

## Abstracts of Session 2c

### Free papers on proctology and phlebology

#### 2c1

##### Outpatient proctological surgery: experience of the last year

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Many proctological surgical procedures can be considered on an outpatient basis. These concern the anal margin, anal canal and lower rectum. Patient selection is mandatory. At the I Surgical Clinic University of Turin, during the last year (November 1999–October 2000) 259 surgical procedures involving the anal canal were performed on outpatient basis. The diseases treated were subdivided as follows. Haemorrhoids 43 cases (II degree: four pts; III: 15 pts; IV: 24 pts); skin tags 24 pts; incision of external thrombosed piles in six pts; anal fissures 34 pts; pilonidal sinus 16 pts; anal fistulas 26 pts (mainly low-medium inter-trans-sphincteric ones); abscesses incised in seven cases; cryptitis one case; condyloma acuminatum 56 cases; polyps neoplasms 21 cases; stomal stenosis polyps three pts; anal papilla 18 pts; others four. All patients were positioned in Sims' position and were submitted to a local anaesthesia with Lidocaine or Marcaine. In all cases except 2 (0.7%) the treatment was complete. In one case, a rectal polyp, the lesion was removed only partially and needed a second look in operating room. In a second case during the excision of the first haemorrhoidal pile the patient had an important bradycardia that requested the control of a cardiologist the recovery in our Department and the end of the surgical treatment in operating room. Complications were observed in 7 patients (2.7%): one Fourniere's gangrene; one haemorrhage (treated as outpatient procedure); one infection (after SLI); three delayed healing; one minor incontinence (in a high fistula treated with seton). No case of urinary retention was recorded and no mortality. All patients were followed in our ambulatory for 1–2 h and then discharged with a paper on postoperative period including drugs and the personal telephone number of the surgeon. In conclusion ambulatory surgery offers advantages as the patient's life is only minimally disturbed and anxiety is diminished; patients return earlier to normal activities and the time off work is reduced; the cost of outpatient surgery is less than inpatient one; and the hospital beds can be occupied by more severe cases all assuring the same safety and radicality in the treatment of the diseases.

#### 2c2

##### Outpatient haemorrhoidectomy: our experience

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Haemorrhoids are the most frequent disease seen in a coloproctological Department. We suggest that only symptomatic haemorrhoids

should be treated, and this could be conservative or surgical and in our experience is also guided by the worldwide accepted classification based on the four degrees. In I and II degrees, conservative treatment or outpatient procedures (rubber band ligation, infrared coagulation, etc.) are suggested while in IV and advanced III degree surgical treatment is advocated. Surgery is the most radical treatment and presents a low incidence of recurrence. Many techniques are proposed: closed hemorrhoidectomies or open ones. Economic policy and long waiting list induced our Department to perform an office haemorrhoidectomy. At the I Surgical Clinic University of Turin from January 1989 to October 2000, 2831 pts suffering from haemorrhoids were visited. Of these, 1811 pts (63.9%) were treated with conservative therapy or with minor operative procedures, while 1020 pts (36%) were treated surgically: 578 pts (56.7%) as an outpatient procedure and 442 pts (43.3%) as an inpatient one. We performed Milligan Morgan technique in almost all patients. All patients treated in office were submitted to a local anaesthesia: lidocaine 2% in 944 of them. The injection of anaesthetic was performed in the intersphincteric space and subcutaneously. All patients were located in left lateral position. Outpatient treatment was excluded in patients affected by psychiatric diseases, coagulopathy, major disorders of heart, kidney, liver, lung, metabolic disorders, obesity and those with referred episodes of allergy to local anaesthetics or great complete circumferential haemorrhoidal prolapse. Complications occurred in 11 pts (1.9%): six hemorrhages; two urinary retentions; one infection; one important bradycardia; one delay in healing. Median healing occurred within 3–4 weeks after surgery. Postop. pain was treated with oral or i.m. analgesics. In conclusion we suggest outpatient haemorrhoidectomy as the gold standard in treating haemorrhoids in well selected patients, considering its radicality (equal to operating room) and the same frequency of complications with an important reduction of costs.

