidectomy is one of the most common surgical interventions carried out on a daily basis. We do not have up-to-date data for Spain, but it is estimated that in the USA 42 in every 1000 inhabitants has haemorrhoidal disease. Doctors operate on 160 000 of these in short-stay hospitals.[1] Even more importantly, in many cases, pain management stops this operation from being carried out as outpatient surgery.[2] In fact, it is known that 959 000 hospital stays per year in the USA and 5165 in the UK are used for patients in need of haemorrhoid treatment.[1,2]

Anal pain management after haemorrhoidectomy has been and always will be key when carrying out the critical analysis of this procedure.[3] The haemorrhoidal plexus, as part of the anal canal, plays a fundamental role in maintaining faecal continence. These structures assist in differentiating the type of faecal content of the anal canal through the anorectal sampling mechanism or reflex. This function is only possible because there is a large network of nerve endings.[4] The removal of haemorrhoidal tissue aggravates this delicate anatomy and is therefore a medical procedure potentially associated with severe postoperative pain.

Pain management is a sign of surgical advances. Over a long time, a lot of work has been put into controlling pain in other surgical procedures, and this is especially so in this type of surgery.[3,5] In spite of this, courses of painkillers are still not adequate today. Worse still, patients and in some cases, specialists consider that the pain associated with the treatment of this condition is inevitable.[3,5] That is why both parties doubt the possibility of being able to perform this surgery without hospital admittance.[2]

The results of a systematic review of the scientific evidence available on postoperative pain management for haemorrhoidectomy have been published recently. This study has highlighted the clinical benefits of using a comprehensive postoperative pain management programme, which includes the use of a suitable preoperative preparation, perianal infiltration with local anaesthetics, and lastly, the correct combination of painkillers, as according to the pain scales.[6]

Random clinical trials analysing painkiller treatments, anaesthetic procedures, or surgical interventions were included in this review article. The main objective of the trials included was to evaluate postoperative pain management after surgery for haemorrhoidal disease. Only the studies that complied with a number of quality indices were selected, principally those based on following regulations published in accordance with the CONSORT criteria. Furthermore, after reviewing the studies published, the PROSPECT working group (Procedure Specific postoperative pain management, www.postoppain.org) selected the resulting clinical information to be recommended by consensus of all the experts of the working group.

A total of 65 articles out of 207 assessed were included. Even though one of the most important limitations of the review was that the quality of the methodology was very variable, the resulting information is highly recommendable from a practical point of view.

The most important points of the information obtained from the systematic review are: firstly, procedures with local anaesthetics, on their own or as an additional treatment, are very effective at managing pain. This is especially true for the procedures that use long-lasting anaesthetics (ropivacaine). Due to ease of administration, perianal injection is considered preferable to using more precise techniques (for example, a pudendal nerve block). Secondly, and even though it may seem obvious, using Paracetamol as the sole painkiller should be avoided. That is why the combined use of drugs is recommended, amongst which are anti-inflammatory drugs (assessing the risk of gastroduodenal haemorrhage), and the possible combined use of opioid drugs in cases of moderate or severe pain. Finally, using manoeuvres in preoperative preparation as well as during follow-up which have proved to be effective in managing pain is also advantageous; for example, the controlled use of laxatives prior to surgery or administration of oral metronidazol.[6]

In conclusion, there is sufficient scientific evidence to recommend the use of a comprehensive pain management programme after haemorrhoidal disease surgery. An adequate preoperative preparation, use of infiltration with local anaesthetics, and administration of combined painkillers should be included in this programme. In this way, we might be able to remove the terrible association between surgery for haemorrhoidal diseases and postoperative pain and thereby make this process more common as an outpatient surgery.

REFERENCES

1. Helton WS. 2001 consensus statement on benign anorectal disease. J Gastrointest Surg. 2002;6:302-3.
2. Faiz OD, Brown TJ, Colucci G, Grover M, Clark SK. Trends in colorectal day case surgery in NHS Trusts between 1998 and 2005. Colorectal Dis. 2008;10:935-42.
3. Wexner SD. The quest for painless surgical treatment of hemorrhoids continues. J Am Coll Surg. 2001;193:174-8.
4. Thekkinkattil DK, Dunham RJ, O'Herlihy S, Finan PJ, Sagar PM, Burke DA. Measurement of anal cushions in idiopathic faecal incontinence. Br J Surg. 2009;96:680-4.
5. Raja SN, Jensen TS. Predicting postoperative pain based on preoperative pain perception. Are we doing better than the weatherman? Anesthesiology. 2010;112:1311-2.
6. Joshi GP, Neugebauer EA. Evidence-based management of pain after haemorrhoidectomy surgery. Br J Surg. 2010;97:1155-68.

David Parés

Servicio de Cirugía General y del Aparato Digestivo, Parc Sanitari Sant Joan de Déu, Sant Boi de Llobregat, Barcelona, Spain

E-mail address: david.pares@pssjd.org