Transform weight loss

Seattle Clinic Kit

FRONT DESK · ENQUIRIES · PATIENT MATERIALS

A reference pack for the team taking the calls: how to answer the questions patients actually ask, what can and cannot be said, and how to tell a good fit from a polite pass.

AUGUST 2026

Within 1 hr	~15 min	~87%	4
FIRST HUMAN CALL	PROCEDURE TIME	SYMPTOM-FREE AT 5 YRS*	CHECKS BEFORE BOOKING

01 · START HERE FOR CLINIC USE ONLY

How to use this kit.

The clinic runs its own enquiries, its own systems, and its own schedule. Nothing here changes that. This is reference material for the people answering the phone, written to be adapted rather than followed exactly. Take what is useful and ignore the rest, with one exception: page 04 is the compliance page, and that one is firm.

GUARDRAIL

Nothing here reaches a patient until the clinic signs off. All patient-facing language and every clinical claim goes through the clinic's own medical and legal review. This kit is a draft written to make that review quick.

THE AGREED LANGUAGE

The procedure, in the words we all signed off on.

These are the facts and the exact phrasing agreed with the clinical team, and they match the patient brochure word for word. If an answer anywhere in this kit ever disagrees with this list, this list wins, and please tell us so we can fix it.

WHAT IT IS	**Thermal Submucosal Hemorrhoidopexy (TSH)**, an **outpatient procedure** for hemorrhoids, performed by a surgeon. Say "outpatient procedure", not "in-office" and never "minimally invasive".
HOW IT WORKS	Under light sedation, the surgeon performs an **incisionless procedure** by applying gentle thermal energy to the tissue just above the hemorrhoid. The tissue contracts and is **drawn back in, alleviating symptoms**. *Do not say the hemorrhoid returns to its "normal position".* One word: **incisionless**.
HOW LONG IT TAKES	The procedure takes **about 15 minutes**. Patients are **discharged within 30 to 60 minutes**.[1]
THE VISIT PATTERN	A **consult first**, then the procedure at a **separate visit**. Never describe it as one single visit.
ANESTHESIA	**Light sedation rather than general anesthesia**, with a local anesthetic added if it is needed. Not "local anesthesia for most patients". CONFIRM: HOW THIS CLINIC WILL RUN IT
RECOVERY	In the study, **most patients went back to work the same or the next day**.[1] A short follow-up visit confirms healing.

DURABILITY	**87% symptom-free at five years** after a single procedure, in the published study of 248 Grade II and III patients.[1]
CANDIDACY	May be an option for ongoing symptoms despite over-the-counter treatments, lifestyle changes, or procedures such as rubber band ligation. **A clinician decides after an in-person evaluation**, never the phone.

THE COMPARISON FIGURES, AND WHERE THEY COME FROM

These are the numbers on the brochure's options panel, now each with a source: more than **1 in 2 adults over 50** live with hemorrhoidal disease;[2] after rubber band ligation **49% see symptoms return within a year**, and banding is often 2 to 3 sessions;[3] after a surgical hemorrhoidectomy recovery typically takes **4 to 6 weeks**.[4] CONFIRM: THE 4 TO 6 WEEK FIGURE Our cited source gives an average of two to four weeks with a range of two to eight, so please confirm the wording the clinic wants before print.

SOURCES

1. Sias F, Milone L. Thermal submucosal hemorrhoidopexy: five-year outcomes in 248 patients with Grade II and III hemorrhoidal disease. *Journal of Surgery*, 2025.
2. Fox A, Tietze PH, Ramakrishnan K. Anorectal conditions: hemorrhoids. *FP Essentials*. 2014;419:11-19.
3. Dekker L, Bak MTJ, Bemelman WA, Felt-Bersma RJF, Han-Geurts IJM. Hemorrhoidectomy versus rubber band ligation in grade III hemorrhoidal disease. *Annals of Coloproctology*, 2021.
4. Cleveland Clinic. Hemorrhoidectomy. my.clevelandclinic.org/health/procedures/hemorrhoidectomy.

WHAT A GOOD ENQUIRY LOOKS LIKE

The four-point check.

Before spending real time on someone, this is what is worth confirming. It takes about thirty seconds, and it is the same list whether the enquiry arrived by phone, by web form, or as a referral.

- [ ] **A real, reachable person**
  A working phone number or email, and a name that is not obviously junk. One verification attempt is enough before marking it spam.

- [ ] **Willing to travel to Seattle**
  Where they live does not matter. Whether they will come to the clinic does. People travel for a procedure like this, so ask rather than assume.

- [ ] **Commercial insurance, or able to self-pay**
  The clinic cannot bill Medicare or Medicaid, so it is kinder to say so early than to let someone get their hopes up.

- [ ] **Has symptoms, and wants them treated**
  Someone still researching is worth keeping warm, not chasing. Someone who wants this dealt with is worth a consult time today.

All four yes → offer a consult. Whether the procedure actually suits them is the surgeon's call at the consult, never a judgement made on the phone. The full triage, including how to close the ones that are not a match, is on page 02.

TWO ANSWERS ONLY THE CLINIC HAS

Fill these in before the team goes live.

Two questions come up on almost every call, and both are clinic decisions rather than something this kit can answer. They may even differ from one location to the next. Write the answers in, and the scripts on the other pages work as they stand.

CLINIC DECIDES

What is the anesthesia approach here?

Per the published paper, every patient in the series received **light IV sedation (midazolam 2 mg)**, with propofol or a local anesthetic added as needed for anoscope discomfort. The patient materials now follow that wording rather than "local anesthesia, not general". Confirm it matches how this clinic will actually run it, and note any exceptions. It drives the honest answer to **"does it hurt?"** and what to say about recovery.

OUR ANSWER

CLINIC DECIDES

Which plans are accepted, and what is the self-pay rate?

Patients are told the clinic takes commercial insurance and offers self-pay. The team needs the accepted-plan list and the self-pay figure to answer cost questions with any confidence.

OUR ANSWER

ANYTHING ELSE TO SETTLE

Questions, corrections, and anything this kit gets wrong about how the clinic actually runs.

