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MILITARY COMMISSIONS TRIAL JUDICIARY
GUANTANAMO BAY, CUBA

UNITED STATES OF AMERICA

v.

KHALID SHAIKH MOHAMMAD,
WALID MUHAMMAD SALIH
MUBARAK BIN 'ATTASH,
RAMZI BIN AL SHIBH,
ALI ABDUL AZIZ ALI,
MUSTAFA AHMED ADAM AL
HAWSAWI

AE 619D (MAH)

Defense Motion to Waive
Mr. al Hawsawi's Appearance
at the
Military Commission Session Scheduled to
begin March 25, 2019

Filed: 12 March 2019

1. ~~(U)~~ **Timeliness:** This motion is timely filed.
2. ~~(U)~~ **Relief Sought:** Mr. al Hawsawi requests to be excused from attending the military commission session presently scheduled to commence on 25 March 2019.
3. ~~(U)~~ **Burden and Standard of Proof:** The burden of persuasion on this motion rests with the Defense. R.M.C. 905(c)(2).

4. ~~(U)~~ **Facts:**

a. ~~(U)~~ Mr. al Hawsawi has been diagnosed with increased complications that are repercussions from torture and sodomy he endured during his detention at black sites. The prolapsed colon, rectal tears and chronic hemorrhoids suffered as a result of this abuse has had long lasting impacts on Mr. al Hawsawi's health and well-being. Mr. al Hawsawi underwent rectal surgery on 14 October 2016, in an attempt to correct these issues.¹

¹ ~~(U)~~ See AE 362P, Defense Motion for Appropriate Relief to Continue December 2016 Hearing (filed 10 November 2016); 362S Reply in same motion series (filed 18 November 2016).

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b. ~~(U//FOUO)~~ The medical records most recently provided to the Defense evidence that he has been diagnosed with anal stenosis, a tightening of the rectal passage which is chronic and painful, in addition to anal verge fibrosis and anal surgical changes. Att. B (Medical report of colonoscopy performed by a person who refers to himself in the medical records as “Dr. Poopy,”). Anal stenosis and chronic rectal pain are among the “most feared long-term complications”² of anorectal surgery, as accompanying pain with defecation, constipation and related symptoms can be debilitating and negatively impact the patient’s quality of life. *See* Att. C. This newest medical complication is sadly unsurprising, given the history of trauma and multiple procedures conducted on Mr. al Hawsawi on that area of his body.

c. ~~(U//FOUO)~~ Mr. al Hawsawi now endures even greater physical pain from the daily struggle with having a bowel movement. The most recent records the defense has been provided (which date from November-January 2019) evidence that various topical ointments which have been tried are of no assistance, resulting in his increased use of Tramadol, a narcotic like pain reliever.³ Side effects for Tramadol which Mr. al Hawsawi has experienced include a general feeling of discomfort, joint and muscle pain, and tiredness. Beyond the chronic anal pain, Mr. al Hawsawi has abdominal pain and sharp lower back pain; his blood pressure is also still not under control. *See* Att. D, E. F.

² ~~(U)~~ Kunitake, H., & Poylin, V. (2016). Complications Following Anorectal Surgery. *Clinics in Colon and Rectal Surgery*, 29(01), 014-021. doi:10.1055/s-0035-1568145.

³ ~~(U//FOUO)~~ Mr. al Hawsawi took Tramadol for his pain 15 days in December 2018, and 12 of the first 22 days in January 2019 (the Defense does not yet have records beyond that date).

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d. ~~(U)~~ The Defense detailed for this Commission in earlier pleadings the surgeries performed on Mr. al Hawsawi and his on-going medical problems.⁴ Before his most recent colonoscopy, which occurred on 30 November 2018, he had two surgeries in short order in April 2017: a colonoscopy to remove a polyp in his colon that was causing continued rectal bleeding, and then – just a week later – a ureteroscopy and laser lithotripsy, to extract a 1.2 cm kidney stone. At the time of the colonoscopy, the surgeon observed oozing hemorrhoids and perianal skin tags prior to the procedure. The ureteroscopy required general anesthesia.⁵ These 2017 surgeries were preceded by two earlier surgeries to the rectal area, one in October 2016 and another in 2006.⁶

e. ~~(U//FOUO)~~ As the Defense has informed this Commission in the past,⁷ Mr. al Hawsawi's multiple health problems stem from the conditions and treatment he experienced in

⁴ ~~(U)~~ See AE 362P (MAH); 362S (MAH); *see also*, AE 565A (MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled April-May 2018 Military Commission Session (Filed 12 Apr 2018); AE 540O (MAH), Defense Motion to Waive Mr. al Hawsawi's Presence at January 2018 hearings (filed 5 January 2018); AE 537H (MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled December 2017 Military Commission Sessions (filed 1 December 2017); AE 522D (MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled October 2017 Military Commission Sessions (filed 3 October 2017); AE 520(MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled August 2017 Military Commission Sessions (filed 20 August 2017); AE 500R (MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled May 2017 Military Commission Sessions (filed 12 May 2017); AE 487 (MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled January-February 2017 Military Commission Sessions (filed 24 January 2017).

⁵ ~~(U)~~ See AE 565A (MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled April-May 2018 Military Commission Session (Filed 12 Apr 2018).

⁶ ~~(U)~~ See AE 362P, Defense Motion for Appropriate Relief to Continue December 2016 Hearing (filed 10 November 2016).

⁷ ~~(U)~~ See AE 520(MAH), Defense Motion to Waive Mr. al Hawsawi's Appearance at the Scheduled August 2017 Military Commission Sessions (filed 20 August 2017).

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black sites. In addition to the recently diagnosed anal stenosis and his chronic anal pain, he regularly suffers from debilitating migraines and persistent ringing in his ears. It bears repeating that Mr. al Hawsawi lived with a painful prolapse in his colon for more than ten years, while imprisoned and while remaining in the custody of the same entities that inflicted these injuries. The whole time, even as he had to reinsert prolapsing tissue back into his anus, he had to relieve himself publicly -- that is, before guards watching over him. The public nature of such a private matter continues by virtue of his being in custody. It is exacerbated moreover, when he has to be transported to court and sit there for hours because, should he need to suddenly relieve himself, he has to publicly request to be excused and temporarily halt the commission proceedings, so that guards can escort him to a holding cell outside the courtroom, where there is a toilet.

f. ~~(U//FOUO)~~ A few months after Mr. al Hawsawi's October 2016 rectal surgery, the Senior Medical Officer then assigned to Camp Seven testified that it takes a prolonged period to recuperate from such a surgery. The officer could not opine precisely how long, conceding that recuperation times were averages and depended on many factors personal to the particular patient. The medical officer's assessment was based on medical averages for similar procedures, and did not consider patients recuperating while held in custody, and after the kind of trauma Mr. al Hawsawi experienced while in confinement.⁸ The Senior Medical Officer's prognosis from October 2016, if not entirely wrong, was at least wildly optimistic, and particularly so given his chronic anal pain and the November 2018 diagnosis that Mr. al Hawsawi has anal stenosis.

⁸ ~~(U)~~ See *United States v. Mohammad et al.*, Transcript (5 December 2016), at 14080-81.

