



Original Article

Subjective processes surgical treatment in patients with stages of the disease hemorrhoidal



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ABSTRACT

Introduction: Hemorrhoidal disease afflicts 4.4% of the world population, being the most common anal disorder. Surgical treatment is used for about 5–10% of cases where conservative procedures have not worked.

Objective: To understand the trajectory and perception of individuals submitted to surgical treatment of hemorrhoidal disease.

Methods: This is a descriptive study with a qualitative approach, which emphasized Cartography as the main method in the analysis of the results. Data were produced through individual interviews recorded and transcribed in full, from March to June 2015, in a Polyclinic and in a public hospital in the municipality of Montes Claros-MG. Twelve interviews were carried out.

Results: The results evidenced the existence of processes of subjectivization that, through affectations, cause individuals to demonstrate a transcendent thought, exemplified by the sensation of a self-knowledge of the disease, including correlating it with possible hereditary, behavioral and alimentary causes. There was an escalation in the various levels of health care, standardized by the public system, sometimes revealing a molar thought, preventing the occurrence of an event, reducing power and failing to achieve a plan of immanence with the complete resolution of the problem. The hard lines, evidenced by a delay in obtaining a treatment thanks for fear and shame, favored self-medication, with a worsening of symptoms.

Conclusion: It was noted that there were obstacles in all levels of the SUS that made it difficult to reach the surgical treatment, but all patients were considered with surgery and with the postoperative period.

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Processos de subjetivação no desenrolar do tratamento cirúrgico de indivíduos com doença hemorroidária

R E S U M O

Palavras-chave:

Hemorroidas
Hemorroidectomia
Cartografia
Pesquisa qualitativa

Introdução: A doença hemorroidária aflixe 4,4% da população mundial, sendo o distúrbio anal mais comum. O tratamento cirúrgico é utilizado para cerca de 5 a 10% dos casos em que os procedimentos conservadores não surtiram efeito.

Objetivo: Compreender a trajetória e percepção dos indivíduos submetidos ao tratamento cirúrgico da doença hemorroidária.

Métodos: Trata-se de um estudo descritivo de abordagem qualitativa, que privilegiou a Cartografia como método principal na análise dos resultados. A produção dos dados ocorreu por meio de entrevistas individuais gravadas e transcritas na íntegra, no período de março a junho de 2015, em uma Policlínica e em um hospital público do município de Montes Claros-MG. Foram realizadas 12 entrevistas.

Resultados: Evidenciaram a existência de processos de subjetivação, que por meio de afetamentos, fazem com que os indivíduos demonstrem um pensamento transcendente, exemplificado pela sensação de um autoconhecimento da doença, inclusive correlacionando-a com possíveis causas hereditárias, comportamentais e alimentares. Evidenciou-se uma escalada pelos vários níveis de atenção à saúde, normatizados pelo sistema público, deixando transparecer em alguns momentos um pensamento molar, impedindo o surgimento de um acontecimento, reduzindo a potência e deixando de atingir um plano de imanência com a completa resolução do problema. As linhas duras, evidenciadas pela demora em se conseguir um tratamento, pelo medo e pela vergonha, favoreceram a automedicação e o agravamento dos sintomas.

Conclusão: Notou-se que houve entraves em todos os níveis do SUS que dificultaram o alcance ao tratamento cirúrgico, mas todos os pacientes se consideraram satisfeitos com a cirurgia e com o pós-operatório.

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Introduction

The fourth-degree hemorrhoidal disease has, in the surgical treatment, a way of obtaining its cure; this disease is the subject of many quantitative studies whose authors were concerned with statistical aspects and did not focus on the individual with the disease and on his/her perceptions. Thus, this study aims to understand the trajectory and perception of patients submitted to surgical treatment for the hemorrhoidal disease, seeking, with the use of the rhizomatic philosophy of Deleuze and Guattari, to investigate the processes of subjectivization that occurred with these patients, mapping the lines of segmentarity that pass through them.¹

Initially, we will introduce the concepts that explain what hemorrhoidal disease is; in which consists its clinical and surgical treatment; and how the access to treatment occurs through the Sistema Único de Saúde/Unified Health System (SUS), that is, its trajectory. Secondly, we will present the concepts used to carry out our analysis of the processes of subjectivization, extracted from the philosophy of Deleuze and Guattari, with clarification on Cartography as a method.

