BSCRS 21st Post-Graduate Course

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Obstructive defecation

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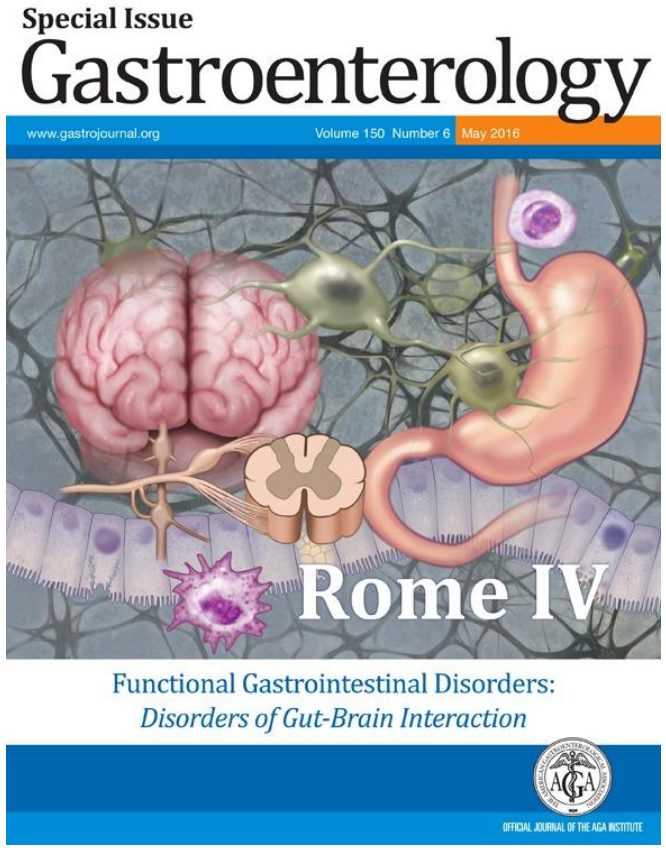
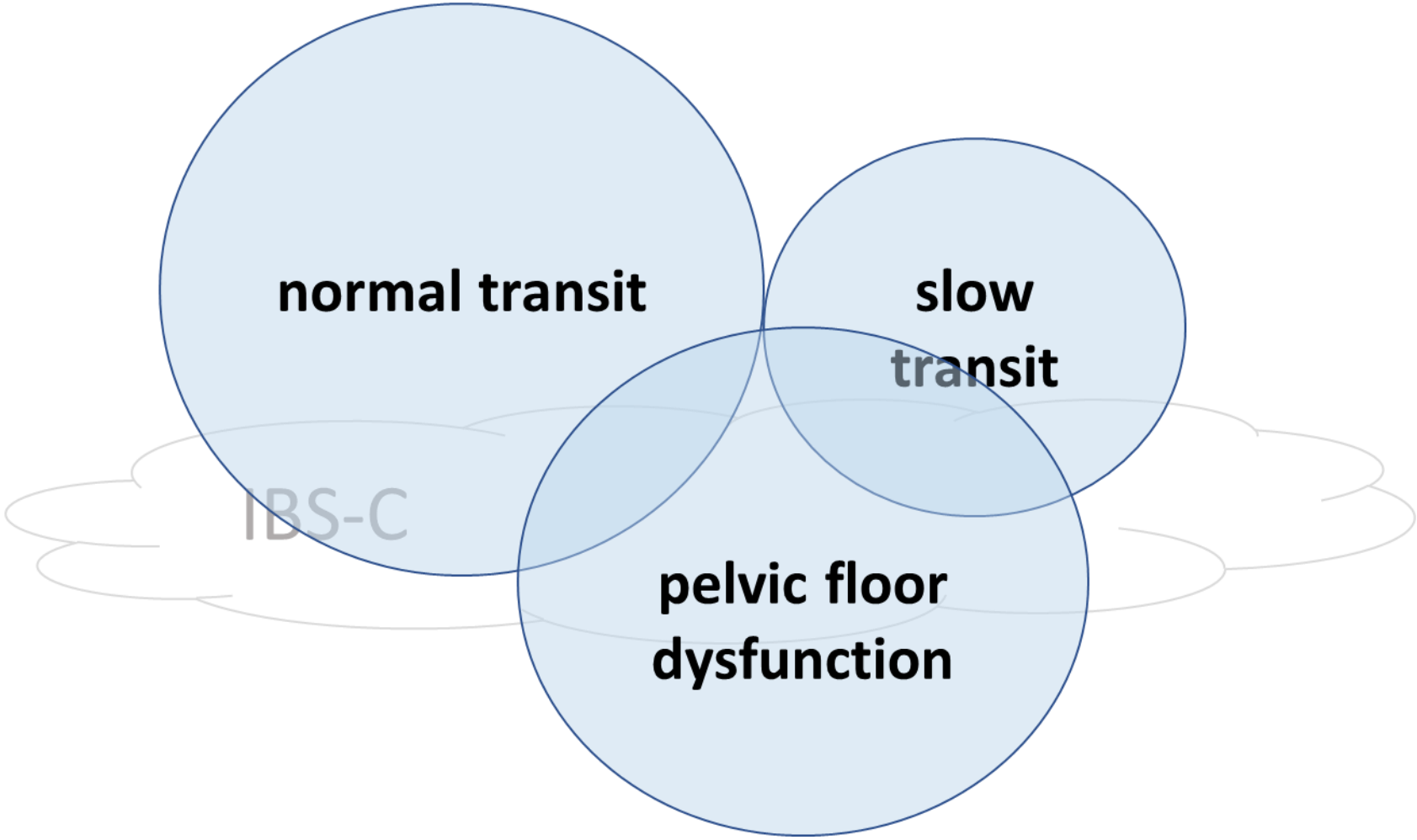
Rome IV criteria functional constipation