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g. ~~(U)~~ The Commission has advised Mr. al Hawsawi of his right to be present, at the onset of over 37 pretrial hearings since the Commission began using the process of advising the accused of the right to presence.⁹ Defense counsel has also explained to Mr. al Hawsawi his right to attend commission hearings, and the effect of his waiving his presence. Mr. al Hawsawi knowingly and voluntarily chooses to waive his right to be present at the upcoming March session of the Commission.

5. ~~(U)~~ **Argument:**

~~(U//FOUO)~~ It is not only legally appropriate but also humane to accept Mr. al Hawsawi's knowing and voluntary waiver to absent himself from these proceedings under the current circumstances. The recent diagnosis that Mr. al Hawsawi suffers from anal stenosis, or a hardening of the tissue around the anal passage, is yet another aftermath of the long history of trauma he has had to the rectal area after being sodomized by the CIA at black sites. Put simply, Mr. al Hawsawi asks to waive his presence at the hearing because he needs to minimize the amount of prolonged sitting he has to do, as well as the time spent away from easy access to a toilet.

~~(U//FOUO)~~ The recent diagnosis of anal stenosis demonstrates that the JTF-GTMO's prognoses about Mr. al Hawsawi's recuperation have proven wholly unreliable. Mr. al Hawsawi's anal pain is chronic, and his anal stenosis is likely the result of the trauma and multiple procedures he has had to endure to that part of his body. The pain this condition causes Mr. al Hawsawi is not

⁹ ~~(U)~~ Pursuant to the Commission's order in AE 37H, Order, Government Motion Regarding Accused's Presence During Commission Proceedings (dated 16 October 2012), at the beginning of every series of hearings the Military Judge has informed Mr. al Hawsawi of his right to be present, and about the process for voluntarily waiving his presence. There have been an estimated 37 sessions of the Commission since October 2012, and at each of these sessions, the military judge informed Mr. al Hawsawi of his right to be present, and the effect of waiving that right.

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under control, and he continues to try different medications to alleviate that pain; he is in general discomfort, with joint and muscle pain, and tiredness that make it difficult for him to concentrate. Furthermore, the prognoses given to-date have not taken into account the particular conditions under which Mr. al Hawsawi lives.¹⁰ There are obvious, debilitating factors that severely impact the management of his condition: he is under a diet that he does not control; he has a schedule that he cannot control; he suffers from unalleviated, chronic head, neck, back and rectal pain; he has to relieve himself under the eyes of prison guards at all times.

~~(U)~~The Rules for Military Commission specifically provide that an accused appearing before a military commission may voluntarily waive his right to be present at sessions of the Commission occurring after arraignment by securing the permission of the military judge on the record. *See* R.M.C. 804(c). Since the Commission began in 2012 to use the process of advising the accused of their right to presence, Mr. al Hawsawi has now been advised on the record of his right at more than 37 pretrial hearings.¹¹ Since that time, Mr. al Hawsawi has regularly waived his appearance after the first day of each session by signing a written waiver; this Commission has accepted these many signed waivers as knowing waivers from him. Mr. al Hawsawi thus understands fully his right to be present, and the meaning of his waiver of attendance. Furthermore, counsel has also advised him of his right in this regard. Accordingly, Mr. al

¹⁰ ~~(U)~~*See United States v. Mohammad et al.*, Transcript (5 December 2016), at 14080-81; Mr. al Hawsawi also articulated this point fully in a previous motion, AE 520 (MAH), filed 20 August 2016.

¹¹ ~~(U)~~*See* AE 37H, Order, Government Motion Regarding Accused's Presence During Commission Proceedings (dated 16 October 2012). At each of Commission hearing since this Order, the military judge has informed Mr. al Hawsawi of his right to be present, and the effect of waiving that right.

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Hawsawi's waiver of his presence at the upcoming March hearing is knowing and voluntary, and it is legally appropriate for the Commission to accept it.

~~(U)~~The military commission process has precedent on which to rely for granting a request to waive presence at the first day of a multi-day session of the commission. The Military Judge, in the commission case of *United States v. Abd Al Hadi Al-Iraqi*, granted the accused's request to waive his presence on the first day of the proceedings. In accepting this waiver, the judge observed that:

~~(U)~~to date the Commission has required the Accused be present at the first session of each scheduled hearing. At the first session, the Commission has advised the Accused of his right to be present under R.M.C. 804, and allowed the Accused to waive his presence at subsequent sessions of the same hearing.¹²

~~(U)~~The procedures the *al Iraqi* Commission employed are identical to the procedures this Commission uses to advise Mr. al Hawsawi of his right to be present. Just as the *al Iraqi* Commission explicitly recognized the significance of previous rights advisements given to the accused there, so should this Commission.

~~(U)~~Neither Mr. al Hawsawi nor the Government will suffer prejudice from Mr. al Hawsawi's voluntary absence from this session. In its Order in AE 037H,¹³ this Commission found that "[t]he MCA 2009 specifically articulates the presence of the accused as a 'right' not a mandate." As the Commission further held:

¹² ~~(U)~~ See *United States v. Hadi al Iraqi*, Commission Ruling (dated May 5, 2017) (Attachment B to AE 500R, Defense Motion to Waive Mr. al Hawsawi's Presence at the May 2017 Military Commissions Session (MAH) (12 May 2017).

¹³ ~~(U)~~ *United States v. Mohammad, et al.*, AE 037H, Order re Government Motion Regarding Accused's Presence during Commission Proceedings (16 October 2012), at 3.

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~~(U)~~ The Commission advised each accused of their right to be present at all sessions and of their option to voluntarily waive their right to be present at certain sessions. Each accused, with advice of counsel, understands their right to be present and their option, under certain circumstances, to voluntarily waive the right.¹⁴

~~(U)~~ Mr. al Hawsawi has been advised by the Commission and by counsel, and is fully cognizant of his rights with respect to attendance, and he is aware of the meaning and effect of the waiver of the right. Where counsel has been able to communicate with his client, the client has been advised of his right to be present, and there is evidence of a knowing and voluntary waiver, counsel can waive the right to presence for a client.¹⁵ Mr. al Hawsawi can voluntarily waive his presence at this pretrial proceeding, and there is no requirement that such a waiver from an accused be compelled through his appearance in open court. *See* RMC 804. Furthermore, Mr. al Hawsawi has the ability to waive his right to presence at trial, even without a written waiver, since waiver of presence can be implied by conduct.¹⁶ In fact, this Commission itself has availed of its ability to imply waiver of presence, when it ordered other co-accused in this case removed

¹⁴ ~~(U)~~ *Id.*

¹⁵ ~~(U)~~ *See United States v. Salim*, 690 F.3d 115, 122-23 (2nd Cir. 2012) (“Although it is certainly preferable that the waiver [of presence] come from the defendant directly, there is no constitutional requirement to that effect.” *Polizzi v. United States*, 926 F.2d 1311, 1322 (2d Cir. 1991). A defendant’s lawyer may waive presence on the defendant’s behalf. But a defendant’s waiver through counsel, like all waivers of constitutional rights, still must be knowing and voluntary on the part of the defendant.”); *cf. United States v. Dunlap*, 577 F.2d 867, 868 (4th Cir. 1978) (approving of trial court’s acceptance of counsel’s representation that client voluntarily waived his presence); *United States v. Wagner*, 280 F. Supp. 3d 811, 815 (W.D. Va. 2017) (court accepts of defendant’s sworn waiver of presence at a victim restitution hearing).

