Author’s response to reviews

Title: Doppler-guided Transanal Hemorrhoidal Dearterilization Versus Conventional Hemorrhoidectomy for Treatment of Hemorrhoids - Early and Long-term Postoperative Results

Authors:

Valentin Popov (popovvalentin@yahoo.com)
Atanas Yonkov (aionkov@abv.bg)
Elena Arabadzhieva (elena_arabadjieva@abv.bg)
Evgeni Zhivkov (ejivkov2000@yahoo.com)
Sasho Bonev (sasho_bn@abv.bg)
Dimitar Bulanov (dbulanov@mail.bg)
Vladimir Tasev (vntasev@mail.bg)
Georgi Korukov (georgikorukov@gmail.com)
Liliya Simonova (liliq.simonova@yahoo.com)
Nayden Kandilarov (naidenk@yahoo.com)
Anna Taseva (annataseva85@gmail.com)
Violeta Dimitrova (v_dimitrovabg@abv.bg)

Version: 1 Date: 06 Jun 2018

Author’s response to reviews:

Dear Reviewers,

I am grateful for your comments and recommendations and for the opportunity to revise the manuscript “Doppler-guided Transanal Hemorrhoidal Dearterilization Versus Conventional Hemorrhoidectomy for Treatment of Hemorrhoids – Early and Long-term Postoperative Results”.

The changes in the manuscript are made according to the Reviewers’ comments.
According to the Reviewer 1’s comments:

1/ The type of the study was prospective, comparative and non-randomized. This was clarified in the Methods section.

2/ The study was non-randomized, patients were informed about the procedures and they underwent the procedures depending on their affordability and will, as well as the surgeon’s personal preference and opinion in each case due to HD status.

3/ About the comment for the different techniques in CH group - all patients in this group underwent an excisional hemorrhoidectomy performed by several devices but the basis of the method is the same. The main difference with THD is the lack of tissue excision during it. Furthermore, several studies found no significant difference in postoperative complications and long-term outcome between non-laser and laser/ cauterity device and Ligasure hemorrhoidectomy. So, we believe that these minor variations in the technique will not reduce the value of the study. We discussed this heterogeneity in the Discussion section.

4/ According to the reviewer’s recommendation, we added a section illustrating both (CH and THD) surgical techniques.

5/ Regarding the question of the sample size - The duration of the study with a minimum follow-up of 18 months was determined prior to the research. So, the sample size of the study represented all patients operated in our department during this period of time and who met the inclusion criteria.

6/ We stated clearly the primary and secondary outcomes and the time points of their assessment in the Methods section.

7/ A statement about obtaining informed consents from the patients for each procedure was added in the Methods section and Declarations, as well.

8/ The Inclusion/Exclusion criteria were clarified in the Methods section. Inclusion criteria were: II, III, IV degree hemorrhoids, both sex, age between 18 and 80 years, ability to understand the procedure, written informed consent. Exclusion criteria were: previous surgery for anal disorders, fecal incontinence, other active anorectal diseases, irritable bowel syndrome. So, this answers the reviewer’s question about the co-existing anorectal conditions.

9/ With regards to the comments of both Reviewers about the duration of hospital stay, we discussed it additionally. The prolonged mean hospital stay, observed for both groups in comparison to other reports, is due to the health insurance system in our country and its requirements for a minimum hospital stay for treatment of the disease (the patient could be discharged on/ after the 3rd day after the admission). Another reason was a substantial delay from the time of admission to the surgery in some cases. With regards to the comparison between Group 1 and Group 2, in our opinion, the lower postoperative pain resulted in the
significantly decreased duration of hospital stay for THD group, which was the secondary
endpoint of the study. The longest hospital stay in CH group could be explained with the
occurrence of postoperative morbidity or the surgeon’s decision for the need of additional
observation of the patient in order to avoid development of complications in home conditions in
cases with preoperative high-grade HD.

10/ The mean and median duration of follow-up in each group and the % of the patients who
were available for assessment at the end of follow-up were added.

11/ Detailed information about the recurrence, not only about the re-operated patients, was
added. P values were provided, as well.

12/ Regarding the question about long-term complications (stenosis, incontinence) – we did not
observe anal stenosis or fecal incontinence and we stated in the article.

13/ Tables 1, 2 and 3 were corrected, according to the reviewer’s recommendations.

14/ According to the comments of both Reviewers, the linguistic revision was made by a native
speaker (an English teacher).

15/ The Discussion part was revised.

According to the Reviewer 3’s comments:

1/ About the limited number of patients, operated during the 5-year period: The total population
of our country is less than 6 000 000, so we could expect that the number of the patients with
hemorrhoids who need surgical treatment would be small, too. This study included the patients
who underwent surgery in a single institution and this also leads to the presented small series. All
surgical procedures are performed by general surgeons.

2/ About the comment for the hospital stay – please, find the answer above.

3/ In the 3rd comment it is stated: “ethical consent how it is come that the patients agree about
CH IN SPITE OF knowledge post operative stormy situation”. The conventional
hemorrhoidectomy (CH) remains “the gold standard” for grade II, refractory to conservative
management, grade III and IV, and in cases of the recurrent disease. Because of that, it is not
surprising that patients agree for the procedure. The risk of postoperative complications is similar
in many reports in the literature, but the procedure is commonly performed all over the world.
Furthermore, at the beginning of 2010, our team was the first who started the performance of
Doppler-guided THD in our country. Because this procedure was new in our country, some
patients were skeptical about the technique and they preferred the proven one.
4/ About the incidence of the HD – it is difficult to estimate the exact prevalence of hemorrhoids because many people use over-the-counter treatments and do not seek medical attention for the condition. Because of that, according to the Reviewer’s recommendation, we decided to remove the specific odds reported in the literature, which were cited in the manuscript.

5/ With regards to the linguistic revision – please, find the answer above.

6/ In the 6th comment it is stated: “one patient has fissure why you don't exclude”. The mentioned patient developed an anal fissure as a postoperative complication. All patients who underwent surgical procedures due to hemorrhoids and co-existing anorectal disorders (fissure, fistula, etc.) were not included in the study.

7/ According to the Reviewer’s recommendation, we added the missing information about constipation as a symptom observed in studied patients.

Thankfully,

Elena Arabadzhieva