

Perception and Management of Hemorroid Disease at the CSREF of the Commune Bamako Mali

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How to cite this paper: Cheickna, T., Hassimy, D.M., Diarra, I., Sanogo, Bakary, K., Tientigui, D.B., Alhassane, T., Adégné, T.P. and Kante, L. (2024) Perception and Management of Hemorroid Disease at the CSREF of the Commune Bamako Mali. *Surgical Science*, 15, 89-97.

<https://doi.org/10.4236/ss.2024.152010>

Received: October 18, 2023

Accepted: February 26, 2024

Published: February 29, 2024

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Abstract

This work was a prospective transversal study over 6 (six) months from May 2 to December 31, 2017 at the Reference Health Center of Commune I and the Chérif la Confessional Health Center in Bamako. The aim was to study the knowledge, attitudes and behavioral practices linked to hemorrhoids in Commune I of the Bamako district, to evaluate the frequency of hemorrhoidal disease, to determine the knowledge, attitudes and behavioral practices linked to hemorrhoids among patients, their companions and traditional therapists in Commune I of the district of Bamako and the factors which influence the motivations and decisions to resort to medical-surgical care and traditional medicine in patients suffering from hemorrhoids in order to analyze the results of the management of hemorrhoidal disease at Cs Ref CI. We collected 36 patients with hemorrhoidal disease, 25 caregivers and 15 traditional hemorrhoidal disease therapists. The sex ratio was 1.25 for patients; 6.5 for traditional therapists and 1.5 for accompanying people. The average age of the patients was 32.75 years; 49 years for traditional therapists and 28.76 years for those accompanying them. 55.6% of patients claim to know about hemorrhoidal disease; 100% of traditional therapists and 80% of accompanying people. The dietary factor of hemorrhoidal disease was mentioned by 90% of patients; 66.7% of traditional therapists and 100% of caregivers. Most patients initially resorted to traditional treatment out of fear of surgery and its after-effects. The patients were treated medically and surgically.

Keywords

Hemorrhoidal Disease, Caregivers, Traditional Therapists, Patients, Surgery, CS Ref CI

1. Introduction

Hemorrhoids from the Greek “Hemorrhoids” are ectasias of the capillaries of the corpus cavernosum recti [1]. Hemorrhoids appear at all ages and in both sexes, rare in children, they become frequent from the age of 20 [2] [3].

In France, 25% of the adult population; its hospital frequency: 6% to 18% among HIV patients in 2001.

In Australia, 4% and 34% of the general population in 2003 [4].

In Mali, 40.15% of all lower endoscopies and 6.35% of all consultations in the internal medicine department of Point G University Hospital [5].

Hemorrhoids are present physiologically, becoming pathological with the occurrence of symptoms which include anal pain, prolapse and rectal bleeding [6].

Multiple and varied contributing factors, the dietary factor was mentioned by 54.7% of patients; They believed that a non-varied diet based on rice and spices, especially chili, would promote hemorrhoids [7].

Hemorrhoidal pathology is considered by the population as a shameful disease, responsible for school and professional absenteeism and considerable aesthetic problems [8].

The confirmatory diagnosis is made by Ano rectoscopy. Complications are thrombosis and hemorrhage. Treatment is medical, instrumental and surgical. The main postoperative complications are anal stenosis, anal incontinence, hemorrhage, urinary retention and pain [9] [10].

Hemorrhoidal pathology is considered by the population as a shameful disease.

Several studies carried out on hemorrhoidal disease in our hospitals have shown a certain mastery of surgical management. No study has been carried out on hemorrhoidal disease in our Cs Ref in Bamako despite the high frequency during our ordinary consultations and surgical emergencies during on-call hours.

Taking into account all these aspects and the fact that there are few studies on hemorrhoidal disease in Mali, we decided to conduct this study in commune I to situate the problem in order to make recommendations.

2. Research Methodology

This work was carried out in the Reference Health Center and the religious health center of Cherifla in Commune I of the District of Bamako. This was a prospective cross-sectional study over 6 (six) months from May 2 to December 31, 2017. We collected 36 patients, 25 companions and 15 traditional therapists suffering from hemorrhoidal disease.

-Inclusion criteria

All patients, all accompanying persons and all traditional therapists admitted for hemorrhoidal disease, having given their consent, treated and followed in the surgery department of the Cs ref and in the Cherifla faith-based health center in commune I of Bamako.

-Non-inclusion criteria

*All patients with hemorrhoids, caregivers and non-consenting traditional therapists.

*All patients with other proctology pathologies without hemorrhoids.

The variables studied were sociodemographic (age, sex, profession, residence); physical examination (general, functional, physical signs); additional examinations (systematic rectoscopy except in cases of hemorrhoidal thrombosis); emergency biological assessment.

(Hemoglobin level, hematocrit, Rhesus group, TP, TCK, blood sugar) and surgical treatment: techniques (Milligan Morgan and Thrombectomy) and short and medium term operative consequences.

The supports used were the patients' medical files, the outpatient consultation and hospitalization registers, recording the patients' reports, the individual investigation sheet and the anesthesia protocol.

