

World Journal of *Gastrointestinal Surgery*

World J Gastrointest Surg 2024 December 27; 16(12): 3643-3906



EDITORIAL

- 3643 Obesity-Surgery is not the end
Ma R, Jiang PQ, Liu SY, Yang DQ, Jiao Y
- 3647 Current status and future of hepato-pancreatico-biliary surgery fellowship training in China
Feng YY, Jin Y
- 3650 Advances in minimally invasive treatment of malignant obstructive jaundice
Kang LM, Xu L, Yu FK, Zhang FW, Lang L
- 3655 Preoperative gastric retention in endoscopic retrograde cholangiopancreatography patients: Assessing risks and optimizing outcomes
Zhou NY, Hu B
- 3658 Correct understanding and intervention of postoperative nausea and vomiting can provide reference for clinical practice
Wang JC, Wang L
- 3663 Dexmedetomidine in colon cancer surgery: Evaluating its impact and efficacy
Solanki SL, Sharma J

MINIREVIEWS

- 3666 Evolution of surgical treatment for hepatolithiasis
Ye YQ, Li PH, Wu Q, Yang SL, Zhuang BD, Cao YW, Xiao ZY, Wen SQ

ORIGINAL ARTICLE**Case Control Study**

- 3675 Protective effect of appendectomy against the onset of ulcerative colitis: A case-control study
Cui M, Shi C, Yao P

Retrospective Cohort Study

- 3685 Laparoscopic anatomical SVIII resection *via* middle hepatic fissure approach: Caudal or cranio side
Peng JX, Li HL, Ye Q, Mo JQ, Wang JY, Liu ZY, He JM

Retrospective Study

- 3694 Comparison of endoscopic and laparoscopic resection of gastric gastrointestinal stromal tumors: A propensity score-matched study
Gu BB, Lu YD, Zhang JS, Wang ZZ, Mao XL, Yan LL

- 3703** Efficacy of multi-color near-infrared fluorescence with indocyanine green: A new imaging strategy and its early experience in laparoscopic cholecystectomy
Li JY, Ping L, Lin BZ, Wang ZH, Fang CH, Hua SR, Han XL
- 3710** Onset and prognostic features of anastomotic leakage in patients undergoing radical surgery after neoadjuvant chemoradiation for rectal cancer
Wang L, Zhang WS, Huang GJ
- 3720** Risk factors for lymph node metastasis and invasion depth in early gastric cancer: Analysis of 210 cases
Xiang Y, Yao LD
- 3729** Value of serum pepsinogen ratio screening for early gastric cancer and precancerous lesions in Youcheng area
Han X, Yu W
- 3737** Effects of comprehensive nutrition support on immune function, wound healing, hospital stay, and mental health in gastrointestinal surgery
Zhu L, Cheng J, Xiao F, Mao YY
- 3745** Effect of hyperthermia combined with opioids on cancer pain control and surgical stress in patients with gastrointestinal cancer
Qian J, Wu J, Zhu J, Qiu J, Wu CF, Hu CR
- 3754** Analysis of the efficacy and safety of endoscopic retrograde cholangiopancreatography for the treatment of pediatric pancreatobiliary diseases
Wang XQ, Kong CH, Ye M, Diao M
- 3764** Intraoperative thermostatic nursing and failure mode and effects analysis enhance gastrectomies' care quality
Wang XY, Zhao YL, Wen SS, Song XY, Mo L, Xiao ZW
- 3772** Long-term survival and risk factors in esophageal squamous cell carcinoma: A Kaplan-Meier and cox regression study
Ren ZT, Kang M, Zhu LY, Li P
- 3780** Robotic-assisted Kasai portoenterostomy for child biliary atresia
Xing GD, Wang XQ, Duan L, Liu G, Wang Z, Xiao YH, Xia Q, Xie HW, Shen Z, Yu ZZ, Huang LM
- 3786** Comparative analysis of conventional laparoscopic surgery and single-incision laparoscopic surgery in gastric cancer treatment: Outcomes and prognosis
Cao C, Tian X, Wang XZ, Wang Q
- 3794** Prognostic value of combined systemic inflammation response index and prognostic nutritional index in colorectal cancer patients
Li KJ, Zhang ZY, Sulayman S, Shu Y, Wang K, Ababaik S, Zeng XY, Zhao ZL
- Observational Study**
- 3806** Novel techniques of liver segmental and subsegmental pedicle anatomy from segment 1 to segment 8
Wang SD, Wang L, Xiao H, Chen K, Liu JR, Chen Z, Lan X

