

THE HIGH COURT

[2022] IEHC 128

Record No.2020/3773P

BETWEEN

A. Z. (SUBSTITUTED BY ORDER)

PLAINTIFF

AND

ROBERT HANNON

DEFENDANT

JUDGMENT of Mr. Justice Michael Hanna delivered on the 24th day of February, 2022.

1. The plaintiff in this action was granted a declaration of anonymity pursuant to s.27 of the Civil Law (Miscellaneous Provisions) Act 2008. She is a married lady, has children and is currently in her 6th decade.
2. The defendant is a consultant general, colorectal and laparoscopic surgeon practicing at the Beacon Hospital, Dublin.
3. The plaintiff alleges in these proceedings that she has suffered serious personal injury, mental distress, loss and damage as a consequence of the negligence, breach of duty and breach of contract of the defendant in the provision of medical and surgical services. Specifically, the plaintiff complains that she developed anal stenosis and a rectovaginal fistula with resultant severe pain and suffering as well as psychological injury in the form of Post-Traumatic Stress Disorder (PTSD).
4. Having successfully completed first and second level education, the plaintiff obtained qualifications in scientific subjects at university level. Circumstances dictated that she take up employment in an alternative sector and she worked happily there for over 20 years. Following voluntary redundancy she has, in recent years, *inter alia*, expanded her qualifications in matters scientific. She has not yet obtained employment in this field; she seeks to attribute this state of affairs to the physical and mental injuries of which she complains.

Background

5. On 15th May 2018 the plaintiff attended her general practitioner (GP) complaining of haemorrhoids. Prior to this her material medical background consisted of endometriosis, pelvic floor repair for urinary incontinence and the removal of a melanoma some 15 years before. Her children were full term normal deliveries. She was referred to the defendant who first saw her on 30th May 2018. She presented with a bulging anal canal and pain and discomfort with cleansing. Physical examination identified a very prominent anal sphincter, a marked perineal descent, and Grade IV external haemorrhoids. The defendant prescribed a conservative treatment regime involving pelvic floor physiotherapy and medication. This was a qualified success and gave her some relief but did not sufficiently improve the plaintiff's complaints.
6. Another consultation took place with Professor Hannon on 11 July 2018. He noted a good result from the pelvic floor physiotherapy. The physiotherapist reported, *inter alia*, that the plaintiff had an overactive pelvis. She was still concerned with her haemorrhoids and

next steps, including the surgical option, were discussed in some detail. Although there is some dispute as to the precise detail of this discussion, this consultation lasted approximately 30 to 45 minutes and included the defendant drawing diagrams to explain what was involved. The plaintiff was of a mind to proceed with surgery.

7. The plaintiff was admitted to hospital and the defendant carried out an open haemorrhoidectomy on 13th August 2018. No issue relating to informed consent is raised. The defendant's operation note records as follows: –

“Lithotomy. Prominent EAS.

Grade IV haemorrhoids.

Pedicle and external component excised.

Mobilised from IAS/EAS at 4, 7, 11 o'clock, leaving adequate skin bridges.

Haemostasis. Spongostan.”

8. In the immediate aftermath of the operation, the plaintiff suffered from severe pain, anal bleeding and had great difficulty passing motion. On 10 September 2018 she returned for a follow-up visit to Prof Hannon who carried out an internal examination under general anaesthetic which revealed, *inter alia*, some oedema at the skin bridges and considerable spasm. He increased her medication and raised the possibility of Botox injections. He also advised a topical cream; the plaintiff previously found that this did not agree with her.
9. The plaintiff's pain and discomfort continued and her GP referred her back to the defendant for immediate assessment on the 1 November 2018. By this stage she was described as being in an extremely distressed state. The defendant arranged examination under anaesthetic on the 12 November 2018. On this occasion, Botox injections were administered by Prof Hannon under general anaesthetic. His notes of the material procedure read as follows: –

“EUA: tight anal canal. Wound healing at 12 o'clock – 6 o'clock. Anal canal dilated with digital manipulation. 100 in Botox at 3 o'clock/9 o'clock.”
10. The plaintiff was discharged having been advised regarding further medication and physiotherapy. She did not attend a follow-up appointment. This was the end of her professional involvement with the defendant. She had lost confidence in him. (On 1 March 2020, after she had been treated by Prof Winter, she wrote to the defendant voicing her concerns. The defendant responded courteously to this letter but, evidently, that did not resolve matters which is why we are here). In any event, the plaintiff continued to experience considerable pain and discomfort and was deeply distressed. Around this time, the plaintiff experienced the emotional hammer-blow of the sudden death of her sister.
11. The plaintiff was referred by her GP to Prof Des Winter. She reported to him that she had been dependent on laxatives since her operation. She described a very thin stool with

pain and difficulty in passing. Prof Winter conducted an examination under general anaesthetic (EUA). He observed stenosis in her anal canal which he measured at 8 French (the grading scale employed for measuring diameter). He dilated the anal canal under general anaesthetic to 18 French. He considered this acceptable for function. He found a co-existent posterior fissure for which he injected Botox. The plaintiff experienced substantial improvement in her condition.

12. She underwent a further examination and dilation of the anal canal under general anaesthetic in July 2019, again carried out by Prof Winter.
13. Around the end of April 2019 the plaintiff attended her GP. She had noticed a small lump in her vagina area. The GP thought this appeared to be a non-infected cyst and prescribed topical cream and baths with advice to return if there was no improvement. The plaintiff attended her GP on 29 August 2019. The lump had remained and was discharging. She was prescribed antibiotics and was referred by her GP to Dr Kroon, a consultant gynaecologist, for treatment of what appeared to be a persistent cyst in the vaginal glands (a presumed Bartholin cyst). Dr Kroon advised that appropriate treatment was to conduct a polypectomy and a marsupialisation. While carrying out this procedure under general anaesthetic on 9 October 2019, a lesion was discovered in the perineal body. The possibility of a fistula (an unnatural channel between two otherwise unlinked organs) was raised and the plaintiff was referred for an MRI scan of her pelvis. This took place on the 17 October 2019 and showed some evidence of a fistula. Dr Kroon referred the plaintiff back to Prof Winter for investigation.
14. On the 22 November 2019, Prof Winter carried out another examination under general anaesthetic and it was noted that there was granulated tissue inside introitus on the posterior wall and there was a fistula connecting with the anorectal junction on the anterior wall. A seton suture was inserted into the fistula tract and this was changed under general anaesthetic on 17 January 2020.
15. The plaintiff underwent a full fistulotomy on 6 March 2020 by Prof Winter. She experienced very severe postsurgical pain and consequent difficulty with sitting, walking, bending and passing motion. Thereafter, these symptoms and her physical condition improved considerably. In November 2020, a barium follow-through and a colonoscopy were carried out to rule out Crohn's disease and irritable bowel syndrome as potential causative factors of the fistula. Overall, the plaintiff has made a full and satisfactory recovery from those physical aspects of her injury, pain and suffering which she attributes to the alleged wrongdoing of the defendant.
16. Since the open haemorrhoidectomy, the plaintiff has undergone eight procedures under general anaesthetic and has suffered severe pain and distress which, she claims, has had a deleterious effect on her personal life and mental health. She lays the blame for this upon the defendant. Dr Abbie Lane, a consultant psychiatrist, gave evidence that the plaintiff developed PTSD. This diagnosis is not disputed by the defendant. Dr Lane examined the plaintiff in May 2021 noted that she was a strong person with good coping skill but that she had a "long way to go" and the prognosis for her PTSD was very

guarded. Dr Lane considers the plaintiff to be unfit for work and recommended the cognitive behavioural therapy and the administration of antidepressant or anxiety medication.

Pleadings

17. The plaintiff's personal injury summons, *inter alia*, alleges negligence, a failure to exercise due skill and exposing the plaintiff to a risk of injury against the defendant. The plaintiff's areas of complaint are fourfold. Firstly, the plaintiff's overactive pelvic floor should have prompted consideration of a more conservative haemorrhoidectomy with less tissue excised and the preservation of larger than average skin bridges. Secondly, the defendant allegedly caused or permitted a full thickness or excessively deep diathermy burn to the rectovaginal septum. Thirdly, the defendant caused a rectovaginal fistula as a consequence of excessive surgical dissection. Finally, the defendant caused or permitted two unusual and unrelated surgical complications to occur as a direct result of sub – standard surgical performance. Generally, the indorsement contains allegations that the anal stenosis and fistula were due to the removal of excessive tissue and the making of too deep an incision.

18. In a full defence, the defendant, *inter alia*, denies any negligence and contends that he carried out the surgery at issue with due skill, care and diligence and that "[t]he surgery was performed in a technically standard manner." Considerable stress is laid upon the medical records including the contemporaneous notes of the surgical procedure. The defendant contends that he paid particular attention to the plaintiff's pre-existing pelvic floor condition and to perineal descent. Any suggestion of an injury or deep diathermy burn to the rectovaginal septum is denied. The defendant contends that injury to that kind to the rectovaginal septum would have resulted in immediate or early postoperative symptoms of rectovaginal fistula. This did not occur. Overall, the defendant acted in accordance, at least, with the standard to be expected of any consultant general and colorectal surgeon of equal qualification and skill, acting with ordinary care.

