

## Hemorrhoidal Laser Procedure (HeLP): A Painless Treatment for Hemorrhoids

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### Abstract

**Introduction:** Hemorrhoidal disease is associated with the theory of arterial blood hyperflow causing swellings in hemorrhoids and, consequently, hyperplasia and venous congestion. The technique helps to promote the obliteration of the terminals of the superior rectal artery branches without the need for anesthesia by electrofulguration with diode fiber LASER. The objective of this study is to describe the results of 55 patients with hemorrhoidal disease treated by the Hemorrhoidal LASER Procedure technique.

**Method:** Without the need of anesthesia, terminal arterioles of the upper rectal artery are identified by a Doppler transducer (20 MHz probe 3 mm) placed on a specially designed proctoscope. After identification, it promotes arteriolar electrofulguration at 980 nm fiber laser diode, causing interruption of hemorrhoidal flow. This procedure is repeated circumferentially, following the clockwise positions.

**Results:** Between 2011 and 2014, 55 patients underwent the Hemorrhoidal LASER Procedure technique for hemorrhoidal disease grades I, II and III. There was no need for anesthesia and only two patients required sedation for the procedure. The overall satisfaction rate was 89%, with symptom resolution in 84% and a decrease of at least one grade in hemorrhoidal disease in 80% of cases.

**Conclusion:** Hemorrhoidal LASER Procedure is a painless outpatient technique that does not require anesthesia, in addition to being safe and easy to perform. It is effective in reducing symptoms and complications of the hemorrhoidal disease grades I and II, with high satisfaction rates.

**Keywords:** Hemorrhoids; Hemorrhoidal LASER procedure; Hemorrhoidal dearterialization

### Introduction

Hemorrhoidal disease affects a large part of the world's population. The prevalence in the United States is approximately 4.4% [1]. The disease is associated with the vascular theory of arterial blood hyperflow, causing dilations in the hemorrhoidal plexuses and, consequently, venous hyperplasia and congestion [2].

In 1995, a Doppler (Moricorn) was used in the assessment and after the arterial flow identification, a high ligation was made in these branches, reducing the blood gradient reaching the hemorrhoidal plexus [3]. Based on this principle, several techniques that require anesthesia have been developed, such as mechanical anopexy and transanal hemorrhoidal dearterialization (THD) [2,4,5].

In search for a surgical technique for hemorrhoidal disease with less postoperative pain, Salfi et al., [6], described the Hemorrhoidal LASER Procedure (HeLP) technique. It is a minimally-invasive technique, which does not require anesthesia, and consists in the identification of the terminal branches of the rectal artery through a Doppler, followed by photocoagulation of these branches using a 980 nm LASER diode fiber [6,7].

This publication aims to describe 55 cases in which the HeLP technique was used. A three-year follow-up was carried out, analyzing clinical and functional aspects of patients operated by the same

surgical team, evaluating pre- and postoperative symptoms, characteristics of the studied population, description of the technique used, need for anesthesia for the procedure and the overall satisfaction index related to the technique.

### Material and Method

Between 2011 and 2014, 55 patients were submitted to the HeLP technique, by the same surgeon, for hemorrhoidal disease grades I and II, or grade III with little mucosal prolapse. Grade IV or grade III hemorrhoids with large mucosal prolapse identified during outpatient proctologic examination were excluded from the study. Data were prospectively collected and analyzed.

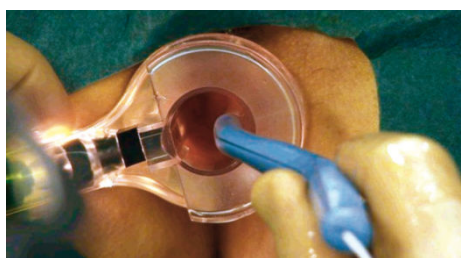
Before undergoing the surgical procedure, the patients were submitted to colonoscopy or rectosigmoidoscopy to exclude other possible causes of bleeding.

The patients signed the free and informed consent, which explained about the procedure to be performed. The patients were evaluated on days 7, 30, 90, 120 and 180 postoperatively. The visual analog scale (VAS) of pain was applied two hours after surgery in all patients and a retrograde questionnaire was applied on the day 7 postoperatively. Anoscopy was performed to evaluate internal hemorrhoids after 30 days postoperatively. Quality of life assessment was questioned after the third postoperative month. Control Doppler evaluation was performed in all patients, after 120 days, postoperatively.

