



Dr. Norman Sohn has experience with a new minimally invasive procedure for alleviating painful hemorrhoids.

and his associates are fairly conservative in recommending it. Since Dr. Sohn has brought the procedure to the colorectal practice, associate **Jeffrey S. Aronoff, M.D.**, has also learned and performs the procedure, and associates **Michael A. Weinstein, M.D.**, and **Frank S. Cohen, M.D.**, are learning the technique, as well.

New Hemorrhoid Technique Enables Some to Avoid Painful Recovery

Norman Sohn, M.D., first learned of the Doppler Guided Hemorrhoid Artery Ligation (DGHAL) technique as he researched options for managing hemorrhoids in patients whose symptoms required surgical hemorrhoidectomy but who had contraindications to surgery—generally impaired anal continence or high risk of incontinence. According to one study, 26 percent of hemorrhoidectomy patients have one or more defects in anal control three years postoperatively.

The technique Dr. Sohn uncovered was developed by Japanese surgeon Kazumasa Morinaga in 1995 and is most commonly used in Japan, Australia and Southeast Asia. Australian Dennis Meintjes, M.D., has used it on thousands of patients. The technique involves tying off arteries that feed hemorrhoids, causing them to shrink and become asymptomatic.

DGHAL uses a VaiDan ultrasonic blood flow detector model KM-25, a special instrument containing a Doppler transducer and a window that allows the surgeon to identify and ligate hemorrhoidal arteries by placing a suture around them. The procedure brings prompt resolution of most bleeding and

protrusion caused by hemorrhoids, and has been over 93 percent successful in 5- to 24-month follow-up studies by Dr. Meintjes, who demonstrated his technique at Dr. Sohn's office while attending a conference in the United States. Since then, Dr. Sohn, who studied medicine at New York University School of Medicine and served residencies at New York University Medical Center and Lahey Clinic, Boston, has been fine-tuning his technique. Patients have come to Dr. Sohn's New York office from around the United States and several foreign countries for the procedure. Because the procedure is less than 10 years old, long-term results aren't yet available.

There's little preoperative preparation, other than arriving with an empty stomach and having a Fleet enema administered at the office before the procedure. Unlike some physicians who do the procedure without sedation or anesthesia, Dr. Sohn uses intravenous sedation—administered by a board certified anesthesiologist. Then he painlessly introduces a local rectal anesthesia and applies nitroglycerin cream to the rectum to enhance blood flow, making it easier to identify blood vessels. Dr. Sohn then

carefully inserts the blood flow detector deep into the rectum, slowly rotating it around the entire circumference, using the pulsating Doppler sounds to identify the six or more hemorrhoidal arteries. Through the window of the scope Dr. Sohn places a suture ligature around each vessel, ties a knot outside of the scope and uses the knot pusher to position and tighten the knot. The procedure generally takes about half an hour, and the patient is fully awake about 10 minutes later. Unlike surgical hemorrhoidectomy, which can produce severe pain for several weeks, this procedure's pain can be managed with acetaminophen or tramadol hydrochloride and rapidly resolves after 12 hours. (Post-surgical patients often feel they need to defecate frequently throughout the first 24 hours.) There's usually little or no immediate postoperative bleeding, and 90 percent of patients return to work within 48 hours.

Having this effective procedure at their disposal doesn't cause Dr. Sohn and his associates at Somerset Surgical Associates, P.C., to rush into performing DGHAL excessively. "Fewer than 10 percent of the patients we see in our office need an operative procedure for hemorrhoids," explains Dr. Sohn, noting that he

Dr. Sohn uses DGHAL when other approaches—dietary manipulation, bulking agents, stool softeners, rubber band ligation, injection sclerotherapy or infrared photocoagulation prove either inappropriate or ineffective for an individual's hemorrhoids. Evverting hemorrhoids (external hemorrhoids that distend and internal hemorrhoids that protrude following straining), for example, usually don't respond to rubber band ligation. Hemorrhoidal size doesn't determine the appropriateness of DGHAL. Purely external hemorrhoids are not good candidates for DGHAL but must be excised. Dr. Sohn also avoids using DGHAL for acute hemorrhoidal thromboses or clots, and patients on Coumadin or aspirin therapy aren't candidates. And, because he's committed to providing what he believes is the most appropriate treatment for every patient, Dr. Sohn isn't interested in participating in a randomized trial of the new procedure.

The clinic's website is at www.ssamed.com. For information or referrals: (212) 249-9010. ■

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