19. This case was heard over 8 days. No dispute arose with regard to the pain, general debilitation and mental distress which was suffered by the plaintiff. As the case evolved it became apparent that the central issues were factual. Were her physical and mental complaints unfortunate consequences of otherwise competent surgical treatment or were they negligently caused? In seeking to establish the latter proposition, the following questions arise. Firstly, when carrying out the haemorrhoidectomy on 13 August 2018, did the defendant leave adequate skin bridges between the surgical scars left by the removal of the haemorrhoids thereby causing the plaintiff to suffer stenosis? Secondly, did the defendant conduct the surgery in a substandard way such as gave rise to the formation of a fistula between the plaintiff's rectal and vaginal areas?

The Evidence on the Issue of Liability

20. With the exception of the plaintiff, all of the witnesses called in this case were medical practitioners. Two independent witnesses were called on the issue of liability. The plaintiff called Mr Oliver Jones whose evidence was heard by video link. The defendant called Prof Deborah McNamara. On behalf of the plaintiff, Prof Des Winter was also called. He was

the surgeon who subsequently treated the plaintiff and, as such, he was primarily a witness as to fact. However, his evidence became centrally important to the plaintiff's case, perhaps more so than had been anticipated during the plaintiff's opening remarks. The defendant also gave evidence. The qualification and expertise of these witnesses to give evidence upon the matters in issue was not in dispute.

21. I propose to set out a summary of the evidence given by each of the above. It is not intended to be an exhaustive account and my conclusions in this matter may allude to details of the evidence not recited under this heading.

Mr. Oliver Jones

22. Mr Oliver Jones, a consultant colorectal surgeon, gave evidence on behalf of the plaintiff. He prepared two medical reports based on the plaintiff's personal statement in the medical records of Prof Hannon, Prof Winter, Dr Kroon, the plaintiff's GP and those of St Vincent's Private Hospital he did not carry out a physical examination of the plaintiff. He has been a consultant in Oxford University hospitals NHS Foundation Trust since 2009 and Clinical Director of that facility since 2018. He has, inter alia, a particular expertise in pelvic floor conditions.
23. Mr Jones gave evidence regarding the plaintiff's material pre-operative condition, her treatment, the operation and its aftermath. The plaintiff suffered haemorrhoids for which there are no routine investigations usually done prior to the treatment of haemorrhoids other than excluding other causes for haemorrhoid-type symptoms. The plaintiff underwent a colonoscopy 18 months previously so that no further investigation by Prof Hannon was warranted.
24. He observed that the plaintiff's prominent anal sphincter illustrated a tightness in the muscle that might contribute to prominence of the haemorrhoids. Patients with a very tight or protracted sphincter might be expected to experience more pain after surgery. Prof Hannon addressed this by prescribing diltiazem which reduces spasm in the internal anal sphincter muscle.
25. The plaintiff's perineal descent, the degree to which the pelvic floor descends, was indicative of a weak pelvic floor which prompted Prof Hannon's referral of the plaintiff for pelvic floor physiotherapy.
26. The topical haemorrhoidal-type creams are good for symptoms of pain, itching and irritation but they do not address prolapse, bulging or the haemorrhoidal lumps themselves. Prof Hannon's initial assessment was reasonable and appropriate and there is evidence that he made an effort to avoid surgery by trying conservative measures.
27. The plaintiff had Grade IV haemorrhoids; her haemorrhoids were permanently prolapsed. Grade IV haemorrhoids cannot be treated in the same way as Grades I-III haemorrhoids i.e. dietary adjustment, outpatient treatment such as injection of irritants or banding. In his opinion, Prof Hannon's surgical treatment of the haemorrhoids was reasonable in the circumstances. When considering the best treatment for haemorrhoids, regard must be

had to the likelihood of success and the degree of attendant pain. The open haemorrhoidectomy was appropriate and most surgeons would not have offered an alternative surgical approach given the anatomical distribution of the plaintiff's haemorrhoids and her symptoms.

28. Turning to the operation, Mr Jones observed that It is difficult to comment on the quality of an operation from the written notes alone as the surgeon will write down a record of what they consider having happened or what was their aspiration. There is a degree of subjectivity involved given that judgments of individual surgeons are involved. The operation notes refer to skin bridges which are areas of skin preserved between each excised haemorrhoid. It was common case between the expert medical witnesses that preservation of adequate skin bridges was a centrally important consideration. The purpose was to enable healing and preservation of the muscles, the internal anal sphincter and the external anal sphincter.
29. Mr Jones said that the operation notes describe a standard open haemorrhoidectomy in the standard position in the anal canal. The notes record that the haemorrhoids were excised leaving adequate skin bridges. While wounds are usually closed to aid healing, stitching closed wounds in the anal canal would involve a very high rate of infection opening up the wounds which is what is intentionally done with an open haemorrhoidectomy. This a common form of haemorrhoidectomy and requires healing to occur from the wound edges inwards from the skin bridges.
30. Determining whether skin bridges are adequate is a subjective assessment. There is no set measurement for a skin bridge and skin bridges are not formally measured during the operation. Skin bridges vary from patient to patient based on their anal canal pressure and how many wounds are being made in the course of the haemorrhoidectomy.
31. It is generally accepted in colorectal surgery that the more radical the excision, the greater the risk of stenosis. In cases of open haemorrhoidectomy, significant stenosis involving anal dilatation is rare and when it does occur this is more often than not because the skin bridges were not of adequate size. In a 2009 review of anal stenosis in the World Journal of Gastroenterology called "The Surgical Treatment of Anal Stenosis", the authors concluded that 90% of anal stenoses are caused by overzealous haemorrhoidectomy.
32. In a nutshell, in the absence of any identifiable feature in the surgical notes, the plaintiff's stenosis was most likely caused by excessively radical excision of skin and tissue during the haemorrhoidectomy. This view was informed by the statistics, such as may be gleaned from the relevant medical literature, and from his own extensive experience.
33. Mr. Jones then turned to the plaintiff's fistula. He described this a very rare complication of open haemorrhoidectomy. The most likely cause was a full thickness injury or deep diathermy burn to the rectovaginal septum (the tissue between the bowel and the septum). The haemorrhoids sent for pathological examination contained the

haemorrhoids but no deeper structures so the cause of the fistula was not the removal of deeper structures rather damage to these deeper structures likely by diathermy.

34. Pain after an haemorrhoidectomy is very variable between individuals and can be very severe. The pain usually peaks several days after surgery and persists for two or three weeks, though often for longer. Most surgeons do not review patients until six to eight weeks after surgery as prior to this it may be difficult to undertake an adequate examination. Prof Hannon was correct in his decision to undertake an examination under anaesthetic on 12 November 2018. There was stenosis at that time and this was stretched up. It was reasonable to inject botulinum toxin to try to counteract any functional obstructions.
35. Mr Jones did not consider it negligent not to have identified the fistula at this time as it might not have occurred yet and a fistula can be very difficult to find: Prof Winter did not detect on 19 April and Dr Kroon was suspicious of it on 9 October 2019 but was not certain and could not detect a connection with the rectum.
36. Mr Jones agreed with Mr Hannon's view that a tighter pelvic floor makes healing of anal wounds slower and would increase the risk of stenosis. In such circumstances, Mr Jones was of the view that a haemorrhoidectomy should be more conservative with less tissue excised and with the preservation of larger than average skin bridges.
37. The complication of rectovaginal fistula is a less common complication quite separate from the issue of stenosis. It is likely that in the absence of any underlying condition, such as Crohn's disease, that the fistula resulted from the surgical dissection being too deep into the tissue between the bowel and the vagina (the rectovaginal septum). Given the appearance of the haemorrhoids under the microscope and the fact that there was no deep tissue included within the resection, it is more likely than not this resulted from a diathermy burn or injury to the deep tissues rather than a full-thickness excision.
38. Whilst it is very difficult to assess the quality of an operation from the written notes alone, the plaintiff sustained two unusual and separate complications. Each would, more likely than not, be attributable to poorly performed surgery. The fact that two separate complications occurred together makes the likelihood even higher that surgery was of an inadequate standard.
39. Under cross-examination by counsel for the defendant, Ms Egan SC, Mr Jones said that it would be reasonable to proceed with the surgery if the plaintiff had been informed that the haemorrhoidectomy would not resolve her problem with her very prominent anal sphincter which she described as her "sticky out bum".
40. Mr Jones says that in circumstances where someone suffers two complications which are recognised complications make it very, very likely that there was negligence. Ms Egan stressed that if 90% of anal stenoses result from overzealous haemorrhoidectomy, the corollary is that 10% do not. Mr Jones replied that, leaving aside the fistula, there would

be a 10% chance that the plaintiff would fall within the 10% of patients not having an overzealous haemorrhoidectomy.