Hemorrhoids are arteriovenous plexuses that surround the distal rectum and anal canal. They are present in all individuals from birth and become symptomatic when they increase in size, become inflamed, thrombosed, or prolapsed.² Thus,

hemorrhoidal disease (HD) can occur in both genders, being more common in males (2:1). This condition afflicts 4.4% of the world population. However, there is no precise data in Brazil for this problem. The main risk factors are high socioeconomic level, heredity, pregnancy, obesity, smoking, a diet rich in fats, alcohol, spices and pepper, as well as low fluid intake.³

Considering its anatomical location, HD may be classified as “internal” (anorectal submucosa above Parks ligament, and covered by mucous epithelium), “external” (below Parks ligament, and covered by modified anal canal skin) and “mixed” (internal and external extensions).⁴

Internal hemorrhoids are further classified into degrees: First degree, when bleeding occurs but without prolapse. Second degree, when prolapse occurs during defecation effort, returning spontaneously to the anal canal. Third degree, when occurs prolapse, with manual reduction; and finally, Fourth degree, when prolapse occurs, without reduction. Mixed (internal-external) hemorrhoids appear above and below the pectineal line.⁵

The diagnosis is established based on the symptomatology and on the results of a proctological examination. The most indicative symptoms are prolapse and bleeding.⁶ Therapy for HD consists of non-surgical and surgical clinical approaches. With regard to the first clinical approach, hygienic and dietary measures should be emphasized, as well

as medications that attenuate its multiple symptoms, such as burning, pain, pruritus, etc. The arsenal of non-surgical approaches includes sclerotherapy, cryotherapy, elastic ligation, and photocoagulation.⁷

Surgical treatment is needed in about 10% of the patients; this therapy is indicated for those patients whose symptoms have been shown to be refractory to conservative treatment, and for patients with a bulky hemorrhoidal disease. The goal of hemorrhoidectomy is the excision of the internal and external components of the hemorrhoidal plexuses and compromised tissues. Different surgical techniques have been described for third- and fourth-degree HD, and usually, the choice of a technique depends on the surgeon's preference. During the last century, open and closed hemorrhoidectomies were proposed by Milligan-Morgan and Ferguson, respectively, and these procedures became the most popular methods for treating this condition.⁸

The period elapsed between the surgical indication and the surgery itself varies among patients cared for in the private network and in health insurance services versus patients cared for in the public network. This interval reaches up to 4-6 months or even longer.^{9,10} The Sistema Único de Saúde (SUS), through its Primary Care Network, Family Health Strategy, or Basic Unit, provides patients' access to the general practitioner who, through a referral system, redirects the sick person to expert assessment, which will result in the indication of the best treatment for each case. SUS offers only surgical treatment by the conventional technique.

We observed that long periods elapsed between the onset of symptoms and discomforts of the hemorrhoidal disease, besides patients' complaints, until the decision in favor of a treatment that would result in improvement of these symptoms and discomforts. Thus, in order to be aware of the processes that led these patients to delay their treatment, a study was needed whose methodology was capable of analyzing the processes of subjectivization that pervade these individuals, as well as their interrelations in the plane of forces (hard, flexible, and escape lines). This methodology is Cartography, which seeks to accompany the pathways without worrying about making decals or representations, and which is totally geared toward an experimentation anchored in the real.

Cartography proposes a methodological reversion: transforming the meta-hodos into hodos-meta, that is, no longer a journey in order to reach predetermined goals (meta-hodos), but a walk that traces its goals along its course (hodos-meta). This is a method that is not to be applied, but to be experienced. Thus, even without giving up the rigor of information, the method stays closer to the movements of life. This map succeeds in mapping the micropolitical movements and in accompanying the processes of actions from minorities that occur during their journey, in an attempt to get a treatment for what is bothering them.

In this sense, this study aimed to understand the trajectory and perception of patients who underwent the conventional Milligan-Morgan surgical technique. It should be emphasized that the patient's perception about hemorrhoidectomy is still a subject not much addressed and discussed within the scope

of the Coloproctology specialty, which speaks in favor of the present reflection.