WHAT'S INSIDE

Six pages, one job: more booked consults.

02 · CONVERT

Lead flow & qualifying

A response cadence built for a busy desk, and the four checks that decide who gets the follow-up time.

03 · CONVERT

Question battlecard

The 14 questions callers ask most, with suggested wording for each in plain, compliant language.

04 · COMPLY

Say / don't say

Approved language, the words never to use, and what must never be promised. The firm page.

05 · PATIENT

Patient materials

The one-page handout, the finished tri-fold brochure with the print PDF, and a conversation card for nurses and NPs.

06 · LEARN

Hemorrhoid education

Symptoms, the words patients use, and every treatment option with where ours sits among them.

WORTH DOING ONCE THE PHONES ARE BUSY

Ideas, for whenever there's room.

None of this is required, and none of it matters in week one. It is the short list of habits that tend to make the next few months easier.

Track the questions

Keep a running note of what callers actually ask. Anything that comes up three times belongs on the battlecard, and the team should send it over so the kit gets updated.

Ask after recovery

A short check-in a week or two after the procedure tells the clinic how patients are really doing, and catches anyone who needs attention sooner.

Ask for the review

Patients who are glad they came will happily say so, but usually only if asked. The best moment is right after a good follow-up, never before.

Note where they heard about it

One line at the end of the first call. Over a few months it shows which referral sources are actually working.

Log the passes

The reasons enquiries are turned away are as useful as the bookings. A pattern in the passes usually points at something fixable.

Keep the handout stocked

The one-pager on page 05 is meant to leave with the patient. It works hardest at the front desk, not in a drawer.

THE ONE HABIT

Answer early, answer honestly, book the right patient.

Fill in the two answers above and the rest of this kit works as it stands. Start with lead flow.

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*From the published study on the procedure. See page 05 for the figure and citation.

02 · REACH AND QUALIFY FOR CLINIC USE ONLY

Catching people while they're still looking.

Two things decide whether an enquiry becomes a booked consult: getting back to someone before they move on, and spending the follow-up time on the people it can actually help. This page covers both. All of it is a starting point to adapt, not a script to follow to the letter.

WHERE ENQUIRIES COME FROM

However they arrive, the clock starts at capture.

The clinic decides how enquiries come in and which tools carry them. Whatever the channel, the moment someone's details are captured is the moment the follow-up window opens.

Phone

Someone calls the clinic directly. If it is answered live, the conversation and the qualifying happen together.

Web enquiry

A form or request on the clinic's own site, landing wherever the clinic routes it.

Referral or walk-in

A physician referral, an existing patient asking about it, or someone who walks in.

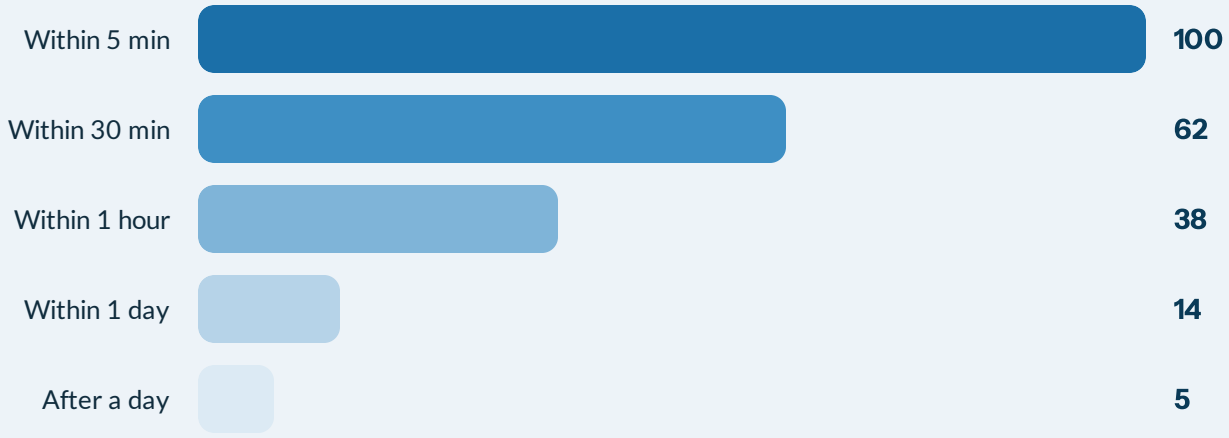
The clock starts when the enquiry is captured, by form, phone call, referral, or any other route the clinic chooses. Everything below is measured from that moment.

CONFIRM: IS THIS THE INTENDED SET-UP

THE CASE FOR GETTING BACK QUICKLY

The first hour counts for a lot.

Relative chance of reaching someone, by how soon the clinic gets back to them.



WHAT IT MEANS IN PRACTICE

The curve is steep at the start and flat after that, which is the useful part: **an instant acknowledgment plus a call within the hour captures most of the benefit**. Nobody has to drop what they are doing within five minutes for this to work. Illustrative of the established speed-to-lead pattern, not clinic data.

A WORKABLE CADENCE

Built for a desk with other jobs to do.

Written for a front desk covering several procedures, with nobody assigned to this one full time. The automated first touch does the time-sensitive work so a person does not have to.

STRAIGHT AWAY

Automatic acknowledgment

A text or email fires on capture without anyone doing anything. It thanks them, confirms a real person will be in touch, and gives a number if they would rather reach out first.

WITHIN THE HOUR

First human call

Whenever the desk next comes up for air, ideally within the hour and the same day at the latest. After hours, first thing the next morning.

DAY 1 TO 3

Two more attempts

If the first call does not connect, try once more on a different channel, then a third time a day or two later. Different people answer different channels.

DAY 5 TO 7

One friendly close-out

A last note saying the door is open. After that, longer-term follow-up beats dropping someone entirely.

IF THE CLINIC ONLY SETS UP ONE THING

Make it the **automatic acknowledgment**. It is the piece that genuinely has to happen fast, it costs nothing once configured, and it buys the desk an hour it does not currently have.

