Presidenti F. La Torre – G. Milito

ABSTRACTS WEB-EDUCATIONAL MEETING

30 NOVEMBRE – 1° DICEMBRE 2020

LUNEDI' 30 NOVEMBRE

UNA WEB-APP IN PROCTOLOGIA 2.0

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Il progresso tecnologico ha aperto numerose strade e possibilità per un nuovo e diverso approccio alla pratica clinica. Da questo nasce l'idea di un'applicazione pensata per l'utilizzo da parte del chirurgo proctologo e dal personale infermieristico, concepita all'interno del progetto Chirurgia Low/Love Cost. La nostra applicazione, disponibile per PC, Tablet e smartphone si propone di migliorare l'assistenza fornita al paziente e, allo stesso tempo, facilitare il lavoro dei professionisti sanitari; tutto ciò mantenendo i costi contenuti. L'APP presenta diverse sezioni dedicate al medico, al personale infermieristico, di reparto e di sala operatoria, ed al paziente. La prima sezione dell'APP è indirizzata al medico. Si affronta in modo sintetico ma completo tutto l'iter diagnostico e terapeutico del paziente proctologico. Vengono spiegate le più comuni e standardizzate tecniche chirurgiche di interesse proctologico ed il loro ambito di applicazione. Nella nuova versione dalla APP abbiamo inserito una sezione contenente i codici DRG utili in proctologia e una sezione con score diagnostici standardizzati. La seconda sezione l'APP è rivolta al personale infermieristico con consigli per il personale di sala operatoria come: lo strumentario necessario per uno specifico intervento chirurgico e la descrizione, corredata da immagini, del corretto posizionamento del paziente sul tavolo operatorio. Vi sono inoltre informazioni utili al personale di reparto riguardo la gestione post-operatoria del paziente. La terza sezione dell'APP è rivolta al paziente anche se, come le altre sezioni, risulta allo stesso tempo un valido aiuto nel facilitare il lavoro del proctologo. Questa sezione contiene alcune immagini e video che il medico può utilizzare, mostrandole al paziente, per spiegare in modo chiaro l'anatomia della regione anale e perianale e la patologia, favorendo una maggior grado di comprensione da parte del paziente, aumentandone quindi la compliance. L'ultima sezione dell'APP è dedicata all'invio di documenti precompilati al paziente. In un unico passaggio è possibile inviare moduli informativi riguardanti tutte le fasi del trattamento. Si potranno, ad esempio, inviare spiegazioni riguardanti le procedure di preospedalizzazione, consigli per la gestione del post-operatorio ed anche il consenso informato con un unico click. Sono state inoltre inserite

brochure informative riguardanti le più comuni patologie proctologiche. In questo modo si favorisce una maggiore informazione del paziente. Questa APP si propone, quindi, come ausilio per tutte le figure partecipi del processo assistenziale. Viene posto al centro del percorso il benessere del paziente e come ulteriore obiettivo ha quello di supportare e facilitare il lavoro di tutti professionisti sanitari tenendo in considerazione il fattore economico, non trascurabile in qualunque iniziativa in ambito sanitario.

CHECKLIST POSTOPERATORIA IN CHIRURGIA PROCTOLOGICA: UTILE SEMPRE, INDISPENSABILE OGGI.

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In passato abbiamo condotto uno studio per valutare la sicurezza percepita dal paziente nel periodo post-operatorio tramite la compilazione di una checklist da inviare tramite smartphone al chirurgo durante la prima settimana post-operatoria. Questo studio, condotto durante il periodo 1 Gennaio-31 Dicembre 2018 presso l'Ospedale Israelitico e il Policlinico Umberto I, ha dimostrato una maggiore facilità di comprensione dei consigli post-chirurgici, inoltre, i pazienti hanno dichiarato che la compilazione di tale checklist abbia influito positivamente sull'esito dell'intervento e hanno avuto la percezione di essere stato seguito meglio nel post-operatorio. Abbiamo concluso quindi che la somministrazione della checklist obbliga il paziente a mantenere uno stile di vita ed un controllo della terapia nell'immediato periodo post-operatorio tali da implementare la sua sensazione di sicurezza e di alta qualità dell'assistenza ricevuta. Il 2020 ha ancora di più dimostrato come strumenti di questo tipo siano necessari per uno stretto follow-up dei pazienti operati, in un periodo in cui limitare l'accesso nelle strutture ospedaliere da parte dei pazienti è necessario e doveroso a causa dell'attuale pandemia. Se gli strumenti telematici ed i mezzi di comunicazione digitale erano già entrati e piccoli passi nella pratica chirurgica degli ultimi anni oggi questi diventano una necessità.

RE-SCHEDULING PROCTOLOGIC SURGERY AFTER LOCK-DOWN: DEVELOPMENT OF A SCORING SYSTEM.

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INTRODUCTION. The covid-19 pandemic has a very critical impact on surgical strategies all over the world. Italy in particular, faced the deepest impact. Elective procedures, screening and follow-up visits have been suspended giving priority to urgent and oncologic procedures. PATIENTS. An observational study was carried out in the Surgical Coloproctology Unit of the Val Vibrata Hospital, on a sample of 137 patients awaiting a proctological surgical treatment at the date of national lockdown. METHODS. In order to monitor the health status of the patients and re-schedule post-lockdown surgical activities, patients were interviewed by telephone submitting a questionnaire. The questionnaire consisted in set of items to investigate the health status perceived and a set of items about clinical information that were matched with clinical recorded data. We calculated a severity index for benign conditions

(hemorrhoids, fissures, sepsis obstructed defecation, etc), classifying the symptoms into moderate, mild and severe according to a dedicated score (Procto-score). Mean age of patients was 51 year (± 16) and there were 75 males [55%] and 62 females [45%]. Patients suffered from fissure 31%, hemorrhoids 28%, sepsis14% and other benign conditions in lesser extent. RESULTS. The data collected were stratified into three classes: urgent (A), deferrable (B), reprogrammable (C). There were forty-five patients in class A needing a prompt surgical treatment, while twenty-four patients were allocated in class B and sixty-five patients in class C waiting for a new ride-plan for surgery. The mean age of the patients classified in Class A was 53±15years and they were older than patients classified in Class B and C, respectively 52±11 and 50±17. Differences were not significant (F test=0.43; p=0.653). The distribution between males and females was not different by Classes (Pearson chi2 test=0.6926; p= 0.707).CONCLUSIONS. The development of new tools like the Procto-score, also helped by tele-medicine, can be useful during the pandemic lockdown in order to establish a priority schedule of surgical patients.

