

Significance of patients' satisfaction with an ambulatory treatment: Experience with sclerotherapy of hemorrhoids

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Abstract

We studied the patients' satisfaction with the ambulatory treatment of second degree symptomatic hemorrhoids by means of injection therapy and the degree of agreement between clinician's and patient's satisfaction.

80 patients were revisited by the same surgeon who performed the sclerotherapy. Later they underwent a questionnaire purposely prepared by psychologists for evaluating their perception of possible changes in functioning and well being after the therapy.

The same percentage of good results are reported by the surgeon and patients, but in individual cases the correlation between subjective and objective results does appear weak. When disagreement is reported, the surgeon seems to overtreat the patients regardless of how they feel about their disease.

Keywords: hemorrhoids, patient satisfaction, questionnaires, sclerotherapy.

INTRODUCTION

Injection sclerotherapy remains a universally popular method for the treatment of first and second degree hemorrhoids in the outpatient clinic. ¹ From the medical point of view its effectiveness has been well established. ² In comparison with other non surgical procedures it is associated with lower incidence of posttreatment pain and increased necessity for retreatment. ³

As for other ambulatory treatments, particularly in non life-threatening diseases, the major challenge is to assess the patient's perception of better functioning and well being thanks to the therapy. Under these conditions the patient's perceptions of their quality of life may be effected not only by their illness but also by the required treatment and the need for medical examinations. ⁴ Moreover the assessment itself can be seen as a form of therapy. ⁵

The complex relationship between observed pathology and symptomatology, the variable awareness of the disease, which other current disorders can alter, and the compliance to a bothersome treatment must be considered.

On the other hand the additional information gleaned from the patient's perspective helps establish the value of the clinical outcomes and the justness of the medical decisions. ⁶

This study was performed to assess the patients' satisfaction with injection sclerotherapy of hemorrhoids, to determine the degree of agreement between patient's and surgeon's evaluation of the treatment results and to look for possible clinical implications.

PATIENTS AND METHODS

From 1997 to 1998 one experienced surgeon treated 342 consecutive patients with hemorrhoids by means of sclerosant injections and kept detailed records of the clinical data. 1% polidocanol (AethoxyskleroIR, Kreussler & Co. GmbH, Wiesbaden, Germany) 0.5-1 ml per hemorrhoid was injected. According with the surgeon's judgment the injections sessions ranged from 1 to 8 per patient, with a median of 3, every 3-4 weeks. Only slight discomfort was sometimes reported after the treatment.

Patients with symptomatic only second degree hemorrhoids and no other anorectal diseases (fissures, fistulas, polyps...) were selected for the study. Patients who did not complete the therapy were excluded as well as those who had major clinical complaints or came from a different geographic area. 120 appeared to be fully suitable for continuing the investigation. 8 later dropped out because of following injections, rubber band ligations or surgical procedures.

From 6 months to 2 years after the end of the treatment the

patients were contacted by phone and asked to come back to the outpatient clinic for a clinical re-examination and health status assessment by means of a questionnaire. The patients were not charged with the extra expenses.

4 could not be found. 10 turned out to be admitted to hospital or seriously ill for non related diseases. 18 could not attend the visit due to problems at work or home. Only one of them openly stated to be unsatisfied with the treatment.

80 patients, of which 53 were male (66%) and 27 female (34%), with a median age of 50 years, ranging from 20 to 78, were seen by the same surgeon who performed the sclerotherapy. Later they alone underwent the questionnaire under the supervision of a psychologist in a separate place. The whole procedure took up to about thirty minutes per patient.

The questionnaire was purposely prepared by a team of psychologists on the basis of a simplified Short Form-36 Health Status Questionnaire⁷ with some disease-specific questions.

For statistical analysis the Spss for Windows package^R (Chicago, Illinois, USA) was utilized.

RESULTS

At time of control the general health status was considered excellent by 11 patients (14%), very good by 25 (31%), good by 32 (40%), not good by 9 (11%), poor by 3 (4%).

Compared to before the treatment, 16 (20%) stated that they were clearly better, 4 (5%) only a little better, 52 (65%) the same, 8 (10%) worse.

50 patients (63%) did not complain of any symptom related to hemorrhoids after the treatment, 57 (71%) would have repeated the injections if needed, 14 (18%) only if symptoms were worsened. On the whole, 63 patients (79%) felt better thanks to the treatment.

On the basis of clinical examination the surgeon found 62 patients (78%) better. He performed more injections on 37 patients (46%), surgery on 3 (4%), no treatment at all on 40 (50%).

The relationship between objective and subjective evaluations are reported in Fig 1. In 58 cases (72.5%) the evaluations were in agreement, in 22 (27.5%) they were in disagreement. Among the former 24 (42%) had more therapy (sclerosis or surgery) at time of control, among the

latter 16 (73%): $p < 0.05$ underwent further therapy.

The relationships between results evaluation and: sex and age of the patients, number of injection sessions, more therapy at time of control, time elapsed since the sclerosis was stopped, patients general health and health variation, are reported in Table I. Differences are not statistically significant.

DISCUSSION

The assessment of patients' perceptions of their general health and well-being as well as of their satisfaction with treatment seems one of the practical tools for the routine monitoring of outcomes in medical practice.⁸

This study was carried out on patients with hemorrhoids under sclerotherapy because these patients were used to coming back often to the out-patient clinic. In non life-threatening diseases the major difficulty often appears to be the recruitment of patients after the ambulatory treatment: those who are unsatisfied are unwilling to come back fearing retreatment, those who are satisfied worry about wasting time needlessly.