1. Must include two or more of the following:
    1. Straining during more than ¼ defecations
    2. Lumpy or hard stools (Bristol Stool Form Scale 1-2) more than ¼ defecations
    3. Sensation of incomplete evacuation more than ¼ defecations
    4. Sensation of anorectal obstruction/blockage more than ¼ defecations
    5. Manual maneuvers to facilitate more than ¼ defecations (e.g., digital evacuation, support of the pelvic floor)
    6. Fewer than three SBM per week
2. Loose stools are rarely present without the use of laxatives
3. Insufficient criteria for irritable bowel syndrome

Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis



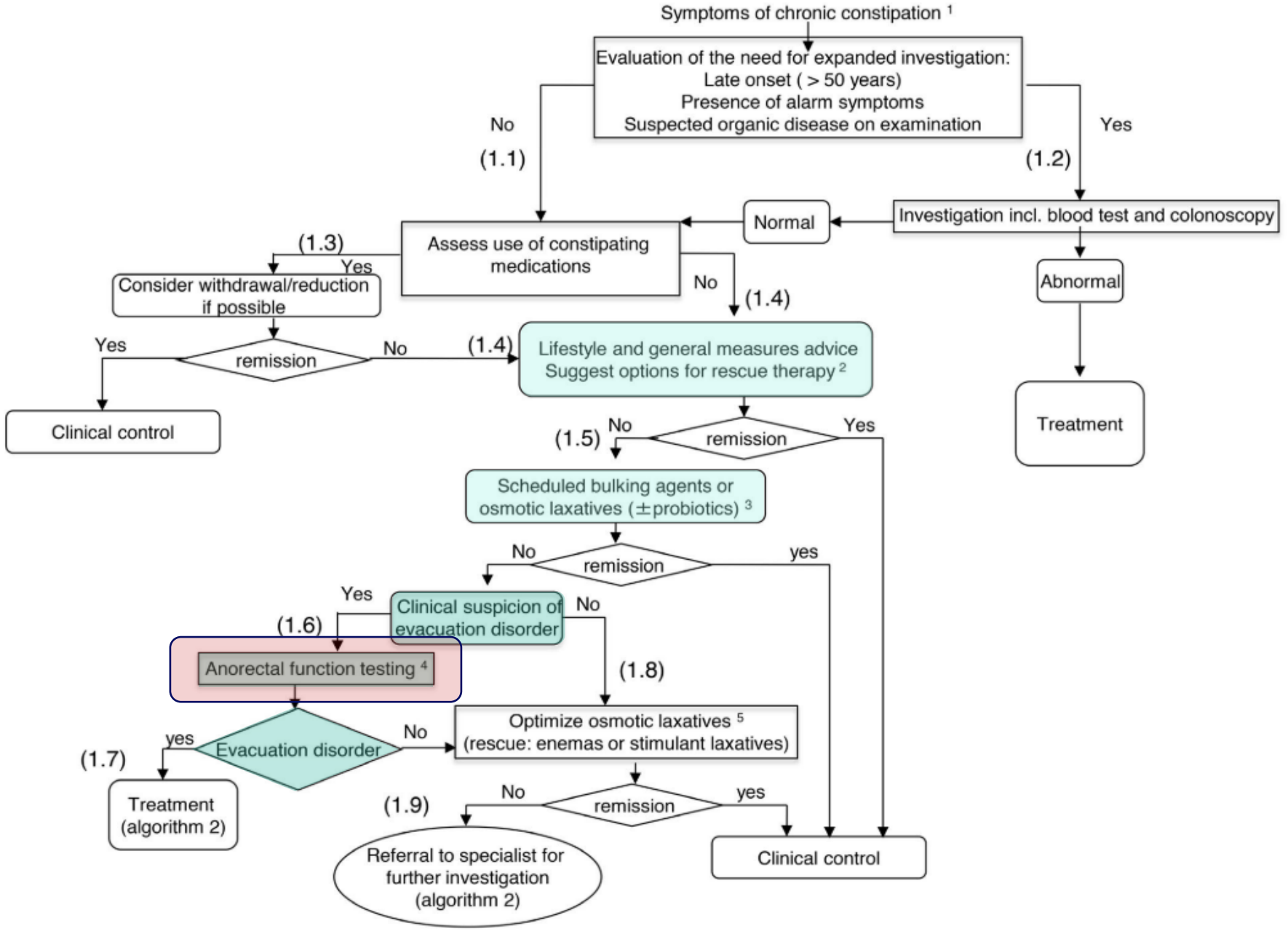
Constipation subtypes



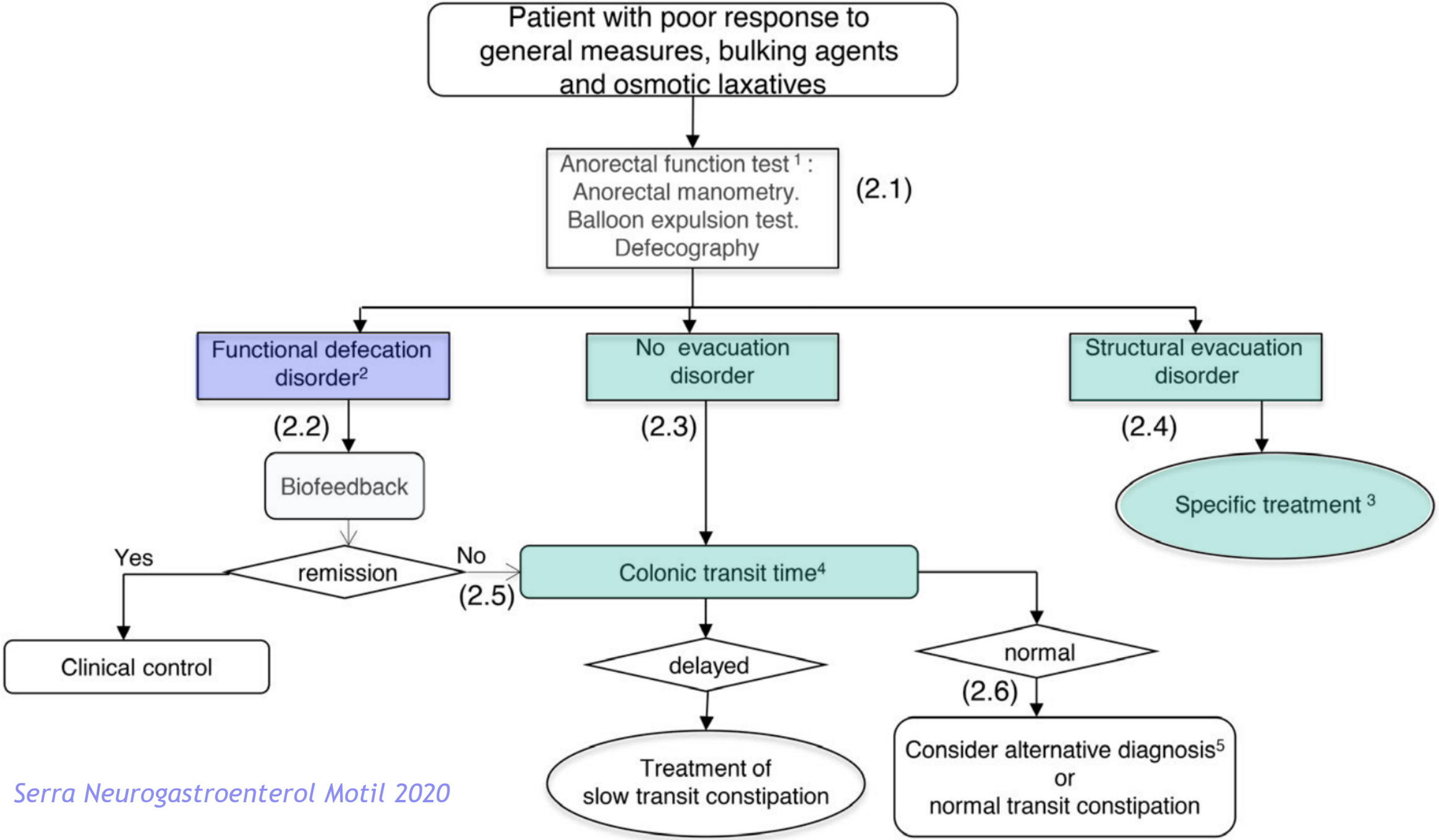
Constipation subtypes

- Obstructive defecation, defecatory disorder, dyschezia
  - Primary: anismus, pelvic floor dyssynergia, dyssynergic defecation
  - Secundary: proctological problems, tumor,…
  - “Mixed”: posterior compartment prolaps,..

Functional or structural evacuation disorder



Serra Neurogastroenterol Motil 2020



Serra Neurogastroenterol Motil 2020

ODS Case 1
“how low can you go”

Let’s go →

Case 1, 43y old female

History

- Medical history
  - Migraine
  - Guillain-Barre syndrome (recovered)
  - Appendectomy
  - Obesity
  - Obstetric: G2P2 (episiotomy, rupture vaginal wall)
- Medication
  - Bilastine, montelukast, semaglutide

Case 1, 43y old female

History

- Constipation and bloating, incomplete evacuation, straining
- Prolapse sensation
- Stress urinary incontinence

Clinical examination

- Cystocoele grade 2, laxity posterior wall, rectocele pocket
- Bilateral levator avulsion with significant ballooning