¹⁶ ~~(U)~~ *See United States v. Mackey*, 915 F.2d 69, 72 (2d Cir. 1990), *citing Illinois v. Allen*, 397 U.S. 337, 359 (1970) (a judge can imply a defendant has waived presence through defendant’s disruptive courtroom conduct).

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due to the Commission's view that their courtroom conduct was unruly.¹⁷ It would lead to a nonsensical result to rule that Mr. al Hawsawi might be barred from Commission proceedings if he were unruly, yet he must be compelled to attend proceedings when he is *not* being unruly and

1.) He is using proper methods to communicate with the Commission his choice to waive his presence; 2.) He has fully and repeatedly been advised of his right to be present and of the consequences of his waiving that presence; and 3.) He knowingly and voluntarily offers to waive his presence.

~~(U)~~ It is legally appropriate, logical and human therefore, to allow Mr. al Hawsawi to waive his presence at the March 2019 hearing.

6. ~~(U)~~ **Request for Oral Argument:** The Defense does not request oral argument on this motion.

7. ~~(U)~~ **Conference with Opposing Counsel:** The Prosecution opposes the waiver to the extent it seeks excusal for the first day of hearings.

8. ~~(U)~~ **Witnesses:** None.

9. ~~(U)~~ **Attachments:**

A. ~~(U)~~ Certificate of Service.

B. ~~(U)~~ Medical Record dated 30 Nov 2018 (MEA-10011-00014691), ~~(U//FOUO)~~,

C. ~~(U)~~ Kunitake, H., & Poylin, V. (2016). Complications Following Anorectal Surgery. *Clinics in Colon and Rectal Surgery*, 29(01), 014-021. doi:10.1055/s-0035-1568145;

D. ~~(U)~~ Chronological Record of Medical Care, 04 Dec. 2018 (MEA-10011-00014716), ~~(U//FOUO)~~,

¹⁷ ~~(U)~~ See, e.g., *United States v. Mohammad, et al.*, Transcript (21 July 2016), at 12,594.

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JOINT TASK FORCE GUANTANAMO BAY, CUBA - JOINT MEDICAL GROUP
BEHAVIORAL HEALTH UNIT (BHU) / DETENTION MEDICAL CLINIC (DMC)

DATE/TIME	INPATIENT NARRATIVE NOTES
20/Nov/2018	Gastroenterology Procedures: Colonoscopy Indications: Hematochezia Patient consented to the procedure. Consent was placed in the chart Proc: The patient was identified. Triage was performed prior to the start of the procedure. The patient was sedated. A pre-proc exam & digital rectal exam were performed. The colonoscope was inserted into the colon to the terminal ileum. The mucosa was slowly withdrawn with careful examination of the colon. The patient tolerated the procedure well. The prep was adequate.
	Diagnosis: MAC Findings: -Rectal Exam: Mild anal stenosis Mild anal vesicle fibrosis Normal Prostate Anal Sigmoid Changes Normal Colon -Colon: (1) Sigmoid stool in the colon (minimal). (2) Normal sigmoid with some mucosal thickening with good vascularization (3) Colon was otherwise normal (4) Normal Prostate & no rectal inflammation -Ileum: (5) Normal terminal ileum Complications: None Disposition: (1) No malignancy or inflammation seen on colonoscopy (2) No endoscopic findings to explain the proctitis (3) Findings (4) Normal Colon & Terminal ileum Recommendations: (1) Attempt a low fiber diet due to anal exam findings (2) Continue with medications (3) Consider laxatives if constipation continues (4) Give flake steady per documentation (5) Discussed with referring physician

ISN:# _____

JTF GTMO JMG 11/2018

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C



Complications Following Anorectal Surgery

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Clin Colon Rectal Surg 2016;29:14–21.

Abstract

Keywords

- ▶ anorectal surgery
- ▶ complications
- ▶ hemorrhage
- ▶ urinary retention
- ▶ pelvic sepsis

Anorectal surgery is well tolerated. Rates of minor complications are relatively high, but major postoperative complications are uncommon. Prompt identification of postoperative complications is necessary to avoid significant patient morbidity. The most common acute complications include bleeding, infection, and urinary retention. Pelvic sepsis, while may result in dramatic morbidity and even mortality, is relatively rare. The most feared long-term complications include fecal incontinence, anal stenosis, and chronic pelvic pain.

Anorectal pathology is prevalent throughout the world, with most anorectal complaints being transient and without the need for formal medical evaluation. For those that do require surgical intervention for their anorectal pathology, the surgery can usually be done safely in the outpatient setting with minimal morbidity. However, no intervention is without risk, and complications frequently arise after anorectal surgery, with rates upward of 50% in some studies.¹ The purpose of this chapter is to review the short- and long-term complications that can arise after anorectal surgery, including the diagnostic approach, interventions, and prevention strategies for these complications.

Short-Term/Acute Complications

Postoperative Hemorrhage

Minor bleeding after anorectal surgery is common. Since we expect patients to continue with normal bowel function, the already disturbed anorectal mucosal becomes further irritated with activity and bowel movements. Since some bloody discharge is normal, the patient should be appropriately counseled on what to expect so as to avoid unnecessary anxiety and phone calls. It may also be helpful to remove/wash out clots from the rectum while still in the operating room to minimize confusion after surgery. However, major bleeding can also occur, albeit rarely, and may require further intervention. While the presentation of major bleeding is not uniform, patients often report frequent passing of small to moderate amounts of clot and bright red blood starting after the first bowel movement.

Hemorrhoid surgery involves the vascular cushions of the anus, so not surprisingly, hemorrhoidectomy is associated with higher rates of bleeding when compared with other anorectal procedures.^{1–3} Bleeding after other anorectal procedures such as procedures for anal fistula or fissure is very low (0.4–1.2%).^{4,5}

Rates of clinically significant bleeding after hemorrhoid surgery vary based on type of the procedure. For conventional hemorrhoidectomy (Milligan-Morgan and Ferguson)⁶ and bipolar energy device hemorrhoidectomy (Ligasure), rates of clinically significant hemorrhage has been reported in the range of 0.3 to 6%, with an average of around 2%.^{1–3,6,7} There does not seem to be a significant difference in rates of bleeding between conventional hemorrhoidectomy and bipolar energy device assisted procedures.