IL FUTURO DELLA CLASSIFICAZIONE DELLA MALATTIA EMORROIDARIA

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La classificazione della malattia emorroidaria, già ampiamente dibattuta, ha portato all' ideazione della PATE 2006, che prende in considerazione parametri anatomici, qualità della vita e gravità della sintomatologia. Permette inoltre, grazie allo score ottenuto, una scelta più precisa del trattamento. Nonostante le numerose classificazioni proposte, quella di Goligher è ancora la più utilizzata. Abbiamo perciò voluto raccogliere le opinioni degli esperti in merito a queste due classificazioni. È stato somministrato un questionario a 30 proctologi indagando l'utilità nella pratica clinica delle classificazioni di Goligher e PATE 2006 e la loro attualità in relazione alle odierne conoscenze scientifiche. È stata indagata l'eventuale necessità di miglioramento della PATE 2006. È stato chiesto agli esperti se parteciperebbero a una consensus conference sulla classificazione della malattia emorroidaria. Entrambe le classificazioni sono state considerate utili nella pratica clinica dalla maggior parte degli esperti (63,3% Goligher; 66,7% PATE 2006). La Goligher è stata considerata attuale per il 26,6%, mentre la PATE 2006 per l'86,6%. Alla domanda sull'eventuale migliorabilità della classificazione PATE 2006 il 70% ha risposto "si molto", il 23,3% ha risposto "si, poco", il 6,6% ha risposto "no". Tutti gli intervistati si sono detti interessati a partecipare alla consensus conference sul tema (100%). Questa indagine ha evidenziato la necessità di revisionare le attuali classificazioni allo scopo di renderle più applicabili nella pratica clinica e meno obsolete. Ciò potrebbe essere ottenuto usando la classificazione PATE 2006 come punto di partenza. Secondo gli esperti è auspicabile una consensus conference sul tema. Abbiamo inoltre voluto coinvolgere la comunità chirurgica proctologica pubblicando una Lettere all'Editore sulla rivista Techniques in Coloproctology invitando i colleghi interessati e valutare la possibilità di lavorare insieme verso l'ideazione di una nuova classificazione che prenda in considerazione tutti gli aspetti clinici e sintomatologici della malattia emorroidaria.

STRUMENTARIO CHIRURGICO PROCTOLOGICO. I DIVARICATORI ISOSTATICI.

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Nel trattamento della malattia emorroidaria sono state proposte numerose tecniche. Nonostante gli avanzamenti tecnologici fatti e l'introduzione di nuove tecnologie la tecnica

principe nel trattamento di questa patologia rimane la Milligan-Morgan. Questa tecnica viene generalmente eseguita con l'ausilio di un divaricatore di Eisenhammer o di Parks. Questi divaricatori risultano tra i più utilizzati nella chirurgia proctologica. Vengono infatti anche impiegati nel trattamento delle emorroidi con altre tecniche e nel trattamento di ragadi anali, fistole, etc. In questa relazione vogliamo mostrare due tipi di divaricatore che utilizziamo abitualmente. Si tratta, in entrambi i casi, di divaricatori isostatici, cioè divaricatori che possono essere agevolmente fissati alla cute del paziente con dei punti di sutura che non lasciano segni visibili al termine della procedura. Il vantaggio principale è dovuto proprio alla possibilità di essere fissati in posizione durante l'intervento. Questo riduce al minimo i movimenti del divaricatore che spesso possono accadere data la scomoda posizione in cui lavora il secondo operatore. Ciò facilita il lavoro del primo operatore e permette al secondo operatore di assumere una posizione che permetta una visione migliore del campo operatorio. Per tale ragione è anche un aiuto per specializzandi e giovani chirurghi che, avendo una migliore visibilità possono partecipare più attivamente alla procedura con una visione migliore dei movimenti del primo operatore e con entrambe le mani libere per aiutarlo. Il primo divaricatore si presenta come un piatto circolare fisso a cui è collegata la parte centrale ruotabile costituita dalle due valve del divaricatore, non dissimili da quelle di un divaricatore di Eisenhammer. Utilizziamo questo strumento principalmente per il trattamento delle emorroidi con la tecnica di Milligan-Morgan. Il secondo è forse più corretto definirlo come valva isostatica in quanto si tratta di uno strumento che permette di coprire, una volta inserito 180 gradi del canale anale lasciando esposta e divaricata la restante metà. Anche in questo caso è possibile fissarlo alla cute perianale ma ha anche un'impugnatura per permetterne l'uso "libero". Utilizziamo questo strumento principalmente per la legatura di gavoccioli emorroidarie per il trattamento del rettocele isolato. In conclusione si dovrebbe discutere della necessità da parte delle aziende ospedaliere di investire in questo tipo di strumentario, pluriuso, piuttosto che puntare sul risparmio momentaneo con l'acquisto di materiale monouso non sterilizzabile.