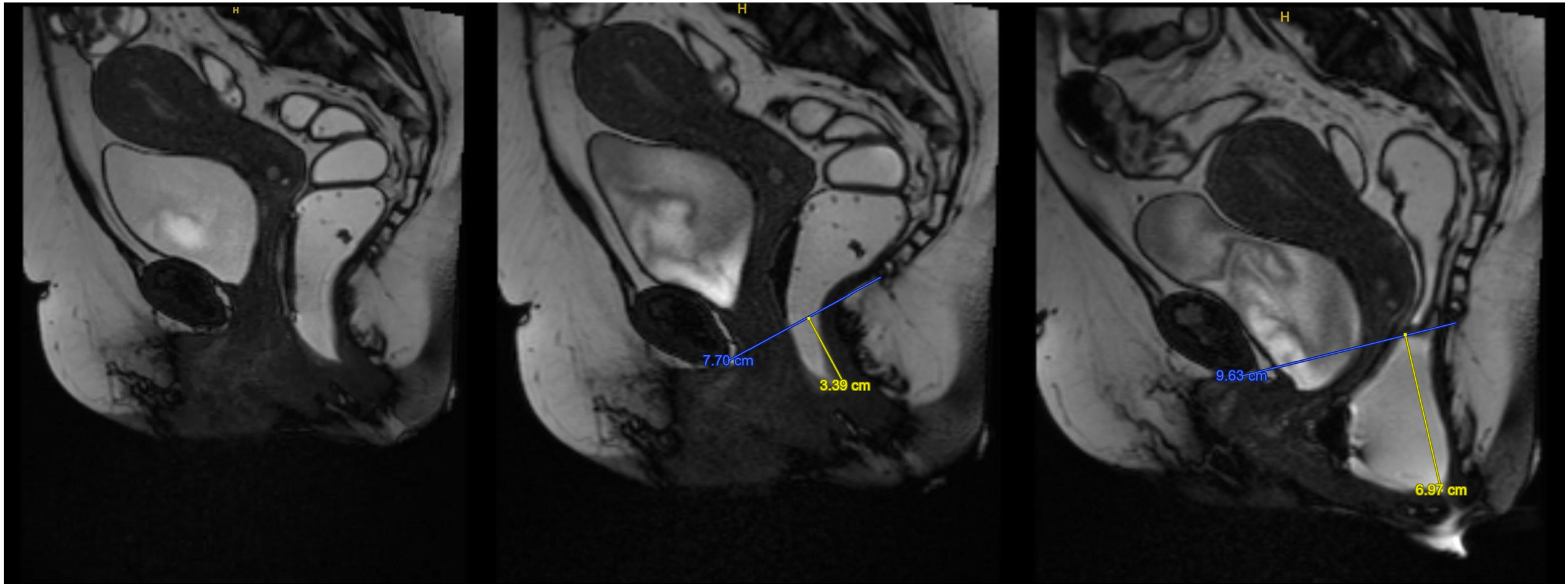
Case 1, 43y old female

Anorectal manometry

- Normal resting pressure, normal contraction
- Paradoxical contraction during straining
- Balloon expulsion failed
- Normal rectal sensibility

Case 1, 43y old female

MRI defecography



What would you do?

1. Straight to surgery, rectopexy is the solution
2. Straight to surgery, colporaphy posterior is the solution
3. Straight to the PF physiotherapist
4. Start enema therapy