The timing of bleeding after hemorrhoidectomy varies, and can be generally divided into immediate and delayed.⁵ Immediate bleeding occurs within 24 to 48 hours of a procedure and is likely related to loss of control of the vascular pedicle. Delayed bleeding is defined as bleeding reported up to 2 weeks postprocedure, and is more often related to infection or local trauma.^{4,5} Delayed bleeding may be influenced by post-operative pain medications. Hemorrhoidectomy is associated with significant postoperative pain, and multimodality management is routinely employed to help alleviate discomfort. NSAIDs are an integral part of this pain management and can increase the incidence of bleeding.⁸

Issue Theme Approaches to Anorectal Disease; Guest Editor: Sean J. Langenfed, MD, FACS

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Thankfully, most bleeding will resolve spontaneously. For bleeding that does not resolve, the treatment depends on the location of the bleeding and the degree of blood loss. If the bleeding is more external in nature, holding pressure with gauze, cauterization, or suture ligation at the bedside are all acceptable interventions with high rates of success. Injection of local anesthetic with epinephrine can also be performed in clinic or on the ward; however, this can be uncomfortable and there are no data available on the success of this approach. For bleeding that is located within or above the anal canal, bedside intervention is more difficult, and the first approach is typically to tamponade the bleed with a finger or a piece of Vaseline gauze. Often, the patient's own sphincter tone acts as a tamponade on bleeding vessels within the anal canal, which can explain the episodic nature of postoperative bleeding. In more severe cases, tamponade with a Foley balloon catheter can be employed, possibly in conjunction with Vaseline gauze and Surgicel.^{4,5} Tamponade can be quite uncomfortable for the patient, and is often used as a temporizing measure while a more definitive plan is being activated.

On an average, 15 to 33% of patients with bleeding after hemorrhoidectomy will require a return to the operating room for control of the hemorrhage.^{3,9} Interestingly, most will not have an identifiable source of bleeding by the time they are examined in the operating room. However, these bleeding episodes can be significant and a return to the operating room for the second look may be justified.

Bleeding after stapled hemorrhoidectomy (procedure for prolapse and hemorrhoids, PPH) is slightly more common than for excisional hemorrhoidectomy, with rates as high as 9.6%.¹⁻³ At the same time, rates of reintervention for bleeding are lower for PPH compared with conventional hemorrhoidectomy.³ Bleeding after Doppler-guided hemorrhoidal de-arterialization has been reported to be low (4.3%); however, this needs to be balanced with the chance of long-term recurrence.¹⁰

Special consideration should be given to patients with an increased risk for bleeding after anorectal surgery. Patients on hemodialysis have reported rates of postoperative bleeding as high as 11.1% after conventional hemorrhoidectomy.¹¹ For patients on systemic anticoagulation, there are limited published data on postoperative bleeding. A study by Nelson et al focused on rubber band ligation for patients on antithrombotic prophylaxis, and reported minimal risk of bleeding for patients on aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs) or coumadin.¹² However, this group found that clopidogrel carried a higher risk of bleeding (8.6%), even if it was held prior to the banding and restarted in a delayed fashion. Data on newer antithrombotic medications and hemorrhoid procedures are not available.

There is significant controversy regarding whether or not antithrombotic therapy should be stopped prior to the surgical treatment of hemorrhoids. Most would consider aspirin and NSAIDs generally are safe to continue through the perioperative period. Coumadin at low doses seems to be safe as well, although several surgeons would recommend stopping it prior to surgery and restarting when chance of bleeding after the procedure decreases. The risk of bleeding while on other antiplatelet therapy such as clopidogrel is significant, and these medications

should be stopped, or the procedure should be delayed until it can be stopped if at all possible.

Infection

Infectious complications after anorectal surgery are thankfully uncommon, but can be significant when they do occur. Since painful drainage (including more fibrinous material) and swelling is expected after most anorectal procedures, the diagnosis of an infection may be difficult and is often delayed. Fever, worsening pain after initial improvement in symptoms, and the development of delayed urinary retention are three very important warning signs. Patients exhibiting these three symptoms should be examined promptly to avoid worsening complications. Imaging, including computerized tomography or magnetic resonance imaging may be considered especially if a deeper abscess or pelvic sepsis is suspected. When an infection following anorectal surgery has been diagnosed, the surgeon should have low threshold for a quick return to the operating room for control of infection and debridement of any devitalized tissue.

Transient bacteremia after hemorrhoidectomy is common, and has been reported in up to 8% of cases,¹³ but clinically significant infections are extremely uncommon. Given the location, it is expected that all wounds will get colonized by bacteria shortly after surgery. The exact rate of infectious complications after anorectal surgery is difficult to interpret. The development of severe pelvic sepsis (Fournier's gangrene) following anorectal surgery has only been described as individual case reports, with 24 published cases between 1978 and 2004.^{14,15} There are a few reports of development of liver abscess and septic emboli after anorectal surgery.¹⁴ Rates of abscess formation after hemorrhoidectomy have been reported between 0.5 and 4%.^{1,3,4,16,17} with most studies reporting a rate of 1%. Patients who are immunosuppressed seem to be at higher risk.^{18,19} There does not seem to be a significant difference between open and closed hemorrhoidectomy or between traditional hemorrhoidectomy and PPH.^{1,15} Several studies also report wound complications (drainage, nonhealing, etc.), but it is possible that these were caused/resulted from infection that was not clinically evident.

There does not seem to be an association between performing a perianal block with local anesthetic and postoperative infection.¹⁴ Rates of infection after procedures for anal fistula seem to be similarly low, but even harder to interpret since localized infection is an indication for surgery and these data are often combined with recurrence/reoperation.^{11,12} There has been no convincing evidence to suggest that either preoperative or postoperative antibiotics decrease rates of infectious complications for anorectal surgery.²⁰ Exceptions to this are discussed in article "Perioperative Management of the Ambulatory Anorectal Surgery Patient" on pp. 7-13.

Urinary Retention

Urinary retention is the most common complication after anorectal surgery, with rates varying between 3 and 50%.²¹⁻²⁶ with most studies reporting a rate around 15%.²²⁻²⁵ Postsurgical urinary retention is multifactorial with

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contributions from irritation/blockade of pelvic nerves and pain evoked reflexes.^{24,27} The multifactorial nature of urinary retention makes it a difficult problem to deal with after anorectal surgery. Pain is a major issue and pain treatment strategies can exacerbate the problem. For example, local anesthetic can significantly improve postoperative pain and nerve irritation; however, it can also lead to decreased sensation of the urge to micturate leading to bladder distention.²⁷

Several risk factors have been identified over the years that increase the likelihood of retention. Some of these factors are not modifiable, including age, male sex, and type of surgery.²³⁻²⁷ Other factors are modifiable and lead to changes in practices associated with anorectal surgery. In general, epidural and spinal anesthesia have been associated with higher rates of urinary retention²³⁻²⁷ compared with monitored anesthesia care. Opioids, often needed after anorectal surgery, can also contribute to the problem.

Excess intravenous fluid has also been shown to significantly increase the risk of urinary retention, and strategies for intravenous fluid restriction are typically employed.^{22,25} A more detailed discussion of fluid restriction can be found in the chapter on ambulatory anorectal surgery. Of note, several medications have been employed in attempts to reduce urinary retention, but the data are mixed and for the most part disappointing. Although well-designed, the previous studies on this topic suffered from small numbers and the use of older medications. Urecholine and prazosin have both been shown to be very effective in treating established urinary retention, but not in preventing it in anorectal surgery.^{22,24}

Typical symptoms of urinary retention include pain, pressure, discomfort, an unproductive urge to urinate, and frequent, small volume micturition with persistent feeling of incomplete evacuation. In patients with good pelvic nerve blockade and decreased sensation, abdominal pressure may be the only early symptoms. Urinary retention can lead to urinary tract infections. If not addressed in the timely manner, retention can result in over distention of the bladder that can further exacerbate the problem and in some cases lead to acute renal injury from postrenal obstruction.²⁷ Clinical symptoms as well as noninvasive bladder scanners are very effective in diagnosing this problem.

