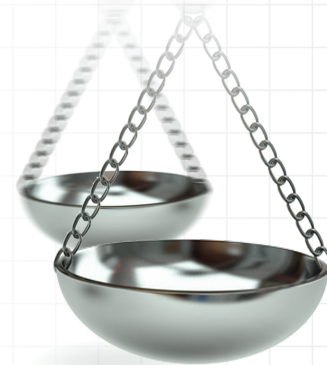




The patient experience in venous disease

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“It is hoped that this information will lead to improved patient care, with earlier diagnosis, appropriate treatment and decreased disease progression and recurrence for both CVD and hemorrhoidal disease.”

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The current issue of the *Journal of Comparative Effectiveness Research* contains two articles reporting results of international web-based surveys: one in individuals with chronic venous disease (CVD) [1], and the other in those with hemorrhoidal disease [2].

CVD is an umbrella term that describes conditions characterized by long-standing morphological and functional venous abnormalities [3], while hemorrhoidal disease is characterized by abnormally enlarged anal venous cushions [4]. Both conditions have complex pathophysiological mechanisms that are not yet fully understood, with neither condition having a single cause [5–7]; however, both involve venous abnormalities [7]. As highlighted by the articles published in this issue, patients with these two conditions have similar comorbidities: allergy, asthma, depression, diabetes, hypertension and psoriasis were commonly reported in both studies [1,2]. There is also an overlap in risk factors, with increasing age, obesity, pregnancy and sitting or standing for prolonged periods of time increasing the risk for both conditions [8,9]. It is therefore perhaps unsurprising that CVD was reported in over half of the patients with hemorrhoidal disease in the large CHORUS study [7]. In the survey published in this issue, hemorrhoidal disease was reported by 28% of those with CVD, compared with only 10% of the general population [1]. Similarly, 49% of patients reporting hemorrhoidal disease also suffered heavy legs or varicose veins, versus 24% of the general population [6]. Thus, if a physician is treating a patient for one condition, it may be prudent for them to also investigate the other.

Burden of disease

While undeniably common conditions, CVD and hemorrhoidal disease both appear to be underdiagnosed and/or undertreated, and there is great variation in estimates of their prevalence [1,2]. Both conditions can lead to diminished patient quality of life (QoL) and result in substantial healthcare costs. As our population ages and becomes increasingly obese, it is likely that the prevalence and financial burden of both conditions will rise [10].

It is estimated that, in Western countries, CVD treatment and care consume approximately 2% of healthcare budgets [10]. Once a patient develops CVD, they are prone to disease progression through a cycle of inflammation and increased venous hypertension, with individual patient risk factors influencing the extent and speed of progression [10]. This progression can be decelerated or prevented through early identification and treatment, including venoactive drugs and lifestyle changes. However, even early-stage CVD has a negative impact on patient QoL and, without proper management, the disease may progress to the point that patients cannot undertake normal activities of daily living [11]. The QoL of patients with severe CVD (C6, active venous ulcers) can be very poor, similar to that of patients with chronic lung disease [9], which underscores the need for early treatment to reduce progression.

Hemorrhoidal disease has been surprisingly under-researched, considering the condition causes substantial economic burden and individual suffering [12]. In 2010, hemorrhoidal disease was the third most commonly diagnosed outpatient gastrointestinal disorder in the US [13]. A study using data from the US employer-insured population estimated that, in 2014, 1.4 million people received medical care for hemorrhoidal disease, at a total cost

of close to US\$800 million [13]. However, this is a gross underestimation of the true financial burden, as the study excluded those aged ≥ 65 years, and also did not include the millions of over-the-counter hemorrhoid treatments that are sold annually in the US [12,13]. The CHORUS study showed a significant association between hemorrhoid recurrence and constipation, older age, obesity, male gender and concurrent CVD [7]. In women, hemorrhoidal disease was also more likely to recur in those who had given birth, and the likelihood of recurrence increased with the number of births. In the study published in this issue, although the duration of hemorrhoidal episodes was generally less than 1 week, 85% of respondents had been experiencing hemorrhoidal episodes for over a year [2]. Thus, although the symptoms can sometimes be self-limiting [7], hemorrhoidal disease often represents an ongoing source of suffering for patients.