- 3818** Diagnostic value of digital continuous bowel sounds in critically ill patients with acute gastrointestinal injury: A prospective observational study

Sun YH, Song YY, Sha S, Sun Q, Huang DC, Gao L, Li H, Shi QD

Randomized Controlled Trial

- 3835** Effects of high-quality nursing on surgical site wound infections after colostomy in patients with colorectal cancer

Cheng Y, Chen YX

Basic Study

- 3843** Zinc pretreatment for protection against intestinal ischemia-reperfusion injury

Cheng MZ, Luo JH, Li X, Liu FY, Zhou WJ

CASE REPORT

- 3857** Recurrent small intestinal perforation from gastric mucosal heterotopia: A case report

Li ZW, Jiang TF, Yang CK, Xu ZJ, Zhu WB, Li E

- 3862** Pathological diagnosis and clinical feature analysis of descending duodenal mucosal adenocarcinoma: A case report

Zhang JY, Wu LS, Yan J, Jiang Q, Li XQ

- 3870** Laparoscopic cholecystectomy with communicating accessory hepatic duct injury and management: A case report

Zhao PJ, Ma Y, Yang JW

- 3875** Pulmonary hypertension post-liver transplant: A case report

Alharbi S, Alturaif N, Mostafa Y, Alfheid A, Albenmoussa A, Alghamdi S

LETTER TO THE EDITOR

- 3881** Therapeutic efficacy of immunotherapy for gastric cancer metastasis

Xie FF, Qian ST, Zhao HY, Liu QS

- 3887** Feeding jejunostomy in post-gastrectomy nutrition management for gastric cancer

Chalkoo M, Habib M, Bhat MY

- 3890** Colorectal cancer lymph node dissection and disease survival

Morera-Ocon FJ, Navarro-Campoy C, Cardona-Henao JD, Landete-Molina F

- 3895** Does lymph node dissection improve the prognosis of patients with colorectal cancer?

Wang L, Liu SS

- 3899** Surgical approach for lower postoperative anal stenosis

Ghanem Atalla AD, Nashwan AJ

3903 Landscape of transarterial chemoembolization represented interventional therapy for hepatocellular carcinoma

Fu YY, Li WM, Cai HQ, Jiao Y

ABOUT COVER

Editorial Board Member of *World Journal of Gastrointestinal Surgery*, Roberto Peltrini, MD, PhD, Surgeon, Research Fellow, Academic Research, Department of Public Health, University of Naples Federico II, Via Pansini 5, Naples 80131, Italy. roberto.peltrini@gmail.com

AIMS AND SCOPE

The primary aim of *World Journal of Gastrointestinal Surgery* (*WJGS*, *World J Gastrointest Surg*) is to provide scholars and readers from various fields of gastrointestinal surgery with a platform to publish high-quality basic and clinical research articles and communicate their research findings online.

WJGS mainly publishes articles reporting research results and findings obtained in the field of gastrointestinal surgery and covering a wide range of topics including biliary tract surgical procedures, biliopancreatic diversion, colectomy, esophagectomy, esophagostomy, pancreas transplantation, and pancreatectomy, etc.