WHAT THE FIRST TOUCH SOUNDS LIKE

Warm, short, and an easy next step.

Of course, ask us anything. The best way to get answers specific to you is a short consult, with no obligation. Would you like us to hold a time this week?

Three things that tend to work

Warm before clinical

Opening with a person and a thank-you lands better than a pitch. This is a sensitive topic.

Always an easy next step

It helps when every message ends with a specific, low-pressure invitation to book.

Keep it short

A few lines is plenty. The first touch is aiming for a conversation, not a decision.

Wording for the acknowledgment, voicemail, text and email

QUALIFYING

Four quick checks on every enquiry.

A thirty-second read that protects the desk's time for the people this can help. Fit itself is always confirmed by the surgeon at the consult.

1. **Are the contact details real and reachable?** — No → mark spam, stop
2. **Willing to travel to the Seattle clinic?** — No → polite pass
3. **Commercial insurance or able to self-pay (not Medicare / Medicaid)?**

   No → polite pass

4 **Has symptoms and wants treatment?** Not yet → nurture

✓ **All four yes → offer a consult**

ON GEOGRAPHY

Where someone lives does not matter. Whether they will come to Seattle does. Patients travel for a procedure like this, so the only question is whether they are willing to make the trip, not which state they are starting from.

THE 30-SECOND TRIAGE

Book, nurture, or pass.

BOOK NOW

Move straight to holding a consult time.

- ✓ Will come to the Seattle clinic
- ✓ Describes symptoms and wants them treated
- ✓ Has commercial insurance, or is fine with self-pay
- ✓ Gives a real phone or email, will talk times

NURTURE

Interested but not ready. Keep the door open.

- ~ Wants to think it over or check their schedule
- ~ Still comparing options or researching
- ~ Needs to sort out timing or budget first
- ~ Reachable and warm, just not booking today

POLITELY PASS

Not a fit. Close kindly, free up the time.

- × Can only proceed with Medicare or Medicaid
- × Not willing or able to travel to Seattle
- × Spam, prank, or no real contact details
- × Unrelated or urgent medical issue

CLOSING THE NO-MATCHES

Kind, brief, and logged.

MEDICARE OR MEDICAID CALLER

> *I want to be upfront so I don't waste your time. We accept commercial insurance and offer self-pay, but we aren't able to bill Medicare or Medicaid. I'm still happy to answer general questions, and if anything changes we'd love to help.*

Warm, no pressure. Log it as a polite pass with the reason, so the clinic can see how many enquiries are lost this way.

SPOTTING AND HANDLING SPAM

- × Gibberish name, fake or unreachable number, off-topic message
- × Bulk or duplicate enquiries in a short window
- × Requests with nothing to do with treatment
- × **Action:** one quick verification attempt, then mark spam and stop. Don't keep chasing.

Edge cases: distance, urgent symptoms, and "just researching"

Optional: stages, if the clinic wants to track this in a CRM

Answer early, then spend the time on the people it can help.

An automatic first touch buys the hour. The four checks protect the rest of the week.

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03 · ANSWER THE QUESTIONS FOR CLINIC USE ONLY

The question battlecard.

The 14 questions callers ask most, with suggested wording for each. Use it close to word for word or adapt it to your own voice, as long as it stays honest, plain, and inside what can be claimed. One answer still waits on a fact the clinical lead needs to confirm, and it is marked.

USE THIS ON EVERY CALL · THE CLOSE

"Would you like me to get you on the schedule for a consult? There's no obligation, and it's the best way to get answers specific to you."

Then capture **name, best phone number, and best time to reach them.** The consult is always the goal. Answers exist to remove what's holding someone back, then return to this line.

READING THE CHIPS

A CONFIRM chip marks wording still awaiting clinical sign-off (see page 01). Say only the approved part and book the consult for the rest.

QUESTION 01	BEST ANSWER
What exactly is this procedure?	"It's an **outpatient procedure** for hemorrhoids, performed by a surgeon. You come in first for a consult, and if it's right for you the procedure is a separate visit that takes **about 15 minutes**. It has published clinical results behind it. The best next step is that short consult."

QUESTION 02

How does it work?

BEST ANSWER

"Under light sedation, the surgeon performs an **incisionless procedure** by applying gentle thermal energy to the tissue just above the hemorrhoid. **The tissue contracts and is drawn back in, alleviating symptoms.**"

CONFIRM: MECHANISM WORDING

Corrected against the published paper. The earlier version described closing off a blood-supply artery, which is a different procedure.

QUESTION 03

How is it different from banding?

BEST ANSWER

"Rubber band ligation often **has to be repeated** over several visits. This is a single outpatient procedure. In the published study, most patients were still symptom-free five years later."

QUESTION 04

How is it different from surgery?

BEST ANSWER

"A surgical hemorrhoidectomy is effective, but it usually means general anesthesia and a longer, harder recovery. This is an outpatient option performed by a surgeon, which is why people ask about it as **the middle path** between repeat banding and surgery."

QUESTION 05 · MOST COMMON

Does it hurt?

BEST ANSWER

"That's the question we hear most. In the published series every patient had **light sedation rather than general anesthesia**, with a local anesthetic added if it was needed CONFIRM: ANESTHESIA, and **the surgeon will walk you through exactly what to expect**. I won't promise a specific experience because it varies person to person, but I can tell you what most patients report."

Coaching: never say painless. Honest and warm wins.

QUESTION 06

What is recovery like?

BEST ANSWER

"Because it's light sedation rather than general anesthesia, there's no downtime from being put under. Everyone in the published study went home within 30 to 60 minutes, and **most went back to work the same or the next day**. The surgeon will give you specifics for your case at the consult."

QUESTION 07

Will my hemorrhoids come back?

BEST ANSWER

"No procedure can guarantee they never return. What I can share is the published evidence: in a study that followed patients for five years, **the large majority stayed symptom-free**."

QUESTION 08

Who performs the procedure?

BEST ANSWER

"**A surgeon performs it**, not a technician or an assistant."

QUESTION 09

Is it FDA approved? Is it safe?