#### 2c3

##### Impact of circumferential mucosectomy with stapler for hemorrhoid and/or anorectal prolapse on day surgery

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**BACKGROUND:** Less postoperative pain and complication is vital as well as achieving symptoms control for day case haemorrhoidectomy. We have adopted the technique of circumferential rectal mucosectomy with stapler (Longo's technique) (CM) for third degree haemorrhoids and incomplete prolapse of anus, and compared with conventional haemorrhoidectomy (Milligan-Morgan) (MM) on degrees of postoperative pains and recovery.

**METHODS:** We assigned 85 patients to CM (38 patients) or to MM (47), as either day surgery (24 patients; 15 patients in CM, 9 in MM) or inpatient (61; 23 in CM, 38 in MM) after the interview. We used a stapling device (PROXIMATE, HCS) for CM. Patients went home on the same day or were discharged when free of pain, took analgesic tablets for 3 days. Degree of postoperative pain was divided into complete pain free (grade 1), pain existed with self-limited (grade 2) and pain requiring supplements (grade 3). They were assessed at 1 and 4 weeks postoperatively.

**RESULTS:** In day surgery, patients with CM experienced significantly less pain, compared with MM (87% with grade 1 and 2 vs. 22% with grade 1 and 2), and returned to normal activities including occupation sooner (3.1 vs. 6.9 days). There needed no washing nor cleansing on every defecation in CM group. In inpatients, mean inpatient stay was lower in CM group, as opposed to MM (2.9 vs. 4.8 nights), with less pain (92% with grade 1 and 2 vs. 16%). CM controlled symptoms of bleeding and original pain in all with haemorrhoid, and prolapse in most patients (10 of 12).

**CONCLUSION:** Circumferential mucosectomy with stapler advanced haemorrhoid with anal prolapse in day surgery.

#### 2c4

##### Ambulatory phlebosurgery

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**INTRODUCTION:** The basic part of the patients with varicose veins has got the treatment in hospital, smaller part — on ambulatory base. Our experience showed that with contemporary organisation could get radical treatment in one of medical structure — centred of ambulatory surgery.

**PRESENTATION OF THE PURPOSE:** Indications have been developed for types of treatment in the conditions of 'one-day surgery' for primary varicoses: sclerotherapy, phlebectomie ambulatoire (methode de Muller), short stripping, endoscopic dissection of the incompetent perforating veins (EDIPV).

**MATERIAL AND METHODS:** During last years in CAS RAS 1400 patients have got surgical treatment of varicose veins, which consist of crossectomy, dissection of perforating veins (K. Storz — endoskope), catheterisation of short or long safenous veins with injection of 1–2% Aethoxysclerol under permanent compression. The diagnostic, pre-, intra- and postoperative control were performed by ultrasound method (SonoSite, USA).

**RESULTS:** Varicose vein disease was successfully treated in the all courses. There were no complications during operation and in post-operative period, there was absence of safenous nerve injury. Skin hyperpigmentation after injection of Aethoxysclerol disappeared during the first year. Small sections and intracutaneous sutures obtain high cosmetic effect. Duplex scanning control showed absence of blood flow in veins, low level of relapses.

**CONCLUSION:** Vascular surgical treatment of the primary varices at the centre of out-patient surgery is a reasonable combination of an operation and sclerotherapy, which provides for the disease elimination radically. Ambulatory phlebosurgery is the mini-invasive cosmetic method also is economically effective.

#### 2c5

##### Minimally invasive surgery (ambulatory phlebectomy) in the treatment of varicose veins

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Ambulatory phlebectomy is a relatively new method in the treatment of varicose veins. Using this protocol, an atraumatic small

headed stripper is turning the vein inside out and is basically peeled out from soft tissues of the leg. No trauma is afflicted to the surrounding soft tissues.