INDEXING/ABSTRACTING

The *WJGS* is now abstracted and indexed in Science Citation Index Expanded (SCIE, also known as SciSearch®), Current Contents/Clinical Medicine, Journal Citation Reports/Science Edition, PubMed, PubMed Central, Reference Citation Analysis, China Science and Technology Journal Database, and Superstar Journals Database. The 2024 Edition of Journal Citation Reports® cites the 2023 journal impact factor (JIF) for *WJGS* as 1.8; JIF without journal self cites: 1.7; 5-year JIF: 1.9; JIF Rank: 126/292 in surgery; JIF Quartile: Q2; and 5-year JIF Quartile: Q3.

RESPONSIBLE EDITORS FOR THIS ISSUE

Production Editor: Zi-Hang Xu, Production Department Director: Xiang Li, Cover Editor: Jia-Ru Fan.

NAME OF JOURNAL

World Journal of Gastrointestinal Surgery

ISSN

ISSN 1948-9366 (online)

LAUNCH DATE

November 30, 2009

FREQUENCY

Monthly

EDITORS-IN-CHIEF

Peter Schemmer

EDITORIAL BOARD MEMBERS

<https://www.wjgnet.com/1948-9366/editorialboard.htm>

PUBLICATION DATE

December 27, 2024

COPYRIGHT

© 2024 Baishideng Publishing Group Inc

INSTRUCTIONS TO AUTHORS

<https://www.wjgnet.com/bpg/gerinfo/204>

GUIDELINES FOR ETHICS DOCUMENTS

<https://www.wjgnet.com/bpg/GerInfo/287>

GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH

<https://www.wjgnet.com/bpg/gerinfo/240>

PUBLICATION ETHICS

<https://www.wjgnet.com/bpg/GerInfo/288>

PUBLICATION MISCONDUCT

<https://www.wjgnet.com/bpg/gerinfo/208>

ARTICLE PROCESSING CHARGE

<https://www.wjgnet.com/bpg/gerinfo/242>

STEPS FOR SUBMITTING MANUSCRIPTS

<https://www.wjgnet.com/bpg/GerInfo/239>

ONLINE SUBMISSION

<https://www.f6publishing.com>

Surgical approach for lower postoperative anal stenosis

Amal Diab Ghanem Atalla, Abdulqadir J Nashwan

Specialty type: Gastroenterology and hepatology

Provenance and peer review: Invited article; Externally peer reviewed.

Peer-review model: Single blind

Peer-review report's classification

Scientific Quality: Grade C, Grade D

Novelty: Grade C, Grade C

Creativity or Innovation: Grade B, Grade B

Scientific Significance: Grade C, Grade C

P-Reviewer: English K

Received: August 7, 2024

Revised: September 29, 2024

Accepted: October 15, 2024

Published online: December 27, 2024

Processing time: 111 Days and 23.5 Hours



Amal Diab Ghanem Atalla, Nursing Administration Department, Faculty of Nursing, Alexandria University, Alexandria 21526, Egypt

Abdulqadir J Nashwan, Nursing and Midwifery Research Department, Hamad Medical Corporation, Doha 3050, Qatar

Corresponding author: Abdulqadir J Nashwan, PhD, Research Scientist, Nursing and Midwifery Research Department, Hamad Medical Corporation, Rayyan Road, Doha 3050, Qatar.
anashwan@hamad.qa