### HeLP technique

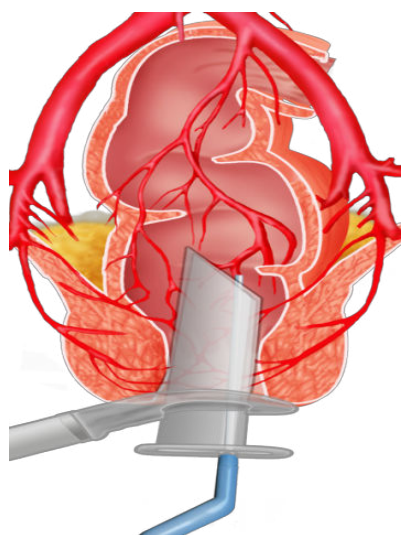
The patient is placed in the lithotomy position, without the need for any type of anesthesia. Only two cases required analgesia, per the patient's request. Antibiotic prophylaxis with cefazolin was used in all cases.

A proctoscope that was specially designed for the HeLP technique is placed in the patient's distal rectum. The terminal branches of the superior rectal artery are identified at 3 cm from the pectinate line through a Doppler transducer (20 MHz, 3-mm probe) located in a small working window drawn on the proctoscope (Figure 1).

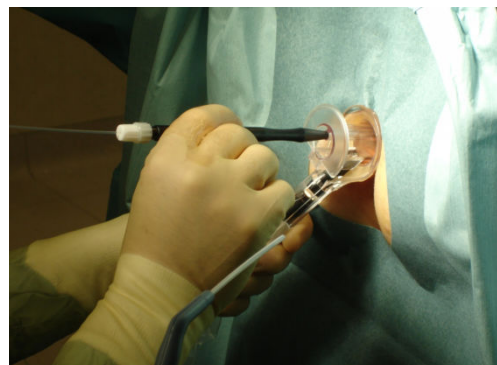


**Figure 1:** Identification of terminal arterioles through Doppler use.

After identification of the arterioles, the Doppler is withdrawn and the 980 nm LASER optical fiber is introduced in the same locus (Figure 2). The Leonardo laser-diode device used in our study was calibrated with a power of 13 W. Interruption of the artery supplying blood flow is performed by activating LASER energy through the optical fiber. First, two operator-controlled shots are performed, at 2 mm from the mucosa, to promote scorching of the latter, followed by three preset shots for arterial obliteration (Figure 3). Each shot lasts 1.2 s, with a 0.6 s interval between them.



**Figure 2:** Identification of arterioles.



**Figure 3:** Arterial obliteration using 980 nm LASER fiber optics.

The method efficacy is evaluated again by Doppler shortly after the last LASER shot and, if the flow persists, a new shot is carried out at the same site. There may be persistence of the arterial flow, and in this case, we believe it to be resonance of the larger peri-rectal arteries.

A clockwise rotation of the rectoscope allows the identification of all branches of the superior rectal artery. In this way, the position of the clock hours is followed, checking at 1, 2, 3 O'clock and so on. A maximum of 12 branches can be treated at the same surgical procedure.

### Results

Characteristics	Patients (n=55)
Mean age (years)	45,5 (22-67)
Gender (%)	
Male	49%
Female	51%
Hemorrhoid grade (%)	
Grade I e II	80%
Grade III	20%
Previous surgeries (%)	
Rubber band ligation	14%
PPH	4%
THD	2%
Main symptoms (%)	
Bleeding	73%
Previous acute episodes (thrombosis)	11%
Anal discomfort	9%
Pruritus	7%

PPH: Procedure for prolapse and hemorrhoids (PPH); THD: Transanal hemorrhoidal dearterialization.

**Table 1:** Patient characteristics.

The HeLP technique was applied to 55 patients, 28 women and 27 men, with a mean age of 45 years (22-67 years). Most the population submitted to surgery (44 patients) was classified as having hemorrhoids grades I and II and 20% of the sample had grade III hemorrhoids at diagnosis (Table 1).

Eleven patients had previous surgeries for treatment of hemorrhoids (8 rubber band ligations, 2 PPHs and 1 THD). No patient showed complications due to the previous procedure, only hemorrhoidal disease recurrence (Table 1).

Regarding the surgical indication, 40 patients had hematochezia as the main complaint, 6 patients had episodes of hemorrhoidal thrombosis (acute pain and anal lumps) treated clinically in other services, 5 patients had anal discomfort secondary to prolapse during evacuation and 4 patients complained of anal pruritus (Table 2).