41. In response to Mr Jones' assertion that the plaintiff suffered stenosis due to overzealous surgery which left behind inadequate skin bridges, Counsel for the defendant put it to Mr Jones that a surgeon of the defendant's expertise, knowledge and experience would appreciate the adequacy of skin bridges and that his recording of same was reliable. Furthermore, no problem with the skin bridges was observed at the plaintiff's first post-operative examination in September of 2018. was carried out by Prof Hannon who noted oedema at the site. Mr Jones responded that, based on the statistics, the likelihood is that the defendant did not leave adequate skin bridges. Mr Jones said very difficult for any surgeon to make an assessment of skin bridges soon after haemorrhoid surgery because patient is uncomfortable and there is a lot of swelling and inflation in the anal canal.
42. Mr Jones was asked by defendant counsel to respond to findings from a physical examination of the plaintiff's perianal area in November 2021 by Prof Deborah McNamara, carried out on behalf of the defendant. She had found, inter alia, wide skin bridges of normal, healthy appearing perianal skin. There were clearly visible scars in the 5, 7 and 12 o'clock positions with evidence of wide separation between the scars, where healthy, mobile perianal skin is observed. No evidence of inadequacy of the skin bridges in any part of the anal canal that could be visualised on inspection.
43. Mr Jones responded that the plaintiff no longer had stenosis so there has been some stretching up of the tissues. The wounds had reduced to 2mm either due to the stretching of the skin bridges or growth of the skin from the edges of the skin bridges into those former sites of the wounds. Counsel for the defendant put it to Mr Jones that Prof McNamara would be able to distinguish between stretched skin than normal looking skin and stretched scarring and normal scarring.
44. Mr Jones said that Prof McNamara's examination was a simple inspection of the skin at the anal verge and it did not involve any exam within the anal canal which is where the stenosis occurred. The skin bridges extend up into the anal canal and those were not visualised. It is not possible to make a definitive opinion on the size of the skin bridges on the inside by inspection on the outside. The stretching was done up inside the anal canal and that was not visible when you look at the anal canal from the outside. Counsel for the defendant put it to Mr Jones that the appearance of normal skin and normal scarring at the site of operation could also be explained by a normal post-operative examination of a normally conducted operation. Mr Jones accepted that, in the absence of subsequent stenosis, this would be compatible with a normally conducted haemorrhoidectomy.
45. Counsel for the defendant asked Mr Jones the likelihood that there would perfectly normal scarring on the outside but abnormal scarring on the inside. Mr Jones responded that it is possible to go wider out into the circumference of the anal canal and be much more radical on the inside than the outside: A retractor is inserted into the anal canal to hold it open and as the dissection continues from the outside into the anal canal, the haemorrhoid is being pulled down as it is lifted away from the tissues underneath which

could potentially pull in tissues from further around the circumference of the anal canal. (This was not in his report as he did not know the physical exam was to take place on 1 November 2021).

46. Mr Jones stated that the risk of significant fibrotic stricture requiring dilation to be less than 1 in 100 and the risk for rectovaginal fistula would be less than 1 in 1,000 citing Bouchard et al "One-year outcome of haemorrhoidectomy, a prospective multicentre French Study". Counsel for the defendant highlighted that the paper cited records an incidence of anal stenosis of 23 out of 633 or 3.6%. Mr Jones said the figure of 1 in 100 was based on his personal experience of performing hundreds of haemorrhoidectomies and accepted that this should have been stated in his report. He accepted that in 10% of cases, anal stenosis occurs where adequate skin bridges are left.
47. Dealing with the fistula, Mr Jones observed that the first sign was on 26 April when a lump was discovered that was suspected (wrongly but understandably) to be a Bartholin cyst. This would still be compatible with a fistula having been present since the date of surgery. An alternative scenario would be that the surgery of August 2018 caused damage to the tissues of the anal canal and the tissue of the anal rectum resulting in a chronic wound that led to tissue break down and development of the fistula over the course of a few weeks. In either scenario he believed it more likely than not the fistula was caused by the surgery in August 2018.
48. Counsel for the defendant put it to Mr. Jones, that if there had been a direct, a full thickness injury at the time of operation, Professor Hannon would have had to go through the internal and external anal sphincters, the rectal wall, the vaginal wall and into the vaginal mucosa in order to produce a rectovaginal fistula: the histology offers no support for this proposition.
49. Mr Jones clarified that his two scenarios are: (1) through a hole from the anorectum into the vagina at the time of surgery with something like diathermy or (2) a partial thickness injury with tissue necrosis and gradual progression. He clarified that the tissues between the anorectum and the vagina are extremely thin especially where there is pelvic floor problems, perineal descent and rectocele. In his report, Mr Jones stated that "the most likely cause of the fistula was a full thickness injury or deep diathermy burn to the rectovaginal septum".
50. He explained a "full thickness injury" as a full thickness instrumental injury or a full thickness diathermy burn to the anal canal. He made clear that he was not referring to a full thickness incision i.e. an incision of tissue that went too deep and beyond the margin of haemorrhoids. He rejected the contention that the first symptoms of the fistula were too far removed from the operation for there to have been full thickness injury at the time of operation: A full thickness injury may not be immediately obvious after surgery because likely a very small connection initially between the anorectum and the vagina. Also in the immediate aftermath of a haemorrhoidectomy, there would have been many distracting symptoms. Prof Hannon may not have detected the fistula in September or November 2018 as fistulae are very hard to detect and he had no reason to look for one if

she was not complaining of symptoms consistent with a fistula. Furthermore, such discharge could be in very tiny amounts in the context of unhealed wounds in her perineum from her haemorrhoidectomy so she would be unlikely to attach any importance to it regardless of the fact that she was post-menopausal.

51. Mr Jones accepted the proposition that a dilator may tear the anal canal ("surgical treatment of anal stenosis" by Bristinda et al) but stated that it was unlikely given that the dilators increased in diameter incrementally and were well lubricated. Fistulae are not formed by a minor break in the skin in the presence of bacteria in the anal canal. He also accepted Crohn's disease as an unlikely but possible cause of the fistula.

Professor Des Winter

52. Prof Winter is a colorectal surgeon who has been in practice for 25 years. He has held the position of Consultant Surgeon in St. Vincent's Hospital for 15 years before which he spent approximately 10 years training in Ireland and the United States.
53. In his consultation of 19 April 2019, Prof Winter found that the plaintiff had both pain and difficulty evacuating with very thin stools and a very narrowed or stenosed anal canal from circumferential scarring owing to dysfunctional healing. He described how circular organs become stenosed when a circumferential wound heals by contraction; I will return to the question of what was meant by "circumferential scarring" presently. The healing wound acts like a purse string and is pulled tighter and tighter together into a narrower and narrower hole. The purpose of leaving skin bridges is to leave areas that will not contract and, therefore, will not lead to stenosis.
54. Prof Winter described the plaintiff's measure of stenosis, 8 French, or the circumference of a Bic biro, as significant. A stenosed anus which admits an index finger is okay for function whereas 8 Fr is smaller than that and so requires dilatation. On 19 April 2019, Prof Winter easily and sequentially dilated the plaintiff's anus to 18 Fr which he considered acceptable for functioning. He used Hegar dilators, metallic instruments with rounded tips that are well lubricated. He noted that they should be employed gently and nimbly to avoid injury. Prof Winter injected Botox for a coexistent posterior anal fissure. The fissure had healed by 19 July 2019 when the plaintiff returned to Prof Winter for further dilatation to 18 Fr.
55. The plaintiff, having been seen by Dr. Kroon in the interim, was referred to Prof Winter on 22 November 2019 for an EUA to investigate a suspected fistula. He discovered some granulation tissue just inside the introitus, or the back of the vaginal entrance, which implies a wound or a fistula. He thus discovered a fistula from the introitus to the front wall of the rectum. The area of the granulated tissue was about a millimetre or two or the size of a Bic biro nib. The fistula track went directly from the back wall of the vagina straight into the front of the anal canal. To remedy this fistula, Prof Winter placed a seton or a stitch through the fistula tract, from the vaginal entrance down through the anal canal and out and tied it on the outside. The plaintiff underwent a colonoscopy and barium follow through to rule out Crohn's disease. Prof Winter highlighted that there are mere millimetres between the vaginal wall and the anorectal area, as thin as a few pieces

of tissue paper which makes it very easy to get punctures. As the opening was so small, the plaintiff initially had a small degree of discharge which became troublesome as her anorectal function improved.

