

FEATURES OF SURGICAL TREATMENT OF COMBINED HEMORRHOIDS IN ELDERLY PATIENTS WITH CHRONIC MYELOID LEUKEMIA

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Annotation. Treatment of combined hemorrhoids in elderly patients with chronic myeloid leukemia requires special attention to general health. It is important to collaborate with doctors to develop an individual treatment plan that takes into account the physical condition and characteristics of the disease.

Surgical methods such as sclerotherapy, laser coagulation or surgery may be considered depending on the severity of the hemorrhoids. However, given chronic myeloid leukemia, additional consultation with a hematologist may be required to determine the safety of surgery in the context of systemic diseases.

Keywords: treatment of combined hemorrhoids, general health, treatment plan, sclerotherapy, laser coagulation, surgical removal of hemorrhoids, hemorrhoidectomy.

The term “hemorrhoids” refers to a pathological enlargement of external and internal hemorrhoids, accompanied by periodic discharge of scarlet blood from the internal nodes and their loss from the anal canal. Internal hemorrhoids are located in the submucosal layer of the final section of the rectum. External hemorrhoids are located under the skin of the perineum [5].

The surgical treatment of combined hemorrhoids typically involves various procedures depending on the severity of the condition. Here are some features associated with surgical interventions:



1. Hemorrhoidectomy:
 - Surgical removal of hemorrhoids.
 - Effective for advanced or large hemorrhoids.
 - Can be associated with more postoperative discomfort.
2. Ligation Procedures:
 - Rubber Band Ligation:
 - Application of rubber bands to cut off blood supply to hemorrhoids, leading to their shrinkage and eventual fall off.
 - Effective for internal hemorrhoids.
 - Sclerotherapy:
 - Injection of a chemical solution into hemorrhoids to shrink and eliminate them.
 - Suitable for smaller hemorrhoids.
3. Stapled Hemorrhoidopexy (Procedure for Prolapse and Hemorrhoids - PPH):
 - Resection of excess hemorrhoidal tissue using a stapling device.
 - Minimally invasive compared to traditional hemorrhoidectomy.
 - Typically associated with less postoperative pain.
4. Hemorrhoidal Artery Ligation (HAL) or Transanal Hemorrhoidal Dearterialization (THD):
 - Identification and ligation of hemorrhoidal arteries to reduce blood flow to hemorrhoids.
 - Minimally invasive with a focus on preserving the anatomy.
5. Laser Coagulation:
 - Application of laser energy to coagulate and shrink hemorrhoidal tissue.
 - Suitable for smaller hemorrhoids.
6. Cryotherapy:
 - Freezing of hemorrhoidal tissue to cause cell destruction.
 - Less commonly used compared to other methods.
7. Radiofrequency Ablation:
 - Use of radiofrequency energy to heat and shrink hemorrhoidal tissue.
 - Less invasive than traditional hemorrhoidectomy.
8. Combination Procedures:
 - Surgeons may combine different techniques based on the characteristics and location of hemorrhoids.
 - Tailored approach to address individual patient needs.
9. Postoperative Care:
 - Management of pain and discomfort through medications and lifestyle adjustments.
 - Dietary recommendations to prevent constipation.
 - Monitoring for potential complications, such as bleeding or infection.
10. Consideration of Recurrence:
 - Hemorrhoid recurrence can occur, and follow-up care is essential to address any new symptoms.

It's crucial for patients to discuss the specific features, benefits, and potential risks of each surgical option with their healthcare provider. The choice of procedure depends on factors such as the severity of hemorrhoids, patient preferences, and overall health considerations.

Transmucosal laser thermal ablation (TLT) has become widespread in the treatment of chronic hemorrhoids. It is more often used in isolation for internal hemorrhoids and less often in combined forms with excision of external nodes and perianal fimbria or their laser destruction [7, 5]. This is due to the fact that during laser treatment of combined hemorrhoids after destruction of internal nodes, the



main reasons that brought the patient to the operating room are eliminated. At the same time, external hemorrhoids remain, which may subsequently pose certain problems for the patient associated with the possibility of their thrombosis, and the perianal fimbria bring not only aesthetic inconvenience, they can become injured, become inflamed, and the patient is left with a feeling of incomplete treatment [8, 5].

The need to eliminate external catches and perianal fimbriae during laser treatment of combined hemorrhoids of 2–3 degrees is a subject of debate, since they are located below the dentate line, in the area of pain sensitivity, and this can cause intense pain and cast doubt on the possibility of performing the operation on an outpatient basis under local anesthesia [3, 4].

There are some surgical treatments of combined hemorrhoids in elderly patients with chronic myeloid leukemia:

1. Patient Assessment:

- Thorough evaluation of the patient's overall health, considering age, chronic conditions, and specifically, chronic myeloid leukemia (CML).

- Collaboration between proctologists and hematologists for a comprehensive approach.

2. Risk Assessment:

- Identification of potential risks associated with surgery in elderly patients with CML.

- Assessment of the patient's ability to tolerate surgical interventions.

3. Hematological Considerations:

- Evaluation of the patient's hematological profile to understand the impact of CML on clotting factors and overall blood parameters.

- Coordination with hematologists to manage hematological aspects before, during, and after surgery.

4. Choice of Surgical Procedure:

- Selection of an appropriate surgical technique, considering the severity of hemorrhoids and the patient's overall health.

- Options may include rubber band ligation, sclerotherapy, hemorrhoidectomy, or newer minimally invasive procedures.