Abstract

After anorectal surgery, hemorrhoids frequently lead to chronic issues, particularly in patients with mixed hemorrhoids. Liu *et al* investigated the outcomes of staple removal at the 3- and 9-o'clock positions following modified stapled hemorrhoidopexy (SH) in patients with grade III or IV hemorrhoids. This study included patients who underwent standard or modified SH between January 1, 2015, and January 1, 2020. Key metrics assessed included hospital stay duration, blood loss, operation time, and the incidence of minor or major complications. The findings indicated that the modified SH technique is a safe option for advanced-grade hemorrhoids, resulting in a lower rate of postoperative anal stenosis compared to standard SH. Notably, this technique also showed reduced anal stenosis rates in patients with prior hemorrhoid treatments. While the modified SH demonstrates immediate benefits, further research is necessary to evaluate long-term effects. Despite its advantages, the study's limited sample size restricts the generalizability of the findings, underscoring the need for larger, long-term studies to validate these results. Clinically, the modified SH method appears to significantly reduce the incidence of postoperative anal stenosis, a common concern following typical surgeries. If confirmed by larger trials, this procedure may become the preferred surgical approach for hemorrhoids. In conclusion, the work of Liu *et al* signifies a meaningful advancement in hemorrhoid surgery, enhancing patient safety and outcomes.

Key Words: Hemorrhoids; Prolapse; Postoperative anal stenosis; Modified stapled hemorrhoidopexy; Anal canal

©The Author(s) 2024. Published by Baishideng Publishing Group Inc. All rights reserved.

Core Tip: The groundbreaking study by Liu *et al* reveals that stapled hemorrhoidopexy (SH) is a successful surgical treatment for hemorrhoids. A modified SH technique that lowers the likelihood of stenosis is described. The authors completed this altered treatment in patients over 5 years, with minimal stenosis rates, recurrence, and other problems. This implies that the modified approach would be preferable to normal SH to reduce the probability of complications. Despite multiple limitations, such as a small sample size, the study highlights the importance of the modified SH technique in reducing complications of anal stenosis after SH and improving quality and safety for affected patients, while suggesting supplementary research and innovative treatment approaches.

Citation: Ghanem Atalla AD, Nashwan AJ. Surgical approach for lower postoperative anal stenosis. *World J Gastrointest Surg* 2024; 16(12): 3899-3902

URL: <https://www.wjgnet.com/1948-9366/full/v16/i12/3899.htm>

DOI: <https://dx.doi.org/10.4240/wjgs.v16.i12.3899>

TO THE EDITOR

Among the most prevalent and often seen chronic anorectal disorders following anorectal surgery are hemorrhoids[1]. These venous clusters form in the lower portion of the rectum by bending, expansion, and congestion of the venous plexus[2]. There are three types of hemorrhoids: internal, external, and mixed. Hemorrhoidal thrombosis-related pain, prolapse, bleeding during or after defecation, and itching are common reasons why patients seek medical attention for their hemorrhoids. Patients who have hemorrhoids that are bothersome and have not responded to nonoperative therapies may need to have additional procedures or surgery. The most successful method of treating hemorrhoids is conventional surgical hemorrhoidectomy, which entails removing hemorrhoidal cushions. Rubber band ligation, harmonic ultrasonic scalpel hemorrhoidectomy, manual anal dilatation, sclerotherapy, cryotherapy, laser hemorrhoidectomy, and ultrasound-guided hemorrhoidal artery ligation are among the procedures. According to the Goligher classification, these techniques are utilized for grade I and II hemorrhoids and are appropriate for outpatient care[3]. However, 5%-10% of individuals show poor response to conservative measures and end up needing hemorrhoidectomies through surgery. These are usually reserved for patients with acute hemorrhoids who have not responded well to other treatments with symptomatic advanced hemorrhoids (grade III and IV)[4].

Although hemorrhoids rarely pose a serious risk to life, there are numerous potential postoperative consequences. If patients know the potential hazards associated with surgery, it is much easier to provide them with options and allow them to make the best decisions. The following possible hazards need to be considered: incontinence, delayed bleeding, anal stenosis, and postoperative discomfort. There have also been reports of soft tissue edema of the skin bridges, bleeding, wound infection, recurrence, and difficulties urinating[5,6].