We needed to have patients with the same level of illness severity according to the same surgeon who was in charge of the treatment as well as of the later judgment. Moreover, the patients had to be treated with the same procedure and to be free from any severe illness which could openly influence their perception of better functioning and well-being thanks to the therapy.

We excluded about two third of the patients: from 342 to 120. Likely due to the careful case selection most of the patients did not complain of bad general health at control nor health variation during the time from the end of the treatment to control.

We collected the data of 80 patients out of the 120 selected but we contacted most of them in order to rule out that the absent ones were neither the most satisfied nor the most unsatisfied.

Due to the mild illness severity and the need to save time in the outpatient clinic, the SF-36 questionnaire was shortened and simplified.

From the collected data the agreement between surgeon's and patients' evaluation of the results clearly emerges in percentage: as regards to the hemorrhoid problem a better

clinical state was reported respectively in 78% and 79% of the cases after treatment. These results are in agreement with those of the literature.^{9 10} However, while the dependence of variables appears statistically significant ($p < 0.05$), the correlation between objective and subjective evaluations is weak (approximate significance = 0.30).

Figure 1

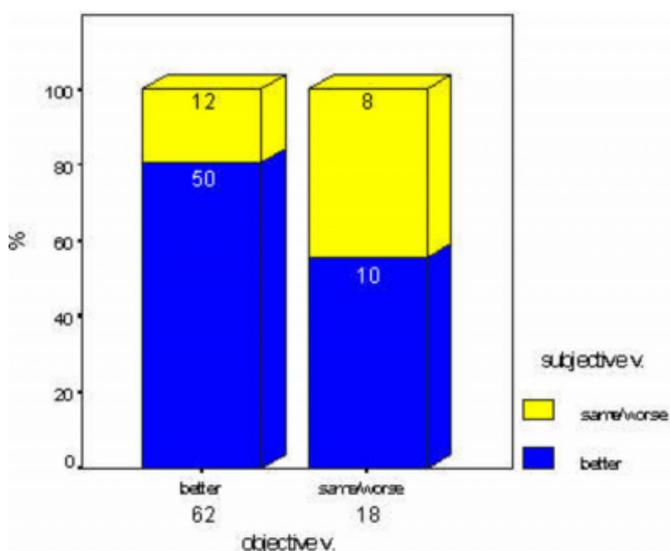


Figure 1. Relationship between objective (surgeon) and subjective (patients) evaluation of the treatment results among the 80 reexamined patients.

Sex, age, number of injections sessions, time elapsed from sclerotherapy, general health and health variation from treatment time, do not seem useful criteria for identifying the patients who, to the greatest extent, are in agreement or in disagreement with the surgeon's evaluation

Although he reported good results with the injection sclerotherapy of hemorrhoids and most of the patients appeared satisfied, the surgeon treated 50% of the patients with more injections or surgery.

Knowing that sclerotherapy can not be a definitive treatment for hemorrhoids and recurrences are more likely to occur as the years go by,¹¹ he tended to overtreat the patients regardless the results evaluation: as far as more therapy is concerned there are no differences between subjective and objective evaluation.

Figure 2

Table 1: Relationship between subjective and objective evaluation of the results according to patients division for the evaluated criteria.

		tot.	subjective evaluation (patients)		objective evaluation (surgeon)					
			better	same or worse	better		same or worse			
			N.	%	N.	%	N.	%	N.	%
sex	males	53	44	83	9	17	39	74	14	26
	females	27	19	70	8	30	23	85	4	15
age	≤ 50 y.	40	30	75	10	25	30	75	10	25
	> 50 y.	40	34	85	6	15	34	85	6	15
injections	1-2	40	32	80	8	20	30	75	10	25
session	> 2	40	31	77.5	9	22.5	32	80	8	20
time from	≤ 12 μ.	40	34	85	6	15	33	82.5	7	17.5
sclerosis	> 12 m.	40	28	70	12	30	27	67.5	13	32.5
more	no	40	35	87.5	5	12.5	38	95	2	5
therapy	yes	40	26	65	14	35	26	65	14	35
	general	good *	68	55	81	13	19	53	78	15
health	no good **	12	8	67	4	33	9	75	3	25
	better	20	18	90	2	10	16	80	4	20
health variation	same	52	40	77	12	23	40	77	12	23
	worse	8	6	75	2	25	5	62.5	3	37.5

* = patients who reported their general health as good, very good or excellent.

** = patients who reported their health as not good or poor.

Interestingly, the only statistically significant difference appears to be in comparing more therapy with agreement or disagreement in results evaluation.

We must be skeptical about the validity of patient-derived values for certain outcomes, but good clinical decisions require an understanding of how patients view certain outcomes.

In modern times, when the value of measuring functional status extends to the surgeon and consumers of health care, we should identify more precisely which kinds of decisions require the more patient participation and develop reliable ways of assessing patient's preferences.¹²

As it appears from this study experience, a flexible policy that reflects how individual patients view positive outcomes would probably be even more useful than one based on an averaged value for utility.

CONCLUSIONS

Generic instruments of quality of life measurements that include health profiles and specific instruments that focus on problems associated with single disease states, patient groups or areas of function may be utilized during the ambulatory treatment of non life-threatening diseases for providing information for policy decisions.

Examining the injection sclerotherapy of hemorrhoids, we can say that, on the whole, patient and clinician share the same evaluation of the treatment results, but in single cases disagreement is not uncommon and that the therapeutic choices are based more on the clinician's formal guidelines than on the patients' preference.

Nowadays, the medical decisions appear more and more standardized and codified, but particularly in the outpatient clinic the patients' preferences are particularly relevant.

Especially during ambulatory treatment we need to identify which decisions require the most patient participation and develop reliable ways of assessing patients' preferences.

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