5. Preoperative Preparations:

- Optimization of the patient's general health before surgery.

- Addressing any specific concerns related to CML, such as platelet dysfunction or bleeding tendencies.

6. Intraoperative Considerations:

- Careful monitoring of blood parameters during surgery.

- Use of techniques to minimize bleeding and complications.

7. Postoperative Care:

- Close monitoring of the patient's recovery, with attention to hematological parameters.

- Appropriate pain management and preventive measures for complications.

8. Follow-up and Long-term Management:

- Regular follow-up to monitor both the surgical site and the hematological condition.

- Adjustment of treatment plans based on the patient's response to surgery and the progression of CML.

9. Multidisciplinary Approach:

- Collaboration among surgeons, hematologists, and other specialists for comprehensive patient care.

10. Individualized Approach:



- Recognition that each patient is unique, and treatment plans should be tailored to the specific needs and circumstances of the elderly patient with combined hemorrhoids and CML.

It is essential for healthcare providers to work closely together to create a customized treatment plan that addresses both the hemorrhoidal condition and the complexities associated with chronic myeloid leukemia in elderly patients.

In conclusion, it is important to emphasize that conservative treatment for hemorrhoidal disease is palliative, bringing the patient a reduction in the severity of the main complaints or transferring the disease to a chronic course. Almost all doctors treating patients with chronic hemorrhoids emphasize that the resumption of constipation, errors in diet, and regular physical activity lead to a relapse of the disease, which reaches almost 100% within up to 3 years. In addition, it is important to remember that the effectiveness of conservative treatment decreases depending on the severity of the clinical manifestations of hemorrhoids. Thus, in the 3rd and 4th stages of hemorrhoidal disease, these methods are ineffective.

References:

1. Abcarion H., Alexander-Williams J., Christiansen J. Benign anorectal diseases: definition characteritron and analysis of treatment. *Amer. J. Gastroenterol*, 1994; 8: 182—190.
2. Badon A. Sclerotherapy of hemorrhoids. *Phlebologie*. 1980, 33(4): 613—616.
3. Longchamp G, Liot E, Meyer J, et al. Non-excisional laser therapies for hemorrhoidal disease: a systematic review of the literature. *Lasers Med Sci*. 2021 Apr;36(3):485–496. Epub 2020 Sep 10. PMID: 32914275; PMCID: PMC7952353. doi: 10.1007/s10103-020-03142-8
4. Мудров А. А. Периоперационное ведение пациентов с хроническим геморроем // *МС*. 2012. №8. URL: <https://cyberleninka.ru/article/n/perioperatsionnoe-vedenie-patsientov-s-hronicheskim-gemorroem>
5. Родоман Г.В., Корнев Леонид Владимирович, Шалаева Т.И. Преимущества комбинированного малоинвазивного лечения в реабилитации больных хроническим геморроем // *Медико-социальная экспертиза и реабилитация*. 2017. №1. URL: <https://cyberleninka.ru/article/n/preimuschestva-kombinirovannogo-maloinvazivnogo-lecheniya-v-reabilitatsii-bolnyh-hronicheskim-gemorroem>
6. Сотников В.М., Каторкин С.Е., Андреев П.С. Результаты хирургического лечения комбинированного геморроя в амбулаторных условиях. *Материалы Всероссийской научно-практической конференции с международным участием «Российский колопроктологический форум»*. Колопроктология. 2019;18(3s):48. doi: 10.33878/2073-7556-2019-18-3-pril
7. Титов А. Ю., Костарев И.В. Субмукозная лазерная термоабляция внутренних геморроидальных узлов. *Хирургия. Журнал им. Н.И. Пирогова*. 2020;(3):89–96. doi: 10.17116/hirurgia202003189
8. Черепенин М.Ю., Горский В.А., Армашов В.П. Результаты лечения геморроя методом деструкции геморроидальных узлов с помощью диодного лазера. *Колопроктология*. 2020, 19(2): 104-111. doi: 10.33878/2073-7556-2020-19-2-104-111
9. Ruziboeva, O. N., Abdiev, K. M., Madasheva, A. G., & Mamatkulova, F. K. (2021). Modern Methods Of Treatment Of Hemostasis Disorders In Patients With Rheumatoid Arthritis. *Ученый XXI века*, 8.
10. Мадашева, А. Г., & Махмудова, А. Д. (2021). Биохимические показатели у больных гемофилией с мышечными патологиями до и после лечения. *Форум молодых ученых*, (4 (56)), 233-238.



11. Gazkhanovna, M. A., Makhmatovich, A. K., & Utkirovich, D. U. (2022). Clinical efficacy of extracorporeal and intravascular hemocorrection methods in psoriasis. *ACADEMICIA: An International Multidisciplinary Research Journal*, 12(2), 313-318.
12. Мадашева, А. Г. (2022). Коррекция диффузной алопеции при железодефицитной анемии. *Science and Education*, 3(12), 231-236.
13. Мадашева, А. Г. (2022). Клинико-неврологические изменения у больных гемофилией с мышечными патологиями. *Science and Education*, 3(12), 175-181.
14. Махмудова, А. Д., Жураева, Н. Т., & Мадашева, А. Г. (2022). НАСЛЕДСТВЕННЫЙ ДЕФИЦИТ ФАКТОРА СВЕРТЫВАНИЯ КРОВИ VII–ГИПОПРОКОНВЕРТИНЕМΙΑ.

