MR 811

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MAIN SUBJECT HEADING:

AN	HU	AT	IH	M
ANALYTICS	HUMAN EFFECTS	ANIMAL TOXICITY	WORKPLACE PRACTICES-ENGINEERING CONTROLS	MISCELLANEOUS

SECONDARY SUBJECT HEADINGS: AN HU AT IH M

- Physical/Chemical Properties
- Review
- Animal Toxicology
- Non-occupational Human Exposure
- Occupational Exposure
- Epidemiology
- Standards
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- Biological Monitoring
- Methods of Analysis
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MR 811

DESICCATION OF HEMORRHOIDS *

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The method I suggest will successfully eradicate hemorrhoids, (1) without a major operation, (2) without the use of the knife, (3) without hospitalization, (4) without loss of time, (5) without a general anesthetic. (6) without the severe postoperative pain and discomfort. (7) without the dangers incident to hemorrhoidectomy.

I have operated on hemorrhoids by about every method I have seen or read about, but for the last thirteen years I have come to the conclusion (subject to correction, of course) that ordinary hemorrhoids are best treated by the desiccating current and that they should never be operated on with the knife.

Let us visualize the course of many patients who undergo a typical operation for piles: Hospitalization from ten to fourteen days, occasionally even for five weeks, rigors of general anesthesia, and postoperative pain. Patients able to return to work within three weeks to a month are fortunate.

I have often wondered how long suffering these patients can be. It is fairly common for them to tell me that their condition has been present as long as 20 years.

The situation is different with the method I advocate. Visualize the course of the patient who has his piles removed by the use of the desiccating needle. He comes to the office, the hemorrhoids are destroyed under local anesthesia. He or she gets off the table and goes home. They are given instruction as to postoperative care, and are advised to remain in bed, or at least stay at home, for three days. I tell them that it is most likely that they will not have much more pain than they have been suffering every day. It is not necessary to see them again, but I request them to come to the office in about a month to see if I have missed any small tag.

Age does not seem to make much difference. I have operated on patients ranging from 20 to 86 years.

I make use of the monopolar Oudin coil and desiccate. I believe that the resultant scar, if any, is smaller and more elastic than is seen after coagulation, at least the end results appear to be fully satisfactory.

Physical Examination. — When a patient presents himself suffering from hemorrhoids, thorough examination of the affected area may prove difficult at times, as it is usually only when the hemorrhoids are acutely inflamed and tender that a patient is driven to seek aid. As far as the operation is concerned it does not matter what type of piles one has, but it is essential to make sure that there is no local growth, which by pressure causes the hemorrhoids. Small fissures, if overlooked, are liable to cause severe postoperative pain. A general physical examination should be a routine procedure to establish the cause of the hemorrhoids. The prostate, too, should be palpated.

Care must be taken before advising removal of hemorrhoids to ascertain that there is no other serious disease of the rectum — such as cancer — or that the piles are not dependent on such local conditions as enlargement of the prostate, uterine fibroids, hepatic or cardiac disease, when an operation might be harmful or at least injudicious.

Have the lower bowel empty. A laxative the night before usually suffices. Morning enemas have not proved satisfactory, except when the evening laxative does not give a good morning evacuation. When the patient first presents himself in the morning a sedative is administered. I usually give about two grains of phenol barbital in half a glass of hot water.

The patient is then placed on the operating table in the left side position. The anal region is washed with soap and water. The gloved left index finger is then placed in the rectum as a guide for the needle in injecting of the anesthetic.

Anesthesia.—For each patient I have freshly prepared, about two (2) ounces of one per cent novocaine solution, with about four

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minims of adrenalin added. I believe the adrenaline helps to prolong the anesthesia. I use a 20 cc. syringe with a 1½ inch, 22 gauge needle.

The skin is pierced by the hypodermic needle at the anterior anal margin and is carried up to and into the sphincter ani muscles, injection of the fluid being made as the needle enters. The needle is then almost withdrawn and its direction changed so that it is pushed laterally and posteriorly on either side of the anal margin.

The needle is then completely withdrawn and a similar injection made at the posterior anal margin.

I prefer to inject both the external and internal sphincter muscles fairly well as they are thereby paralyzed, making it much easier to manipulate the piles and insert the speculum. One should avoid injecting the levator ani muscles.

Operation. — In a very few minutes the sphincter muscles relax around the surgeon's finger and the external and semi-external piles can be easily turned out and a good view of them obtained. They are now ready to be desiccated.

Any diathermy machine with a good Oudin coil attached is suitable. I use ordinary sewing needles from two to four inches long. They can be held with any good holder with cord attached. The current is now turned on and the spark gaps adjusted so that the current will be of a strength to throw a spark about ⅛ inch in length. Under good light, insert the needle into the base of the pile about ⅛ inch from its margin and turn on the current by use of the foot switch. Hold the needle steady until there appears an area of desiccation, in the form of a dirty grey color around the needle. It is only by experience that one learns the proper degree of desiccation to obtain. It is best to first experiment on raw meat in order to prevent the tissues from becoming carbonized by too much current.

In external and semi-external piles it suffices to desiccate around their base, leaving them to gradually slough off.

Internal piles have to be desiccated through a speculum. I use round glass specula of different sizes and lengths. Desiccate as much of the base of the interior piles as can be reached, I think it would be just as well to go over their whole surface. Insert a haemorrhoidal suppository and the operation is completed.

Postoperative Treatment. — The postoperative treatment is very simple. For pain I prescribe a tablet containing an antipyretic and a half grain (½) of codein.

Mineral oil emulsified with the seaweed agar agar is ordered as a combination best preventing seepage from the bowel, and promoting a gentle and soft bowel motion least irritating to the inflamed parts.

After the initial contraction of the piles there follows a reaction which causes swelling of the parts, and with large external piles the patient may be unable to replace them for about two days. (If these become painful, hot foments or sitting in a hot bath generally give relief.) By that time contraction starts to take place, the swelling goes down rapidly and the piles can be replaced with ease.

The following points may prove of some interest:

The Discharge From the Bowel. — For the first few days there will be a bloody discharge from the bowel which may prove alarming to the patient unless he is forewarned, because it looks to the patient as though he is losing a great amount of blood. What really happens is that the piles throw out quite a large amount of fluid which is mixed with the blood clot in the piles, and is squeezed out as they contract.

Making the Injection. — When making an injection of the anesthetic into the anterior anal margin of male patients one should be careful to keep the needle just under the mucosa of the anal canal and close to the guiding finger and not to inject too much solution. If the needle is thrust too far forward one may inject either too close to the urethral bulb or actually into it. This causes a reaction either in the bulb itself or around its area, or even into the lower part of the prostatic gland, and results in dysuria.

Prolapse of Anus. — In some cases with a slight prolapse of the anus, say not more than a quarter of an inch, the condition can be corrected by desiccating around the lower part of the anal canal making a shallow ring about ⅛ inch wide. The contraction of this healing tissue along with the contraction of the healing pile area, tends to draw the prolapsed tissue back into place.

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