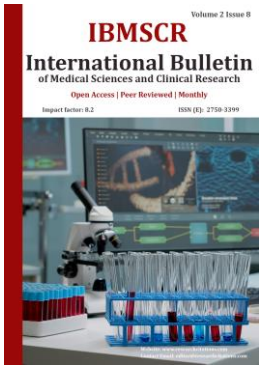

TREATMEHT METHODS EPITHELIAL-COCCYGEAL COURSE

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https://doi.org/10.5281/zenodo.8255728

Keywords: coloproctologist, epithelial-coccygeal passage, subcutaneous adipose tissue.

Relevance. The causes of such fistulas in most cases are infection and chronic inflammation of a narrow canal (passage) lined with normal skin epithelium in the distal part of the intergluteal fold, which opens outwards with one or less often several pinholes near the edge of the anus, between it and the top of the coccyx. Among the patients of a coloproctologist, sometimes there are patients with constantly functioning or recurrent purulent fistulas of the sacrococcygeal region. This course is a congenital anomaly of the skin associated with an incomplete reduction of the muscular and connective structures of the caudal region - the epithelial-coccygeal course.

Purpose of the study. Ttactics of surgical treatment of the epithelial-coccygeal passage.

Materials and methods. In the coloproctology department at the clinic of Samara State Medical University from 2017 to 2022. 45 patients with chronic epithelial-coccygeal course underwent surgical treatment. All underwent radical treatment. Surgical tactics, treatment of epithelial-coccygeal passage is practically unified. It comes down to excision of the pathological section with suturing to the bottom of the wound. 7 patients (16%) received blind mattress sutures. Postoperative complications from this group of patients occurred in 1 patient (14%). After these complications, a semi-open method of surgical treatment began to be used, taking into account the anatomical parameters and the degree of complexity of the form of the disease. The most unfavorable group included patients with a high configuration of the buttocks, an acute angle of the intergluteal depression, and a crease that was long in length. For this group of patients, a developed and modified method of surgical treatment was used by doctors at the clinic of Samara State Medical University. After excision of the pathological focus within the healthy tissue, a wedge-shaped flap of subcutaneous fat was additionally excised on both sides of the wound in such a way as to ensure sufficient mobility of the skin edges displaced to the bottom. The wound was sutured with return sutures, separately for each half, so that after tightening all the sutures, a narrow wound remained, no more than 0.2 cm. In this group, 38 patients (84%) were operated on. Complication was observed in 4 patients. The remaining 34 people were operated on with partial excision of the wedge-shaped flap of subcutaneous fat, suturing to the bottom of the wound. Complications were observed in 2 patients. After excision of the pathological focus within the healthy tissue, a wedge-shaped flap of subcutaneous fat was additionally excised on both sides of the wound in such a way as to ensure sufficient mobility of the skin edges displaced to the bottom. The wound was sutured with return sutures, separately for each half, so that after tightening all

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Conclusion. Thus, an individual approach to the choice of surgery depending on the topographic features of the sacrococcygeal region, along with the use of a set of measures to prevent complications during aftercare, allows achieving good recovery results.

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