RADIOFREQUENCY HEMORRHOIDECTOMY WITH NEW LIGASURE EXACT: A TECHNICAL GUIDE OF OUR STANDARDIZED TECHNIQUE

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Authors contributions: *All the authors contributed equally to this work. Mastrangeli MR and Menditto R performed the PubMed research, Lisi G and Milito G analyzed the data and wrote the paper.*

BACKGROUND: Haemorrhoidectomy is frequently associated with significant postoperative pain and prolonged hospital stay. New techniques to reduce these problems are constantly under evaluation. Amongst these, LigaSure haemorrhoidectomy with the new Ligasure Exact is a safe and fast technique that fulfils the requirements of low-complication rate, fast wound healing and quick return to work, reduction in postoperative pain and hospitalization. MATERIALS: We analysed 8 randomized controlled trials (760 patients) comparing LigaSure procedure also focusing on the key points of our standardized technique with the new Ligasure Exact. RESULTS: LigaSure Exact had a significantly shorter duration of operation (P = 0.001) and postoperative pain score (P = 0.001) than other techniques (classic fail-safe N >35) in the absence of significant differences in healing rate between the techniques (P 0.05). CONCLUSION: LigaSure technique with the New Ligasure Exact resulted in significantly less immediate postoperative pain without any adverse effect on postoperative complications,

convalescence and incontinence rate; thus, this technique was superior in terms of patient tolerance. A well standardized technique with a proper device improves outcomes and quality of life.

"EMBOLIZATION OF THE SUPERIOR RECTAL ARTERY FOR SYMPTOMATIC HEMORRHOIDAL DISEASE. RESULTS AT 6 MONTHS FOLLOW-UP OF THE FIRST 43 PATIENTS TREATED AT TREVISO HOSPITAL."

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AIM Superior rectal artery embolization is the latest therapeutic approach available in the treatment of symptomatic hemorrhoidal disease. The aim of the study is to assess technical and clinical success in the treatment of grade II and III hemorrhoidal disease. MATHERIAL & METHODS Since March 2019, 43 patients who could benefit from embolization treatment were recruited. Clinical success was assessed at 7 days, 1 month and 6 months follow-up by update of clinical scores. Statistical analysis was performed using SPSS Statistics 25.0. RESULTS 43 patients completed the 6-months follow-up with anamnestic questionnaire and disease scores: French Bleeding, Goligher Prolapse, VAS for pain, Quality of Life. 25 patients suffered from II degree- and 18 from III degree- prolapse; 96% of the first cluster and 77% of the second one were symptomatic for bleeding. The average hospital stay was 24 hours. The reduction in the French bleeding score (global and by single entity) was statistically significant in the II degree prolapse cluster ($p = 0.001$). Improvement in quality of life was significant in both groups treated ($p < 0.05$). No serious complications were registered. CONCLUSIONS At 6 months follow-up, hemorrhoidal embolization is a safe and effective technique in the treatment of symptomatic hemorrhoidal disease. It can be offered to young patients unwilling to undergo a surgical procedure but can also be indicated in the emergency setting, for patients in anticoagulant therapy, or unfit for surgery. It requires a maximum of 24 hours hospitalization; patients do not suffer from post-procedural pain and can return to daily activities after discharge.

ACTIVE PERIRECTAL BLEEDING AFTER STAPLED HAEMORRHOIDOPEXY TREATED WITH ANGIOEMBOLIZATION, HOW TO MANAGE A RARE COMPLICATION OF A COMMON PROCEDURE.

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ABSTRACT: Stapled haemorrhoidopexy has gained widespread acceptance among surgical community for its technical feasibility and its purpose to correct the pathophysiologic process underlying heamorrhoidal disease. Nevertheless, stapled trans anal surgery carries the risk of rare as well as under-reported life-threatening complications like extra-rectal bleeding. Here we report the case of a 41-years old woman who underwent stapled haemorrhoidopexy for symptomatic third grade haemorrhoidal disease, unresponsive to previous medical treatment. The procedure was complicated by active peri-rectal bleeding and hemorrhagic shock,

successfully treated with a timely super selective angioembolization. In literature, evidence is lacking about the management of this complication and various approaches have been reported without uniformity. Therefore, we propose an hemodynamic - based algorithm for the management of extra-rectal bleeding, which includes transanal packing for stable hematoma, upper rectal artery angioembolization for active blush on CT scan and upfront transanal hemostasis for unstable patients, eventually associated to explorative laparoscopy if positive Eco Fast is found. When left undrained, close monitoring of potential hematoma super-infection is mandatory, as prompt surgical drainage and toilette would be required. In conclusion, we believe that stapled transanal surgery should always be performed only by anorectal and pelvic floor surgeons, in a tertiary center, well equipped for overnight CT-scan, interventional radiology and emergency surgery.

EMORROIDECTOMIA IN DUE TEMPI: UN ESEMPIO DI TAILORED SURGERY "OBBLIGATA".