56. The plaintiff had the seton suture changed on 17th January 2020 and a fistulotomy on 6th March 2020. A fistulotomy involves opening up the remaining tract and removing the stitch once it has cleared the muscle. At this time the plaintiff no longer had anal stenosis. Prof Winter considered the plaintiff to have excellent anorectal function and prognosis at this point and did not expect any further issues with a fistula or a stenosis.
57. Prof Winter strongly refuted the suggestion that the plaintiff's fistula was caused by his dilatation. Fistulae were a known complication of haemorrhoidectomy. He explained that it is wounding inside the anal canal and not dilatation of a stricture that is likely to lead to a fistula. In Prof Winter's opinion the likely sequence of events was that the plaintiff experienced difficulty with the healing of the circumferential haemorrhoidectomy wound which led to sepsis and then resulted in a fistula which was not immediately apparent due to the plaintiff's other distracting symptoms. He agreed that sepsis can arise without any fault on the part of the treating doctor.
58. The expression "circumferential scarring" appeared during the course of Prof Winters examination in chief by Mr Doyle SC. From a relatively innocuous beginnings it exploded into a perceived "game changer" as far as the plaintiff's lawyers were concerned as is evident from the contrast between Mr Doyle's opening and closing submissions. To be fair, Mr Doyle did couch his opening remarks with reference to the fact that he had not yet consulted with Prof Winter. The significance of the term used, or at least the interpretation which the plaintiff sought to attach to it, was not immediately apparent to Ms Egan SE whose cross examination of Prof Winter was admirably short and to the point. When it became apparent during the course of Prof Hannon's evidence that the defence did not understand it to mean a complete circumferential cut or wound with no apparent skin bridges, as was the interpretation asserted by Mr Doyle, I took the course of having Prof Winter recalled for the purpose of clarification. This was done without objection from either party.
59. Prof Winter gave further evidence by video link. He did not resile from his use of the expression "circumferential scarring". Ms Egan took up cross examination and put it to him that what he had observed and had described as a circumferential scar was stenosis. In response, Prof Winter stated: –

"I would agree that that is exactly what stenosis means, stenosis means a circumferential scar, the origin of which is dysfunctional healing. If you wish me to stray into the causation, the possible reasons why that may occur are multifactorial".
60. He went on to agree that, given the plaintiff's pre-existing conditions of anal spasm and so forth, her healing process was "challenging". He asserted that he was going to confine himself to what he observed. Under re-examination by Mr Doyle SC he said that he saw

"anal stenosis which by definition is circumferential scarring and the word circumferential I mean precisely to be that. Like all clinical doctors, it is precise language that we use, there is no ambiguity in that, that means all around the circumference. It does not mean intermittently".

61. At the conclusion of re-examination, Prof Winter made the following remarks: –

"I am here simply as a witness to fact rather than getting into matters of causation or not. But the simple fact is she had stenosis. That is by definition. Quite why that may occur is multifactorial."

Professor Robert Hannon

62. Prof Robert Hannon, the defendant in this action is a Consultant Colorectal and Laparoscopic Surgeon practising at the Beacon Hospital in Dublin. He is a graduate of University College Dublin and the Royal College of surgeons of England. As part of his higher surgical training he underwent speciality training in colorectal surgery in Manchester in 2008. He completed specialist fellowship training, *inter alia*, in colorectal surgery at the Hope Hospital in Salford and was appointed Assistant Clinical Professor and Clinical Lecturer in Surgery and Surgical Specialities in the School of Medicine in University college Dublin in 2016. In 2020, he was promoted to the position of Associate Professor.

63. The plaintiff was first referred to him on 30 May 2018 with external haemorrhoids and difficulty cleansing. She described difficulty emptying her rectum and problems with constipation. He noted that she had previously undergone, colonoscopy and previous surgery for prolapse with a mid – urethral sling. The plaintiff had grade IV external haemorrhoids in a circumferential arrangement, a very prominent anal sphincter and perineal descent. He formed the view that many of her symptoms, such as the bulging anal canal, arose from her pelvic floor dysfunction and he referred her for physiotherapy and prescribed a muscle relaxant cream, Diltiazem, to treat anal spasm.

64. When he saw her again on 11 July 2018 he felt her problems with her pelvic floor spasm and building were much improved. However, she said she still had problems with her self-described "sticky out bum". She wanted her haemorrhoids removed. He says that he described the operation to her including drawing a sketch of what was involved. He explained to her, *inter alia*, that he would be unable to remove all of the bulging or haemorrhoidal tissues to enable healing. He described telling the plaintiff that she might not be happy with the result of a haemorrhoidectomy. He explained that a haemorrhoidectomy was a painful procedure with a long recovery time, carrying with it the risk of bleeding and infection. Prof Hannon said that this discussion lasted 30 to 45 minutes. The plaintiff decided to proceed with the operation.

65. The operation took place on 13 August 2018. His notes recorded that the pedicle and external component were excised and mobilised from the internal anal sphincter and external anal sphincter at 4, 7 and 11 o'clock positions. He had recorded, *inter alia*, that he had left adequate skin bridges. He emphasised that a haemorrhoidectomy is an

elective procedure for a benign condition. Therefore, it is imperative, *inter alia*, that skin bridges are left behind. He outlined his operation technique which included marking out the skin bridges having administered local anaesthetic. He says that he cut a V – shaped incision using the diathermy needle in cut mode with the narrowest point of the V in the anal canal and the broadest point either side of the pedicle. There were no adverse events during the operation.

66. Prof Hannon saw the plaintiff again on 10 September 2018. She was complaining of a lot of pain. Upon examination, he could find the skin bridges and observed a lot of swelling and oedema. He also observed a lot of spasm in the pelvic floor. He didn't see anything that he was concerned about; it had a normal, post-operative appearance. The skin bridges looked adequate. They looked swollen but not untoward or beyond anything he expected. He recommended and prescribed various medications and wrote to the plaintiff's GP suggesting review and a further 4 weeks. He raised the possibility of Botox injection to deal with the spasm.
67. On the 12 December 2018 the defendant examined the plaintiff under anaesthetic. He administered a Botox injection and performed a digital dilatation. He carried out a visual examination of the internal part of the anal canal. It was his practice in these circumstances to use an Eisenhammer retractor which he would insert and expand to dilate gently and examine the canal. He thought that the wounds are healing well and saw no sign of infection. A further appointment was made which the plaintiff did not keep. There ended the defendant's treatment of the plaintiff. The next involvement between the two was the exchange of correspondence concerning the plaintiff's complaints.
68. Prof Hannon disputed Mr Jones' theory that the plaintiff's fistula was caused as a result of a full thickness injury or deep diathermy burn to the rectovaginal septum. It was unlikely, he felt, that such an injury could occur without the surgeon realising it. Further, there was nothing in the pathology to indicate that anything like this occurred. Regarding Mr Jones' suggestion that it may have arisen as a result of a deep diathermy burn to the rectovaginal septum, again Prof Hannon discounted this. He conceded that, were confronted with excessive bleeding, and injudicious application of diathermy may arise. However, no such bleeding occurred in this case so further, he would have used sutures rather than diathermy had such a problem arisen. He would have been able to observe a fistula, had one occurred, when he examined the plaintiff using the retractor. He observed that the symptoms of a fistula would have occurred much sooner had its origin been the haemorrhoidectomy in August.
69. Prof Hannon identified the cause of stenosis as being the plaintiff's pelvic floor dysfunction and anal spasm which would have the effect of reopening wounds and interfering with healing. He observed no stenosis when he examined the plaintiff in September. He accepted that there was circumferential scarring – this was stenosis. When pressed in cross examination he said there was no not circumferential wounding all the way around the clock. He maintained he had left adequate skin bridges which she had marked out

prior to removing the haemorrhoidal skin and tissue. Prof Winter had observed the stenosis which unfortunately arose in this case.

Professor Deborah McNamara

70. Prof Deborah McNamara gave evidence on behalf of the defendant. She is a consultant in general and colorectal surgery in Beaumont Hospital in Dublin. She is currently the Clinical Professor of Surgery in the Royal College of Surgeons in Ireland and, formerly, was Clinical Director of Surgery in Beaumont Hospital between 2014 and 2017. She prepared two reports on behalf of the defendant: a report on liability and causation and a report on condition and prognosis. Prof McNamara also conducted an external physical examination of the plaintiff.
71. Prof McNamara's opinion was that the haemorrhoidectomy carried out by the defendant, according to the medical records, appeared to be performed in a technically standard manner. The contemporaneous operation notes report that the operation was performed leaving adequate bridges and that the anal sphincters were preserved. In the follow-up visit it was noted that there were oedematous skin bridges present.
72. Prof McNamara stated that the degree of tissue excision and size of the residual skin bridges are matters of operative judgment. The notes show that the defendant in planning and executing the operation had due regard to the importance of preserving adequate skin bridges. Prof Hannon's visualisation of the skin bridges at the follow up appointment is additional evidence that they were preserved.
73. The extent to which Prof Hannon adapted the operative approach to the identified pre-existing condition is not well documented but the preservation of adequate skin bridges is consistently noted throughout. Prof McNamara stated that she would be very cautious in patients with pelvic floor conditions because of the risk of slow healing.
74. Turning to the question of an excessive intraoperative wound, Prof McNamara found no evidence of an injury or deep diathermy burn to the rectovaginal septum in the medical records. She considered the full thickness injury to be unlikely as one would not normally have a lump but an immediate mechanical communication. In the case of partial penetration followed by necrosis, Prof McNamara would expect the fistula to become symptomatic 6-8 or 12 weeks after the causative infection.
75. In Prof McNamara's opinion the pre-existing perineal descent and overactive pelvic floor were the main contributory factors to her slow recovery and anal stenosis. It is her opinion that a fistula arising directly at a time of haemorrhoidectomy should have been present between 6-12 weeks of the operation and would likely have been visible on 10 September and 12 November when the examinations under anaesthetic were carried out.
76. Prof McNamara carried out a physical examination of the plaintiff on 24 September 2021. She visually inspected the perianal and perineal areas as the plaintiff did not consent to internal digital examination. Visual inspect confined the presence of wide skin bridges of normal healthy appearing perianal skin. There were clearly visible scars in approximately

the 5, 7 and 12 o'clock position with evidence of wide separation between the scars where healthy, mobile perianal skin was observed. The scars were straight, less than 2mm each in width and radially orientated to the anal orifice. There was no evidence of any distortion or narrowing of the visible areas of the anal canal. There was no evidence that the skin bridges were inadequate in approximately the lower third of the anal canal which could be visualised on inspection. Anal stenosis occurs when a ring of fibrotic scar tissue forms and results in narrowing of the anal canal. It is a well described complication of the open or Milligan-Morgan haemorrhoidectomy with 3.6% incidence rate in haemorrhoidectomy patients.

