EDITORIAL

"The treatment paradigm needs to change. Definitive resolution of all symptoms or complete anatomical correction is not a realistic aim. Disease progression varies and the pattern of treatments must be adapted to each individual to maintain everyday comfort without initiating a more aggressive procedure."

Hemorrhoidal disease: a very common medical condition in the general population

by P. Godeberge, *France*

Philippe GODEBERGE, MD
Senior consultant
Division de proctologie
Département de Gastroenterologie
Institut Mutualiste Montsouris et
Faculté de Paris V
Paris, FRANCE

Hemorrhoids have long been recognized as a disease entity, the first historical trace going back to Ancient Egypt. Yet, despite this long history, much concerning hemorrhoidal disease remains unclear. Its admittedly complex pathophysiology, for instance, is incompletely elucidated. Nonetheless, over the last 20 years, conceptual advances as well as the refinement of treatment strategies have been driven by learned societies and by many consensus conferences, which have yielded recommendations and practical advice. Certain innovative concepts—such as hemorrhoidopexy—have led to a review of the therapeutic approach. In minimally invasive surgery, hemorrhoidal disease has been the subject of a good many high-level randomized studies, many more, in fact, than some treatments deemed definitive, such as appendectomy!

These more recent strategies place the patient at the heart of decision making. Evidence-based medicine includes, in the "right" decision, the scientific data, of course, but also the practitioner's experience and the patient's wishes. The former is especially important in mastering various instrumental and surgical techniques. The best technique is that over which the physician has complete mastery, both technically and in terms of its indications and contraindications.

It is important to take the patient's wishes into account, particularly because hemorrhoidal disease is a benign condition. Everyone is different and the social and physical impact of the disease depends on the patient's job, age, symptoms, both their frequency and intensity, and medical history, notably obstetrical. The risk-benefit ratio, which guides the choice of treatment, is defined both by the physician (the denominator, ie, the risk) and the patient (the numerator, ie, the hoped for benefit). This ratio is optimized by the increasing use of outpatient management, which is promoted by public authorities mainly for economic reasons. This benefit, though, is important for physicians, whose resource allocations are not unlimited, and for patients. When possible, outpatient surgery involves careful planning and organization on the part of the physician and for the patient results in a reduced hospital stay (whence a decrease in hospital-acquired infections) and a rapid return home, the corollary being less use of painkillers. Moreover, the aim, especially with minimally invasive approaches, is to reduce pain and morbidity, and in this regard medical treatment remains fundamental, particularly that applicable to the greatest number of patients, benign forms of hemorrhoidal disease being by far the most common (over 80% of patients are eligible for medical treatment alone), and that which optimizes the risk-benefit ratio by meeting the patient's wishes, because of its ease of use, safety, and tolerability.

Address for correspondence:
Philippe Godeberge,
10 rue Jean Richepin
75116 Paris, France
(email: philippe.godeberge@imm.fr)

Medicographia. 2019;41:50-51
www.medicographia.com

Medical treatment is close to the pathophysiology of the disease, as it combines the mechanical approach and management of the vascular component. While the factors that accelerate hemorrhoidal disease are well-defined (pregnancy, constipation, dyschezia), we now know it is also an age-related degenerative disease. It involves involution of the support structures and alteration of the vascular structures, and venous involvement plays an important role, which has been evaluated in numerous studies, even though some of the processes are still under discussion. The level of proof concerning the precipitating factors is often low, leaving room for affirmations that are closely tied to local habits and beliefs.

To date, the main etiological factors that should be taken into account when deciding on treatment are bowel disorders, obesity, and multiparity. This limits the risk of complications, such as recurrence favored by constipation and incontinence favored by pre-existing lesions of the perineum and sphincter. The other important criterion is the grade of the disease defined using the Goligher classification, which is simple to use, but takes into account the anatomical dimension of the disease and considers only anal prolapse as a sign, and then just in its most severe form. The classification does not take into account the presence of an external component, which is actually very frequent, nor does it consider the nature or intensity of symptoms or signs (other than prolapse) or their progression. Lastly, as there is an important vascular component, experience shows that the volume of hemorrhoids varies greatly. So, there may be a mismatch between the patient's complaints, the results of the clinical examination, and the appearance of hemorrhoids in the operating theater. The Goligher classification is used because it is simple and, among other things, enables between-study comparisons. Very often in surgical studies, the symptoms, which are nonetheless well known, are not detailed and it is unclear what has prompted surgery and what was the treatment aim. In contrast, trials assessing medical treatments focus almost exclusively on symptoms and take into consideration all the patient's complaints.

Based on current understanding, the first treatment line is medical, given that hemorrhoidal disease is benign. Management of bowel disorders is universally recommended. Constipation or alternating diarrhea and constipation can be managed first by increasing dietary fiber intake. In "real life," outside clinical trials, adherence to treatment and to dietary and lifestyle changes is mediocre. As the symptoms are intermittent, the use of intermittent treatments is logical. There are several such treatments, but few have been evaluated while observing the standards of high-level clinical research: the use of topical medication, whether suppositories or ointments, is not based on even a modest level of proof. In several meta-analyses, micronized purified flavonoid fraction is the first-line reference for symptom management. It has the advantage of acting on the venous component, which is particularly important in the early stages of the disease.

If treatment is insufficient (as defined by the patient), it is necessary to act on the mechanical component. The choice of method is guided by the grade of the disease, the symptoms, the type of disease (internal, external, or mixed), and the context. In internal forms of the disease, when not advanced (≤grade 3), several instrumental treatments are feasible in the physician's office. The principle in common is to return the hemorrhoidal tissue in the anal canal to a physiological position, and to fix it. When less mobile, the internal plexus no longer prolapses or bleeds. Depending on the country and the availability of techniques, use is made of sclerosing therapy, infrared photocoagulation, or rubber band ligation. Scarring of the inflammatory zone by chemical, heat, or ischemic injury reduces the volume of the hemorrhoid and induces fibrosis, which retracts the tissue, thus replacing fixation. These techniques have the advantages of simplicity and low cost. Their main limitation is limited efficacy over time, as they cannot curb the natural involution of tissues. Their association with medical treatment improves their effectiveness, and they may therefore be sufficient in many cases because the disease does not inexorably progress to grade 4 in all patients. If medical and instrumental treatment fails, minimally invasive techniques have a role to play in management of grade 2 or 3 internal disease, by suspending the cushions, either by pulling on them in a circular motion (hemorrhoidopexy) or after devascularization and targeted traction (Doppler-guided hemorrhoidal artery ligation). Lastly, when nothing controls the symptoms, when failure is patent or foreseeable, this should be accepted, the patient should be informed, and what could not be reduced, controlled, or repositioned should be surgically removed or destroyed. Excision is the reference treatment: several variants or tools are available. The most recent variants (laser, radiofrequency, Ligasure®) are all designed to reduce postoperative pain. Medical treatment, including micronized purified flavonoid fraction, in addition to surgery, can be effective in simplifying post-surgery follow-up.

In conclusion, the treatment paradigm needs to change. Definitive resolution of all symptoms or complete anatomical correction is not a realistic aim. The shortcut first-line treatment/failure or recurrence/surgery is neither valid nor consistent with this degenerative disease, which progresses over time. It is therefore legitimate, as for example with osteoarthritis, to repeat treatments. Disease progression varies and the pattern of treatments must be adapted to each individual to maintain everyday comfort without initiating a more aggressive procedure. ■

Keywords: disease progression; hemorrhoidal disease; symptoms; treatment paradigm