Patient experience

The results of the two surveys published in this issue highlight that both CVD and hemorrhoidal disease are most likely underdiagnosed and undertreated, often because patients are reluctant to seek help, or delay seeking help, from a medical practitioner [1,2].

In the CVD survey, patients had symptoms for an average of 1 year before seeking advice or treatment, and even then, less than half consulted a physician [1]. It is possible that patients may view some clinical signs, such as varicose veins, as purely cosmetic rather than a sign of a chronic disease that is prone to progression. Additionally, patients may disregard CVD symptoms because they are relatively nonspecific and not life-threatening [3]. Thus, CVD is often not diagnosed until it is at a late stage, meaning more aggressive treatment may be required to slow progression.

Although the exact reasons are unclear, it is generally assumed that patients with hemorrhoidal disease may be reluctant to seek medical attention due to embarrassment, cultural constraints or assumptions that the doctor will not be able to help or the symptoms will ‘just go away’ [2,14]. This reluctance can also lead to patients doing their own research, resulting in a self-diagnosis of hemorrhoidal disease, yet available data suggest that the majority of people who self-diagnose hemorrhoidal disease are mistaken [7]. This is concerning on several levels, including the fact that common hemorrhoid symptoms, such as anal bleeding and pain, fecal seepage and mucus discharge, may be symptoms of other more serious conditions, including cancer or inflammatory bowel disease [2]. Furthermore, early treatment with appropriate agents or lifestyle modifications may prevent or delay progression or recurrence of hemorrhoidal disease [7]. In contrast, self-diagnosis may be driving the large sales of over-the-counter treatments [12].

Importance of the physician–patient relationship

The above-mentioned delays in patients seeking medical assistance for CVD or hemorrhoidal disease underscore the importance of a good relationship between patients and their general practitioners. It is imperative that practitioners are proactive and ask targeted questions based on a patient’s risk factors to diagnose and treat early and effectively both diseases, rather than waiting for the patient to raise problems that they may find embarrassing or deem unimportant or untreatable.

In a French study, after targeted questioning, 14% of patients were found to have an anal symptom, even though only 2% went to the doctor for a proctological problem [14]. Worryingly, in over a third of the patients who received a proctological diagnosis, there was no physical examination of the anus, which must call into question the accuracy of the diagnosis. Possible reasons for the lack of physical examination include patient embarrassment, no chaperone, lack of time in a consultation and lack of physician training [14]. Improved physician education may encourage more thorough examinations of patients suspected of having hemorrhoidal disease.

Indeed, improved patient and physician education is necessary for both conditions and may aid in timely diagnosis and appropriate management. Patients should be made aware of the modifiable risk factors for the two conditions, and encouraged to mitigate them where possible [15]. Patient education regarding hemorrhoidal disease may help reduce the stigma around anal conditions, as well as encourage patients to seek assessment in order to rule out more serious conditions [2]. For both patients and physicians, an improved awareness of the importance of CVD, as well as knowledge of the signs and symptoms, is required [9]. It is apparent that a number of physicians are not fully aware of the correct diagnosis, treatment and referral procedures for CVD, which can lead to underdiagnosis and mistreatment [9,10].

Importance of the two studies published in this issue of the journal

The two web-based patient surveys published in this issue give voice to the patients with CVD and hemorrhoidal disease, and provide information on how these patients see their own symptoms and their route along the disease pathway. Both surveys highlight the need for improved patient awareness of the importance of investigating symptoms indicating CVD or hemorrhoidal disease, as well the need for a strong patient–physician relationship to aid diagnosis when symptoms may not be mentioned. It is hoped that this information will lead to improved patient care, with earlier diagnosis, appropriate treatment and decreased disease progression and recurrence for both CVD and hemorrhoidal disease. Further, it can help to prevent missing sinister diseases, such as cancer or inflammatory bowel disease, thus ultimately improving patient care in the field of proctology.

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