Case 1, 43y old female

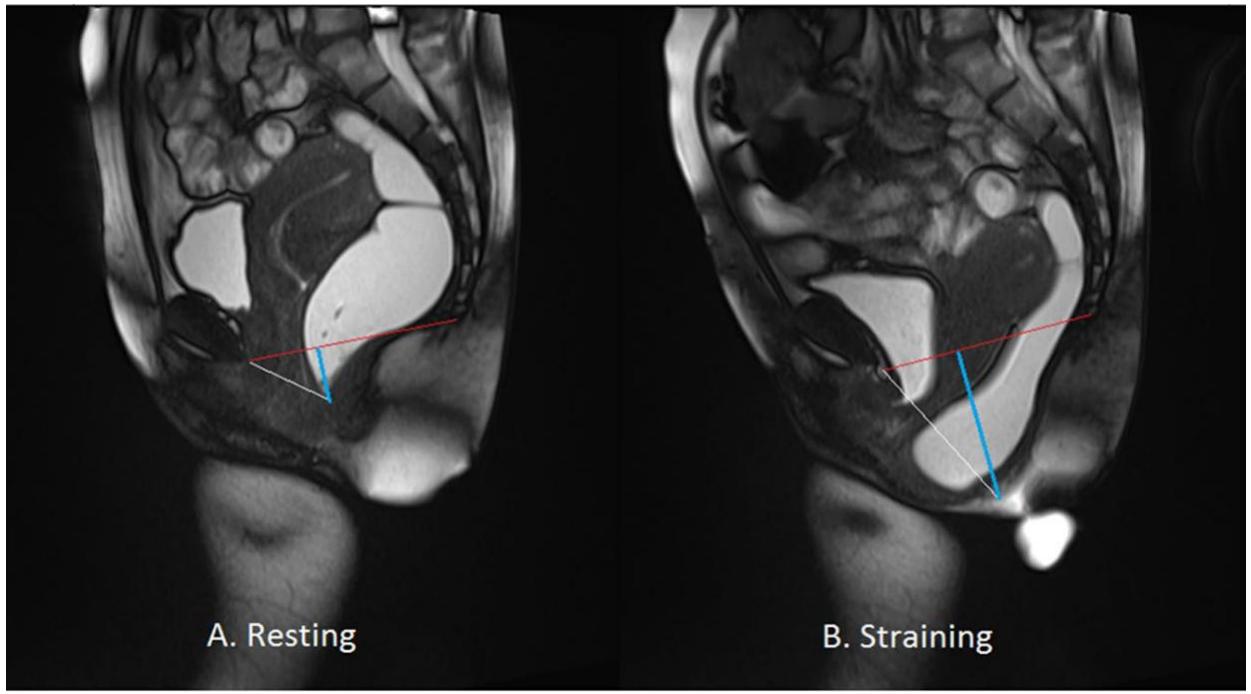
What we did

- MDT 1: physiotherapy first (biofeedback, support techniques)
  - After 4 sessions straining pattern much improved
  - Incomplete evacuation and prolapse sensation persist

- MDT2: POP surgery indicated, colporraphy anterior and posterior was chosen
  - Shared decision making: surgery will probably not relieve all symptoms

« Descending perineum » syndrome

- Caudal movement of the anorectum >4 cm below the pubococcygeal line
- Neuropathic damage (risk of anal incontinence)
- Difficult to treat



Descending perineum syndrome in constipation

	DPS	Other constipation	*p* value
Total (*N*)	23	277	
Female (*N*, %)	23 (100%)	223 (80.5%)	0.02
Age (years) (mean, 95% CI)	50.2 (43.4–57.0)	41.7 (39.7–43.7)	0.03
BMI (kg/m^2) (mean, 95% CI)	22.1 (20.0–24.3)	22.9 (22.3–23.6)	0.34
Ehlers-Danlos syndrome (*N*, %)	5 (21.7%)	7 (2.5%)	0.0009
Obstetrics history			
Percent who had at least one delivery (*N*, %)	17 (77%)	85 (41.5%)	0.0015
Percent who had at least one vaginal delivery (*N*, %)	16 (84.2%)	64 (31.4%)	<0.001
Percent who had at least one traumatic vaginal delivery[a] (*N*, %)	5 (26.3%)	23 (11.3%)	0.071
Average number of births			0.0006
(mean, 95% CI)	2.24 (1.72–2.75)	0.94 (0.78–1.10)	
(median, IQR)	2 (1.5–3)	0 (0–2)	
Hysterectomy (*N*, %)	8 (42.1%)	27 (16.2%)	0.012

