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CORRESPONDENCE

Long-term results of stapled hemorrhoidectomy

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Dear Sir,

We want to thank Du and colleagues [1] for the interest shown in our paper and would like to respond to their comments which highlight some interesting issues.

Our paper [2] analyzed the long-term results after stapled hemorrhoidopexy (SH) and not stapled hemorrhoidectomy, which is basically different. Stapled hemorrhoidopexy includes the hemorrhoids in the resection specimen while hemorrhoidopexy only removes a rectal sleeve. Regarding the analysis of postoperative fecal incontinence, we used the Fecal Incontinence Severity Index (FISI) score (range 0–61) which analyzes the frequency of symptoms giving a final score, as for the Cleveland Clinic Florida Fecal Incontinence Score (CCF-FIS). We also reported the time symptoms appeared, which was mainly within the first year after surgery, proposing how to treat these symptoms as soon as possible. Only 30% of the symptomatic patients after SH agreed to undergo pelvic floor rehabilitation, and the improvement rate was 80%.

Concerning the Goligher grade as an indication for stapled surgery, we did not exclude grade IV patients from the pool of patients treated between 2003 and 2005 because there were no grade IV patients treated with a stapled procedure. Due to our initial experience with stapled surgery in that period we did not use it to treat grade IV hemorrhoids.

However, the main problem is the definition of Goligher grade IV, which is characterized by the irreducibility of hemorrhoids [3]. Since SH is an operation that lifts and reduces the hemorrhoidal tissue inside the anal canal, the presence of irreducible hemorrhoids should not be considered as an indication for surgery. In our opinion, with the evolution of surgical techniques for hemorrhoids, the Goligher classification is losing value. We agree, that SH can be a good solution even for fourth degree hemorrhoids, where irreducibility must be seen as a preoperative clinical symptom and not a sign that the hemorrhoid(s) cannot be reduced with a surgical procedure.

In our study, we clearly described the type of stapler that we used: PPH03. However, we do not think that the difference between PPH01 and PPH03 due to the height of staples influences the recurrence rate though it might have an impact on the postoperative bleeding rate.

Regarding the treatment of symptomatic prolapse recurrence, it was not the aim of our study to define which kind of surgery to perform. We reported only that 9.3% of the patients with recurrence needed further surgery. This topic was also analyzed in the letter from Mascagni et al. [4] in which the authors emphasized the importance of a correct indication to reduce the recurrence rate. Furthermore, evaluation of postoperative pain (visual analogue scale) was not reported because our study was based on phone questionnaires, administered 12 years after surgery. We reported the persistent anal pain related to stapled procedure because our aim was to analyze long-term results and not the immediate postoperative results.

We believe that the published paper focusing on a very long-term follow-up after SH reported in detail the outcomes and the possible complications, and also how to treat them. It revealed that SH using the first-generation devices is safe and feasible but associated with a high recurrence rate in the long term.

Author contributions Alessandro Sturiale and Gabriele Naldini contributed equally to the conception, the drawing up, the critical revision of the manuscript and to the approval of the version to be published of the correspondence.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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Ethical approval This article does not contain any studies with human participants performed by any of the authors.

Informed consent For this type of study, formal consent is not required.

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