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CORRESPONDENCE

Treatment of thrombosed external hemorrhoids in Russia: an online survey

T. N. Garmanova[1] · M. I. Bredikhin[1] · E. A. Kazachenko[2] · A. V. Alekberzade[3] · I. A. Tulina[1] · P. V. Tsarkov[1]

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Dear Sir,

We have read with interest the SICCR (Italian Society of Colorectal Surgery;Società Italiana di Chirurgia Coloretale) consensus statement on hemorrhoidal treatment published on your journal [1]. In the section on the treatment of thrombosed external hemorrhoids (TEH), the authors suggest conservative treatment (with/without topical nifedipine) as opposed to surgical intervention and excisional hemorrhoidectomy as opposed to thrombectomy when surgical treatment is needed. We conducted an online survey of 124 proctologists and surgeons with TEH treatment experience. The collected data show that employees of state institutions have more opportunities for carrying out surgical treatment 24 h a day. Overall, 28.2% of the surgeons clearly preferred conservative treatment of TEH, whereas 16.1% preferred the surgical treatment. Most respondents (79.84%) base decision making about treatment modality on the thrombosed hemorrhoidal piles' size. If the thrombosed pile is > 2–3 cm, most respondents choose surgical treatment. The time factor affects the respondents' choice quite often, 60% apply conservative treatment if TEH duration is > 4 days. Interestingly, 72% of respondents in state institutions preferred conservative treatment for patients with TEH > 4 days vs. 40% in private institutions ($p < 0.001$). Additionally, pregnancy and old age were shown to affect the choice of treatment. The majority of all respondents (71.8%) use to conservative treatment for pregnant or breast feeding women. But the main factors influencing the choice of treatment modality choice are the presence of large ($r = 0.592$) painful TEH piles ($r = 0.841$), especially in the first 3 days of thrombosis ($r = 0.901$). Moreover, most respondents think that thrombosed pile size is directly related to severity of pain. However, 30% of the surgeons note that the choice of treatment should not depend on the intensity of pain.

Only few prospective and retrospective studies of various conservative and surgical treatment methods have been published. Comparative analysis at a Croatian university center showed the efficacy of an "economy" hemorrhoidectomy (excision of an external thrombosed hemorrhoid pile) vs. thrombectomy and vs. conservative treatment with nifedipine ointment on the 4th day of follow up with no difference at one month and less recurrence in the excision group after one year [2]. The study by e Greenspon et al. [3] also confirmed the advantage of surgical treatment over conservative treatment: the recurrence rate after surgical treatment was lower.

In another prospective cohort study, 62.5% patients 6 months after the TEH episode considered themselves "cured" [4]. However ongoing problems were reported in 45.8% of the patients who complained of itching (18.8%), presence of a "bump" in the anal area (10.4%), anal pain and bleeding (8.3%).

Perrotti et al. [5] in a randomized controlled trial comparing the use of 0.3% topical nifedipine plus 1.5% lidocaine ointment with 1.5% lidocaine alone for TEH demonstrated a total resolution of pain and swelling at 2 weeks in 92% of the patients in the nifedipine group versus 46% of controls.

All these data indicate that there is a wide range of treatment options for TEH. Traditionally, conservative treatment has been used to treat TEH. In the literature there were no evidence-based data proving that surgical treatment can be used only in the early stages of TEH. This practice seems to be based on clinical observations made over many years. It seems more correct to choose the treatment method based

✉ T. N. Garmanova
garmanova@kkmx.ru

1 Clinic of Coloproctology and Minimally Invasive Surgery, Clinical Center, University Hospital n2, Sechenov First Moscow State Medical University, 1/1 Pogodinskaya str, 119991 Moscow, Russia

2 Medical Faculty, Sechenov First Moscow State Medical University, Moscow, Russia

3 Surgery Department, Sechenov First Moscow State Medical University, Moscow, Russia

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not on the onset of symptoms, but on their severity and negative effect on quality of life as well as on the patient preference.

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