	DPS constipation	Non-DPS constipation	*p* value
N	20	275	
Anorectal manometry			
Maximum pressure at rest (mmHg)	83.2 (69.60–96.80)	95.0 (91.4–98.7)	0.051
Maximum pressure with squeeze (mmHg)	138.8 (106.9–170.7)	174.5(165.9–183.1)	0.0006
Volume to first rectal sensation (mL)	41.67 (28.86–54.5)	37.03 (33.7–40.4)	0.53
Volume to rectal urge sensation (mL)	93.33 (67.75–118.9)	71.9 (65.2–78.6)	0.27
Volume to rectal discomfort sensation (mL)	154.12 (119.5–88.7)	111.3 (102.4–120.2)	0.075
Digital rectal examination			
Estimated mean pelvic floor descent (cm)	3.38	2.15	0.0023
Puborectalis tenderness (%)	13.4	34.6	0.038
Increased resting anal sphincter tone (%)	8.7	31.6	0.03
Paradoxical contraction (%)	22.7	50.8	0.014

- Treatment:
  - Manual perineal support
  - PF physiotherapy (succes rate 30-50%)
  - Surgery for associated prolaps (but usually not sufficient, no long term data)

ODS case 2
“duck”

Let’s go →

Case 2, 50y old female

History

- Medical history
  - ERCP for choledocholithiasis
  - Abdominoplasty
  - Obstetric: G2P2A0, episiotomy with ventouse extraction

- Medication
  - Mometasone

Case 2, 50y old female

History

- Mixed urinary incontinence, dominant symptom for patient
- Obstructive defecation, straining ++, incomplete evacuation, need for vaginal support during evacuation (splinting)
- Laxatives lead to bloating and discomfort