Thankfully, most issues with urinary retention are self-limited, and will resolve without major intervention. Since inflammation and swelling seem to contribute to the problem, patients with mild retention are often counseled to sit in a bath of very warm water, filled above the waist, to see if this can alleviate swelling and facilitate urination. When this is unsuccessful, patients may require bladder catheterization. This may involve intermittent straight catheterization or a temporary indwelling catheter, which can typically be removed after a few days without further testing. α_1 antagonists such as tamsulosin can be helpful, and attempts to minimize opioid intake is also worthwhile.²⁷ While these measures alone will aid most patients, a referral to a urologist for further studies is indicated if prolonged urinary retention occurs.

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Other Acute Complications

Thrombosed hemorrhoids and fissures following anorectal surgery have been described by several papers^{1-5,18,19} and are likely related to local tissue trauma, injection of local anesthetic with epinephrine, and constipation. Incidences of these complications in all the studies reviewed are very low (although possibly underreported), so it is hard to make meaningful conclusions about true risks and preventive strategies. In general, sitz baths and avoidance of constipation can be helpful in avoiding fissures and thrombosed hemorrhoids, as well as in the treatment of these conditions when they develop.

Severe constipation is common after anorectal surgery, with rates between 15 and 30%.¹⁻³ Hemorrhoidectomy has the highest rates reported. A fear of bowel movements and the associated pain can lead to functional constipation. Opioid consumption also plays a major role. While fecal impaction can develop, this is less common, and disimpaction is rarely required, with most cases treated on an outpatient basis. A solution to postoperative constipation is the combination of a strict bowel regimen with a multimodality pain regimen that limits opioid consumption. It is important to note that several patients have pre-existing constipation as a cause of their underlying anorectal disease, and vigilance is needed to avoid exacerbating this problem after surgery.¹⁶

Anal fistulas have also been reported after anorectal procedures. In cases where fistula-in-ano was not a primary problem, it is either the result of infection, trauma to the anal canal, or abnormal healing. The treatment of these fistulas varies significantly based on the degree of sphincter muscle involvement. Rectovaginal and ano-vaginal fistulas have also been reported with higher prevalence in PPH procedures. This can occur when the rectovaginal septum incurs damage, so it is more common in surgeries that involve the anterior anal canal and rectum, including hemorrhoidectomies and full thickness trans-anal excisions.³ For this reason, careful dissection and postprocedure examination of the rectovaginal septum is warranted to avoid fistula.

Long-Term Complications

Complications after anorectal surgery are not always immediate, and can instead take months or years to fully develop. In general, these complications are more severe and more difficult to treat than those that occur in the acute postoperative period. We will discuss the most common and most feared long-term complications below.

Anal Stricture/Stenosis

If excluding coloanal anastomoses, anal stricture and stenosis are most commonly seen after hemorrhoidectomy, but can occur after any surgery within the anal canal. Stenosis can complicate a stapled or radical amputative hemorrhoidectomy in 1 to 7.5% of cases.^{10,27-29} In these patients, the normal pliable anoderm is replaced by cicatrized tissue due to excessive removal of the anoderm and distal rectal mucosa. The patient may also suffer from injury to the underlying anal sphincter muscle, leading to severe and progressive stenosis.

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Patients with anal stenosis often report straining to have a bowel movement, smaller caliber stools, and pain with defecation. Anal stenosis may also lead to fecal impaction and overflow incontinence.

A review of the patient's previous operative reports along with a detailed anorectal exam can confirm the diagnosis. Office evaluation with a digital exam, anoscopy, and proctoscopy are usually adequate, but patients with severe stenosis or pain may require an exam under anesthesia. An examination under anesthesia may also be helpful in determining how much of the stricture is from anatomic distortion versus a functional problem leading to muscle hypertonicity. With functional stenosis, the anus will relax under anesthesia while anatomic stricturing will not change. If the etiology of the stenosis is unclear, biopsies of the area are appropriate to exclude neoplastic or inflammatory etiologies.

Anal stenosis may be classified by the severity of the stricture as well as the level of involvement of the anal canal (—Table 1).³⁰ The management of anal stenosis is determined by the degree of symptoms rather than the degree of stenosis, and an asymptomatic patient does not necessarily require intervention, given that a malignant cause of the stenosis has been excluded.

Mild strictures can often be treated with dietary modifications, stool softeners, or fiber supplements. The regular passage of stool provides the most "natural" stretching possible. Digital dilatation or the use of anal dilators can be part of the treatment plan if medical management is not sufficient. The initial dilation should be performed under anesthesia and patients should continue daily dilations using a digit or a plastic dilator at home. The author recommends the use of the plastic insert from a disposable anoscope with lidocaine jelly as an effective dilator for home use. If patients remain symptomatic with these measures, it is important to ensure that the symptoms are not due other causes, such as an anal fissure.

Patients with moderate or severe strictures who have failed conservative management require surgical intervention. To

determine the proper surgical procedure, the differential involvement of the anoderm compared with the underlying anal sphincter complex must be determined. A patient with a healthy anoderm and underlying fibrotic internal sphincter may only need a unilateral or bilateral sphincterotomy.^{31,32} Treatment of a fibrotic anal sphincter with sphincterotomy alone is most successful if the stricture is mild and low in the anal canal. Results of sphincterotomy alone for anal stenosis are limited but good results have been reported in up to 67% of patients.³⁰

Patients with stenosis of the anoderm require the introduction of healthy tissue into the anal canal, replacing lost or diseased nonpliable anoderm with elastic and compliant neoanoderm.^{32,33} Several advancement flaps are described below. Patients with scarring of the anal sphincter muscle as well as stenosis of the anoderm should undergo a flap procedure combined with an internal sphincterotomy. Simple release of a stricture may provide temporary relief of symptoms but generally should be avoided because of the high rate of recurrent stricture.

There are multiple types of flaps for anal stenosis, which are generally classified as advancement, rotational, or adjacent tissue transfer flaps.³² The choice of flap is influenced by the location of the stricture. Mid and upper anal canal stenoses are optimally treated with mucosal advancement flaps. For stenoses below the dentate line, a dermal advancement flap anoplasty is recommended. The V-Y advancement flap is used for strictures at the dentate line. Longer stenoses are best treated with diamond or house flap. Very large defects may require multiple house flaps or an S-plasty.^{31,32}

Mucosal Advancement Flap

Mucosal advancement flaps are best suited for treating midlevel and upper anal canal stenosis. The scar tissue is excised and a unilateral or bilateral internal sphincterotomy is performed if the underlying anal sphincter complex is also scarred and stenotic. A flap of healthy proximal rectal and anal mucosa with the underlying muscle is then undermined for 2 to 5 cm and advanced over the defect. Advancing the flap too far and suturing it to the anal verge may result in ectropion, leading to difficulty with incontinence and mucus discharge. Studies demonstrate success rates of up to 90% with the main complications being abscess, fecal leakage, and restenosis.³⁴

Anoplasty

Several options for flap configuration exist, of which the most common flaps will be described below (—Figs. 1 and 2). In general, the operative techniques include adequate mobilization to avoid tension and the maintenance of a healthy blood supply to the flap. The pedicled flap should typically retain a wide base, with care taken not to cone in when dissecting deep to the anoderm.