Data entry and analysis were carried out using SPSS 22.0 software.

The Student comparison tests and the Chi square were calculated on Epi info 6.4 and p with a significance threshold of $p < 0.05$. Verbal informed consent from all patients, accompanying persons and traditional therapists was requested.

3. Results

We identified 36 patients including 22 patients at the Cs Ref, *i.e.* 3.65% (22/603) of consultations and 5.66% (22/389) of hospitalizations; (14/915) in Chérifla, *i.e.* 1.53% of consultations and (14/488) *i.e.* 2.87% of hospitalizations. Accompanying people (N = 25) and traditional therapists (N = 15) were selected in the different districts of commune I in this study (**Table 1**).

*Patients: The average age was 32.75 years (extreme 18 years and 64 years), standard deviation (16.432) with a sex ratio of 1.25 (20/16) in favor of the male sex. The working profession represented 52.8% of cases; 55.6% of patients claimed to know about hemorrhoidal disease through radio broadcasting (65%) with the name "koko" (90%) of cases (**Table 2**).

The reasons for consultation were constipation (97.22%), anal pain (94.44), hemorrhoidal prolapse (83.33%) and rectal bleeding (77.78%) (**Table 3**). The general condition was maintained in all our patients. The contributing factors were constipation (95%), diet (90%), working in a seated position (60%) and pregnancy (30%) (**Table 4**).

Inspection of the anal verge found hemorrhoidal marisques (27.8%), anal ulceration (16.7%), anal swelling (69.4%), anal fistulas (20), anal abscess (20%) and anal fissures (60%). Rectal examination was done in all our patients, painful (86.11%), tonic sphincter (50%), painless (13.9%) and hemorrhagic (77.78%).

All our patients underwent ano-rectoscopy including 2 (2.7%) biopsies. The diagnosis made by anotoscopy according to the progressive stage: hemorrhoids stage I (38.9%), stage II (19.4%), stage III (27.8%), and stage IV (11.1%) and types: external hemorrhoids (50%), internal hemorrhoids (16.7%), thrombosis (16.7%), internal + external hemorrhoids (16.7%).

Table 1. Sociodemographic data.

Sociodemographic data		Number	Percentage
Age	Under 20	1	2.80
	[20 to 40 years]	30	83.30
	40 years and over	5	13.90
Sex	Male	20	55.60
	Feminine	16	44.40
Occupation	Worker	19	52.80
	Official	6	16.70
	Household	11	30.50
Origin	Municipality I	30	83.30
	Commune II	4	11.10
	Commune II	2	5.60
Total		36	100

Table 2. Distribution of patients according to education, knowledge of hemorrhoidal disease and source of information.

Education/Knowledge and Source of info		Number	Percentage
Schooling	Schooled	10	27.80
	Unschoolled	26	72.20
Knowledge of hemorrhoidal disease	Yes	20	55.60
	No	16	44.40
Information source	Radio	13	36.11
	Parent	5	13.89
	Health structure	2	5.60
	None	16	44.40
Total		36	100

Table 3. Distribution of patients according to functional signs of hemorrhoidal disease.

Functional signs	Number (n = 36)	Percentage
Anal pain	36	100
Anal swelling	34	94.44
Constipation	27	75
Recectorgia	15	41.67
Anal pruritus	13	36.11
Meteorism	11	30.56
Others	9	25

Table 4. Distribution of patients according to the etiologies of hemorrhoidal disease.

Etiologies of hemorrhoidal patients		Effectif (n = 20)	Pourcentage
Main causes	Constipation	19	95
	Food	18	90
	Sit for a long time	12	60
	Pregnancy	6	30
Foods incriminated	Yes	18	90
	No	2	10
Food	Cereal	15	75
	Meat	13	65
	Spicy	3	15
	Tuber	2	10

Medical treatment (61.1%) was based on transit regulators (91%), venotonics (100%) and analgesics (86.36%). Our patients, 14 (38.9%) underwent surgery (hemorrhoidectomy according to Milligan-Morgan 13/14 (93%)) and (7%) thrombectomy. Spinal anesthesia was the type of anesthesia in all our patients. The outcome was simple for all our patients.

*Traditherapists: The average age was 48.33 years (Extreme 36 years and 72 years), Standard deviation (19.331) with a sex ratio of 6.5 (13/2) in favor of the male sex. All traditional therapists claimed to know diseases of the anal verge and 66.7% were illiterate (not educated).

The name “koko” “tiéman” and “moussoman” was cited by all traditional therapists.

The manifestations of hemorrhoidal disease according to traditional therapists were constipation (100%), anal pain (100%), anal button (93%), sexual impotence (40%), anal pruritus (26.7%) and blood loss during stools (86%). The contributing factors according to traditional therapists were constipation (86.7%), diet (66.7%), work in a seated position (46.7%), pregnancy (26.7%), diarrhea (40%) and bad spells (33.3%). The foods incriminated were rice (80%), meat (66.67%), spices (46.7%) and fruits and/or vegetables (40%).