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INTRODUZIONE La patologia emorroidaria è una delle patologie più frequentemente affrontate in campo coloproctologico. Sebbene i trattamenti siano per lo più standardizzati per le varie presentazioni cliniche, in alcuni casi ci troviamo di fronte a casi eccezionali che richiedono una attenta pianificazione ed un approccio estemporaneo alla cura. CASO CLINICO Si presenta il caso di un uomo di 67 anni, senza particolari comorbidità, affetto da patologia emorroidaria da anni, con peggioramento clinico nei mesi antecedenti al controllo proctologico. Alla visita presenta un voluminoso prolasso muco-emorroidario (IV grado con spiccata componente esterna fibrosa). Al paziente viene proposto un intervento di emorroidectomia escissionale. TRATTAMENTO Il trattamento programmato, è stato modificato in quanto, dopo l'esecuzione dell'anestesia spinale e il posizionamento del paziente in sala operatoria, si è evidenziato un abnorme dimensione del prolasso muco emorroidario con importante componente fibrosa esterna coinvolgente tutti i quadranti, rendendo quindi molto difficoltosa la scelta dei settori da asportare e preservare. Il paziente è stato quindi sottoposto ad emorroidectomia parziale con radiofrequenze, preservando un ponte mucoso posteriore senza intervenire anteriormente. _A distanza di 6 mesi, è stato eseguito nuovo intervento chirurgico con asportazione del prolasso muco emorroidario preservato in precedenza. Il paziente è stato seguito a livello ambulatoriale, con ottimo risultato funzionale e soddisfazione da parte del paziente. CONCLUSIONI In casi particolarmente complessi, la variabilità nelle decisioni terapeutiche assumono il ruolo di tailored surgery anche in campo proctologico. Va sottolineato come l'attenta prosecuzione dei controlli ambulatoriali sia fondamentale per la valutazione sia dei risultati che del timing chirurgico.

"EMBORRHOID" TECHNIQUE FOR BLEEDING HEMORRHOIDS IN PATIENTS UNFIT FOR SURGERY

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Introduction: bleeding haemorrhoids should be first treated with medication and non-operative outpatient procedure such as rubber band ligation and injection sclerotherapy. Excisional haemorrhoidectomy remains the mainstay operation for persistent or recurrent disease. "Emborrhoid" is an interventional radiology technique that has been

described as a painless and safe alternative treatment for bleeding haemorrhoids. *Methods*: pts with bleeding grade II and III haemorrhoids with III or IV American Society of Anesthesiologists status, using oral anticoagulants, with risk for transmission of viral (HCV and HIV) infections and those with disabilities that did not allow to take the lithotomy position during surgery were submitted to percutaneous selective embolization of the terminal branches of the superior rectal arteries with metallic microcoils. Bleeding resolution and complications were reported. *Results:* 12 pts were submitted to Emborrhoid. Three pts experienced the appearance of a self-resolving hematomas at the site of the inguinal puncture. Two pts had a persisting, even if reduced, bleeding during defecation. One patient underwent additional embolization with full success. No anal pain or rectal ischemic complications were observed. After a mean follow-up period of 22.6 months only one patient complained persisting bleeding during defecation. *Conclusions*: Emborrhoid appears to be a safe, painless and effective treatment for bleeding grade II and III haemorrhoids in pts unfit for surgery.

OPEN HEMORRHOIDECTOMY UNDER LOCAL OR SPINAL ANESTHESIA: A RETROSPECTIVE COMPARATIVE STUDY

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Purpose To evaluate the safety and efficacy of open hemorrhoidectomy under local anesthesia in the outpatient clinic versus spinal anesthesia in the operating room. *Methods* Sixty patients with grade III or IV hemorrhoids underwent open hemorrhoidectomy with Ligasure during a 6-year period. Of them, 30 procedures were performed in the operating room under spinal anesthesia and other 30 procedures were undertaken in the outpatient clinic under local anesthesia with ropivacaine. *Results* Patients operated in the operating room had greater Golligher's grade and ASA score than cases treated in the outpatient clinic. Although short-term complication rate was higher in the spinal anesthesia group, no difference in long-term complications and number of reinterventions was observed in between groups. *Conclusion* Our results suggest that open hemorrhoidectomy with Ligasure can be safely performed in selected patients under local anesthesia in the office setting.

MARTEDI' 1° DICEMBRE

TRANSANAL HEMORRHOIDAL DEARTERIALIZATION DOPPLER-GUIDED (THD-DG) AND HEMORPEX SYSTEM® PLUS (HPSP) WITH MUCOPEXY FOR THE TREATMENT OF GRADE II-III HEMORRHOIDS: OUTCOMES OF 122 CONSECUTIVE PATIENTS

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Background Conventional hemorrhoidectomies are associated with post-operative complications such as intense pain, bleeding, incontinence and anal stenosis. Primary aim of this retrospective study is to evaluate long-term results (recurrence and patients' satisfaction) of THD-DG and HPSP with mucopexy for the treatment of grade II-III hemorrhoidal prolapse. *Methods* Between January 1, 2014 and March 31, 2020, 122 patients underwent surgery at Chivasso Hospital – General Surgery Unit (TO), Italy. Ligation of the superior hemorrhoidal

artery terminal branches and mucopexy at 1-3-5-7-9-11 o'clock were performed in all cases. After discharge, patients were subjected to 1 week, 1, 3, 6 and 12 month clinical controls. Thereafter, they were outpatient examined annually. *Results* 76 (62.3%) THD-DG and 46 (37.7%) HPSP were performed. Mean surgical time was 29 ± 7 minutes for THD-DG vs 25 ± 5 for HPSP. Intense post-operative pain and bleeding requiring hemostasis occurred in 2 (1.6%) and 3 (2.5%) patients, respectively. Median follow-up was 36 months (6-76). We recorded 41 (33.6%) recurrences and 13 surgical revisions were necessary. 91 patients (74.6%) reported complete satisfaction. 1 patient (HPSP + sphincterotomy) developed incontinence. No anal stenosis was registered. *Conclusions* In our study, recurrence rate was higher than reported in other series. However, low incidence of other complications and good patients' satisfaction grade make these two techniques a valid alternative to hemorrhoidectomies. Doppler guide does not seem to offer clear advantages.