Method

This is a descriptive study with a qualitative approach, which emphasized Cartography as the main method for data production.¹¹

Based on the work of the French philosophers Gilles Deleuze and Félix Guattari,¹ Cartography is considered one of the principles of the rhizome, which is defined as a thing that is rooted, a complex system, with very diversified forms, from the ramified surface in every sense to its concretions in bulbs and tubers, having as characteristics the principles of connection and heterogeneity, multiplicity, a-significant rupture with its lines of segmentarity (hard, flexible, and escape lines), Cartography and decals. Cartography consists of monitoring processes, aiming at an interventional investigation and using an attentive recognition.¹²

Cartography is an important method to evaluate subjective and complex conditions, which aims to supply important contributions to the studies of subjectivity and to the clarification of the truths of individuals.^{11,12} As a qualitative research, Cartography seeks to interpret what individuals say about the treatment they undergo, and how they deal with it.¹³

The study was carried out at a public health unit in the municipality of Montes Claros, Minas Gerais, where basic care and medical consultations are offered, resulting in the diagnosis of hemorrhoidal disease and also in the postoperative follow-ups in a University Hospital where the surgeries were performed.

In order to select the participants, the following inclusion criteria should be met: a diagnosis of Fourth-grade hemorrhoidal disease, residing in cities in the Northern region of Minas Gerais, a hemorrhoidectomy carried out from July 2014 to January 2015, and signing of a Free and Informed Consent Term (FICT), accepting to participate in the research through individual interviews. Patients who were treated for other anorectal conditions at the same time as hemorrhoidectomy were excluded from the study.

All ethical precepts were followed, according to resolution 466/12/CNS, which deals with research involving human beings.¹⁴ The study project was submitted to the Ethics and Research Committee of the Universidade Estadual de Montes Claros and was approved by opinion 911.381/2014.

Data production was conducted between March and June 2015 in three phases.

Phase 1

This is an exploratory phase, where the individuals undergoing hemorrhoidectomy were surveyed during the period from July 2014 to January 2015. The data production was performed by consulting the registry book of the surgical suite of the hospital studied.

Phase 2

Individuals who underwent hemorrhoidectomy and who met the inclusion criteria were identified. These individuals were contacted by telephone and invited to participate in this study. At this stage, the records of hospitalization and case progress were analyzed to identify any surgical complications.

Phase 3

Detailed interviews with participants were scheduled; these interviews were guided by the guiding question: What is your perception of the surgical treatment you underwent (hemorrhoidectomy)? The interviews were recorded with the permission of the interviewees and were carried out at the Centro de Atendimento de Especialidades Tancredo Neves (CAETAN) and at the Policlínica do Alto São João.

Twelve individuals, seven men and five women, aged 25–58 years, were interviewed. The interviews were conducted in discrete and silent environments, ensuring the privacy of the interviewees and allowing the dialogs to be recorded and later transcribed in full for their analysis and interpretation, through the theoretical referential of Cartography. The speeches were transcribed and organized in the program Atlas.ti, version 6.0, allowing the codification of the themes presented, which resulted in three categories: trajectory, patients' perceptions about the hemorrhoidal disease, and their perceptions related to the surgical treatment. In the program, it was possible to gather the information obtained at times of the construction of the research field, in memorandums that enabled the description of this phase with greater detail. From then on, it was possible to elaborate the Cartography.

Results and discussion

In order to interpret the results, concepts derived from Cartography were used.¹¹ The interest in the subject studied in this article arose from more than twenty years of working in this area, together with some questions that needed answers. During the treatment of patients with hemorrhoidal disease, emerged in us the desire to become aware of the patient's perception of the disease and its treatment. In this way, we attempted to avoid the reproduction of another working model already ready for use and in consonance with the so-called "scientific" systematization of knowledge, in order to value, with this form of approach, elements such as invention and creativity.