BEST ANSWER

"It's performed by a surgeon, and it has a **peer-reviewed published study with five-year results** behind it, with hundreds of patients treated to date. Safety and your specific situation are exactly what the surgeon will go over at the consult." CONFIRM: REGULATORY WORDING

Coaching: never say "FDA approved" or "FDA cleared", and never paraphrase FDA status. If a caller presses on FDA specifically, that answer belongs to the surgeon at the consult.

QUESTION 10

How much does it cost?

BEST ANSWER

"We accept **commercial insurance plans**, and we also offer self-pay. The consult is where we confirm your coverage and any out-of-pocket cost, with no obligation."

QUESTION 11

Do you take insurance or Medicare?

BEST ANSWER

"We accept **commercial insurance plans**, and we also offer self-pay. We aren't able to bill Medicare or Medicaid."

Coaching: Medicare or Medicaid-only callers are a polite pass. See page 02.

QUESTION 12

Am I a candidate?

BEST ANSWER

"The procedure helps a **wide range of people with hemorrhoids**. The best way to know if it's right for you is a short consult, where the surgeon will review your history and answer everything."

QUESTION 13

Do I have to travel to Seattle?

BEST ANSWER

"Yes, the clinic is in Seattle. **Patients travel to us from well beyond the city**, so it's really a question of whether the trip works for you."

QUESTION 14

Can I see proof it works?

BEST ANSWER

"There's a **peer-reviewed study** published on the procedure. I can send you a plain-language summary, and the surgeon will walk through the evidence with you at your consult."

The summary is the one-page handout on page 05.

Three tone rules that hold the whole card together

Figures from the published paper FOR CLINIC USE ONLY

Sias F, Milone L (2025), *Journal of Surgery*. Do not hand these figures to patients; they are here so the team answers from the paper rather than from memory.

Anesthesia	Every patient received light IV sedation with midazolam 2 mg. Propofol 30 to 40 mg was added in 35 patients, and local lidocaine (2%, 10 ml) in 72, for anoscope insertion discomfort. *Not "local anesthesia for most patients"; the paper does not support that.*
Procedure time	Average 10 minutes, range 5 to 15 minutes.
Discharge	All patients discharged within 30 to 60 minutes of surgery.
Pain	92% reported no pain in the first five post-op days; 8% reported some, with a maximum VAS of 4 out of 10. Only 25 patients needed analgesics for more than two days.
Return to work	Most patients resumed work the same or the next day.
Complications	38 (15.3%) minor bleeding, no intervention. 5 (2%) rehospitalised for bleeding requiring transfusion, days 1 to 8. 10 (4%) hemorrhoidal thrombosis. No urinary retention.
Five-year outcome	216 of 248 (87%) completely asymptomatic. 32 (12.9%) minor residual prolapse or proctorrhagia, retreated locally.
Pre-op guidance	Eat whole foods, increase fiber, avoid white bread and processed food, avoid constipation and straining. Patients are asked to fast beforehand for anesthesia purposes. *From Meribel's clinicians, not from the paper. The paper protocol overrides it.*

> *"For a total of 248 patients (ages 22–78), 220 male and 128 female, with second-, 12%, and third-degree, 88%, hemorrhoids were treated using this technique. All the patients received Midazolam (2 mg); 35 received supplemental Propofol (30-40mg); 72 received local anesthesia with Lidocaine (2%, 10 ml). The average operative time was 10 minutes (5-15 minutes) and all patients discharged within 30-60 minutes from the surgery."*

Two arithmetic inconsistencies sit in the source itself: 220 male plus 128 female totals 348, not 248, and the introduction describes a series of 232 patients while the results report 248. Worth raising with the clinician review before any of this is quoted externally.

Answer the worry, then come back to "let's get you a consult

time."

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04 · STAY COMPLIANT FOR CLINIC USE ONLY

Say this, not that.

The one page in this kit that is firm rather than suggested, because the rules here come from outside the clinic. Where this page and a sales instinct disagree, follow this page.

WORDS WE NEVER USE

Banned on every channel.

These read as hype or as promises we can't make. They're off the table in calls, texts, emails, and anything written.

~~painless~~ ~~pain-free~~ ~~minimally invasive~~ ~~quick~~ ~~fast~~ ~~rapid~~ ~~revolutionary~~ ~~cutting-edge~~ ~~breakthrough~~ ~~guaranteed~~ ~~cure~~ ~~permanent~~ ~~miracle~~ ~~best in class~~

Swap the instinct for the approved line.

~~"It's painless"~~ → "In the published study 92% reported no pain in the first five days. The surgeon will explain what to expect for you."

~~"Pain-free"~~ → "Most patients do not report high levels of pain. Everyone in the study had light sedation, and the surgeon will speak to your needs."

~~"Minimally invasive"~~	→	"An outpatient procedure"
~~"Quick recovery"~~	→	"Most patients in the study went back to work the same or the next day. The surgeon will walk you through recovery."
~~"Revolutionary / cutting-edge"~~	→	"Backed by published five-year results"
~~"Guaranteed to work"~~	→	"Most patients were symptom-free at five years"
~~"It cures hemorrhoids"~~	→	"It treats them, with durable results in the study"

Qualifiers that keep a sentence safe.

Almost anything is sayable with a qualifier in front of it. These are the words that turn a promise into an honest description. Reach for one whenever a sentence is about to state a certainty.

~~most~~ ~~often~~ ~~typically~~ ~~usually~~ ~~many patients~~ ~~in the published study~~ ~~for most people~~ ~~your surgeon will confirm~~ ~~it varies person to person~~

HOW TO USE THEM

"It takes 15 minutes" becomes **"it usually takes about 15 minutes"**. "You'll be back at work the next day" becomes **"most patients in the study went back the same or the next day"**. The qualifier is not hedging, it is the difference between a description and a promise we cannot make.

THE VOICE

How we talk to patients.