77. Prof McNamara considered it very unlikely that the fistula resulted from a full thickness injury and/or deep diathermy burn. In her opinion, a fistula resulting from an injury would become apparent within days to no more than 12 weeks of the haemorrhoidectomy and should have been visible on either of the 2018 examinations under anaesthetic. There was also nothing consistent with a full thickness excision in the histology report. Prof McNamara also considered a partial thickness injury followed by necrosis to be unlikely because of the 8-month delay prior to manifestation of symptoms and because the haemorrhoidectomy wounds were not breaking down but actively healing and becoming more fibrotic.
78. Prof McNamara said that a more likely cause of the plaintiff's fistula is the dilatations of Prof Winter and Prof Hannon. She stated that the risk of a fistula as a result of dilatation is small. Prof McNamara stated that infection is a hazard of coloproctology which can occur without any wrongdoing on the part of the operating surgeon. When the anorectum is examined surgically there is an intrinsic risk of tearing which can, in turn, lead to a pocket of bacteria that can lead to an abscess that results in a fistula. While training as a registrar, Prof McNamara witnessed this risk materialise and now she administers intravenous antibiotics to patients undergoing anal dilatations to avoid this outcome. Prof McNamara relied on an article by Brisinda et al entitled "Surgical treatment of anal stenosis" which stated that a dilator may tear the anal canal. This article referred to self-dilatation but Prof McNamara opined that the mechanical impact is potentially the same. It is normal for minor bleeding to occur in anal dilatation so that may not have been something noted by Prof Hannon or Prof Winter when they were conducting their respective dilatations.
79. Prof McNamara noted that at the time of this report Prof Winter had proposed additional tests to assess the patient for the condition. She stated that Crohn's disease is very hard to rule out but that the standard tests carried out in the plaintiff's case show no evidence of Crohn's disease. The Barium follow-through on 27 August 2020 indicated that the plaintiff had stenosis of the terminal ileum and ileocecal valve which Prof McNamara said can be characteristic, not diagnostic, of Crohn's disease.
80. Prof McNamara's opinion based on her physical examination of the plaintiff on 24 September 2021 is that she has made a full physical recovery with no residual colorectal symptoms attributable to her surgery.

81. Due to the plaintiff refusing internal digital examination, Prof McNamara was limited to inspecting the lower third of her anal canal. Prof McNamara was unable to say where in the anal canal the stenosis took place but stated that, according to the literature, 65% of anal stenoses occur in the lower third of the anal sphincter. The higher up the stenosis occurs, the less likely it is to relate to skin bridges because there isn't skin in the upper two-thirds of the anal canal. Further, if the stenosis is caused by inadequate skin bridges the scarring is permanent and visible on inspection. She added that the operating surgeon would have to go very far astray for there to be standard skin bridges externally and substandard skin bridges internally. She conceded that the stenosis could have occurred higher up the anal canal than she was able to observe.

Submissions

82. The law as enunciated by the Supreme Court in *Dunne v National Maternity Hospital* [1989] I R 91 and followed and affirmed by the court in *Morrisey v HSE* [2020] IESC 6 was accepted as applicable without any argument. The plaintiff bears the burden of establishing, on the balance of probabilities, that the stenosis and the fistula which the plaintiff undoubtedly suffered were caused or substantially contributed to by negligent surgical technique on the part of the defendant.
83. Mr Declan Doyle SC, for the plaintiff, said that it was common case that the overzealous or excessive excision of skin and tissue when conducting a haemorrhoidectomy amounts to negligence. As a consequence of negligence in this case the plaintiff suffered two rare but well-known conditions. The overwhelming weight of the evidence, he argued, pointed in this direction and was substantially supported by the evidence of Prof Winter. The latter's evidence brought this case within the cohort of 90% of cases of stenoses being caused by excessively radical surgery and underpinned the evidence of Mr Oliver Jones. He stressed that the plaintiff's case was not reliant on *res ipsa loquitur*. Similarly, the fistula was most likely negligently caused by a full or partial thickness surgical injury as evidenced by its proximity to 1 of the scars on the plaintiff's anal canal. Other possible causes or sources, namely Crohn's disease and injury caused during dilatation of the plaintiff's anal canal for EUA can be discounted.
84. For the defendant, Ms Adrienne Egan SC accused the plaintiff's lawyers of trying to "ride two horses"; he started off with, at the very least, an implicit case grounded on *res ipsa loquitur*. The plaintiff's case, as enunciated by Mr Oliver Jones, was granted entirely in statistics. She disputed that Prof Winter provided the underpinning support suggested by Mr Doyle. Prof Winter observed stenosis. The objective evidence was that Prof Hannon left adequate skin bridges. This is borne out by the totality of the evidence. The skin bridges were observed post operatively both by Prof Hannon and by Prof McNamara. Ms Egan urged that the case fell within the unfortunate minority who suffer from anal stenosis notwithstanding professionally competent haemorrhoidectomy. Although the defendant does not have to establish an alternative cause, Ms Egan pointed to the plaintiff's presenting condition of perineal descent and overactive pelvic floor as being the most likely origin of the plaintiff's stenosis. As regards the fistula, Ms Egan argues that the evidence points against any alleged surgical failings arising during the

haemorrhoidectomy as suggested by Mr Jones. A more likely cause was the subsequent mechanical dilatation of the plaintiff's anal canal and unavoidable infection. There is no suggestion of any blame-worthiness for this occurrence.

Discussion and Determinations

85. The plaintiff's case is that the anal stenosis and the fistula which, undoubtedly, she suffered were caused by the negligence of the defendant during the course of the surgical procedure carried out by him on 13 August 2018. At paragraph 23 clause viii of the personal injury summons these two conditions are specifically described as "... two unusual and unrelated surgical complications...". They were dealt with accordingly as the evidence progressed during the course of the trial.
86. When the case was opened, counsel's opening remarks might reasonably have been interpreted as hinting broadly at ultimate reliance upon *res ipsa loquitur*. However, in his concluding remarks, Mr Doyle eschewed any such reliance. Each of the adverse conditions arose as a consequence of separate and distinct alleged acts of negligence, albeit occurring during the one surgical procedure, according to the plaintiff. That evidence, Mr Doyle contended, was underpinned substantially by the testimony of Prof Winter. He candidly and properly admitted that, absent Prof Winter's evidence, the plaintiff's case might be "more tricky", as he put it.
87. Ms Egan was somewhat critical of the plaintiff's evidence for its reliance upon statistics. It may well be that the defence apprehended that the 90/10% statistical split in favour of relating stenosis to overzealous haemorrhoidectomy pointed to a case reliant upon the doctrine of *res ipsa loquitur*. As it happens, no such claim was made. Such statistics do not prove the plaintiff's case by themselves. However, statistics properly analysed, reviewed and understood can be an invaluable tool in divining probability.
88. The defendant contends that the plaintiff's stenosis was an unfortunate but unavoidable aftermath of the surgery. It is not accepted that the fistula was caused by the operation or originated during it. Whereas Prof Hannon does not have to accept the burden of establishing an alternative origin of the complaint, nonetheless both he and Prof McNamara point to subsequent mechanical dilatation of the plaintiff's anal canal as being the likely aetiology. No fault is suggested in the latter procedure.
89. The development of either a stenosis or a fistula post operatively does not, necessarily, give rise to an inference of a want of surgical care in the course of a haemorrhoidectomy. The occurrence of both, quite understandably, would greatly stimulate suspicion were the operation to be the sole source of the complaints. No doubt there could be circumstances in which such outcomes were the clear consequence of medical negligence. By the same token, they could be an unfortunate consequence of otherwise perfectly competent treatment.
90. The plaintiff is clearly convinced and passionately believes that she was ill – served by Prof Hannon. Her feelings and the impact of the surgery upon her are evident from her

evidence and from Dr Lane's report and evidence. The defendant, an experienced surgeon, contends that he treated the plaintiff with all appropriate care and skill.