When we decided in favor of Cartography to investigate this theme, some questions arose: How to do it? Will I be an integral part of the process? Could this model change the paths to be covered? The answers would only come with the work. Thus, we started the proposed project, making appointments for the interviews with the patients, in order to inquire them about what they could report with respect to the treatment to which they were submitted. At first, there were difficulties, since it was necessary to de-territorialize the doctor's position and to re-territorialize the cartographer's; and at that moment, there were the questions and the way of doing them.¹⁵

Twelve interviews, one at a time, were conducted; and in this process, re-territorialization was possible. The processes of subjectivization were crossed by the segmentation lines and, in an attentive and quiet way, the patients reported their impressions about the disease and its treatment. The speeches of these patients coursed similar but not identical paths, revealing details of each individual. Doubts arose as to whether cartographic clues were adequately followed, certainly because of the inexperience in this first work as a cartographer.¹⁶

In this study, the concepts used in the analysis of the perception and trajectory of patients submitted to hemorrhoidectomy are the following: subjectivity – here understood as multiplicity, and collective – that is, in connection with the world, the forms of composing with life.¹⁷ The process of subjectivization points to three types of lines that make up our relations: those of hard segmentarity, which are characteristic of the molar sets (strata), for instance, social and gender classes; those of malleable segmentarity (flexible) characterized by molecular relationships (de-stratification), and escape lines, that are characterized by a rupture with strata (absolute de-stratification). Hard lines stipulate dualities, for example, rich-poor; boss-worker; married-single, etc.; the malleable lines show greater fluidity and rhizomatic functioning, related to multiplicity and connectivity – points that intercommunicate by tracing new lines; there are no axes or centers where events destroy stratifications and form new flows.¹⁸

The micropolitics¹⁹ is compared to the telescope, an optical instrument that is able to see the movements, not being allowed to be codified by dual systems; escape lines are lines of rupture – which produce abrupt but often imperceptible changes, not being over-coded. These are lines that are sometimes invented. The three lines mix constantly. The term "immanence" is described as a marginal outpouring that traverses nomadic, invented paths; it is the encounter between desire and thought and, in this way, values the experimental plane. Transcendence is the way of thinking of the traditional, hierarchical, stratified, representative philosophy.²⁰ After a judicious and careful reading, we proceeded with the analysis of the discourses, thus identifying the three categories that emerged after the interpretation of these discourses by the researcher.

Perception of individuals about hemorrhoidal disease

Transcendental thinking

In the analysis of the discourses, one notices what Deleuze and Guattari called "transcendent thinking" in relation to the disease, where one already has a knowledge about the disease, when the participants informed that it is a very common problem among people, which occurs in a chronic way, in crises, without major risks and, therefore, the treatment does not require a greater rigor.²⁰

Hard (molar) lines

One also perceives a molar condition that is crossed by hard lines, for example, the fact of getting accustomed to the symptoms, accepting the disease as a natural consequence due to work, consumption of certain foods or drinks, self-medication, and hearing opinions of friends and relatives about

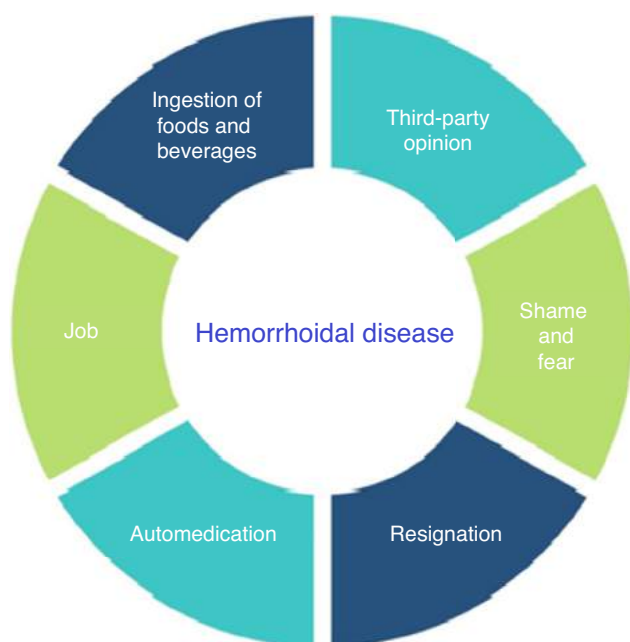


Fig. 1 – Hard lines.



Fig. 2 – Flexible lines.

empirical treatments, which makes it difficult to carry out an event or affectation that can change the flow of these hard lines to flexible or escape lines.^{21,22}

“A long time ago, when I worked in the Central – the rail network – I used to lift big loads there. Thus, with all my time worked, and the sun, dust, weight... I began to feel that I was exposing my hemorrhoids, sometimes with bleeding” (E7)

Self-medication is also demonstrated as a hard line in the speech:

“People spoke of this babosa thing; I used it, on the advice of my aunts; Home remedies, I used a lot; but they did not solve the problem. “(E8)”Homemade medicine that we use from time to time, they used to relieve what I felt.” (E7)

Other flows interpreted as hard lines have also been observed; these flows hindered the emergence of creative and inventive thinking, thus making it impossible to break the cycle of suffering from the disease; for example, the fact of this being an intimate place, I felt shame and fear²² (Fig. 1).