DO

- ✓ Plain, specific language. **Numbers over adjectives.**
- ✓ Be honest that experience varies person to person
- ✓ Empower the patient to decide. No pressure or urgency
- ✓ Treat a sensitive topic with calm dignity
- ✓ Defer clinical questions: "the surgeon will go through that with you"

DON'T

- × Use superlatives or the banned words above
- × Create urgency ("limited spots", "act now")
- × Be euphemistic or crude about the condition
- × Promise outcomes, comfort, or recovery times
- × Diagnose, or paraphrase FDA status

CLAIM SAFETY

Green to say, amber to confirm, red to never.

Safe to say now | Only the approved wording | Never

Green · say freely

Outpatient procedure, performed by a surgeon: a consult first, then the procedure at a separate visit, about 15 minutes. Incisionless, thermal energy, no tissue cut away. We accept commercial insurance and offer self-pay. Peer-reviewed study, hundreds of patients treated, large majority symptom-free at five years.

Amber · approved wording only

The anesthesia approach, and the accepted insurance plans and self-pay rate. Use only the clinic's confirmed wording, once page 01 is filled in. Until then, offer the consult.

Red · never

Painless or pain-free. Guaranteed or permanent. A cure. Promises it won't come back. "FDA approved" or "FDA cleared", or any paraphrase of FDA status. Any claim of being better than a named competitor.

WHEN IN DOUBT

Say less, and book the consult. "That's exactly what the surgeon will go over with you" is always safe, always credible. A booked consult beats a risky claim every time.

Specific over superlative.
Evidence over hype.

One voice throughout: clinically grounded, empathetically direct, never selling.

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05 · PATIENT

Patient materials.

Three pieces. A **one-page handout** to give someone on the spot, a **tri-fold brochure** to leave out for people to pick up, and a **conversation card for nurses and NPs**, the people most likely to raise the topic with a patient first. The patient pieces are concepts for sign-off, with placeholder photography.

PATIENT DRAFT · PHOTOS ARE PLACEHOLDERS · PENDING CLINICAL REVIEW

THE HANDOUT

One page, handed over in person.

Plain, printable on a single sheet, and written to survive being read in a waiting room or on a kitchen table that evening. It answers the four things people ask before they ask anything else, and it always ends with the clinic's number.

You're not alone, and it's treatable.

Hemorrhoids are very common. Most people just want to feel like themselves again without a big operation or a long recovery. There is an outpatient procedure that may be able to help, and this page covers the basics.

What is it?

A procedure called **thermal submucosal hemorrhoidopexy (TSH)**. It is performed by a surgeon as an **outpatient procedure**: a consult first, then the procedure at a separate visit. There is no hospital stay.

How does it work?

Under light sedation, your surgeon performs an **incisionless procedure** by applying gentle thermal energy to the tissue just above the hemorrhoid. The tissue contracts and is **drawn back in, alleviating symptoms**.

How long does it take?

The procedure itself takes **about 15 minutes**. Plan on a normal office appointment overall, and patients go home within 30 to 60 minutes.

What about anesthesia?

It is done under **light sedation rather than general anesthesia**, with a local anesthetic added if it is needed, so there is no being put under and no waking up groggy. Your surgeon will confirm the approach for your case at the consult.

CONFIRM: ANESTHESIA

Does it hurt?

Everyone's experience is different, so we won't promise you a particular one. Your surgeon will explain exactly what to expect, and what is used to keep you comfortable, at your consult.

Does it last?

No procedure can guarantee hemorrhoids never return. In the published study that followed patients for five years, **most remained free of symptoms.**

WHAT HAPPENS NEXT

1. **A consult.** A short appointment where the surgeon examines you, answers everything, and tells you honestly whether this suits your situation.

Ready to talk it through?

425-305-5182

transformweightloss.com

2. **The procedure,** if it is right for you. A separate outpatient visit, about 15 minutes.
3. **A follow-up,** so we know how you are doing.

A consult carries no obligation. Plenty of people come in, ask their questions, and decide it isn't for them. That's a perfectly good outcome.

Transform Weight Loss
Seattle, WA

We accept commercial insurance and offer self-pay. We are not able to bill Medicare or Medicaid. This page is general information, not medical advice, and it is not a substitute for an examination. Published five-year results: Sias F, Milone L (2025), *Journal of Surgery*. CONFIRM: CLAIMS REVIEW

HOW THE HANDOUT IS MEANT TO BE USED

Give it to someone **after** a conversation, not instead of one, and write the consult time on it if one has been booked. It is also the right thing to post or email to a "just researching" caller who is not ready to book yet.

THE BROCHURE

The tri-fold, for the waiting room.

A double-sided piece to leave at the front desk for patients to pick up. The current brochure is embedded below exactly as it prints: standard letter, 8.5 by 11 inches, landscape, folded in three.

OUTSIDE · THE SIDE YOU SEE FIRST

OUTPATIENT PROCEDURE

Thermal Submucosal Hemorrhoidopexy

(TSH)

Treating hemorrhoids with thermal energy, without an incision.

What does it mean to treat a hemorrhoid without an incision?

Under light sedation, your surgeon applies gentle thermal energy to the tissue just above the hemorrhoid. That tissue contracts and is drawn back in, alleviating symptoms.

It is an **incisionless procedure**: the tissue is treated and drawn back in rather than cut away.

Who performs it, and where?

A surgeon, as an outpatient procedure. You come in first for a **consult**. If TSH is right for you, the procedure is a separate visit and takes about **15 minutes**, with no hospital stay.

Is it right for me?

TSH may be an option if you have **ongoing hemorrhoid symptoms** despite trying over-the-counter treatments, lifestyle changes, or office procedures such as rubber band ligation.

It may be considered for patients with symptoms such as bleeding, swelling, irritation, discomfort, or tissue that comes out during bowel movements and goes back in on its own or with help. **A clinician will evaluate your symptoms and determine whether TSH is appropriate for you.** Schedule your consultation to find out.

Talk with your healthcare provider to find out if TSH is an option for you.

Sound familiar?

- [ ] Bleeding when you go
- [ ] Itching or irritation
- [ ] Swelling, or a lump you can feel
- [ ] Discomfort when sitting
- [ ] Flare-ups that keep coming back

If any of these sound like you, it is worth a conversation.