SCLEROTHERAPY WITH POLIDOCANOL FOAM IN SYMPTOMATIC SECOND- AND THIRD-DEGREE HAEMORRHOIDAL DISEASE: TECHNICAL NOTES AND THREE YEARS RESULTS IN COLOPROCTOLOGY UNIT "BARI 2" - VIDEO -

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INTRODUCTION: Sclerotherapy (ST) with 3% polidocanol foam induces an inflammatory reaction with sclerosis of the submucosal tissue and consequent suspension of the haemorrhoidal tissue. The aim of this study was to evaluate the short-term effectiveness and safety of ST with 3% polidocanol foam for the treatment of symptomatic second- and third-degree HD. **PATIENTS AND METHODS**: A total of 124 patients with symptomatic second- and third-degree HD underwent Sclerotherapy treatment. A visual analogue scale score was used to assess post-operative pain and patient satisfaction. The symptoms severity continence were investigated through Nystrom and Vaizey score at baseline, at 4 weeks and after 1 year and 2 years **RESULTS:** 101 of 124 patients were male (81.4%) and 23 were female pts (18,6%), and the mean age was 51 (29-79; SD ± 12) years. No intraoperative complications and no drug-related side effects occurred. All patients resumed their normal daily activities the day after the procedures. 1 pt refers pain (VAS 7) and 1 bleeding for the first 4 days. The overall success rate was 83,06% after a single ST session (II degree haemorrhoidal disease 85.71% versus III degree haemorrhoidal disease 77.50%). Recurrences are 21 (17,3%); a second ST session was necessary in 11 pts and a surgical procedure was performed for 10 pts. **CONCLUSIONS:** ST with 3% polidocanol foam is a simple, safe, cost-effective and repeatable conservative treatment. The use of this treatment as a bridge to surgery in patients with symptomatic haemorrhoids is a future area of research regarding this technique.

TRANSANAL MUCOPEXY AND HAEMORRHOIDAL DEARTERIALIZATION (MHD): TECHNICAL NOTES AND 3 YEARS RESULTS IN COLOPROCTOLOGY UNIT "BARI 2"

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INTRODUCTION : MHD is a suspensive technique of mucosal plication and artery ligation for prolapsed and bleeding haemorrhoids. Dearterialization treats bleeding of symptomatic haemorrhoids. The doppler guide can be associated to identify the hemorrhoidal arteries. The

aim of this work is to evaluate effectiveness and outcomes in the surgical treatment of II-III haemorrhoidal disease (HD) with mucopexy and dearterialization without Doppler. PATIENTS AND METHODS: We enrolled symptomatic II-III degree HD. At the beginning Transanal Haemorrhoidal Dearterialization with Doppler was performed, but this technique was abandoned for excessive costs and mean operative time. The Endorectal proctoscope Sapimed called ERODE is the device we normally use for MHD without using Doppler. Between 2017 and 2019, 104 pts underwent this technique. Outcome evaluated by a weekly health diary: pain score (VAS), bleeding, tenesmus and urgency. Follow up in 7 post-operative day, 1-3-6-12-24 and 48 months. RESULTS: Mean operative time was 38,4 min. Pain: VAS 4,6±2,2; bleeding (reported until 7 POD): 61 pts (63,4%), tenesmus: 60 pts (62,4%). Complications: 3 major bleeding, 4 thrombosis. Recurrence 2 cases. CONCLUSIONS: MHD is a safe, satisfying and effective technique. In our experience the use of Doppler increases mean operative time and does not modify patients' outcome in terms of recurrence. We recommend ERODE device because of cost effectiveness and better ergonomics. Moreover, this device can be useful for rectocele repair procedure.

MANAGEMENT OF SYMPTOMATIC HAEMORRHOIDAL DISEASE IN COLOPROCOLOGY UNIT BARI 2. TECHNICAL NOTES FOR OFFICE AND SURGICAL TREATMENTS. – VIDEO -

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INTRODUCTION In our Coloproctology Unit, national and international guidelines are highly practiced. After a shared decision making with the patients, we use combined techniques or a higher degree treatment in cases of refractory symptoms or contraindicated procedures. All patients underwent proctological examination, proctoscopy, endoscopy, defecography if necessary. Surveys are collected to evaluate the impact of disease and the influence on the quality of life. We suggest:

- **Sclerotherapy with 3% Polidocanol foam** determines sclerosis of the submucosal tissue and consequent suspension of the haemorrhoidal tissue. A direct intravenous injection is performed inside the haemorrhoids. Indications: symptomatic 2nd HD, in 3rd HD as bridge to surgery; severe anaemia as emergency procedure; recurrences.
- **Rubber Band Ligation:** indicated in 2nd degree, especially if prolapse is more relevant than bleeding or in cases of evident haemorrhage; practiced every 2 weeks. The ligator's cylinder slides and releases rubber bands around the base of the haemorrhoids to reduce blood supply.
- **Mucopexy and dearterialization without using Doppler** with Erode Sapimed proctoscope: indicated in 3rd degree, even in cases of recurrence and for each pathological pile. It is based on plication of prolapsing mucosa with 6 polygliactin sutures.
- **Stapled Haemorrhoidopexy** indicated in cases of more prevalent prolapsing mucosa with moderate OD symptoms than bleeding. Classical technique: performance of a tobacco pouch and a circumferential rectal mucosectomy.
- **Milligan Morgan technique**: indicated in 4th HD or in cases of relevant haemorrhoidalis external plexus prolapse or in cases of skin tags removal; ultrasound or radiofrequency scalpel are recommended.