91. The material medical notes in this case covering the period during which the plaintiff was under the care of Prof Hannon do not overtly reveal any mis – step on the defendant's part according to Mr Jones and he offers no material criticism of the notes, *per se*, insofar as they describe the course of treatment. He did, in evidence, raise the possibility of a more conservative approach to the haemorrhoidectomy, perhaps involving more than one procedure. However, this never elevated into a material criticism. Therefore, as far as the medical records reveal of themselves, nothing untoward arises as far as Mr Jones is concerned. However, a shortfall in the surgical notes is observed by Prof McNamara. Having regard to the plaintiff's pre-existing conditions of marked perineal descent and overactive pelvic floor, two separate conditions as identified by her, she remarks that the "... extent to which the surgeon adapted his operative approach bearing in mind the patients pre-existing condition (which he clearly identified) is not well documented although the importance of preservation of skin bridges is consistently noted." The first and conservative course of treatment involving medication and physiotherapy was entirely appropriate. Notwithstanding some degree of success in that course of treatment, it was appropriate, in May 2018, to entertain and to decide to proceed with the haemorrhoidectomy.
92. The fundamental issues in this case revolve around the excision of skin and tissue and the application of surgical instruments (in particular diathermy) during the course of the haemorrhoidectomy. Firstly, did the defendant leave any or adequate skin bridges in the particular circumstances of this patient? Secondly, did he cause negligent surgical injury which caused or contributed to the evolution of the fistula?

Stenosis

93. It is common case between the parties that the preservation of as much skin as possible during the course of the operation is a paramount consideration for the operating surgeon. It is not in dispute that failure to leave adequate skin bridges can lead to the development of stenosis. Both parties are agreed that 90% of cases of stenosis arising from haemorrhoidectomies are the consequence of the excessive excision of skin and tissue from the anal canal. (The corollary of this, of course is that 10% of cases do not fall into this category. As far as the evidence went, we were never told what the entry qualifications were, presumably various, for this latter cohort). A distinction should be drawn between this elective procedure embarked upon to treat surgically a benign condition and surgery conducted in more serious or life-threatening conditions; cancer surgery or an emergency surgical response to potentially catastrophic bleeding are obvious examples. It is not contested that failure to leave adequate skin bridges when conducting an open haemorrhoidectomy can amount to negligence.
94. There is no dispute that stenosis is a potentially serious and, clearly, a highly unpleasant condition. Its treatment varies depending on the level of severity. Treatment for the more serious cases includes mechanical dilatation of the anal canal under general anaesthetic; such was the case here. All of the medical witnesses acknowledged that the plaintiff

suffered serious stenosis. Prof Hannon seemed a little reluctant to acknowledge this degree of seriousness under cross examination but I suppose one could put this down to a degree of tension being generated by the occasion. It was accepted by all that the plaintiff's stenosis resulted from the haemorrhoidectomy conducted by Prof Hannon.

95. Prior to the surgery, Prof Hannon treated the plaintiff appropriately and competently. After the initial, and partially successful, conservative course of treatment which included physiotherapy, he engaged with the plaintiff in a consultation in July 2018 which took in the region of 45 minutes. They discussed the operation option, including the use of graphic explanatory drawings to explain to her what was involved and what she might expect by way of outcome. The defendant maintains that he suggested to the plaintiff that she might not be happy with the outcome and that the surgery would leave behind residual skin or a "bulge". The plaintiff disputes that Prof Hannon told her that there would be a "bulge" left behind after the surgery. Getting rid of it was a reason for the surgery, she said. If he was not going to fix the "bulge", what was the purpose of having the surgery? The plaintiff does recall skin bridges being mentioned. She accepts that she saw the diagram drawn by Prof Hannon. However, it is clear that there is a dispute in recollection between the plaintiff and Prof Hannon. I am satisfied that he did touch on the issue of skin bridges which is scarcely surprising since this is a paramount consideration in every open haemorrhoidectomy. I am not satisfied that the plaintiff was made fully aware of what the likely outcome of the operation, all things going well, would be. That said, no issue as to informed consent arises in this case.
96. Turning to the surgery, at the outset I accept Mr Jones description of the surgical notes as being, in some respects, aspirational. Therefore, the fact that Prof Hannon described the skin bridges as "adequate" does not, necessarily, make them so. I have no doubt that that was his intention.
97. The question remains, were the skin bridges adequate or was too much excised? Did the defendant apply the standard of care of an appropriately skilful and qualified colorectal surgeon acting with ordinary care? The defendant, according to the surgical notes, did have regard to maintaining skin bridges. He noted them as adequate of the operation and observed them some weeks later. Nonetheless, we know that in April 2019 the plaintiff was observed to be suffering from significant stenosis whose origin, it is accepted, was the surgery. Further, I feel it likely that stenosis was present when Prof Hannon examined the plaintiff under general anaesthetic in November 2018. On that occasion, as we know, he dilated digitally the plaintiff's anal canal and injected botulin to relieve her distressing condition.
98. Mr Jones feels it likely that this stenosis arose because of inadequacy of the skin bridges. Prof Hannon's operation note referring to adequate skin bridges was aspirational to an extent in that the adequacy or otherwise of the skin bridges was as yet unknown. He does not feel that Prof Hannon's note and observation of skin bridges at the follow-up consultation in September tells us very much because they were oedematous and that observation of the wounds at that time would not have given a reliable view as to the

adequacy of the skin bridges. I am persuaded by his views on this and on his observations of Prof McNamara's external examination of the plaintiff which was conducted at a remove of three years from the operation. The stenosis in this case, according to Mr Jones, is not a stenosis of the skin at the anal verge or outside it. It is narrowing up the anal canal. He discounted her findings on the grounds that, by that stage, the stenosis had recovered, the wounds had well healed and the skin had grown and/or stretched. By this stage, one could not reliably identify what had occurred at the operation. Further, Prof McNamara's examination was external only and did not report a view of what was observable inside the plaintiff's anal canal. In any event, this stenosis was gone by that stage. In summary, Prof McNamara was looking in the wrong place for something that wasn't there.

99. Mr Jones concludes that the stenosis probably resulted from the inadequacy of the skin bridges, bringing it into the majority cohort of 90% of cases of stenosis arising from haemorrhoidectomy arising from "overzealous surgery" or, more explicitly, excessive removal of skin and tissue in the circumstances.
100. Mr Jones' evidence has the advantage (or disadvantage depending on your viewpoint) of viewing the case retrospectively. Prof Winter gave evidence after Mr Jones' evidence had concluded. When the case was opened by Mr Doyle on behalf of the plaintiff, reference to Prof Winter was somewhat measured and his role portrayed as essential but supportive. Of course, he had played a vital role in the plaintiff's treatment. She had turned to him after she had lost faith in Prof Hannon. He examined her and successfully treated her stenosis. Indeed, the plaintiff made a good recovery from the stenosis earlier than expected. He also treated the plaintiff's fistula, again successfully. He carried out an EUA on 19 April 2019 and gave evidence of what he found. His reference to "circumferential scarring" and "circumferential wounding", or at least the plaintiff's lawyers' interpretation of it, certainly led to the plaintiff's case "upping a gear". By this, did he mean a "round-the-clock" surgical wound indicating either no or minimal skin bridges? If so, here was the objective evidence.
101. As we know, Ms Egan disagreed with that interpretation and had conducted a very brief cross examination. When this difference of interpretation became apparent during the cross examination of Prof Hannon it was deemed appropriate to recall Prof Winter. He was then cross examined at length by Ms Egan and re-examined by Mr Doyle. Did this solve the riddle of interpretation? Both parties cite his evidence in aid of their respective cases.
102. Having reviewed the evidence, I am satisfied that Prof Winter observed scarring covering the entire circumference of the plaintiff's anus. What he observed was serious stenosis which had contracted down to the extent that only a minute aperture, measuring 8 French, was left. The likely cause of this was the excessive excision of skin and tissue from the plaintiff's anal canal during the course of the haemorrhoidectomy. In my opinion, on the balance of probabilities, Prof Hannon failed to leave adequate skin bridges.
103. In my view, Prof Hannon failed to have due regard to the plaintiff's pre-existing conditions during the course of the surgery. One of these, perineal descent had previously been

observed and noted by him. The second condition, an overactive pelvic floor, had been identified by a physiotherapist preoperatively and had been flagged to him. However, this does not appear to have been formally noted by him and, as observed by Prof McNamara, the extent to which he adapted his operative approach to take account of these conditions is not well documented. These pre-existing conditions are identified, not least by Prof McNamara, as playing an important, contributing role in the development of the plaintiff stenosis. I accept the evidence of Mr Jones that the defendant ought to have adopted a more conservative approach to the surgery and to have left larger than average skin bridges. This course of action would represent the appropriate standard of approach of a consultant colorectal surgeon acting with ordinary care. The defendant failed to do this and, in this regard, failed to meet the standard on this occasion.