Write your questions here and bring them to your consult.

_____

_____

Book a consult today?

425-305-5182

or scan the code · transformweightloss.com

1. Sias F, Milone L. Thermal submucosal hemorrhoidopexy: five-year outcomes in 248 patients with Grade II and III hemorrhoidal disease. Journal of Surgery, 2025.
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Draft concept · pending clinical review

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OUTPATIENT PROCEDURE

Thermal Submucosal Hemorrhoidopexy

(TSH)

An outpatient procedure for hemorrhoids, performed by a surgeon, without an incision.

WHAT IT IS AND HOW IT WORKS

Potential benefits of **thermal submucosal hemorrhoidopexy**

Hemorrhoids are common. Most people just want to feel like themselves again, without a big operation or a long recovery.

- **Incisionless.** The tissue is treated and drawn back in, not cut away. No cuts, stitches, or staples.
- **A 15-minute procedure.** Done as an outpatient procedure, after your consult.
- **Home within 30 to 60 minutes.** Patients are discharged the same day.[1]
- **Light sedation, not general anesthesia.** A local anesthetic is added if it is needed.[1]
- **Back to your week.** In the study, most patients went back to work the same or the next day.[1]

15	1+1	87%
minute procedure	consult + procedure visit	symptom-free at 5 years[1]

Book a consult today?

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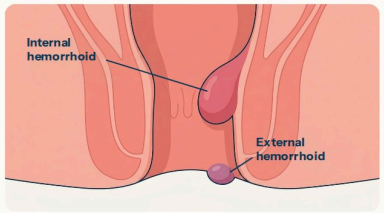
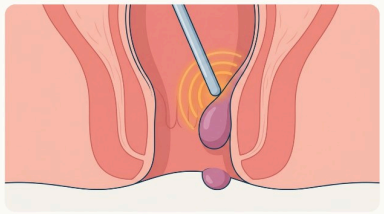
How does it work?

01.



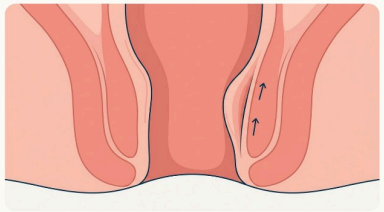
An enlarged hemorrhoid sits inside the canal. This is where the itching, bleeding, and discomfort come from.

02.



Under light sedation, your surgeon performs an **incisionless procedure** by applying gentle thermal energy to the tissue just above the hemorrhoid.

03.



The treated tissue contracts and is **drawn back in, alleviating symptoms**. Patients are discharged within 30 to 60 minutes.[1]

What happens after?

Patients are discharged within 30 to 60 minutes. A short follow-up visit lets your surgeon confirm how you are healing, and in the study most patients went back to work the same or the next day.[1]

WHERE THIS FITS

Hemorrhoids and your options.

HOW COMMON IT

More than **1 in 2 adults over 50** live with hemorrhoidal disease.[2]

THE USUAL PATH

49% **49% return within a year** after rubber band ligation.[3]

OFTEN NOT ONE VISIT

Banding is often **2 to 3 sessions**, weeks apart.

THE SURGICAL ROUTE

4-6 WEEKS After a **surgical hemorrhoidectomy**, recovery and return to normal activity typically take 4 to 6 weeks.[4]

A DIFFERENT OPTION

TSH is the in-office procedure performed by a surgeon in less than 15 minutes, with minimal anesthesia and little disruption to your day.

87% **symptom-free at 5 years** after a single TSH procedure, in the published study.[1]

WHAT THE VISIT LOOKS LIKE

A 15-MINUTE PROCEDURE	CONSULT, THEN ONE VISIT	HOME THE SAME DAY

These steps describe the procedure for informational purposes only. Procedure time, anesthesia needs, recovery, and return to normal activity vary by patient and clinical circumstances. A qualified clinician will determine whether TSH is appropriate after an in-person evaluation. Individual results may vary.

WHERE THE BROCHURE STANDS

This is the **current brochure**, not a layout mock: copy, photography, the labelled step illustrations, and the options infographic are all in place, and the **print PDF above is true 8.5 by 11 inches**. The comparison figures now carry sources (see the source list on page 01). **One figure still needs the clinic's word:** the brochure says a surgical hemorrhoidectomy takes **4 to 6 weeks** to recover from, while the Cleveland Clinic page cited for it gives an average of two to four weeks and a range of two to eight. Final production still goes to a designer, built to the exact size, bleed, fold, and colour profile of the print shop the clinic chooses.

THE NURSE CONVERSATION CARD FOR CLINIC USE ONLY

For the nurses and NPs who bring it up first.

Patients rarely raise hemorrhoids on their own. It is usually a nurse or NP who hears the hint, a mention of itching, bleeding, or trouble sitting, and decides whether to open the topic. This card gives the team the words, so the conversation feels routine instead of awkward. It pairs with the education page (06) for the deeper background.

Talking about hemorrhoids, comfortably.

Most patients have carried this quietly for years. If the person raising it sounds unbothered and matter-of-fact, the patient usually follows their lead. That tone is the whole technique.

- **Normalize it first**

  Hemorrhoids are one of the most common conditions we see, and many people wait years before mentioning them. Saying **"this is very common"** early does more to open the conversation than any clinical detail.

- **Keep the facts short**

  There is an outpatient option: **performed by a surgeon, about 15 minutes, light sedation, incisionless**. That is the whole pitch. The handout on this page carries the rest.

- **Use the patient's words**

  Patients say "flare-up", "itching", "trouble sitting", "bleeding when I go". **Mirror their language** rather than correcting it. The vocabulary guide on page 06 maps what they say to what it may mean.

- **Know where the line is**

  Never diagnose, grade, or promise an outcome in the hallway. **"The surgeon will go through your specific situation at the consult"** is always the right close, and page 04 covers the words to avoid.