COMPARISON OF CENTELLA WITH FLAVONOIDS FOR TREATMENT OF SYMPTOMS IN HEMORRHOIDAL DISEASE AND AFTER SURGICAL INTERVENTION: A RANDOMIZED CLINICAL TRIAL

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Phlebotonics' effects were evaluated to reduce time-to-stop bleeding and anal irritation in 130 patients who complained of hemorrhoidal disease (HD); bleeding and pain after hemorrhoidectomy (31 patients) and hemorrhoidal thrombosis (34 patients) in the short time. Sixty patients were randomized to receive the routine treatment (both conservative and surgical) (control Group C). The treated group (both conservative and surgical) was divided into two subgroups: one treated with flavonoids (Group A, n=73), the other with Centella (Group B, n=66). Time-to-stop bleeding was checked at baseline and checkups (0 up to day 42). Healing was estimated with Kaplan- Meier method, the Kruskal-Wallis test estimated changes in the VAS scores. The HD median time-to-stop bleeding was 2 weeks for Groups A and B; 3 weeks for Group C. VAS scores comparison among Groups (irritation): A vs C, p=0.007; B vs C, p=0.041; and A vs B, p=0.782 resulted respectively. As for operated hemorrhoids, the time-to-stop bleeding was 3 and 4 weeks in Groups A and B and 5 in Group C. Histopathology showed an association between flavonoids and piles' fibrosis (p=0.008). Phlebotonics in HD showed significant beneficial effects. Flavonoids are the most effective phlebotonics against bleeding and anal irritation. The hemorrhoidal disease (HD) has a general population prevalence ranging from 13% to 36%1 with an estimated incidence of approximately 50% between 45 and 65 aged2. HD appears with symptoms and signs of soiling, itching, pain, prolapse, and defecation bleeding that are commonly associated with enlarged hemorrhoidal cushions. It may also be symptomatic of other diseases3-4. Anal irritation in the anorectal region can be due to fissure, anal itching, diabetes skin tags, yeast infection, acquired immunodeficiency disease syndrome, herpetic infection, allergic or irritant dermatitis, and fungal infections on the anus skin. Hemorrhoids are anal vascular cushions needed to ensure complete closure of the anus to gas, and liquid stools4. Varicose dilatation of the hemorrhoids often develops from a persistently elevated venous pressure within the vascular plexus. Etiology seems to relate to triggering factors (i.e. constipation that affects many women but not all women) and the predisposition grounds (i.e. menstrual period). In fact, many women develop piles during menstrual period and pregnancy (up to 80%). The hormones and the oral contraceptive pill's intake seem to facilitate HD and acute hemorrhoidal crisis3. Moreover, age, poverty related factors, and low-in-water and low-in-vegetable-fibers diets promote constipation that is related to the start of HD1-4. Sedentary jobs can cause a difficult plexus discharge, a pressure increasing, and dilatation of cushions. The conservative management (diet rich in water and fibers, stool softeners and hygienic cares) is a possible HD treatment from I to III grade in Golligher's classification1. Furthermore, there are a lot of therapies available for bearings' treatment, both surgical and conservative. Among conservative available therapies, we evaluated the effects of two phlebotonics (flavonoids and Centella) in comparison between them and with the control group. The involvement of free radicals in the hemorrhoids' precipitation is "a consequence of

improper balance between reactive oxygen species and their metabolites". It is known that free radicals are neutralized by antioxidants contained in phlebotonics. This is a therapeutic effect on the HD management. As stated by Evans and Halliwell, "herbal extracts rich in phytoantioxidants like polyphenols, flavonoids and other related compounds are known to possess positive health effects and eventually reduces the incidence of diseases". Therefore, many researchers focused their attention "on the use of natural antioxidants, that can provide more significant health benefits with minimal toxicities" as observed also in our own experience. Perera et al. defined phlebotonics as "a heterogeneous class of drugs consisting of plant extracts (i.e. flavonoids, Centella asiatica) and synthetic compounds (i.e. calcium dobesilate)". Corsale et al. noticed that phlebotonics in HD therapy "improve venous tone, stabilize capillary permeability and increase the lymphatic" and the hemorrhoidal "drainage. Anti-inflammatory activities of flavonoids are widely studied. Faujdar et Al. reported that "oxaprozin binding mode is compared to the active site of cyclooxygenase enzyme (COX) which is responsible for inflammatory mediator's catalysis". Moreover, they stated that "pharmacophore's structure shows specific features required to bind the inhibitor to the active site of COX"27. These researches mapped the oxaprozin structures and noticed that they have the same structure of the well-known COX-inhibitor. Rabiskova et al. found out that the "inhibition of some key enzymes involved in inflammation response explains the anti-inflammatory effect of rutin"28. It promotes colonic healing in inflammatory bowel disease (IBD) by myeloperoxidase activity suppression at a dose of 10 mg/kg28. Rutin is a promising preparation, without side effects, suitable for lifelong IBD therapy. In another study, it was proved that Rutin inhibits the edema of the ear caused by xilol. Moreover, rutin reduces cell migration in both peritonitis (carrageenan-induced) and air pouch (zymosan-induced) based on animal models. The study also showed reduced levels of cytokines. Yoo, Ku, Baek, and Bae found that Rutin potently inhibits HMGB1 release. In particular, the Rutin reduces HMGB1 inflammatory response in human endothelial cells. Similarly, rutin reduces vascular hyper permeability and leukocyte migration caused by HMGB1in mice model. Kim et al. demonstrated that "rutin has an anti-inflammatory effect and it might protect against allergic rhinitis". For the first time, they showed that "rutin suppresses chemokines (ICAM-1 and MIP-2) and the reduction of inflammatory cells by regulating the levels of the vascular endothelial growth factor (VEGF)"32. In addition, they observed that "rutin reduces inflammatory cytokines and the activation of caspase-1". "Hydroxyethylrutosides (HR), also known as oxerutins, is a mixture of semi-synthetic flavonoids obtained through the hydroxylation of rutin"33. Antignani et al. demonstrated that "the most important pharmacologic action of oxerutins is the inhibitory effect on microvascular permeability"33. This effect allows to reduce the development of edema that follows several types of injury33. Petruzzellis et al. demonstrated "the edema's reduction in controlled double blind clinical trials, both in healthy volunteers and in patients with chronic venous insufficiency (CVI)" 34. They concluded that "considering both noninvasive tests and clinical evaluation, oxerutin is effective in controlling chronic venous hypertension, without side effect, and with good tolerability". Aziz et al. carried out a systematic review of oxerutins efficacy and tolerability referring to signs and symptoms in CVI35. Their findings showed that oxerutins produces "modest improvements in several CVI symptoms". In a review on fourteen trials, Alonso-Coello compared "the use of phlebotonics versus placebo or without treatment in HD"8. Literature shows that purified micronized flavonoids fraction (PMFF) reduces the severity of bleeding and prevents its relapse8,13-20,36. Numerous trials, assessing the effects of phlebotonics compounds in

