

Circular stapled haemorrhoidectomy

Interventional procedures guidance

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www.nice.org.uk/guidance/ipg34

1 Guidance

- 1.1 Current evidence on the safety and efficacy of circular stapled haemorrhoidectomy appears adequate to support the use of the procedure, provided that normal arrangements are in place for consent, audit and clinical governance.
- 1.2 Clinicians wishing to learn circular stapled haemorrhoidectomy should be trained, mentored and monitored, as described in the Association of Coloproctology's consensus document on the procedure (see the Association's [website](#)).

2 The procedure

2.1 Indications

- 2.1.1 Circular stapled haemorrhoidectomy is used to treat internal haemorrhoids, which develop when cushions of vascular tissue in the anus undergo pathological change. Haemorrhoids may prolapse and cause bleeding, faecal soiling, itching and occasionally pain.

2.2 Outline of the procedure

- 2.2.1 In circular stapled rectal haemorrhoidectomy, a stapler is used to excise an annulus of rectal mucosa above the haemorrhoids. This reduces the size of internal haemorrhoids by interrupting their blood supply, and reducing the available rectal mucosa with the potential to prolapse. By contrast, conventional surgical haemorrhoidectomy involves excision of haemorrhoidal tissue, anoderm and perianal skin.

2.3 Efficacy

- 2.3.1 The studies suggested that patients had less pain and returned to normal activity more quickly after stapled haemorrhoidectomy than after conventional haemorrhoidectomy. In one randomised controlled trial with 84 patients, the average time of return to work was 6 days after the circular stapled technique, compared with 15 days after conventional surgery. For more details refer to the 'Sources of evidence' section.
- 2.3.2 The Specialist Advisors stated that circular stapled haemorrhoidectomy was relatively new, but that an increasing number of surgeons were using this approach. The Advisors considered stapled haemorrhoidectomy to be as effective as the surgical alternative. They noted that there were limited long-term data, and that the durability of the procedure was therefore unclear.

2.4 Safety

- 2.4.1 The studies suggested a lower overall postoperative complication rate with circular stapled haemorrhoidectomy than with conventional haemorrhoidectomy. A systematic review published in 2001 indicated a significant reduction in the risk of bleeding during the first 2 weeks after the procedure. For more details refer to the 'Sources of evidence' section.
- 2.4.2 The Association of Coloproctology's consensus document stated that adverse events were related to the possibility of a full thickness excision to the rectal wall, with the potential for injury to the internal anal sphincter. In addition, stretching of the anal sphincter by the stapler head may, in theory, cause injury.
- 2.4.3 The Specialist Advisors suggested that most of the safety concerns were theoretical and that many of them were not supported by the trials that have been published.

2.5 Other comments

- 2.5.1 It was noted that long-term data were lacking and that the Association of Coloproctology of Great Britain and Ireland is undertaking an audit on this procedure. Surgeons doing this procedure are strongly encouraged to include patients in this audit.

Andrew Dillon
Chief Executive
December 2003

3 Further information

Sources of evidence

The evidence considered by the Interventional Procedures Advisory Committee is described in the following document.

'Interventional procedure overview of circular stapled haemorrhoidectomy', November 2002.

Information for patients

NICE has produced [information on this procedure for patients and carers](#) ('Understanding NICE guidance'). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

4 About this guidance

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedure guidance](#) process.

We have produced a [summary of this guidance for patients and carers](#). Information about the evidence it is based on is also [available](#).

Changes since publication

30 January 2012: minor maintenance.

Your responsibility

This guidance represents the views of NICE and was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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Endorsing organisation

This guidance has been endorsed by [Healthcare Improvement Scotland](#).