104. I am persuaded, on the balance of probabilities, that, had this been done, it is likely that the plaintiff would not have gone on to suffer the stenosis and the protracted pain, suffering and distress which ensued. What was likely to be an unpleasant and painful operation in any event was rendered much worse in terms of outcome. The plaintiff's enduring symptoms of pain and dysfunction, with or without the involvement of the late – heralded fibrotic scarring, were the outcomes the surgery ought to have been adequately designed to avoid in the first place.

Fistula

105. The debate on the aetiology of the fistula was no less fraught than that surrounding the cause of the stenosis. The fistula was first suspected by Dr Kroon in October 2019. An MRI scan showed a suspected fistula tracking from the anal canal at approximately the 12 o'clock position to the back of the introitus of the vagina. As we know, the fistula was subsequently successfully treated by Dr Winter. It was never suggested that the fistula simply occurred by chance. The effect was not in doubt – what was the cause? Some agency or combination of agencies must have been at work. The plaintiff alleged that the haemorrhoidectomy was the starting point. The defendant suggested, *inter alia*, that post – haemorrhoidectomy dilatation was a possible cause.
106. In brief, the plaintiff's case is that the fistula was caused by substandard surgery in one of two ways. Firstly, as a consequence of a through and through injury between the anorectum and the vagina. Consequential infection would have led, ultimately, to the manifestation of symptoms some time later. It was not suggested that the defendant had, in effect, scooped out, surgically, excessive quantities of skin and tissue. The origin of the fistula, it is claimed, was the probable negligent application of diathermy. Secondly, by way of alternative, the plaintiff suffered a deep injury to the tissues in her anal canal during the operation. This gave rise to necrosis and subsequent infection over a period of weeks or months until there was a connection with the vagina. No other cause, such as underlying inflammatory bowel disease or subsequent dilatation, played any part.
107. As observed, the defendant denies any want of care and skill with regard to the surgery. Further, the fistula, he says, could not have arisen from the surgery because of the lapse of time between the operation and the appearance of symptoms. Subsequent mechanical dilatation of the plaintiff's anal canal without fault on anyone's part, coupled with

unavoidable infection, was a more likely cause. During cross examination of Mr Oliver Jones by Ms Egan for the defence, Prof Winter's dilatation of April 2019 was specifically identified as the origin of the fistula. She put it to him that the chances were that it arose after this EUA and dilatation. Prof Hannon also pointed to this dilatation (not his own, earlier, digital dilatation) as the supposed cause of the fistula. This suggestion came from him in cross examination after Prof Winter had been recalled. The defendant had not alluded to this previously, as far as I can make out, in his evidence in chief. Neither did he canvass it is a possibility in his letter of 18 March 2022 the plaintiff. Indeed, in that letter, he didn't identify dilatation, good bad or indifferent, as having any role in the fistula. The defence also points to the fact that the fistula was not discovered during EUA conducted by Prof Hannon and Prof Winter.

108. Prof Hannon trenchantly denied that the fistula was as a result of his surgery. However, the fistula did occur. To borrow from Prof Winter's evidence: – "... There are laws in medicine and that if an event happens, it relates to the initial event... and it is rarely another condition". The fact that it occurred does not mean that the "initial event", whatever that might be, was negligently caused brought about. Nonetheless, the haemorrhoidectomy is the first such event in time. What other "events" took place or conditions occurred which might reasonably identify an alternative cause?
109. One significant possible cause of the fistula was Crohn's disease. The view of the medical witnesses in this case is that it is highly unlikely that the plaintiff is suffering from this condition. Neither is it likely that she will suffer from it in the future. On the basis of the evidence, therefore, it is highly improbable that Crohn's disease had any involvement in the development of the fistula. For the purpose of this judgement I am satisfied that I can rule it out.
110. As observed above, the fistula was diagnosed and treated in late 2019. Significant debate took place, *inter alia*, on whether the fistula could have been spotted earlier. The defence argued that the fistula would have been apparent on physical examination on two occasions subsequent to the operation; EUA's were carried out by Prof Hannon on 12 November 2018 and Prof Winter in April 2019. On neither occasion was the existence of the fistula reported. Prof McNamara, who had encountered a fistula before, was of the view that a fistula could have been observed, if it was there, either of these occasions. Prof Hannon, who had never encountered a rectovaginal fistula during his professional career, agreed; something like a bead of puss could have been detected. Prof Winter and Mr Jones took an entirely different view. They both felt that it would be extremely difficult to find a fistula even if you knew what you are looking for and were, in fact, looking for it. Both these gentlemen had experience of dealing with fistulae. Prof Winter, notwithstanding his experience, did not suspect or observe a fistula during his

examination. I found Prof Winter to be most persuasive. I prefer the view expressed by him and Mr Jones. Accordingly, for the purpose of my findings in this case, the absence of observation of a fistula during the course of the two material EUA's is not determinative with regard to my findings of fact.

111. When did the symptoms of the fistula first appear? I am satisfied, on the balance of probabilities, that the plaintiff's symptoms of this complaint first became apparent to her shortly prior to her first meeting with Prof Winter in April 2019. The symptoms comprised apparent vaginal bleeding which, as was acknowledged by Prof McNamara, was a significant symptom in a postmenopausal female. However, at that time, and probably for some period before that, any symptoms of the fistula would have to be seen against the backdrop of significant pain and distress which the plaintiff was suffering at the time due to her ongoing post – haemorrhoidectomy complaints, including stenosis. In addition to this, the plaintiff was then suffering from significant psychological difficulties as a consequence of the combination of her physical complaints and the emotionally traumatic experience of the death of her sister. It is common case that the plaintiff was in the throes of psychiatric injury, specifically Post Traumatic Stress Disorder. Accordingly, it is quite possible that she had been showing symptoms of the fistula before this but such symptoms may have been masked by her supervening physical and mental complaints. She did mention this bleeding to Prof Winter but, understandably, given her physical and mental distress, this "took a back-seat". Prof Winter proceeded to deal with the plaintiff stenosis by dilatation and Botox injection on 19 April 2019. His treatment of the plaintiff stenosis concluded with relative success on 19 July 2019.
112. The next symptom of the fistula which was noted was the lump in the perineal region observed by the plaintiff's GP on 26 April 2019. I am satisfied that this is not related to Prof Winter's procedure a few days earlier. This lump began to discharge over the months of July and August, some three months later. The plaintiff attended her GP about this distressing condition and was referred to Dr Kroon with the suspected Bartholin cyst. As we know, a fistula was suspected and investigated, the plaintiff was referred back to Prof Winter who discovered the fistula on examination on 22 November 2019. He treated the plaintiff's fistula concluding with the fistulotomy in March 2020.
113. Therefore, concrete symptoms of the fistula were first noted prior to the plaintiff's first attendance with Prof Winter. It is probable that she had some minor symptoms before this which were masked by her immense physical and mental suffering. In that context, it is reasonable that she would not have paid attention to what may well have been relatively minor symptoms.
114. I now turn to the possible involvement of dilatation in the aetiology of the fistula. I think it likely that Prof Hannon used a retractor during the course of the EUA in November 2018 for the purpose of expanding the plaintiff's anal canal. Equally, it is clear that Prof Winter mechanically dilatation at the canal from 8 to 18 French in April 2019. I accept that both of these procedures were carried out by professional practitioners using appropriately lubricated instruments. When confronted with the possibility that his actions could

possibly have led to the development of a fistula, Prof Winter was little short of aghast. Even without the suggestion of any fault on his part, he regarded such a suggestion as professionally insulting. It is safe to say that Prof Winter roundly discounts the possibility of any relationship between dilatation and fistula.

115. Mr Jones also discounted dilatation, mechanical or digital, when carried out by a doctor, as being capable of giving rise to the development of a fistula. To be fair, he acknowledged it as a remote possibility. However, he had never seen or heard of any such an instance. Prof McNamara, in the course of her evidence, referred to one such experience when she was a registrar – whether it occurred at her hands or another’s was not quite clear. Prof Hannon, notwithstanding his adoption of the supposition that Prof Winter’s April 2019 procedure was “in the frame”, did not inform us of any such an occurrence or experience encountered during a professional life during which he has undoubtedly carried out numerous dilatations.
116. No alternative cause or origin of the plaintiff’s fistula was pleaded; nor need it be. There is no onus on the defendant to suggest an alternative mechanism for the plaintiff’s complaints. However, the defence suggested post-operative dilatation as being a prime suspect for causing the plaintiff’s fistula. Prof McNamara does refer to the dilatations in her first medical report. However, the reference is somewhat general, referring to an event occurring “in the aftermath” of dilatation. In her oral evidence, both EUA’s feature as possible alternative causes of fistula. Medical literature was offered in support but it transpired that this referred to self – administered dilatation by patients and not to professionally conducted dilatation carried out under general anaesthetic. I should repeat that Prof Hannon’s replying letter to the plaintiff’s letter of complaint makes no mention of his anal dilatation as a possible cause or contributor to the plaintiff’s fistula.
117. On this aspect of the case I found the evidence of Mr Jones and Prof Winter to be more persuasive. I find it highly improbable that the digital and mechanical dilatations carried out, with the patient under general anaesthetic, by Prof Hannon and Prof Winter, both qualified and experienced surgeons, could have caused injury to the plaintiff. In my view, it is most unlikely that the intervention of Prof Hannon on 12 November 2018 or Prof Winter on 19 April contributed in any way to the formulation and development of the plaintiff’s fistula.
118. Another mainstay of the defendant’s alternative scenario was the question of timing. Prof McNamara opined that a fistula would take either 6 to 8 or 8 to 12 weeks to develop. Mr Jones, the other hand, said that fistula might take some months to develop and might not be symptomatic for some considerable time. He found no difficulty in the time lapse between the surgery in August 2018 and the appearance of the symptoms in 2019. In reality, I feel that Prof McNamara was probably closer to Mr Jones view than might, first, be thought. In accepting the possible involvement of Mr Hannon’s procedure in November 2018 in the formation of the fistula and linking it with Prof Winter’s procedure of April 2019 she is painting on a very broad canvas in terms of time. Certainly, the suggestion

that Prof Hannon's procedure of November 2018 could possibly have given rise to the fistula somewhat undermines this aspect of the defence argument.