The aim of our work was to show results in the treatment of varicose veins using ambulatory surgical protocol during the period from 1.1.1999 to 30.6.2000 at our Department of Vascular surgery, Clinical Centre Ni{.

Prospectively we have analysed a group of 36 patients who underwent his surgical procedure. Male:female ratio was 1:2 with median patients age of 49.3 years (22–66 years). All patients (100%) were operated in loco-regional anaesthesia. We have analysed: operating time, postoperative complications, recovery time and return to work, the need for postoperative analgesia and the cosmetic effect.

The average operating time was 50 min per leg (40–100 min). We have registered no postoperative complications. The average hospitalisation was 8 h (6–14 h) and most patients went back to work after 7 days (3–14 days). A number of 12 patients (33%) did not need any postoperative analgesia and the cosmetic effect was much improved compared with standard procedures.

The advantages of ambulatory phlebectomy are simplicity, practically no postoperative complications, short hospitalisation period and early return to work.

In conclusion, ambulatory phlebectomy is a minimally invasive procedure and by avoiding general anaesthesia, hospital setting and convalescence it is also a very cost efficient procedure as well.

Type	Oral communication	Poster	Video	Other
Tools needed	35 mm slide	Video	Overhead projector	Computer

#### 2c6

##### Duplex power phlebography (DPP) in ambulatory phlebosurgery practice

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**INTRODUCTION:** Is to show the necessity and efficiency of DPP in diagnosis and ambulatory surgery of varicose veins.

**PRESENTATION OF THE PURPOSE:** Our data indicate that DPP is an efficient and accurate method for depicting pathogenetic mechanisms of varicose veins disease and should be used in routine practice of phlebologist.

**MATERIAL AND METHOD:** Was developed simple and miniinvasive method (sclerosurgery, SS) for outpatient treatment of primary varicoses. SS includes crossectomy, Cocket-procedure (SEPS) and catheter sclerotherapy of long or short safenous veins by Aethoxysclerol (Kreussler). Diagnosis of disease was carried out by means of duplex power scanning (B&K Medical, Panther-2002, SonoSite, USA) with 7–8 MHz transducers sensitive for low velocity of blood flow. The operated limbs were evaluated by DPP in all stages of treatment: pre-operative mapping, intraoperative visualisation and post-operative dynamic control. We performed 2190 DPP in 730 patients.

**RESULTS:** The pre-operative DPP allows: (a) to diagnose pathogenetic mechanisms of varicosity; (b) to detect anatomical variations of incompetent perforants and junctions; (c) to make the cartography of the reflux-mode of primary varicoses. Intra-operative step ensures visualisation of catheter moving and controls sclerosant introduction in superficial venous system. Post-operative dynamic control evaluates the quality of surgical manipulations and superficial vein obliteration.

**CONCLUSION:** Together with miniinvasive surgical and sclerotherapy treatment, DPP helps to ensure radical and its aesthetic result of treatment varicose veins in the centre of Outpatient Surgery.

## 2c7

### One-day surgery of varicose veins — early results

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Varicose veins resection is one of the most common procedures a vascular surgeon performs today. Surgical treatment of varicose veins on a day-case basis has the advantage of the early return of the patient to his usual activities, thus also reducing the cost and occupation of hospital beds. The purpose of our study is to evaluate the early results of the one-day surgery of varicose veins.

Between 1996 and 1999, 1910 patients with primary varicose veins in 2500 legs were operated as outpatients. From these patients 357 (18.7%) were males and 1553 (81.3%) were females. The diagnosis was based mainly on clinical examination, while further investigation included doppler ultrasound, triplex scanning and/or phlebography. The type of operation was based on the localisation morphology and stage of the disorder. The surgical therapy was depended on two principles: resection of affected segments only, and functional operation according to the hemodynamic parameters. The patients were admitted in the hospital the day of the operation and operated on with epidural anaesthesia. The average operation time was 35 min. Two hours after the operation, the patients started walking freely and after the fourth postop hour, they were able to return to home.