The Y-V advancement flap is performed by making a Y-shaped incision with the vertical limb of the Y extending into the area of stenosis and the two arms of the Y extending widely out onto the perianal skin to form the V. The V flap is mobilized, generally down to the underlying fascia to

Table 1 Classification of anal strictures

Severity of stricture	
Mild	Tight anal canal can be examined by a well-lubricated index finger or a medium Hill-Ferguson retractor
Moderate	Forceful dilation is required to insert the index finger or a medium Hill-Ferguson retractor
Severe	Neither the little finger nor the small Hill-Ferguson retractor can be inserted without forceful dilation
Level of stricture	
Low	At least 0.5 cm below the dentate line
Middle	0.5 cm proximal or distal to the dentate line
High	More than 0.5 cm proximal to the dentate line

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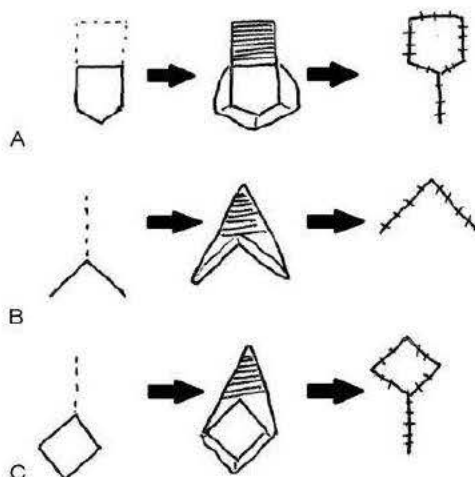


Fig. 1. Anoplasty (A: house flap, B: Y-V flap, C: diamond flap).



Fig. 2. Anoplasty. (Image courtesy of W. Brian Sweeney, MD.)

maintain its subdermal vascular plexus. This is then sutured into the vertical limb of the Y incision. If the proximal portion of the flap is too narrow, the patient may have insignificant widening of the stenosis.

V-Y advancement flap is performed by making the V-shaped incision with the wide base oriented toward the dentate line. Once again, the flap is mobilized ensuring that the subdermal vascular plexus is preserved. The donor site is closed primarily, creating the vertical limb of the Y. The flap is then secured proximally to replace the area of excised scar.

To create a diamond flap, the scar tissue is incised and a diamond-shaped flap is created on the perianal skin at the distal end of the incision. Again, the flap is advanced over the area of incised scar and the donor site is closed primarily. Similar to the diamond-shaped flap, the U-shaped flap is

created on the perianal skin after the anal stenosis scar tissue is incised and the flap is advanced over the area of incised scar. The donor site is left open to heal.³⁵

The house flap anoplasty is used for anal stenosis when a V-Y advancement flap may not provide adequate tissue coverage. It has the advantage of a larger, flat proximal segment without a corner that can be susceptible to ischemia. A longitudinal incision is made from the dentate line to the end of the stenosis. The flap is created in the shape of an inverted house with the base oriented proximally and is advanced into the anal canal and secured in place. It is of paramount importance that the flap be created with an adequate length and width to cover the defect. The donor site can be left open or closed primarily. Bilateral house flaps can be used for severe stenosis or ectropion.³⁶⁻³⁸

Rotational S flap

The rotational S-plasty flap is well suited for coverage of large areas but it does not work as well to open strictures as an advancement flap. Rotational S-plasty flaps are full-thickness flaps with the length of the base equivalent to its length. After the scar at the anal canal is excised, the flaps are rotated such that the apex is sutured to the opposite side of the anal canal and the side of the flap is sutured to the lateral wall.

Farid et al compared 63 consecutive patients with anal stenosis by utilizing the house flap, rhomboid flap, and V-Y anoplasty. A total of 90% of patients with a house flap had clinical improvement at 1 year compared with 60% of patients with a rhomboid flap and 30% of patients with Y-V anoplasty. The incidence of complications was lowest in the house flap cohort and included ischemia of the flap in one patient, delayed healing in one patient, and sepsis in one patient. Patient satisfaction was significantly higher among patients with a house flap compared with a rhomboid flap or Y-V anoplasty.³⁷

Fecal Incontinence

Fecal incontinence following anorectal surgery can result from several issues. In cases such as fistulotomy, sphincter muscle may have been intentionally divided with an underestimation of the functional consequence. At other times, damage to the anal sphincter or associated nerves occurs unintentionally. This can be due to direct mechanical or thermal trauma, or due to subsequent infection. Meticulous surgical technique is paramount in avoiding unintentional damage to the anal sphincter. It is also essential that the risk of fecal incontinence be included in the informed consent prior to surgery. Incontinence related to specific anorectal procedures, as well as the approach to diagnosis and treatment of incontinence, is included below.

To prevent fecal incontinence after fistula surgery, the integrity of the anal sphincters prior to surgery must be kept in mind, as many patients undergo multiple surgeries to treat their anal fistula. It is extremely important to document an objective assessment of the patient's preoperative fecal incontinence, as this may aid in your surgical decision making, and also allows a more accurate assessment of postoperative disturbances in continence.

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In select cases, it may also be beneficial to obtain preoperative imaging of the sphincter complex prior to fistula surgery. In a prospective study of 120 patients undergoing preoperative endorectal ultrasound, 37 (30.8%) patients had an internal anal sphincter defect and 17 (15.9%) had an external anal sphincter defect at baseline. Of the 83 patients with no preoperative internal anal sphincter defect, 47 (56.5%) had an internal defect after surgery. Of 103 patients with no previous external defect, 20 (19.4%) were found to have a postoperative external defect.³⁹

Some degree of new-onset fecal incontinence has been reported in 8% of patients following a fistulotomy for a simple fistula, 24% of patients following a fistulotomy for a complex fistula, 25% of patients after a fistulectomy and sphincter repair, and 52% of patients after fistulectomy and advancement flap.³⁹⁻⁴¹ Fistula characteristics, the number of abscesses incised, the number of fistulotomies performed, and the number of sphincter-sparing procedures are associated with the presence of fecal incontinence during follow-up. As expected, patients treated for a subcutaneous fistula tract have a lower risk of fecal incontinence than those with more complex fistulas.^{40,41}

Although endorectal advancement flap is considered a sphincter preserving technique, the sphincter complex can be injured by stretch during the operation, the proximal internal sphincter could be disrupted by the raising of the flap, and an ectropion caused by advancing the flap beyond the internal fistula opening at the dentate line can cause moisture and fecal leakage. In one study, fecal incontinence after endorectal advancement flap for cryptoglandular fistulas was 13.2% and for Crohn fistulas it was 12% at an average follow-up of 28.9 months.⁴²

Incontinence after hemorrhoidectomy is associated with a high incidence of partial or full-thickness internal anal sphincter injury and occasionally external sphincter defects.⁴³⁻⁴⁵ Incontinence has also been seen with intact sphincters, as the hemorrhoidal cushions are known to provide 15% of the patient's resting anal tone, and removal can unmask issues with incontinence that were being aided by these cushions. Excision of hemorrhoids with secondary healing may also cause decreased sensitivity and reduced capacity for rectoanal discrimination.⁴⁶

Fecal incontinence can also occur after PPH, and is usually related to a low-placed staple line or by injury to the internal sphincter due to the large diameter of the circular stapler. In a prospective, randomized trial of 134 patients, de novo fecal incontinence at 1 year was reported in 2.5% of patients undergoing a stapled hemorrhoidopexy compared with 7.5% of patients who underwent a Milligan-Morgan hemorrhoidectomy.⁴⁷ In another study of 257 patients undergoing stapled hemorrhoidopexy with a mean duration of follow-up of 6.3 ± 1.2 years, 11 patients (4.9%) reported newly developed fecal incontinence.⁴⁸

Fecal incontinence is seen in 1.5 to 8% of patients after lateral internal sphincterotomy.^{49,50} In a study of 31 women who underwent lateral internal sphincterotomy (LIS) for a chronic anal fissure, continence scores were significantly correlated with the extent of division of the internal anal sphincter muscle.

