

Tying up loose ends

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Dear Sir,

Hemorrhoids are among the most common anorectal diseases seen in the USA and Europe. Hemorrhoidectomy has been long considered as the gold standard in the definitive treatment of hemorrhoids secondary to its low long-term recurrence rate. Historically, this has outweighed the severe postoperative pain and prolonged recovery. Several innovative techniques have been proposed as alternative modalities to address these concerns, while matching the low recurrence rates seen following hemorrhoidectomy. Among the alternative procedures is dearterialization, a non-excisional technique that has historically raised skepticism as to the anatomical rationale for ligating hemorrhoidal arteries, the usefulness of Doppler guidance, and most importantly, unknown long-term recurrence rate [1–3].

In the 20 years since dearterialization was first introduced, there have been a number of studies and randomized trials [4–7] evaluating its efficacy relative to preexisting surgical modalities. A recent systematic review [8] including 2904 patients from twenty-eight studies concluded that dearterialization is associated with less postoperative pain and is safe for patients with grade III hemorrhoids. In fact, in 2010, the UK National Institute for Health and Care Excellence described [9] dearterialization as an “efficacious alternative to conventional hemorrhoidectomy” with “no major safety concerns,” citing level I evidence in its recommendation. Furthermore, follow-up data at 3 years post-dearterialization demonstrated

comparable recurrence rates with fewer chronic complications as compared to hemorrhoidectomy [10].

Despite supporting evidence of the benefits of dearterialization, there continues to be a paucity of acknowledgement and discussion in the current literature. A recent review [11] on hemorrhoids published in *New England Journal of Medicine*, albeit otherwise comprehensive, fails to provide but one sentence under the “area of uncertainty” section discussing dearterialization. While the article states that more studies are needed to show the efficacy of dearterialization, it overlooks established evidence and recommendations provided within its own references [12], which likely reflects a lack of experience with THD in the USA. Nonetheless, there is a new large series of patients treated with THD in the USA published in this issue [13]. Although this study is retrospective, it shows that there is increasing attention to this procedure in that country.

This editorial is neither suggesting that the aforementioned studies are without flaws nor negating the need for larger randomized trials with superiority design and longer follow-up. Nevertheless, the value of dearterialization is often understated by narrative reviews and outdated guidelines. This should bring to light the ample data supporting dearterialization as an efficacious modality and tie up the loose ends of current literature on the surgical management of hemorrhoids.

Conflict of interest None.

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