THREE WAYS TO OPEN THE TOPIC

1. **"A lot of people deal with this and never mention it.** If it has been bothering you, we can talk about it."
2. **"This is one of the most common things we see.** Nothing you say will surprise anyone here."
3. **"You don't have to live around it.** There are options now that don't mean a big operation, and the consult is just a conversation."

Then hand over the one-page handout, offer the brochure, and, if they are interested, offer to book the consult while they are still in the room.

What to hand the patient

1 · The patient one-page handout, at the top of this page

2 · The tri-fold brochure

3 · A consult time, if they want one

Deeper background for the team: page 06, Hemorrhoid education.

Internal reference for the clinical team, not a patient piece. All patient-facing language follows the approved wording on page 04, and clinical questions belong to the surgeon at the consult.

The published protocol, step by step

FOR CLINIC USE ONLY

Pulled from the technique section of Sias & Milone (2025) so the clinic has a written first-step protocol to adapt. Awaiting review by Meribel's clinician.

1 · Position	Patient in the Sims position, left lateral decubitus.
2 · Sedation	Light intravenous sedation with midazolam, supplemented as needed with propofol or a local anesthetic for anoscope insertion discomfort.
3 · Exposure	The operative anoscope is inserted with the windows aligned to the left lateral, anterior, and right posterior hemorrhoidal nodules.
4 · Treatment	Once the mucosa is identified, within 1 cm of the pectinate line, the electrode is inserted into the submucosa and a low-intensity current is delivered for 5 to 10 seconds, until visible whitening and volume reduction.
5 · Repeat	Repeated above each hemorrhoid position, then the anoscope is rotated 180 degrees and the intermediate sites are treated the same way.
6 · Recovery	Discharge within 30 to 60 minutes. All patients re-examined within 30 days.

Source: Thermal Submucosal Hemorrhoidopexy, Gavin Publishers. Meribel's clinician notes from Dr. Gumbs and Dr. Milone sit alongside this as added context; where they differ, the paper protocol takes precedence.

Figures from the published paper FOR CLINIC USE ONLY

Sias F, Milone L (2025), *Journal of Surgery*. Do not hand these figures to patients; they are here so the team answers from the paper rather than from memory.

Anesthesia	Every patient received light IV sedation with midazolam 2 mg. Propofol 30 to 40 mg was added in 35 patients, and local lidocaine (2%, 10 ml) in 72, for anoscope insertion discomfort. *Not "local anesthesia for most patients"; the paper does not support that.*
Procedure time	Average 10 minutes, range 5 to 15 minutes.
Discharge	All patients discharged within 30 to 60 minutes of surgery.
Pain	92% reported no pain in the first five post-op days; 8% reported some, with a maximum VAS of 4 out of 10. Only 25 patients needed analgesics for more than two days.
Return to work	Most patients resumed work the same or the next day.
Complications	38 (15.3%) minor bleeding, no intervention. 5 (2%) rehospitalised for bleeding requiring transfusion, days 1 to 8. 10 (4%) hemorrhoidal thrombosis. No urinary retention.
Five-year outcome	216 of 248 (87%) completely asymptomatic. 32 (12.9%) minor residual prolapse or proctorrhagia, retreated locally.
Pre-op guidance	Eat whole foods, increase fiber, avoid white bread and processed food, avoid constipation and straining. Patients are asked to fast beforehand for anesthesia purposes. *From Meribel's clinicians, not from the paper. The paper protocol overrides it.*

> *"For a total of 248 patients (ages 22–78), 220 male and 128 female, with second-, 12%, and third-degree, 88%, hemorrhoids were treated using this technique. All the patients received Midazolam (2 mg); 35 received supplemental Propofol (30-40mg); 72 received local anesthesia with Lidocaine (2%, 10 ml). The average operative time was 10 minutes (5-15 minutes) and all patients discharged within 30-60 minutes from the surgery."*

Two arithmetic inconsistencies sit in the source itself: 220 male plus 128 female totals 348, not 248, and the introduction describes a series of 232 patients while the results report 248. Worth raising with the clinician review before any of this is quoted externally.

A calm, dignified piece patients can pick up and trust.

Plain language, real evidence, no hype. The same voice as everything else in the kit.

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Seattle Clinic Kit · August 2026.

06 · KNOW THE CONDITION FOR CLINIC USE ONLY

What the front desk should know.

Callers describe symptoms in their own words, mention treatments they have already tried, and ask how this compares. This page covers the condition, the words patients actually use, and the full treatment landscape, so the team can follow a conversation without ever having to diagnose.

Search a symptom, treatment, or term, like banding, prolapse, or gr

THE ONE RULE FOR THIS PAGE

Understanding is not diagnosing. Everything here exists so the team can follow a caller and answer plainly. Deciding what a patient has, what grade it is, or which treatment suits them is the surgeon's job at the consult, every time.

THE BASICS

What a hemorrhoid actually is.

Everyone has hemorrhoidal cushions. They are normal, and they help with continence. The problem starts when they swell, bleed, or slip out of position. That is what people mean when they say they "have hemorrhoids."

Internal

Above the dentate line, inside the anal canal. There are few pain nerves up there, so internal hemorrhoids more often show up as **painless bleeding** or as something bulging out, rather than as pain.

External

Below the dentate line, under the skin around the opening. This area has plenty of pain nerves, so these are the ones that **hurt**, especially if a clot forms (thrombosed).

WHY THIS DISTINCTION MATTERS ON A CALL

A caller saying "it doesn't hurt, there's just blood" and a caller saying "there's a painful lump" may be describing two different things. Do not sort it out on the phone. Note what they said, and let the surgeon examine it.

COMMON SYMPTOMS

What callers describe.

The five things people ring about, and a sense of what each usually means.

Bleeding

Bright red blood on the paper, in the bowl, or on the stool. The single most common reason people call, and usually painless.

"There's blood when I go."

Prolapse

Something bulges out during a bowel movement. It may go back on its own, need pushing back, or stay out. This is what grading measures.

"Something comes out."

Itching or irritation

Ongoing itch, burning, or dampness around the area. Common, and often the symptom people are most embarrassed to name.

"It itches constantly."

Pain

More typical of external hemorrhoids. Sudden severe pain with a firm lump can mean a clot has formed.

