



Telephone follow-up following office anorectal surgery

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ABSTRACT

INTRODUCTION Patients with minor anorectal conditions are frequently reviewed at an 8-week out-patient appointment (OPA). This study was designed to assess whether telephone follow-up could reduce OPA numbers whilst maintaining patient satisfaction.

PATIENTS AND METHODS Over an 11-month period, 46 patients (23 male) underwent banding of haemorrhoids and 14 were prescribed medical treatment for fissure-in-ano (3 male). All were telephoned at 6 weeks and were offered an 8-week OPA if they had continuing problems. Patients were telephoned at a later date by a member of the hospital's patient panel to assess satisfaction.

RESULTS Overall, 88% were contacted at 6 weeks, 60% at the first attempt; 40% required two or more attempts. Of those who underwent banding, 68% were asymptomatic, 17% requested an OPA for re-banding and 15% requested an OPA for a different problem. Of fissure patients, 25% were cured; the remainder were prescribed either second-line medical treatment (8%), anorectal physiology (42%) or surgery (25%). All avoided an OPA. Of a potential 60 OPAs, 47 were saved by telephone follow-up. None of 7 non-contactable patients accepted a written offer of an OPA. Overall, 89% of patients were contacted by the patient panel; of these patients, 93% reported a high level of satisfaction.

CONCLUSIONS Telephone follow-up can reduce the number of OPAs following out-patient treatment of minor anorectal conditions whilst maintaining a high level of patient satisfaction. However, it requires considerable consultant time. This process could be developed into either a nurse-led service with booked telephone appointments or a patient-led service to a dedicated hotline.

KEYWORDS

Haemorrhoids – Rubber band ligation – Fissure-in-ano – Telephone follow-up

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Haemorrhoids and fissure-in-ano are common conditions managed using either rubber-band ligation or topical 0.2% glyceryl trinitrate (GTN) paste of 0.2 or 0.4%.¹ Many patients with these conditions, when seen at follow-up, are symptom-free and are discharged.

This study was undertaken to assess the feasibility of telephone follow-up in the out-patient management of patients treated for haemorrhoids or fissure-in-ano. In particular, we assessed whether this sort of follow-up could lead to a reduction in the total number of follow-up appointments required whilst at the same time maintaining patient satisfaction. The study also allowed us to audit our practice and assess the efficacy of our first-line treatments for haemorrhoids and fissure-in-ano, *i.e.* rubber-band ligation and GTN paste.

Patients and Methods

During the 11 months from January to November 2004, 60

patients (25 male) received either rubber-band ligation of haemorrhoids (46 patients) or GTN paste treatment of a fissure (14 patients). Patients were offered the choice of telephone follow-up as part of the study or a follow-up appointment in the clinic at 8 weeks. No patient declined telephone follow-up. A correct telephone number for each patient was obtained at the time of recruitment.

Patients were telephoned at 6 weeks by the consultant and their symptoms discussed. They were offered a clinic appointment within 2 weeks (*i.e.* 8 weeks after treatment) if they had on-going problems. After the telephone consultation, patients treated for haemorrhoids were either discharged or given an appointment for further banding. Patients with fissure-in-ano who were asymptomatic were discharged. If patients were still symptomatic, further management options were discussed. Some chose to try a second-line medical treatment and were prescribed 2% diltiazem. Women requiring surgical intervention were referred

Table 1 The three-point 'yes/no' questionnaire used in the telephone audit

1. Were you satisfied with the initial consultation with the doctor?
2. Did you find it acceptable to be contacted by telephone for the follow-up consultation?
3. Would you have preferred to have been seen in clinic for follow-up rather than a telephone follow-up consultation?

for anorectal physiology prior to being considered for either an endo-anal advancement flap or lateral sphincterotomy. Men who failed medical management and needed surgery were listed directly for day-case lateral sphincterotomy.

We were unable to contact 11.7% of patients. They were each sent a letter offering a further out-patient appointment.

Our hospital has a 'patients panel' who volunteer their time to the audit department to interview patients, either in person or on the telephone. A sample of 45 patients were contacted by the patient panel, initially by letter to make them aware of the study and then by telephone. They were questioned regarding their satisfaction with their treatment and follow-up via a simple three-point 'yes/no' questionnaire (Table 1). Free-text comments were encouraged, providing qualitative data to support the quantitative data. Formal validation of the questionnaire was deemed unnecessary due to the number and nature of questions although content validity was achieved through the use of a focus group, including patients, deciding which questions to include. As the interviewers were non-clinical and independent, the results obtained are also valid.