Immediate complication were injury of the common peroneal nerve in one case and in another injury of the posterior tibial artery. Activation of coexisting lymphedema was noticed in two cases and in another patient edema was presented due to venous thrombosis (the patient received anticoagulant therapy). In nine patients showed pseudolymphatic fistulas, which subsided after elastic bandaging. At the end of the first trimester 1755 patients (91.9%) reported satisfactory results with or without additional sclerotherapy.

One-day surgery of varicose veins has good results, led to rapid rehabilitation and return of the patients to his usual working program.

## 2c8

### Operation for recurrent sapheno-femoral incompetence in a day surgery unit

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**INTRODUCTION:** Operations for recurrent sapheno-femoral incompetence can be difficult and bloody procedures. The following technique, proposed by Nabatoff and Li, facilitates the re-ligation of the sapheno-femoral junction.

**PURPOSE:** To evaluate feasibility, safety and results of this operation in a day surgery unit.

**METHODS:** Consecutive patients (27), with recurrent varices have been treated in this department between 1993 and 2000. All patients had previously undergone flush ligation of the sapheno-femoral junction,

associated with stripping of the long saphenous vein. All patients with recurrent varices underwent clinical and duplex examinations. We operated on symptomatic patients with a duplex scanning demonstrating reflux emanating from the femoral vein. All re-operations were performed under selective subarachnoid anaesthesia on a day surgery basis. In 15 patients, a longitudinal skin incision was made in the groin over the femoral pulse. In 11 patients an inguinal incision was done just above the previous one. The dissection is then deepened through the fascia to expose the femoral artery and directed medially to expose the femoral vein above and below the sapheno-femoral junction. The stump was ligated and the junction divided. All patients had multiple phlebectomies and were discharged on the same day of operation: seven ones subsequently underwent sclerotherapy for residual below knee varices.

**RESULTS:** Our follow-up varies from 1 to 108 months. One patient developed superficial infections, two hematomas in the groin wounds and one lymphorrhea. A number of 25 limbs revealed no evidence of persistent sapheno-femoral incompetence both on clinical and duplex examinations. We observed no major complications. All patients were regularly followed up every 6 months and a simple questionnaire was submitted. A number of 26 (96.2%) patients were satisfied and observed clinical improvement; one patient had no benefit and none a worsening of the symptoms.

**CONCLUSIONS:** Operation for recurrent varices is a major surgical act. The technique described allows a dissection through normal tissue thus avoiding the scar and permits early control of the femoral vein. Good results can so be safely obtained on an outpatient basis.

## 2c9

### How to simplify post-operative controls and wound care on operated varicose veins

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The objective of our study was to simplify post-operative care for the patient by offering a comfortable and secure dressing, which would limit post-operative visits to the centre. **METHOD:** Surgery was performed on 300 patients. Incisions were made in the inguinal regions and on one or both legs with a resorbable intra-dermic stitch. Steristrips® were placed on the leg incisions and covered with a semi-permeable film. A thin hydrocolloid dressing covered the inguinal regions.

All patients were controlled ensuring for each; one post-operative visit at 24 h where we evaluated wound and skin conditions, odor, pain and patient satisfaction. The same control was undergone on the tenth day to remove the Steristrips® and the dressings. **RESULTS:** Out of the 300 patients we found the following disadvantages in the use of such dressings for three cases; nauseating odor, blisters produced by tension on the setting of the film and maceration with pus.

Patient satisfaction was high, there were no complaints about pain. Comfort and security was appreciated as well as the possibility to have a shower.

**CONCLUSIONS:** This dressing technique clearly simplifies outpatient post-operative follow up for the medical and nursing teams. The reduction of health costs is a direct consequence. The following advantages were objectivated; eased visual control, a non-traumatic dressing change in a period of 10 days and finally, no stitches to take out! The quality of the scarring is good.