treating HD, suggest that they are able to obtain better results. Cho and other researchers noticed that, aside from flavonoids, Centella asiatica (Ca) stimulates collagen type-1 synthesis, production and accumulation of new extracellular matrix. Ca improves vascular-connective tissue deposition and repair processes, which act on enzymatic hydrolysis of microbes and leucocytes to shield collagen. On the basis of these considerations, we thought it could be useful to carry out a randomized trial on the clinical effects of flavonoids and Ca (treated Group) in comparison to a control group in HD patients. The same study was performed on surgical patients (i.e. post-hemorrhoidectomy and thrombosis).Conclusion These results and the analysis of literature agree that flavonoids are effective treatment in terms of shorter time for disappearance of bleeding and anal irritation in patients with grades II-III-IV HD. Bleeding heals by the first week if patients are treated with flavonoids, whereas either flavonoids or Ca21 were equally effective on irritation. Both have better performance than traditional treatment. Patients, who underwent hemorrhoidectomy, and those incised and drained for HT probably started treatments too late to avoid intervention. There were neither complications nor toxicity in the enrolled patients and phlebotonics studied resulted safe and tolerable. As for efficacy, grade III-IV HD patients, who took either flavonoids or Ca, showed fibrosis and understaging aspects of their hypertrophic piles. Finally, at the moment, both flavonoids and Ca are considered semi-essential nutrients and are purchased over-the-counter. The use of these products in clinical practice should be reconsidered and such compounds should be classified as medication. A diet regime rich both in water and boiled-vegetable-fiber is needed to resolve constipation in 4 weeks.

THE ROLE OF MESOGLYCAN FOR PAIN CONTROL AFTER OPEN EXCISIONAL HAEMORRHOIDECTOMY: MEHAEMO STUDY

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Excisional haemorrhoidectomy remains the gold standard technique in patients with III and IV degree haemorrhoidal disease (HD). However, its main drawback is the frequent severe postoperative pain. The aim of our study was to evaluate the efficacy of mesoglycan in the post-operative period of patients who underwent open excisional diathermy haemorrhoidectomy (OEH). Three hundred ninety-eight patients from sixteen colorectal referral centres who underwent OEH for III and IV HD were enrolled. All patients were followed-up on the first post-operative day (T1) and after 1 week (T2), 3 weeks (T3) and 6 weeks (T4). BMI, habits, SF-12 questionnaire, VAS at rest (VASs), after defecation (VASd), and after anorectal digital examination (VASe), bleeding and thrombosis, time to surgical wound healing and autonomy were evaluated. In the mesoglycan group, all patients experienced less post-operative pain at each time point ($p < 0.001$ except for VASe T4 $p = 0.003$) as a consequence of a reduced thrombosis rate of the muco-cutaneous bridges. There were no significant differences between the two groups regarding the time to surgical wound healing or post-operative bleeding. Both the physical component summary score (PCS) and mental component summary score (MCS) of the SF-12 improved in the post-operative period in the two Groups. the MCS improvement was statistically significant in the MG ($p < 0.05$).

The antithrombotic and anti-inflammatory properties of mesoglycan have led to a reduction in post-operative pain with a consequent early resumption of autonomy, probably due to the reduction in thrombosis of the mucocutaneous bridges..

FROM AN ANAL FISSURE TO A COMPLEX FISTULA DISEASE: A CASE REPORT

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A 39-years man was referred to our department with a perianal trans-sphincter fistula after a long surgical history in other hospitals since 2015, when an anterior anal fissure was diagnosed. The 2020 pelvic RMI showed a complex fistula from the anterior anal portion, that after few millimetres divided into four branches: two posterior and two anterior. The anal fistula is a tract that connects the perineal skin to the anal canal, and is results from the chronic infection and epithelialization of an ano-rectal abscess drainage tract [1]. Due the complexity of the clinical case, we decided to perform a double fistulectomy and a fistulotomy of the most superficial lesions. At the same operative time we performed a terminal colostomy to exclude the rectum from the intestinal transit to allow wound healing.Conclusion: Our goal was to eliminate as much disease as possible, but also to exclude the rectum and the anus from the intestinal transit. We refused to perform an aggressive approach and chose to do a colostomy to allow the complete healing of the multiple fistulas. Two months after the surgery the perianal condition is considerably improving and we are looking for to perform a stoma closure.