Division of less than 25% of the internal anal sphincter (IAS) was correlated with a minimal risk of incontinence.⁵¹

The evaluation of patients with fecal incontinence should start with a thorough history and physical examination. Further studies including anorectal manometry, endorectal ultrasound, and pudendal nerve testing can assist in determining the cause of fecal incontinence. Anorectal manometry is a useful objective measure of the power of the internal sphincter and the external sphincter during voluntary contraction. Endoanal ultrasound is useful for the identification and detection of defects in the anal sphincter muscles. Magnetic resonance imaging of the anal sphincter complex is an alternative to ultrasound with equivalent accuracy, but it is significantly more expensive than ultrasound, and should be reserved for select cases.

Medical management is the best treatment for the majority of patients with fecal incontinence after anorectal surgery. Bulking of the stool with fiber or antidiarrheals can make the stool easier to control and decrease the frequency of incontinence episodes. Biofeedback and sacral neuromodulation have also been shown to decrease fecal incontinence severity and improve quality of life.^{52,53} However, this has not been well studied in patients with iatrogenic injury to the anal sphincter complex. For patients with sphincter disruption, sphincteroplasty may also be helpful,⁵⁴ although this surgery is not typically associated with long-term durability.

Chronic Pain

Chronic anal pain after anorectal surgery can be disabling for the patient and difficult to treat. To some degree, acute anal pain is common following anorectal surgery, particularly after hemorrhoidectomy, but this generally resolves completely within 3 to 4 weeks. Prior to surgery, patients should be counseled about the anticipated duration and intensity of postoperative pain.

The causes of chronic pain after anorectal surgery are numerous. This pain can be related to residual underlying pathology, new or ongoing fissures and/or thrombosed hemorrhoid, or subtle anal infections. If postoperative pain persists beyond what is expected, the patient should undergo a detailed evaluation focused on the above-mentioned causes, with special attention paid to the possibility of an occult infection or a nonhealing wound. If a thorough exam cannot be completed in clinic, an exam under anesthesia may be helpful to determine the source of pain.

Chronic pain syndromes after stapled hemorrhoidopexy are uncommon but well described. Patients undergoing stapled hemorrhoidopexy generally have less immediate postoperative pain and less chronic pain than open hemorrhoidectomy.^{28,55} In a prospective randomized trial at a mean follow-up of 16 months, 14/50 patients undergoing an open hemorrhoidectomy and 9/50 patients undergoing stapled hemorrhoidopexy complained of occasional long-term pain.⁵⁵ When chronic pain does occur after PPH, it may be due to smooth muscle incorporation into the staple line. It has also been attributed to persistent hemorrhoidal disease, sphincter spasm, anal fissure, anorectal sepsis, or retained staples. Overall rates of chronic pain after PPH range from 1.6 to 31%.⁵⁶

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Treatment of chronic pain following anorectal surgery should be targeted to the underlying source. Warm sitz baths and nonsteroidals can relieve mild pain. Antispasmodics such as diazepam or cyclobenzaprine may be added if levator spasm is noted. Anismus may be treated with botulinum toxin injection.⁵⁷ Sacral neuromodulation has also been described for chronic pelvic pain after anorectal surgery.⁵⁸ If retained staples after PPH are identified, an exam under anesthesia with staple removal is appropriate. Thankfully, many patients with pain will slowly improve over time. Overall, chronic pain after anorectal surgery can be quite difficult to manage, which reinforces the importance of proper knowledge of the anatomy and use of meticulous surgical technique.

Conclusion

While anorectal surgery is generally well tolerated, short- and long-term complications frequently occur. To battle this, the surgeon should perform a thorough preoperative work-up of the patient's baseline disability, along with a detailed discussion of complications during the informed consent process. When complications do occur, prompt identification and elimination of the offending pathology can limit the long-term impact on the patient's quality of life.

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) JTF -JMG, Medical Department, Guantanamo Bay, Cuba
04 Dec 18/1520	<p>SMD Note:</p> <p>Here to discuss A/I- GI results and BP. He had colonoscopy Friday night. This did not show any cause of proctitis, but did show anal structure, likely 2/2 prior hemorrhoid surgery x2. GI believes this is the source of rectal pain and bleeding. He verbalized to me that he recommends trying dietary changes + 3-6 months, will reevaluate at next visit and do balloon dilation at next visit w/ pt consent. o/w scope clear. Pt reports pain w/ every Bly and w/h/p w/ AAP. NSH/D team case.</p> <p>BP noted to be very high on day of procedure. Pt had BP in 180s/100s w/o. He took meds on day prior to procedure, but skipped on AM of procedure. scope was @ 1900. Review of records show previously on HCTE 50mg unclear if this was d/c'd 2/2 pt tolerance, side effect, or lack of efficacy.</p> <p>VS: BP 144/97 HR 72 SpO2 100% Pw 0/0</p> <p>Gen A-0 x 3, Pt cooperative + engaged.</p> <p>Reals:</p> <p>Imaging from c-scope reviewed w/ pt.</p> <p>A/ I) Anal structure. Cause of pain and bleeding. Rec'd to try to relax w/ Blys but pt stated cannot. Will trial cons. injunct + reeval w/ GI in 3-6 months.</p> <ul style="list-style-type: none"> - Will research feasibility of getting site marker study at AWH, rec'd to eval. sternal related GI complaints - Will bring handout for low fiber diet. Discussed high fiber foods to avoid. - Will reach out to GI for pain recommendation. Trial benzo? Nitro paste? - Print out remainder of labs from October. <p>2) BP. Not well-controlled on verasc. Will add 2nd agent depending on anal conb. results.</p> <ul style="list-style-type: none"> - Recheck BP in wk 2 after starting new conb. BP med. - F/A w/ SMD in 2 wks. <p style="text-align: right;">Jmo</p>