Prior research has documented that those patients undergoing standard stapled hemorrhoidopexy (SH) experienced initial complications such as bleeding and urinary retention, which were manageable during hospital stays. However, insufficient research has been performed on the long-term effects of SH, particularly the prevalence of anal stenosis and recurrent prolapse[7]. One uncommon long-term consequence of SH is stenosis. It happens an average of 125 days \pm 5 days postoperatively and has been reported to occur less than 5% of the time. This could result in over-scarring and stricture formation if excessive tissue is removed from the surgical wounds surrounding the anal canal without creating mucosal bridges between them[8-10].

ASSOCIATION OF MODIFIED SH AND POSTOPERATIVE ANAL STENOSIS

The study conducted by Liu *et al*[11] is a comprehensive and meticulously designed investigation assessing modified SH and postoperative anal stenosis. Patients with grade III or IV hemorrhoids who had surgery at their colorectal facility between January 1, 2015, and January 1, 2020 were examined in this retrospective analysis. The preoperative evaluation comprised clinical and proctological examinations. When it was difficult to perform anoscope examination using a well-lubricated scope and when passing stool during follow-up at the outpatient department, the researchers recorded anal bleeding, postoperative infection, recurrence, symptomatic prolapse, and anal stenosis. These parameters were evaluated before, during, and after surgery. Patients who defecated for longer than half an hour reported difficulty passing stool, and their feces were narrow and fragmented into pellets. Laxatives and high-fiber diets were suggested for these patients. When the outpatient department was unable to relieve the patient's symptoms or dilate the stenosis with an anoscope, additional surgical intervention was scheduled.

Patients with grade III or IV hemorrhoids who had standard or modified SH performed at their colorectal center between January 1, 2015, and January 1, 2020 were included, according to Liu *et al*[11]. Records were kept on the duration of the hospital stay, blood loss, operation time, and occurrence of minor or significant problems. A total of 313 patients (mean age, 53.0 years) and 187 patients (mean age, 50.9 years) who had received standard SH were the subjects of our investigation. Compared to 40.3% of patients in the conventional SH group, 54% of patients in the modified SH group had previous surgeries for hemorrhoids. Five (2.7%) patients with anal stenosis were included in the modified SH group, whereas anal stenosis complications affected twenty-one (6.7%) patients in the regular SH group. Multiple regression

analysis revealed a strong correlation between the modified SH and the rate of postoperative anal stenosis, with values of 0.211 (0.069-0.641) and 0.251 (0.085-0.741). Compared to regular SH, the modified SH approach may have a decreased incidence of postoperative anal stenosis and is a safe surgical procedure for advanced-grade hemorrhoids.

We applaud Liu *et al*[11] for their diligent effort comparing the results of staple removal at the 3- and 9-o'clock positions during modified SH in patients with mixed hemorrhoids. One common and complex complication of SH is postoperative anal stenosis. Hence, finding a method to lower this risk is clinically significant. The authors comprehensively explain the technical adjustments to the typical SH process. This facilitates a more profound understanding and possible replication of the methodology. The results were more consistent and reliable because the same skilled surgical team performed every procedure.

However, it is important to consider the limits and weaknesses of this study. Five hundred cases were enrolled during 5 years, resulting in a modest sample size. Due to the study's single center setup and lack of a control group, bias may have gone unnoticed. Additionally, the duration of the follow-up was brief, and it is possible that many difficulties had not yet materialized at the time of the previous follow-up, which caused the number of complications to be underestimated. Second, there may be some partial exclusion of the confounding effect because there was inadequate recording of information on important confounders of the associated risks, such as family history, obesity, smoking, alcohol consumption, dietary patterns, diabetes mellitus, hypertension, and many other comorbidities. Third, because our hospital is located in the heart of Taipei, Taiwan, which serves a reasonably sized but densely populated and affluent area, we did not address cost-effectiveness. Furthermore, to compare various prolapsed hemorrhoid therapies and investigate these results, large-scale prospective studies are required.