“Regarding the hemorrhoid problem, this is a rather complex place, because it is too intimate a place; thus, we ended up postponing the visit to the doctor. We started to notice a local bleeding and then we started to see a bulge in the place, but, out of shame, and because it is an intimate place, we end up pushing the problem.” (E12)

Flexible (molecular) lines

Just as the factors – getting used to illness, third-party opinions, self-medication, shame, and fear – here identified as hard lines for stratifying and coding patients, these same factors – in the face of disease progression – are understood as affectation and potentiate an event that changes the direction of the flow of forces. Then, flexible lines emerge which translate into

a desire to seek a more effective treatment and, at this time, the individual makes up his/her mind by seeking for a health professional. In this sense, hard lines are not necessarily bad – as long as there is no fixation in its flow²³ (Fig. 2).

“There came a moment when I really needed to go to the doctor to try to ease my situation. That’s when I went to the health clinic.” (E12)

In another speech, one perceives the onset of an affectation, potentiating a flow of forces and transforming the hard lines into flexible ones, which aim at reaching a plane of immanence, making it possible to experience the pleasures of life²³ (Fig. 3).

“If I took a walk [I always like to walk in the afternoon], when I pushed hard, I felt uncomfortable, bleeding, and in great pain. So that was the reason that led me to do the treatment.” (E7)

Trajectory and escape lines

All patients participating in this study were treated by the Sistema Único de Saúde, a public system that guarantees health as everyone’s right and a duty of the State, and whose principles are universality and integrality in the provision of health services. In the analysis of the speeches, we realized that long periods had to pass so that the individual could be effectively treated. Thus, the patients had a fragmented²⁴ and stratified therapy, with the observation of molar and transcendent traces, and hard lines that cross all levels normalized by SUS. As a result, patients lost focus on the treatment and cure of the disease.^{20,21} This hegemonic model, based on molarity and stratified and binary transcendence, and which values dead labor versus live work in the act, does not admit to being affected by more creative forms. Thus, this model becomes



Fig. 3 – Perception of the patient about hemorrhoidal disease.

a limiting cause for achieving a plan of immanence, freeing patients from disease and decreasing its potency.^{19,20}

The trajectory runs through several levels, depending on the interviewees’ speeches, beginning at the level of Primary Care with the medical consultation in the PSF; referral to the secondary level with the opinion of the specialist and carrying out laboratory examinations; and, finally, at the tertiary level, which is the hospital where the treatment with the surgery is completed. Notwithstanding this structuring of the SUS, this situation reminds us once again of the hard lines and of the transcendence plane, so that there is a delay in treatment of several months and even years.^{21,23}

“It took me three years to operate, to get to operate.” (E4)”

“It took a while, that took some time indeed, even after the doctor asked for the surgery, it took about 4 years.” (E6)

In some patients’ speeches, we found the presence of a micropolitics, where the speeches given with each other in the corridors and in the waiting room of the consultation office aimed at the exchange of information about the disease that were affecting them, considering that each patient sought for a solution, thus promoting ruptures, that is, escape lines, which allowed a de-territorialization and the emergence of events that shortened the paths to the dreamed solution of the problem, which imprisons them in the transcendent plane.^{19,21}

“Luckily I knew the girl from the Block, and she sent me to look for the girl from the reception, because I had already gone there a lot of times and had not gotten anything.” (E2)

“Since then, I’ve been waiting for someone’s quitting at the Alto São João polyclinic. Then, hopefully, I could do it.” (E5)

Trajectory



Fig. 4 – Trajectory of patients submitted to hemorrhoidectomy.

“I was lucky because it seems that some person was quitting the procedure; thus, they sent me over, in the place of that person.” (E9)

These speeches demonstrate some of the molecular shifts used to break the hierarchical strata constituted by the health system. Fig. 4 exemplifies how the individuals’ usual trajectory is through the various normative strata of the public health system.