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CHRONIC ANAL FISSURE TREATEMENT: FISSUROTOMY AND METHYLENE BLU DYE INJECTION

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BACKGROUND: Anal fissure is one of the most frequent pathological conditions in proctology, with incidence rate that varies according to the data reported in the literature between 4 to 10% of the general population. OBJECTIVE: The aim of this video is to present anal fissurotomy in the treatment of chronic symptomatic anal fissure refractory to medical therapy, evaluating the easy execution and reproducibility of the surgical technique. PATIENTS AND METHODS: The patient is a 40 year-old man without surgical history or noteworthy conditions, suffering from double chronic anterior and posterior anal fissure. After failure of conservative medical therapy, the patient underwent anal fissurotomy under spinal anesthesia. Anoscopy and rectal exploration are the initial procedures. After infiltration of the bed and margins of the fissure with local anesthetic (ropivacaine 1fl) and methylene blue dye, the bed of the fissure was subsequently explored with a curved specimen exposing the anal crypt associated. Cryptectomy and fissurotomy were subsequently performed, removing the edges and the bed of the anal fissure with the associated skin cap. Hemostasis was obtained with DTC. The wound was left open to close by second intention. RESULTS: No intra, peri and post-operative complications were recorded. The patient was discharged on the same surgical day. The clinical course was regular, with good pain control without any episodes of post-operative bleeding. CONCLUSIONS: The anal fissurotomy represents today only one of the possible surgical techniques to treat anal fissure. Although in many countries,

internal lateral sphincterotomy is still considered the gold standard approach of the disease, the high rates of incontinence linked to the procedure (about 30% of cases) limit the surgical success. In this context, fissurotomy appears as a safe and easy to perform technique in the treatment of double chronic anal fissure refractory to medical therapy.

CLOSED RIGHT-LATERAL INTERNAL PARTIAL SPHINCTEROTOMY AND DIATERMOCOAGULATION OF MARGINS AS OFFICE TREATMENT IN LOCAL ANAESTHESIA FOR ANAL FISSURE. TECHNICAL NOTES AND RESULTS IN OUR COLOPROCTOLOGY UNIT IN THE LAST 4 YEARS

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INTRODUCTION: In Coloproctology Unit Bari 2, 3 steps can be considered as anal fissure treatment. First step: conservative treatment with calcium channel blocking drugs (Nifedipine) ointment associated to Lidocaine, local ialuronic acid, lassative. Second step to be used in patients refractory to first line management: glyceryl trinitrate ointment and anal dilatation. Third step: closed right-lateral internal partial sphincterotomy (SLI) and coagulation of margins(DTC) PATIENTS AND METHODS: Between 2017 and 2020, 362 pts were affected by anal fissure, whose 280 treated with 1-2 step for 30 days and 82 underwent 3rd surgical step. Technique: Local anaesthesia with Lidocaine 2% inside the anoderm and perianal area, using a quadrijet device. Insertion of the small Beak Surgical Proctoscopes from SapiMed. At first DTC of the margins. Subsequently RIGHT-SLI: small incision with triangular n.11 blade at the intersphincteric groove, insertion of the blade parallel to the internal sphincter, cutting it laterally to medially (from one third to one half) and rotating. Haemostasis was obtained with manual compression for 5 minutes. In 10% an absorbable stitch was necessary for haemostasis. All patients were controlled 1 hour after the procedure and discharged. RESULTS VAS pre operative 8 ±1,587 (SD) - VAS post operative 4 ± 3,029 (SD). Pre operative QoL 3 ± 0,737 (SD); Post op QoL 8 ± 1,497 (DS). Complications: 12 bleeding, 4 haemorrhage; faecal incontinence (1 case of minor f.i.) CONCLUSIONS: Our analysis reveals that closed right SLI is an effective, safe and reproducible technique for the surgical treatment of chronic anal fissure.

SURGICAL TREATMENT OF SEPTIC COMPLICATIONS OF CHRONIC ANAL FISSURE.

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INTRODUCTION. Septic complications occur not rarely in the clinical course of anal fissure posing problems of differential diagnosis and treatment. On the other hand, it has been hypothesized that intersphincteric infection represents a trigger in the pathogenesis of chronic anal fissure. In this study we examined the incidence and type of septic complication on a large number of patients affected by anal fissure. PATIENTS AND METHODS. In the

period January 2012-December 2019 we treated 931 patients affected by chronic anal fissure not responding to conservative measures. In137 cases the fissure showed gross appearance of a deep ulcer surrounded by edematous skin tags; in 41 of these cases such pictures were accompanied by signs of local sepsis. There were 18 acute abscesses, 19 fistulas, 11 intra-sphincteric (two anterior) and 8 low trans-sphincteric, 4 horse-shoe. Pre-operative VAS score was 7.2+-1.2(mean+-sd). CC Continence score was 0.1+-0.3 (mean+-sd). The operation was conducted by excision of the inflamed tissue with the whole fissure, wide drainage of the intersphincteric space, posterior sphincterotomy and anoplasty according to Arnous (in order to avoid key-hole deformity). Intra-sphincteric fistula were excised “en-bloc” with the whole inflamed tissue. Low trans-sphincteric track were curetted within the muscle, inter-sphincteric space left widely opened, drained and gently packed with gauze. The 4 patients with horseshoe fistula had partial fistulectomy up to the external sphincter, curettage and drainage of the inter-sphincteric plane together with fissurectomy, posterior sphincterotomy and anoplasty. RESULTS. Postoperatively, patients were followed on day 7-10 and then every two weeks until complete Healing, occurring after a mean of 6.1 weeks (range 3-14 weeks). Mean VAS score dropped to 2.6+-0.7 at first follow-up visit, thereafter it was reported unremarkable. At the end of postoperative follow up, CC Continence Score improved and rose to 0.3+-0.5. A control visit was proposed to these 41 patients after a median follow up of 49 months. 14 refused due to long distance from the hospital, declaring excellent clinical conditions. In the remaining 27 local examination was unremarkable, with normal resting anal tone and good anal voluntary contraction. Pain score was unremarkable and continence was reported normal. CONCLUSIONS. The septic complication in chronic anal fissure should not be considered as a classical cryptoglandular disease and its true incidence is unknown. Excision of the septic tissues, combined with drainage of the inter-sphincteric plane may represent the cornerstone of successful treatment. Various approach can be reserved for the treatment of the remaining fistulas, preferably conservative.