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) JTF - JMG, Medical Department, Guantanamo Bay, Cuba
10 Jan 19/1440	<p>SMD Note:</p> <p>pt here today to discuss other options to manage his chronic rectal pain. Per pt, he has had rectal pain since his initial surgery at his rectum in 2006. He also had another rectal surgery in 2016 for hemorrhoidectomy (internal and external) as well as rectal prolapse repair. He reports that he always has rectal pain, which gets worse after bowel movements. Reports intermittent bright red blood with bowel movements. The topical medications that he has tried did not help per patient. He reports straining with bowel movements and reports soft normal amount stools. He denies any nausea, or changes in appetite. He reports of occasional abdominal pain on the right and left side.</p> <p>O: T 98° F BP: 157/103, repeat 168/112 P: 73 O₂ sat: 100% Room air</p> <p>Gen: well appearing in no apparent distress CV: S1/S2, RRR, no murmurs/rubs/gallops neck: & carotid bruits bilaterally Resp: CTAB & wheezes/rales/rhonchi Abd: hyperactive bowel sounds, non-tender to deep palpation, no rebound, no guarding, soft Rectal: noted anal skin tags, noted anal surgical change, no evidence of thrombosed external hemorrhoids, no rashes (see next page)</p>

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SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
JTF - JMG, Medical Department, Guantanamo Bay, Cuba

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
10 Jan 19/1440	<p>SMO Note continued:</p> <p>(1) <u>Rectal pain, chronic</u>: unclear etiology, however, likely due to surgical changes from previous procedures. Colonoscopy performed on 30 Nov 2018 did not reveal any malignancy or inflammation, no findings to explain CT findings and noted normal colon and terminal ileum. Trial of topical rectiv 0.4% lidocaine ointment and diltiazem, however, no improvement per patient. Continue to use stool softeners to include Mg Oxide, Miralax and metformin. Also has been using tucks without improvement.</p> <ul style="list-style-type: none"> - discontinue rectiv and topical lidocaine given no improvement and patient request - patient may continue tucks if preferred, however, may discontinue later on since it does not improve his pain. - may consider using Lincos for likely constipation (pt reports straining during bowel movement despite of Mg Oxide, miralax and metformin) - may consider consulting gastroenterologist for other options to manage rectal pain including trial of topical norepinephrine <p>(2) <u>Hypertension, essential</u>: On Lotrel 5/20 mg daily. BP today elevated at 157/102 and 168/112 on repeat. Denies headache, visual changes and chest pain. Physical exam unremarkable.</p> <ul style="list-style-type: none"> - per JNC 8 BP goal <150/90; will increase dose of Lotrel to 2 tabs, thus, total dose of 10/40 mg daily - continue blood pressure log - follow-up in 4-6 weeks for hypertension management <p>(3) <u>History of kidney stones</u> flank pain improved. Denies any urinary symptoms. No further work up or management at this time. Reviewed previous CT findings of non-obstructive stones.</p> <ul style="list-style-type: none"> - Discontinue flemox. <p style="text-align: right;">SMD JFP SMO</p>

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MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
<small>PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies where relevant to their interest in regulating, investigating or prosecuting. The Social Security Number authorized by Public Law 92-507 Section 7(b) and Executive Order 11652 is used as a unique identifier to distinguish between individuals with the same name and birth date and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.</small>			
DATE	TIME	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
1/1/2019	0310	ISN requested and received 3 Tylenol, 2 Tramadol and one morphine. ISN refused evening scheduled med.	
1/1/2019	2100	ISN was active in his room. ISN not available during night med pass.	
1/3/2019	0340	ISN gave 10M his weight for the month of January which was 144.1. ISN also refused all evening medications, except the 4x morphine and 10mg powder. SMO to be notified.	
1/3/2019	1631	I asked ISN about why he is refusing his meds and he said that he just don't want to take any of them anymore. I asked if there is a specific reason and he said no, he just don't want to. I explained to him that his blood pressure medications is on the meds because he is hypertensive and he said that he knows and he don't want to take anymore medications. He said that he just wants his other med his morphine. I also asked to get a sample of his urine for his urology appointment that is coming up and he said that he refused it and already told SMO that he didn't want to go.	
1/3/2019	1730	ISN refused his evening medication. I explained to him that it is important to take the blood pressure meds without and he said that he doesn't want any of it. He was complaining of a headache and requested tramadol. The computer is currently waiting on pharmacy to fill the order so he can get it. Corporal ask him how bad is the headache and he said that it was really bad and would want for the tramadol. He was asked again if he wants the meds and he said that he didn't want it, he denied any further treatment and is waiting on the tramadol to come.	
1/3/2019	1520	ISN requested and received 3 325mg Tylenol, 2 50mg Tramadol for 710 head pain. ISN refused evening scheduled med.	
1/4/2019	900	ISN requested and received 100mg Tramadol and 975mg Tylenol. ISN also received fentanyl and morphine. ISN requested to have a TSI guard to replace Psych during the appointment.	
1/4/2019	1600	New order transcribed to MAR. D/C Dilazepam cream. Start receive 0.4% ointment. Apply to affected area twice daily with Lidocaine.	
1/4/2019	1021	ISN was asked if he would like to reconsider and attend Urology consult that was scheduled for him as he refused previously. ISN agreed to appointment. Wash Commander informed of change.	
1/4/2019	800	ISN requested and received 100mg of tramadol and 975mg of tylenol. ISN refused urology appointment, claims that he is too tired. ISN also complained of a headache after using the rectal suppository. SMO has been notified.	
1/4/2019	1330	ISN requested receive rectal during morning med pass and evening med pass. Transcribed to MAR.	
1/7/2019	1342	ISN requested and received 100mg Tramadol and 975mg Tylenol. ISN was told corporal will come back to room in one hour to ask if pain level is better. ISN Understood. J06836778 present.	
1/8/2019	1020	ISN requested to speak with a Corporal stating he would like to speak with SMO about his back. Revis and Lidocaine cream. ISN said he would still like to continue with his medications and his treating with SMO. ISN was asked if he knows the implications of d/c his medications and he said he understood. J06817791 was present on Tier.	
1/9/2019	1464	ISN requested and received 100mg Tramadol and 975mg Tylenol. ISN was told corporal will come back to room in one hour to ask if pain level is better. ISN Understood. J06851150 present.	
1/10/2019	1315	ISN refused rectal and lidocaine during evening med pass.	
1/11/2019	406	New order transcribed to MAR per SMO. 1 D/C Revis. 2 D/C Lidocaine topical. 3 Change font to S20mg (Take 2 tabs PO daily at the same time). 4 D/C Tramadol 97.5mg CAP.	
1/12/2019	1100	ISN requested and received 100mg of Tramadol and 975mg of tylenol.	
1/12/2019	1315	ISN complained of lower back pain. ISN described it as sharp 10/10 pain. Corporal explained that he was given naproxen as part of his evening med pass. Corporal instructed the ISN to notify corporal if the pain persists an hour after taking naproxen. SMO notified.	
1/14/2019	2025	ISN requested and received 100mg of tramadol and 975mg of tylenol.	
1/17/2019	1335	Upon evening med pass, offered ISN an annual physical with SMO and ISN refused. ISN has no other concerns at this time.	
1/17/2019	1820	ISN requested and received 100mg of Tramadol and 975mg of tylenol.	
1/20/2019	906	SMO requested 10M to take ISN BP checks today. 3x week until further notice.	
1/20/2019	1320	ISN requested and received tramadol 100mg and morphine 975mg and amoxicillin with evening med pass.	
1/22/2019	1524	ISN requested and received 100mg 2 tabs of Tramadol. ISN denies any further treatment or medication.	

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