

Hemorrhoidal Disease, from Legacy to a Change of Perspective

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Since Sir Alan Parks studies, describing pathogenesis and surgical treatment[1] of hemorrhoidal disease[2-4], the diagnosis and clinical approach of this pathological entity, has come a long way. The studies about the real cause of this common pathology got an impulse since the findings, by a Japanese group[5] of pathophysiology of hemorrhoidal artery perfusion, that lead to a new clinical and surgical approach to this clinical entity.

Anorectal disorders are a common problem that all kind of clinicians face in daily practices, from General Practitioners to Emergency doctors ending to Colorectal Surgeons. The most common of them is hemorrhoidal disease, from one side the most diagnosed (sometimes with excess from some clinician category) that attributes every perianal discomfort or bleeding to this pathological entity. A lot of scientific papers are present in literature: if you realize a simple keyword search on PUBMED®, searching for “hemorrhoids”, more than 5630 articles will show up as results. One pivot point is present in all articles, also the recent ones: Park’s classification of hemorrhoidal disease[4]. Other pathologies were object of revision and modernizations of classification criteria (just think about IBS and Rome Criteria) [6], but legacy resisted to ageing for what concerns hemorrhoidal disease.

We still classify and accordingly treat hemorrhoids using studies that were accomplished and applied circa seventy years ago, with no doubts still good results.

But there is a significant part of scientific community that started not to accept this kind of pathway, starting with the studies and the subsequent changes in surgical approach led by the Italian surgeon Longo[7] in the late nineties, which moved the entire concept of hemorrhoidectomy from a orificial point of view to a more complex, pelvic-linked pathophysiological disease. This obviously shacked the scientific community, creating debate and obviously a series of scientific researches comparing the classical excisional technique[8, 9] to the other and trying to establish a new pathway of treatment and finally define what to do and in which kind of patients. After a short period of trials, some negative point arose around the Longo technique [10-18], with this debate still in place in congresses and symposium around the word and in modern literature[16].

Some part of the colorectal surgical community decided to use the classical clinical approach, some others embraced the new idea and started to treat all patients with the new technique. But everyone continued to use the traditional Park’s approach to classification of hemorrhoidal disease. Some scientific societies started again to look inside the classifications, posing to the scientific community the question about the opportunity to revise the Park’s approach[19], at the beginning with fierce resistance from the academic community.

Then again, something new started to arise. New studies about physiology published by Morinaga in 1995, at the beginning ignored by great part of surgical community, but with the merit of switching attention from the technical approach to the physiological cause of hemorrhoidal disease and its evolution: vascularization. After more or less 10 years and the development of surgical devices that are dedicated

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to operate with a standard technique, the Transanal Hemorrhoidal Desarterialization stepped up as a new and minimally invasive approach for the treatment of hemorrhoids[20-28].

Again, some authors are still debating if this is the correct approach, with new studies[29] and verifying the efficacy and feasibility of this relatively new surgical approach.

Again, Sir Alan Parks classification is still in place, after 70 years, defining clinical and surgical options. As I said in the previous paragraph, if a technique is so superior to others, why the flourishing of new technical approaches in a so (relatively) smaller time? Is there something we, as scientific community, are missing? Maybe the way we look to and classify this disease?

Some colleagues are trying to change perspective. A new concept in hemorrhoids surgery is taking place, that hemorrhoidal disease is not a “symmetrical” clinical problem, both for symptoms both from an anatomical point of view. Patients can have a III degree (according to Parks’ classification) nodule associated to a II-degree one and an internal mucosal prolapse, not affecting the hemorrhoidal tissue at all in terms of volume on one side, all in one patient. Do we use a “one-size-fits-all” therapeutic approach as we do today, with failure rates still statistically significant, or it is time to propose a more “tailored” approach to this common pathology[30]?

Is it time to change perspective, so to change clinical and mainly surgical approach?

Arezzo in this paper from 2011 states that “Societies’ guidelines recommend a tailored surgery, i.e., the use of different procedures according to the grade of hemorrhoids, which suggests that patients should be operated by a specialist colorectal surgeon, able to perform different surgeries and to deal with complications and failures”[31].

The path is still long and full of doubts, and we as scientific community, must keep the debate and experimentation alive, as well as our mind open to new perspectives, running away from dogmas.

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