The clinical implications of this work by Liu *et al*[11] are significant despite several limitations. Compared to the standard SH, the improved surgical method appears to dramatically reduce the incidence of postoperative anal stenosis. This is a significant advantage because anal stenosis is a regular and concerning side effect of the typical surgery. The study indicates that the improved approach, with low rates of hemorrhoid recurrence, remained efficient in treating hemorrhoid illness despite the technical adjustments. In addition, the updated method probably improves overall results and quality of life for individuals undergoing hemorrhoid surgery by lowering the chance of stenosis. One significant benefit is avoiding the need for additional surgeries to treat stenosis. For many patients with hemorrhoids, the modified SH may become the go-to surgical procedure if larger trials confirm the low stenosis rates and other encouraging outcomes.

CONCLUSION

For the surgical treatment of patients with grade III and IV protruding hemorrhoids, the modified SH was proven to be a safe and effective procedure. This method produced a lower rate of postoperative anal stenosis than traditional SH, even in individuals who had previously undergone hemorrhoid treatments. Modified SH has numerous immediate advantages and is safe. Nonetheless, more research is required on the long-term effects. This study's description of the modified SH technique marks a significant development in the surgical treatment of hemorrhoids. The authors were able to retain the treatment's overall efficacy in treating hemorrhoids while considerably lowering the risk of the concerning complication of postoperative anal stenosis by implementing particular technical adjustments to the usual approach. This work significantly contributes by showing how to improve hemorrhoid surgery success, quality, and safety. Novel strategies like the one shown here will be crucial in enhancing patient outcomes and quality of life as minimally invasive treatments develop further. This study is a call to action as well as a scientific examination because it opens various new avenues for future research. It is important to carry out a more extensive, multi-center randomized controlled trial to confirm the benefits of the new technique's generalizability and reproducibility in various surgical situations and patient demographics. This would support the steady decline in rates of postoperative stenosis and other positive results. Extending patient follow-up beyond the 5 years described in this study to evaluate the long-term sustainability of the low rates of recurrence and stenosis would offer insightful information on how long-lasting the clinical advantages are. Furthermore, validated patient-reported outcome measures should be included to evaluate the improved technique's effects on quality of life, patient satisfaction, and other subjective endpoints in a more thorough manner. By pursuing these and other lines of inquiry, the medical community can build upon the promising foundation laid by this study, ultimately optimizing the surgical management of hemorrhoid disease and improving quality and safety for affected patients. This makes a substantial contribution to the field and provides insightful evidence with an influence on forthcoming clinical practice, public health policies, and imminent research.

FOOTNOTES

Author contributions: Ghanem Atalla AD and Nashwan AJ wrote the draft and critically reviewed the literature.

Conflict-of-interest statement: All the authors declare that they have no conflict of interest.

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <https://creativecommons.org/licenses/by-nc/4.0/>

Country of origin: Qatar

ORCID number: Abdulqadir J Nashwan [0000-0003-4845-4119](https://orcid.org/0000-0003-4845-4119).