"I can't sit down."

Feeling of fullness

A sense that the bowel has not fully emptied, sometimes with mucus or seepage.

"It never feels finished."

"I've tried everything"

Creams, fiber, maybe banding that did not hold. This caller is often the best fit for a consult, and the most frustrated.

"Nothing has worked."

WHEN TO STOP AND ESCALATE

Heavy or continuous bleeding, dizziness or faintness, severe unrelenting pain, or fever. **Do not book a routine consult.** Advise prompt medical care and flag it to the clinical team straight away. The same applies to anyone who mentions a change in bowel habits or unexplained weight loss, since bleeding has causes other than hemorrhoids and only a clinician can tell them apart.

GRADES

How clinicians describe severity.

Internal hemorrhoids are graded I to IV by how far they prolapse. A caller may know their grade from a previous diagnosis. Note it if offered, and leave the judgement to the surgeon.

I

Visible but does not prolapse. May bleed.

II

Prolapses with straining, goes back on its own.

IN THE PUBLISHED STUDY

III

Prolapses and has to be pushed back manually.

IN THE PUBLISHED STUDY

IV

Stays out and cannot be pushed back.

THE SAFE LINE ON GRADES

"That's exactly the kind of thing the surgeon will look at during the consult." **Grade never decides a booking on the phone.** Someone with symptoms who wants treatment and clears the qualifying checks gets offered a consult.

THE TREATMENT LANDSCAPE

Every option, and where ours sits.

Callers have usually already tried something, and often ask how this compares to what their last doctor offered. This is the map. Read it so the conversation makes sense, not so it can be recited.

TREATMENT	WHAT IT IS	TYPICALLY USED FOR	WORTH KNOWING
START HERE · ALMOST EVERY PATIENT BEGINS WITH THESE			
Diet and lifestyle fiber, fluids, habits	More dietary fiber, more water, and less time and straining on the toilet.	Every grade, as a first step and alongside anything else.	Clinical guidance is that treatment almost always starts here, whatever comes next.
Over-the-counter creams, ointments, suppositories, sitz baths	Pharmacy products that calm the symptoms.	Mild or flaring symptoms.	These soothe. They are not aimed at the underlying hemorrhoid, which is why symptoms often return.
IN-OFFICE PROCEDURES · NO HOSPITAL STAY			
Rubber band ligation banding · RBL	A small band is placed at the base so the tissue is cut off from its blood supply and drops away.	Lower grades.	The most common office treatment today. Often has to be repeated over several visits.

TREATMENT	WHAT IT IS	TYPICALLY USED FOR	WORTH KNOWING
Sclerotherapy injection	A solution is injected to shrink the hemorrhoid.	Lower grades.	Often chosen when a patient has a bleeding disorder or takes blood thinners.
Infrared coagulation IRC	Infrared light creates scar tissue that cuts off the supply.	Lower grades.	Quick to perform, often needs more than one session.
Hemorrhoidal energy therapy HET	Gentle compression combined with heat.	Lower grades.	A caller who has researched online may raise this one by name.
Thermal submucosal hemorrhoidopexy TSH · our procedure OURS	Under light sedation, gentle thermal energy is applied to the tissue just above the hemorrhoid. The tissue contracts and is drawn back in, alleviating symptoms. **Incisionless**: nothing is cut away.	Grades II and III in the published study.	An outpatient procedure done by a surgeon after a consult, about 15 minutes. Published follow-up at five years reports most patients symptom-free.
SURGICAL · OPERATING ROOM			
Excisional hemorrhoidectomy Milligan-Morgan	The hemorrhoid is surgically removed.	Higher grades, external and mixed disease, and cases that have come back.	The long-standing reference standard. Usually general anesthesia, with a longer and harder recovery.
Stapled hemorrhoidopexy PPH	A circular stapler lifts and fixes the tissue back into position.	Prolapse-dominant cases.	Less post-operative pain than excision, with its own specific risks the surgeon discusses.

TREATMENT	WHAT IT IS	TYPICALLY USED FOR	WORTH KNOWING
Doppler-guided artery ligation HAL-RAR · THD	A Doppler probe locates the feeding artery, which is then stitched closed.	Lower to middle grades.	The closest modern relative to our procedure in intent: both target the problem without removing tissue.

READ THIS BEFORE USING THE TABLE ON A CALL

Describe our procedure on its own terms and never rank it against another treatment by name. Comparative claims are off-limits, and this table exists to help the team follow a caller, not to argue with one. Where a caller wants a comparison, the answer is always the same: *"The consult is the best place to compare the options for your situation."* The clinical detail here still needs sign-off. CONFIRM: CLINICAL REVIEW OF THE MATRIX

Where our procedure sits in the landscape

PATIENT VOCABULARY

What they say, what it means.

People rarely use clinical words for this. Recognising the everyday version keeps the conversation comfortable, and there is no need to correct anyone's language.

WHAT THE CALLER SAYS	WHAT THEY ARE DESCRIBING
"Piles"	Hemorrhoids. Common usage, especially for British and older callers.
"Roids"	Hemorrhoids, informally. Mirror the caller's comfort level rather than their exact word.
"Something's coming out"	Prolapse. Whether it goes back on its own is what grading turns on.

"I have a lump"	Often an external hemorrhoid, possibly thrombosed if it came on suddenly and hurts.
"There's blood when I go"	Rectal bleeding. The most common presenting symptom, and one that always deserves a clinician's eyes.
"I had the bands done"	Rubber band ligation. Ask when, and how many times, and log it.
"Skin tag"	Loose skin that can remain after a hemorrhoid settles. Not the same thing as a hemorrhoid.
"A tear" or "a cut"	Possibly an anal fissure, which is a different condition with different treatment. Note it and let the surgeon sort it out.

KIT TERMS

The few work terms used in this kit.

Not clinical, but they appear on the other pages.

Terms from the rest of the kit

Enough understanding to follow the conversation.

Never enough to diagnose, and never a reason to skip the consult. When a new word or question keeps coming up on calls, add it here.

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