*Accompanying people: The average age was 28.76 years (Extreme 18 years and 56 years), Standard deviation (6.522) with a sex ratio of 1.5 (15/10) in favor of the male sex.

Accompanying people (80%) knew about hemorrhoidal disease through parents (35%) and or patients with hemorrhoid (35%), radio broadcasting (20%) and television (10%) and 64% were illiterate (no schooled). The manifestations of hemorrhoidal disease according to the companions were constipation (70%), anal pain (100%), anal button (75%), anal pruritus (40%) and blood loss during stools (55%).

The contributing factors according to traditional therapists were constipation

(100%), diet (100%), working in a seated position (85%) and pregnancy (30%). The foods in question were rice (50%), meat (45%), spices (60%) and vegetables (55%). Our companions (75%) would have recommended medical consultation in the face of hemorrhoidal disease and 35% a rich and varied diet (**Table 5**).

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Table 5. Distribution of patients according to first therapeutic recourse.

First therapeutic recourse	Effective	Percentage	
Traditional medicine	18	50	
Modern medicine	10	27.80	
Self-medication	5	13.90	
None	3	8.30	
Motivations for therapeutic use	Traditional medicine	18	50
	Fear of surgery	9	25
	Poverty	4	11.11
	Trust	3	8.33
	Social prejudices	2	5.55
	Modern medicine	10	27.77
	Trust	7	19.44
	Information or recommended	3	8.33
Total	36	100	

Table 6. Distribution of patients according to positive diagnosis and treatments received.

Positive diagnosis and treatments received		Effectif	Pourcentage
Positive diagnosis	External hemorrhoid	18	50
	Internal hemorrhoid	6	16.7
	Internal hemorrhoid + External hemorrhoid	6	16.7
	Hemorrhoidal thrombosis	6	16.7
Therapeutic attitudes	Medical treatment	22	61.1
	Surgical treatment	14	38.9
Medications received	Veinotonics in suppository	22	100
	Laxatives	20	91
	Analgesics	19	86.36
	Anti-inflammatory suppositories	18	81.81
	Hemorrhoidectomy according to Milligan Morgan	13	93
	Thrombectomy	1	7
Total		36	100

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The contributing factors according to traditional therapists were constipation (100%), diet (100%), working in a seated position (85%) and pregnancy (30%). The foods in question were rice (50%), meat (45%), spices (60%) and vegetables (55%). Our companions (75%) would have recommended medical consultation in the face of hemorrhoidal disease and 35% a rich and varied diet.

The name “Koko” was common in Bambara in all Malian series. The contributing factors were constipation (95%), diet (90%) and prolonged sitting (60%) were found in other series [2] [6]. The manifestations of hemorrhoidal disease were pain (100%), anal swelling (95%), constipation (75%) and rectal bleeding (40%) of cases are comparable to literature data. The first recourse of our patients was traditional therapists (50%) followed by modern medicine (27.8%) due to the fact that our society is more focused on traditional beliefs.

Reasons for consultation: constipation (97.22%); anal pain (94.44%) and hemorrhoidal prolapse (83.33%); inspection found hemorrhoidal prolapse (69.4%) and marisques (27.8%). Rectal examination was painful (86.11%) and sphincter hypertonia (50%) of cases. This rectal examination was the key diagnostic examination according to the literature. External hemorrhoids represented 50% including stage III (27.8%) compared to more than half of the patients at ROSA in Italy [11] and at Dicko ML in Mali [5], ($p = 0.000$). Associated proctological pathologies such as fissures (60%) and fistulas (20%) were the most observed in our patients. Medical treatment was the most observed with 55.6% of cases. The

drugs used were venotonics (100%), laxatives (91%) and analgesics (86.36%) of our patients.

The average age of traditional therapists was 49.33 years and those accompanying them 28.76 years. The sex ratio of traditional therapists was 6.5 and 1.5 of accompanying persons can be compared to the data in Mali [2] [3] [4]. The low rate of women would reflect the socio-cultural conditions of women in African society, particularly in Mali. The high rate of non-schooling of accompanying persons (64%) and traditional therapists (66.7%) was evident.

All traditional therapists claimed to know about hemorrhoidal disease compared to 80% of cases of accompanying people.

The main signs of hemorrhoidal disease cited by traditional therapists were constipation (100%), anal pain (100%), anal button (93.3%) and other symptoms unknown in the medical literature [12] [13] [14] [15] such as sexual impotence, conjunctival pruritus, plantar heat, physical asthenia, fever and insomnia; but are less known by those accompanying them. The call for modern medicine by traditional therapists could reflect the existence of a collaboration between modern medicine and traditional medicine.

4. Conclusion

Hemorrhoidal disease is a very common pathology, patients and those accompanying them had partial knowledge about this disease in common. Like modern medicine, traditional medicine has its value system, its units of measurement and its way to protect but despite everything it has its limits. The promotion of this medicine necessarily requires its proper structuring.

Acknowledgments

To patients who have given their informed consent, to the staff of the general surgery department of the CS Ref of commune I of the Bamako district.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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