# EDITORIAL BY THE EDITOR-IN-CHIEF

***Dear Readers***

In this issue, I particularly recommend the article on the treatment of proctological patients with immunodeficiency. Currently, we increasingly encounter immunocompromised patients in our medical practice. Most of them are oncology patients (as many as 30% of oncology patients experience proctological disease) who receive chemotherapy. The remainder are patients receiving biological therapy for inflammatory bowel disease, those receiving long-term immunosuppressive medications after organ transplantation, and those with acquired immunodeficiency syndrome due to HIV infection. The authors present three case studies, which serve as a context for discussing the treatment of these patients. This article is particularly valuable because its authors work daily in a department where organ transplants are performed, thus presenting their practical observations on patients receiving long-term immunosuppressive therapy.

I also recommend reading an overview article on the treatment of pilonidal cysts using the Gips procedure. Although this method is not new (it was first described in 2008 by Moshe Gips), but it is not popular in Poland. It is a certain alternative in the treatment of patients with pilonidal cysts. It is minimally invasive and can also be performed in an outpatient setting, which makes it an attractive therapeutic option. However, it seems that, as with any other surgical method, the key to therapeutic success with the Gips procedure is the appropriate qualification of patients with pilonidal cysts.

Personally, I believe that "you can never talk too much about Crohn's disease", so I encourage you to read the case report of a patient with multiple anal fistulas, which turned out to be the first symptom of Crohn's disease (CD). In the described patient, gastroenterological diagnostics was not performed immediately, but approximately 12 months after the onset of the disease, because the previous sclerotherapy could have raised the suspicion of iatrogenic fistulas. In approximately one-third of all patients with rectal manifestations of CD, an abscess or fistula is the first symptom of the disease, and proctological surgery often precedes diagnosis. In my opinion, CD etiology should always be ruled out in patients with multiple fistulas (endoscopy of the entire gastrointestinal tract should be performed in each case, with biopsies taken for histopathological examination), as the diagnosis of CD has a practical impact on the patient's treatment.

This issue also includes a review article on the principles of treating fistulas branching into the scrotum, which are classified as complex fistulas. Infection in the tissues surrounding the scrotum can be particularly dangerous, as if surgical intervention is not undertaken early enough, it can lead to a fulminant perineal phlegmon, also known as Fournier's gangrene.

Finally, in the history section, I published my own article presenting the life of Associate Professor Mieczysław Tylicki, describing his contribution to the development of Polish proctology. For seven years, I had the opportunity and great fortune to work on the same team as the Associate Professor, observing his work, and assisting him almost daily in the procedures he performed. Later, in my professional work, I largely "based" on the teachings acquired at that time from both Associate Professor Tylicki and Dr. Maciej Grochowicz, while simultaneously learning new techniques from other colleagues and gaining surgical experience herself. This article is an attempt to assess Mieczysław Tylicki's contribution to Polish proctology and answer the question posed in the title: "What has changed, and what has endured?". Utilizing the knowledge of master surgeons is invaluable, but this does not relieve us physicians of the obligation to continually educate ourselves and modify surgical techniques in line with medical advances.

*I wish you pleasant reading*
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