Perceptions related to surgical treatment

The surgical treatment performed in the patients was conventional, that is, an open hemorrhoidectomy with local anesthesia and sedation. This procedure was performed at the University Hospital, but with outpatient surgery characteristics. After surgery, the patient remained under observation for a few hours and was then discharged, followed by outpatient follow-up. From the speeches transcribed, there is agreement that the results were satisfactory.

It was observed that with the completion of the surgery and the success of the results, all patients were affected and crossed by an increase in potency, thus allowing them to come closer to a plane of immanence that made them able to live their lives. All patients reported that the pain after surgery is rewarded for the certainty of cure and problem solving and

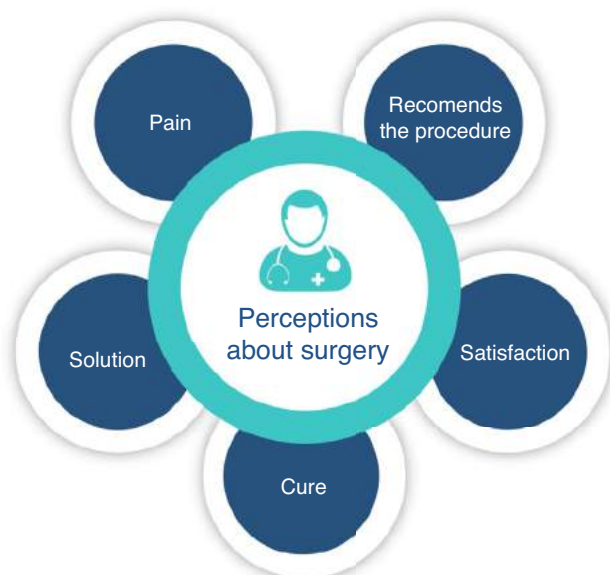


Fig. 5 – Perceptions of the patient about hemorrhoidectomy.

recommend the treatment. It was also observed that, through micropolitics at all levels covered in the health system, this treatment will be announced, and an increasing number of people will have access to it.^{19,20}

“I did the surgery [...] it’s cool, in a sense neither a problem. There was nothing else. I’m feeling good! There is no problem at all! Ahhh, this treatment is the salvation of who has, had my problem. To all who have this problem that I have, that I had, this is the solution, right?! It is the only resource that someone has, is this surgery.” (E8)

“Yes! Today I do not feel anything anymore! And I evacuate normally! I no longer have the symptoms of itching and it does not bother me anymore, until my sexual relationship; it changed, improved too... because when we were, when I had the symptoms, it bothered me, I was insecure with my partner. I’m married, but today, thank God, everything is fine.” (E10)

It was then realized that the processes of subjectivization that emerged with the surgical treatment were crossed by hard and escape lines, allowing a high degree of satisfaction to be obtained with the solution of the problem. Fig. 5 summarizes these processes.

Conclusion

This study comprised the trajectory and processes of subjectivization of individuals submitted to surgical treatment for hemorrhoidal disease, anchored in the cartographic approach, according to the epistemological and philosophical hypotheses of Gilles Deleuze and Félix Guattari. This methodology allowed us to follow the paths taken by patients in the SUS network, with the discovery of the emergence of hard lines that cross this trajectory, being these lines responsible, at least in part, for the long periods in which the patients remained

suffering from their uncomfortable symptoms, without obtaining the surgical treatment. Obstacles occurred at all levels of the network: primary, secondary and tertiary ones. Other hard lines have also been observed that contributed to the patients’ delay in deciding in favor of surgery, such as shame and fear, and the perception that hemorrhoidal disease is a very common and benign condition, with a low risk for serious complications.

Through micropolitics, molecular relations, and escape lines, the interviewees were able to obtain the treatment they considered as curative and, despite the postoperative discomfort (mainly pain), the results were considered rewarding, thus potentiating the flow of forces and transforming the transcendent trajectory into a plane of immanence with a high degree of satisfaction in function of the results obtained, therefore speaking in favor of the surgical treatment. Due to the involvement of complex issues, such as perceived subjectivization processes, the surgical treatment of hemorrhoidal disease depends on a more flexible and rhizomatic approach on the part of public health system administrators, so as to take into account the multiple ways of access to this treatment by the patients, without the stratifications perceived in its various levels.