S-Editor: Chen YL

L-Editor: Filipodia

P-Editor: Zheng XM

REFERENCES

- 1 **Ryan P.** Observations upon the aetiology and treatment of complete rectal prolapse. *Aust N Z J Surg* 1980; **50**: 109-115 [PMID: [6930224](https://pubmed.ncbi.nlm.nih.gov/6930224/) DOI: [10.1111/j.1445-2197.1980.tb06643.x](https://doi.org/10.1111/j.1445-2197.1980.tb06643.x)]
- 2 **Wilson MZ,** Swarup A, T Wilson LR, Ivatury SJ. The Effect of Nonoperative Management of Chronic Anal Fissure and Hemorrhoid Disease on Bowel Function Patient-Reported Outcomes. *Dis Colon Rectum* 2018; **61**: 1223-1227 [PMID: [30192331](https://pubmed.ncbi.nlm.nih.gov/30192331/) DOI: [10.1097/DCR.0000000000001193](https://doi.org/10.1097/DCR.0000000000001193)]
- 3 **Clinical Practice Committee;** American Gastroenterological Association. American Gastroenterological Association medical position statement: Diagnosis and treatment of hemorrhoids. *Gastroenterology* 2004; **126**: 1461-1462 [PMID: [15131806](https://pubmed.ncbi.nlm.nih.gov/15131806/) DOI: [10.1053/j.gastro.2004.03.001](https://doi.org/10.1053/j.gastro.2004.03.001)]
- 4 **Cerato MM,** Cerato NL, Passos P, Treigue A, Damin DC. Surgical treatment of hemorrhoids: a critical appraisal of the current options. *Arq Bras Cir Dig* 2014; **27**: 66-70 [PMID: [24676303](https://pubmed.ncbi.nlm.nih.gov/24676303/) DOI: [10.1590/s0102-67202014000100016](https://doi.org/10.1590/s0102-67202014000100016)]
- 5 **Agbo SP.** Surgical management of hemorrhoids. *J Surg Tech Case Rep* 2011; **3**: 68-75 [PMID: [22413048](https://pubmed.ncbi.nlm.nih.gov/22413048/) DOI: [10.4103/2006-8808.92797](https://doi.org/10.4103/2006-8808.92797)]
- 6 **Sneider EB,** Maykel JA. Diagnosis and management of symptomatic hemorrhoids. *Surg Clin North Am* 2010; **90**: 17-32, Table of Contents [PMID: [20109630](https://pubmed.ncbi.nlm.nih.gov/20109630/) DOI: [10.1016/j.suc.2009.10.005](https://doi.org/10.1016/j.suc.2009.10.005)]
- 7 **Avgoustou C,** Belegris C, Papazoglou A, Kotsalis G, Penlidis P. Evaluation of stapled hemorrhoidopexy for hemorrhoidal disease: 14-year experience from 800 cases. *Minerva Chir* 2014; **69**: 155-166 [PMID: [24970304](https://pubmed.ncbi.nlm.nih.gov/24970304/)]
- 8 **Petersen S,** Hellmich G, Schumann D, Schuster A, Ludwig K. Early rectal stenosis following stapled rectal mucosectomy for hemorrhoids. *BMC Surg* 2004; **4**: 6 [PMID: [15153248](https://pubmed.ncbi.nlm.nih.gov/15153248/) DOI: [10.1186/1471-2482-4-6](https://doi.org/10.1186/1471-2482-4-6)]
- 9 **Fazio VW.** Early promise of stapling technique for haemorrhoidectomy. *Lancet* 2000; **355**: 768-769 [PMID: [10711919](https://pubmed.ncbi.nlm.nih.gov/10711919/) DOI: [10.1016/S0140-6736\(00\)00086-6](https://doi.org/10.1016/S0140-6736(00)00086-6)]
- 10 **Rao AG,** Nashwan AJ. Redefining hemorrhoid therapy with endoscopic polidocanol foam sclerobanding. *World J Gastroenterol* 2024; **30**: 4021-4024 [PMID: [39351248](https://pubmed.ncbi.nlm.nih.gov/39351248/) DOI: [10.3748/wjg.v30.i36.4021](https://doi.org/10.3748/wjg.v30.i36.4021)]
- 11 **Liu YH,** Lin TC, Chen CY, Pu TW. Modified stapled hemorrhoidopexy for lower postoperative stenosis: A five-year experience. *World J Gastrointest Surg* 2024; **16**: 2787-2795 [PMID: [39351563](https://pubmed.ncbi.nlm.nih.gov/39351563/) DOI: [10.4240/wjgs.v16.i9.2787](https://doi.org/10.4240/wjgs.v16.i9.2787)]



Published by **Baishideng Publishing Group Inc**
7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA

Telephone: +1-925-3991568

E-mail: office@baishideng.com

Help Desk: <https://www.f6publishing.com/helpdesk>

<https://www.wjgnet.com>