119. I also take account of, and view as significant, the fact that the fistula appears to track from the 12 o'clock position on the plaintiff's anal canal. This corresponds with the site of one of the three haemorrhoids removed surgically by the defendant. The presence of this fistula is identified on the MRI scan and any shortcomings in the clarity of its appearance is appropriately explained by Mr Jones; he said that one of the limitations of an MRI scan is that sometimes it struggles to see the end of the fistula track as it actually enters the anal canal. At the very end of the trial, during re-examination, Prof McNamara, the final witness, raised the absence of the appearance fibrosis on the MRI scan in the area of the anorectal septum as material in determining the aetiology of the fistula. This was neither put to nor debated with Mr Jones and I disregard it.
120. Prof Winter was called as the plaintiff's treating surgeon and, as such, his primary role was that of witnesses to fact. However, as is often the case in medical negligence cases, treating doctors unavoidably touch upon areas material to causation. I have no difficulty taking such evidence into account and weighing it appropriately. In the instant case, Prof Winter is of considerable importance, not only due to his level of involvement in material matters but also because of his undoubted and long experience as a colorectal surgeon. His evidence was substantially supportive of the view of Mr Oliver Jones. He said that "... The origin of the fistula is almost certainly, in my mind, as a result of sepsis as a result of haemorrhoidectomy, sepsis; haemorrhoidectomy; difficulty; circumferential wound leading to stenosis and fistula". In my view, particular weight must be given to the evidence of the doctor who treated (happily successfully) the plaintiff for both of the physical conditions with which we are concerned.
121. With regard to the plaintiff's fistula, in my view, we can eliminate underlying inflammatory bowel disease and the EUA's carried out subsequent to the haemorrhoidectomy by Prof Hannon and Prof Winter. The only other identifiable cause of the fistula was the haemorrhoidectomy carried out by the defendant. The fact that surgery was carried out in that area is not in doubt. I have already determined that the extent of the surgery in terms of removal of skin and tissue was excessive in the circumstances. As such, I have already determined same to be negligent.
122. We are dealing here with two separate and distinct injuries and, although the two are undoubtedly connected, nonetheless the negligent genesis of the stenosis does not automatically convert itself into the wrongful agency which brought about the fistula. I still must ask myself whether there is a plausible explanation for the fistula and if it was brought about by negligence. At the risk of tedious repetition, the defendant is under no obligation to offer any explanation but, as is often the case, it is wise to do so. On occasion, I found that some of the evidence offered by the defendant and on his behalf, focussed on the extreme rather than the more nuanced. For example, Prof Hannon's rather apocalyptic description of what would be required to cause a surgical injury (cutting through internal and external sphincters, rectovaginal septum and into the

vagina) contrasted with Prof Winter's description of the relative ease with which such an unfortunate injury could occur. Similarly, Prof McNamara's statement at the conclusion of her cross examination that 90% of cases of stenosis are caused by the absence of skin bridges and 10% are not does not, at first blush, consider into which category extant but inadequate skin bridges might fall.

123. I am satisfied that there was no through and through surgical wound in this case. I am, however, persuaded that the defendant probably removed too much tissue at the 12 o'clock position inside the plaintiff's anal canal thereby creating a partial thickness wound. This corresponds with one of the 3 areas upon which Prof Hannon was operating. This wound became infected and progressed, over ensuing months, to the formation of the fistula. It is probable that, absent the excessive degree of the wound, the fistula would not have developed. The occurrence of the infection per se is not necessarily indicative of fault. It is, however, probable, in this case, that the excessive surgical wound in this case gave rise to the fistula, a "...well described complication of haemorrhoidectomy".
124. In addition to the foregoing, I also take account of the fact that I find that there has been no plausible explanation for the origin and subsequent growth of the fistula apart from the negligent surgical intervention of the defendant. This has been identified by Mr Jones as the probable cause of the fistula and I prefer his evidence. Taking the evidence as a whole, I am satisfied that the surgical wound was caused by negligent surgery.
125. In conclusion, I am satisfied that both of the plaintiff's post-operative conditions, anal stenosis and fistula, arose because the surgery was not performed to an adequate standard appropriate to the plaintiff in the given circumstances. As such, the defendant's care of the plaintiff falls short of the standard identified in *Dunne v National Maternity Hospital* and *Morrisey v HSE*.
126. Accordingly, the plaintiff is entitled to succeed and I find for her.

Damages

127. The plaintiff's injuries have been briefly outlined earlier in this judgement. There is no dispute that she has suffered Post Traumatic Stress Disorder as a direct consequence of her unfortunate experience. Fear for the impact of publicity upon the plaintiff's health led to the successful application under section 27 of the Civil Law (Miscellaneous Provisions) Act 2008.
128. The plaintiff gave evidence of the severe physical and mental effects which he has experienced. Allowance must be made for the fact that open haemorrhoidectomy may well be a most unpleasant and painful procedure. However, I am satisfied that the physical pain and discomfort, both from the surgery and the consequential functional problems, greatly exceeded that which might reasonably be expected. It left her mentally and physically ill equipped to deal with the sudden death of her sister. I take account of Prof Lane's evidence that the bereavement and its understandable impact upon her art separate and distinct from the mental injuries of her physical complaints.

129. The plaintiff describes how she felt mutilated and abandoned. She felt great anger at the defendant. Her home life was greatly affected. She suffered from irritability, depression and anxiety. She felt guilt for having the operation and experienced considerable embarrassment at the thought of being regarded as a "frequent flyer" because of the multitude of her hospital attendances. Her relationship with her husband was adversely affected. She became disengaged and her motivation and capacity for enjoyment greatly diminished. She was particularly involved in singing the soprano line in a cappella singing with friends. She abandoned this all together for some time but is hoping to resume it.
130. The effect of the injury has impacted upon her career path. As observed before, she took up further education after she left the bank and achieved further qualification. She has had some opportunity for employment in a scientific area (more of a "foot in the door job") which she has been unable to pursue for reasons related to her physical and mental problems. I accept that she has applied for a number of jobs, thus far unsuccessfully. It is unfortunate that her physical and mental indisposition has coincided with the Covid 19 pandemic. She feels that she has lost 2 ½ years of her life and that this fact and her age will count against in her intended pursuit of a career; the latter will now, in my opinion, more likely be the greater hurdle.
131. She has undertaken therapy to assist in her psychological recovery. Prof Lane advises that her mental recovery is inextricably related to her physical well-being. Any setback in the latter could impact on the former. She will have to engage in therapy for approximately one or 2 years. Prof Lane does not feel that medication is warranted. She still has a long way to go towards recovery.
132. The evidence indicates that the plaintiff will probably go on to make a full recovery provided she engages with the appropriate counselling as envisaged by Prof Lane. It is unlikely that the plaintiff will require medication. The physical outlook, in broad terms, would appear to be optimistic.
133. I have noted that special damage has been agreed subject to proof of liability in this case. However, I am unaware of the amount; presumably I will be informed when this judgement has been handed down. As to general damages, I take account of the severe pain and suffering which the plaintiff experienced over and above that which would probably arise after this admittedly unpleasant surgery, the severe and continuing and embarrassing symptoms which she experienced, almost unabated, until after April 2019. I have regard to her continuing symptoms, the distressing and embarrassing and the painful surgery and treatment for the fistula and any residual physical symptoms in the aftermath of the successful fistulotomy. I also take account of the serious degree of psychiatric injury in the form of Post Traumatic Stress Disorder which she experienced and will continue to experience for up to 2 years with the possibility of a relapse, albeit unlikely, in the event of a physical deterioration of her symptoms. Finally, I take account of the overall impact upon her life in terms of her potential employment, her family, her friends and her general level of social engagement. For general damages to date I assess an appropriate sum to be €100,000. For general damages into the future I assess a figure

of €75,000 to which total sum of €175,000 should be added any agreed sum for special damage. This figure makes some modest and proportionate allowance for loss of employment opportunity. If any agreed figure for special damages has already taken account of this I will entertain an application for a reduction of the total general damages award.