Conflicts of interest

The authors declare no conflicts of interest.

REFERENCES

1. Deleuze G, Guattari F. Introdução: Rizoma. In: Deleuze G, Guattari F, editors. *Mil platôs: capitalismo e esquizofrenia*. Rio de Janeiro: Editora; 1995. p. 10–36.
2. Halverson A. Hemorrhoids. *Clin Colon Rectal Surg*. 2007;20:77–85.
3. Costa LMP, Silva TB. Doença hemorroidária: incidência, etiopatogenia e aspectos clínicos. In: Campos FGCM, Regadas FSP, Pinho M, editors. *Tratado de coloproctologia*. São Paulo: Atheneu; 2012. p. 53, 749.
4. Misra MC, Imlitem U. Drug treatment of haemorrhoids. *Drugs*. 2005;65:81–91.
5. Greenberg R, Karin E, Avital S, Skornick Y, Werbin N. First 100 cases with Doppler-guided hemorrhoidal artery ligation. *Dis Colon Rectum*. 2006;49:485–9.
6. Bleday R, Breen E. Treatment of hemorrhoids. Waltham (MA): UpToDate; 2015. Available at: <http://www.uptodate.com/contents/treatment-of-hemorrhoids>. Access 15 Sep 2015.
7. Breen E, Bleday R. Anal abscesses and fistulas. Waltham (MA): UpToDate; 2009.
8. American Gastroenterological Association. American gastroenterological association medical position statement: diagnosis and care of patients with anal fissure. *Gastroenterology*. 2003;124:233–4.
9. Carvalho TC, Gianini RJ. Equidade no tempo de espera para determinadas cirurgias eletivas segundo o tipo de hospital em Sorocaba, SP. *Rev Bras Epidemiol*. 2008;11:473–83.
10. Ribeiro ML, Cunha MI. Trajetórias da docência universitária em um programa de pós-graduação em saúde coletiva. *Interface – Comun Sau, Educ*. 2010;14:55–8.

11. Martines WRV, Machado AL, Colvero LA. A cartografia como inovação metodológica na pesquisa em saúde. *Tempus – Actas de Sau colet.* 2013;7:203–11.
12. Romagnoli RC. A cartografia e a relação pesquisa e vida. *Psicol Social.* 2009;21:166–73.
13. Turato ER. *Tratado da Metodologia da Pesquisa Clínico-Qualitativa.* Petrópolis: Vozes; 2013.
14. Brasil. Conselho Nacional De Saúde. Resolução no 466, de 12 de dezembro de 2012. Brasília: Trata de pesquisa em seres humanos; 2012.
15. Haesbaert R, Bruce G. A desterritorialização na obra de Deleuze e Guattari. *GEOgraphia.* 2002;4:7–22.
16. Kastrup V, Escóssia L. *Pistas do método da cartografia: pesquisa-intervenção e produção de subjetividade.* Porto Alegre: Sulina; 2012. p. 52–75.
17. Peres RS, Borsonelo EC, Peres WS. A esquizoanálise e a produção da subjetividade: considerações práticas e teóricas. *Psicol em estudo.* 2000;5:35–43.
18. Ferreira FT. Rizoma: um método para as redes. RJ: Liinc em revista; 2008. p. 28–40.
19. Merhy EE. *Cadernos de Saúde Pública.* RJ. 2009;25:898–906.
20. Fuganti LA. *Saúde, desejo e pensamento, Saúde Loucura.* São Paulo: Hucitec; 1990. p. 19–82.
21. Schopke R. O pensamento como ultrapassamento da razão clássica. In: Schopke R, editor. *Por uma filosofia da diferença: Gilles Deleuze, o pensador nômade.* Rio de Janeiro/São Paulo: Contraponto/EDUSP; 2004. p. 19–42.
22. Paulon SM, Romagnoli RC. Pesquisa intervenção e cartografia: melindres e meandros metodológicos. *Estudos Pesquisas Psicolog.* 2010;10:85–102.
23. Cassiano M, Furlan R. O processo de subjetivação segundo a esquizoanálise. *Psicol Soc.* 2013;25:372–8.
24. Mendes EV. *As redes de atenção a saúde.* 2 ed. Brasília: Organização Pan-Americana da Saúde; 2011.