No patient contacted refused to participate.

Results

Of the patients, 88% were contacted by telephone at 6 weeks, 60% on the first and 17% on the second attempt.

Only 17% of patients required three or more attempts to contact them, the maximum being six attempts.

Of the 46 patients treated for symptomatic haemorrhoids with rubber-band ligation, 41 were contacted at 6 weeks. Of those contacted, 68% were asymptomatic and were discharged. A further 15% were no longer complaining of their initial haemorrhoidal symptoms but now had a new symptom for which they returned to clinic. Rubber-band ligation was effective in relieving symptoms in 83% of patients. However, 17% were still symptomatic and returned to clinic to allow repeat banding. Five patients whom we were unable to contact were sent a letter offering a further out-patient appointment (OPA); none chose to attend.

Of 14 patients treated for fissure-in-ano with GTN paste, 12 were contacted at 6 weeks; of these, three patients (25%) were asymptomatic and were discharged. One patient requested a second-line medical treatment. Five symptomatic female patients were referred for anorectal physiology prior to any further management decisions. Three symptomatic male patients were listed directly for lateral sphincterotomy. Two non-contactable patients declined a written offer of an OPA.

Of the 60 patients in the study, only 13 were followed up in out-patient clinic. Based on four consultant out-patient clinics per month, this equates to 1.2 OPAs saved per clinic.

The patient panel successfully contacted 47 patients. All answered all three questions, the results of which are summarised in Table 2.

Discussion

Symptomatic haemorrhoids and fissure-in-ano are common diagnoses amongst patients attending colorectal out-patient clinics. The prevalence of haemorrhoids in the US ranges from 4.4% of the general population to 36.4% in general practice² with approximately one-third of affected individuals seeking medical treatment for their symptoms.³

The introduction of the 'two-week-wait' for suspected colorectal cancer has greatly increased the pressure on colorectal clinics. A study at our own hospital has shown that the average wait for 'non-two-week-wait' referrals has markedly increased since its introduction.⁴ There has also been a negative effect on the availability of follow-up

Table 2 Responses to three-point questionnaire

Question	Yes	No	No preference
Satisfied with initial consultation?	96%	4%	–
Telephone follow-up acceptable?	93%	7%	–
Would you have preferred clinic follow-up?	14%	84%	2%

appointments in our clinics. Ideally, patients with haemorrhoids or fissure-in-ano treated in the out-patient clinic would be brought back for review at 8 weeks to assess response and allow referral for any further investigations or listing for surgery. However, most are discharged from the clinic at this point.

In general practice, it is common to see dedicated time-slots when a doctor or nurse can be consulted by telephone.⁵ Telephone consultation has also been used successfully in the follow-up of patients attending for day-case transurethral prostatectomy,⁶ laparoscopic cholecystectomy⁷ or tonsillectomy⁸ and has been shown to be safe and cost-effective.

We have shown that the majority of patients being treated in the out-patient setting for minor anorectal conditions do not require formal clinic follow-up. In our experience, follow-up telephone consultation is very satisfactory for the patient and good for personal audit. However, it is very time consuming, especially if more than one attempt is needed to contact the patient. Each successful telephone call resulted in a conversation of approximately 5 min; however, if multiple attempts were needed to contact the patient, the total time spent was considerably longer.

Due to time restraints, it is not feasible for a consultant to perform telephone follow-up on top of other activities. Other approaches to telephone follow-up could be a nurse-led telephone clinic with each patient being contacted routinely, preferably at a date and time already pre-arranged with the patient. Alternatively, it could be patient-led with a nurse being available at a set time if the patient wishes to make further contact. However, in our practice at present, patients receive a telephone number so that they can ring at 6 weeks and arrange a further appointment if necessary.

There is a financial issue with regard to telephone follow-up. Currently there is no system with our primary care

trust for funding telephone follow-up and we are not aware of any such system elsewhere. Obviously, this results in a loss of revenue for the trust. However, reducing the number of follow-up patients has reduced the pressure generated by the 'two-week-wait' target freeing up space for new patients.

Conclusions

Patients treated for minor colorectal complaints can be followed up via telephone consultation whilst maintaining high levels of patient satisfaction. Further negotiation is needed to organise funding by primary care trusts.

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