A Closed Technic in Anorectal Surgery*

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For several decades it has been customary to leave anorectal wounds (at least cutaneous wounds) open after operation. This has been considered necessary to avoid infection by providing adequate drainage.1, 6, 7

A variety of technics have been employed, but in medical literature only a few reports recommend suturing the wounds completely.2, 5, 6, 8, 9

It is common knowledge that the open-wound technics have two disadvantages—slow healing and excessive pain. In our experience, the average time required for complete healing, employing open methods, has been 28 days.4 We believe that the pain is due, to a considerable degree, to exposure of extensive areas denuded of epithelium. Pain often is felt even without dilatation or defecation.

The present investigation was undertaken to study the risk of infection when the closed technic is employed and to ascertain if it is possible to shorten the time required for healing and to lessen postoperative pain.

Materials and Methods

Two groups of patients with anorectal disease requiring surgical treatment were studied. The first group of 64 patients treated at the Instituto Mexicano del Seguro Social (IMSS), Clínica Núm. 1, in Morelia, Michoacán, underwent anorectal surgery during the period from May 1966 to November 1967. The second group of 192 patients, treated in the Hospital Tecamachalco del Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE) in Mexico City, underwent anorectal surgery from May to November 1967.

In the entire series, there were 132 men and 124 women, whose ages ranged from 15 to 78 years. One hundred ninety-two patients underwent hemorrhoidectomy, 39 had fissurectomies, and 25 had fistulectomies.

Hemorrhoidectomy

Our hemorrhoidectomy technic consists of fusiform resections of each quadrant, or in three segments of the anorectum, to remove larger external and internal hemorrhoids. Fibers of the internal and external sphincter muscles are exposed. Then the adjacent anal margins are undermined and retracted to expose and remove the varicosities from beneath the intervening bands of epithelium. The wound margins are separated to facilitate subsequent mobility necessary for wound closure.

Lock stitches of 000 chromic, atraumatic catgut are introduced into the mucosa. Sutures are tied at the anorectal line, and a continuous whip stitch is used to close the anoderm and perianal skin. In recent patients, however, we have used intradermic sutturing (Figs. 1-5).

Fissurectomy

The operative procedure for fissures consists of fusiform resection of the ulcer, the
sentinel pile, and the associated hypertrophied papilla. A standard procedure consists of retracting the wound margins and extirpating the hemorrhoids in the manner described previously (Figs. 4–6).

Fistulectomy

In all patients studied, rectoperineal fistulas were simple, each having only one secondary opening. To remove them, a probe was introduced along the fistulous tract and a wedge excision was performed. The wounds were then closed, employing the suture technics described previously. In each case, when removing fissures or extirpating fistulous tracts, hemorrhoids are removed also.

Our patients were examined daily during the postoperative period of hospitalization (three to four days) and once or twice a week thereafter until complete healing had taken place. The periods of time required for healing are shown in Table 1. A comparison of the periods required for healing of open and closed wounds is shown in Table 2.

Comments

The most important fact learned in this work was that infection—in the form of either abscesses or perianal cellulitis—is not a necessary consequence of closed technics in anorectal surgery. In our series, abscesses developed in only four patients (1.56 per