None of the surgeries required the use of anesthesia. The mean surgical time was 9.9 min, ranging from 7 to 19 min. The mean number of branches of the superior rectal artery that were obliterated was 10.1 arterioles (7-12). Only 2 patients were anxious in the preoperative period and we chose to perform sedation with midazolam and fentanyl for the safety of the procedure. Bleeding during the surgical procedure occurred in three patients, but all were treated with LASER fiber, requiring no more invasive maneuvers for hemostasis. No procedure was performed on the external components (Table 2).

The mean visual analog pain scale in the first 2 h was 1.4 (0-3). The mean time between surgery and hospital discharge was 4 h.

At the re-evaluation on day 7 postoperatively, 11 patients complained of self-limited bleeding and 8 patients complained of tenesmus, which showed complete resolution during follow-up. On day 30 postoperatively, 44 of the 55 patients had a reduction of at least one grade in the classification of hemorrhoidal disease.

Characteristics	Patients (n=55)
Time of surgery (min)	9,9 (7 - 19)
Perioperative bleeding (%)	5%
Postoperative pain VAS (mean)	1,4 (0 - 3)
Intraoperative anesthesia	0
Intraoperative sedation (%)	4%
Postoperative tenesmus (%)	15%
Evaluation at 6 months (%)	
Symptom disappearance	84%
Overall satisfaction index	89%
Hemorrhoids volume reduction (1 grade)	80%
min: minutes; VAS: visual analogue scale.	

**Table 2:** Perioperative and follow-up period.

All patients were assessed with Doppler after day 120 postoperatively. We verified that some patients had flow at some of the previously photocoagulated points, albeit not necessarily accompanied by symptom return. The bleeding decreased in all cases for which it was the main complaint. At 180 days, postoperatively, 46 of 55 patients reported symptom disappearance. The overall satisfaction with the surgical and postoperative procedures reached 89%, and 80% of the patients showed reduction of at least one grade of hemorrhoidal disease (Table 2).

## Discussion

The dearterialization of the terminal branches of the superior rectal artery undoubtedly constitutes an efficient way to treat hemorrhoidal disease [2-15].

Several techniques used for the treatment of hemorrhoidal disease seek to balance efficiency and less postoperative pain. The conventional techniques bring fear to many patients [16,17], who refrain from being adequately treated, either due to previous experience, or from reports of friends and relatives.

Current techniques aim to interrupt the flow in the terminal portion of the arterioles, with minimal tissue excision and, consequently, less painful sensation [2-15,18-20] when compared to the so-called excisional or conventional techniques [16,17]. The importance in choosing the technique is paramount to the success in each case.

The HeLP technique is well-established for the treatment of grades I and II hemorrhoidal disease and some grade III cases, where the small prolapse is not part of the complaint. It has been successfully disseminated in the United Kingdom, Italy, Czech Republic, Spain, and Turkey, as well as in Mexico, Argentina and others [6,7,21-23]. Despite our experience described in this study, new publications with larger samples and longer follow-up are necessary, always aiming at achieving excellence in the treatment of these cases.

Giamundo et al., in a comparative study with rubber band ligation for grades II and III hemorrhoidal disease showed less postoperative pain ( $p < 0.001$ ), greater symptom resolution ( $p < 0.001$ ), greater number of patients with a one-grade reduction of hemorrhoidal disease ( $p < 0.001$ ) and better quality of life ( $p = 0.002$ ). Therefore, although it is a higher-cost technique, it has very satisfactory short- and long-term results [21].

It is noteworthy the fact that it is a technique that does not require anesthesia and can be repeated several times, as many as necessary, without causing damage to the anorectal anatomy and physiology. The fact that it does not require anesthesia does not prevent its performance with the aid of sedation or even compound analgesia [6,7,21-23].

Our study was limited to hemorrhoids grades I and II, as well as grade III hemorrhoids with small prolapse, but new studies have demonstrated good results of HeLP use with associated mucopexy when the patient has a large mucosal prolapse [22].

There are also some economic barriers, mainly because it is a relatively new and less disseminated technique in our country, but comparative studies with other existing techniques have reported a higher index of patient satisfaction [6,7,21-23]. This procedure decreases the costs of the hospital stay, which represents an important part of the amount spent with treatment.

We conclude that this is an efficient, painless, ambulatory, and easy-to-perform technique, in which the learning curve becomes small, given the number of times the same procedure of identification and photocoagulation is performed in a single patient.

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