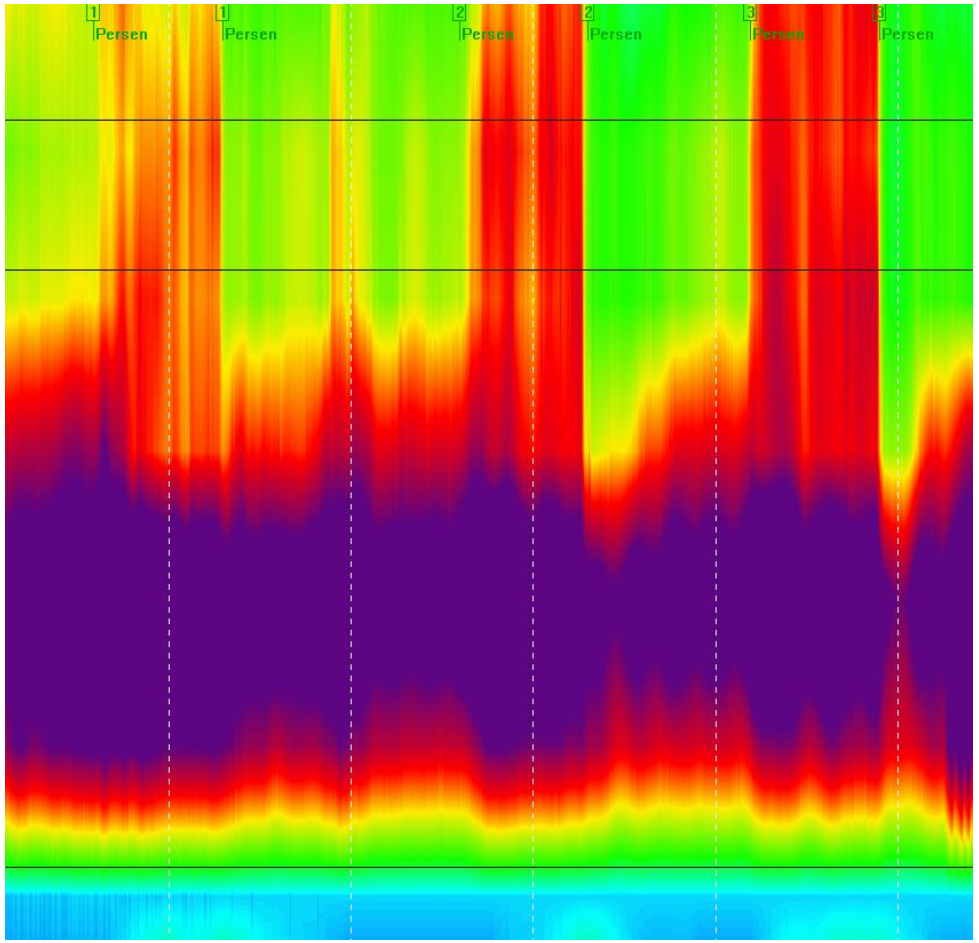
Clinical examination

- No descending perineum
- Paradoxical straining pattern
- Cystocoele and rectocoele grade 2

Case 2, 50y old female

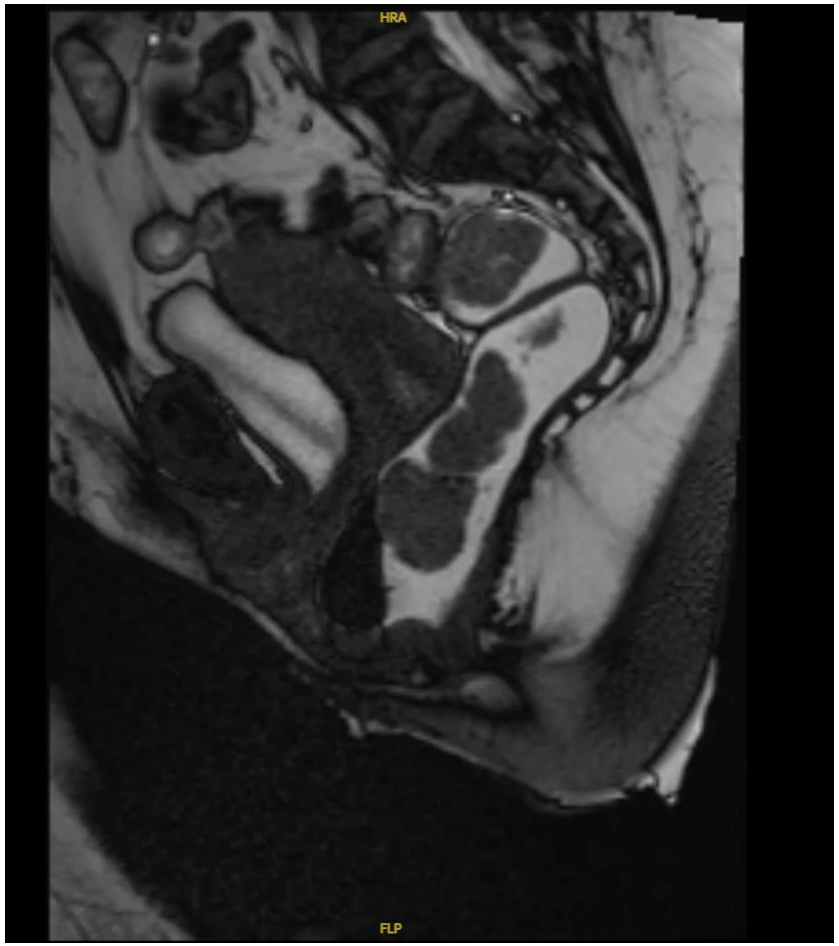
Anorectal manometry

- Normal resting pressure, weak active contraction
- Paradoxical contraction during straining
- Balloon expulsion succesfull
- Normal rectal sensation



Case 2, 50y old female

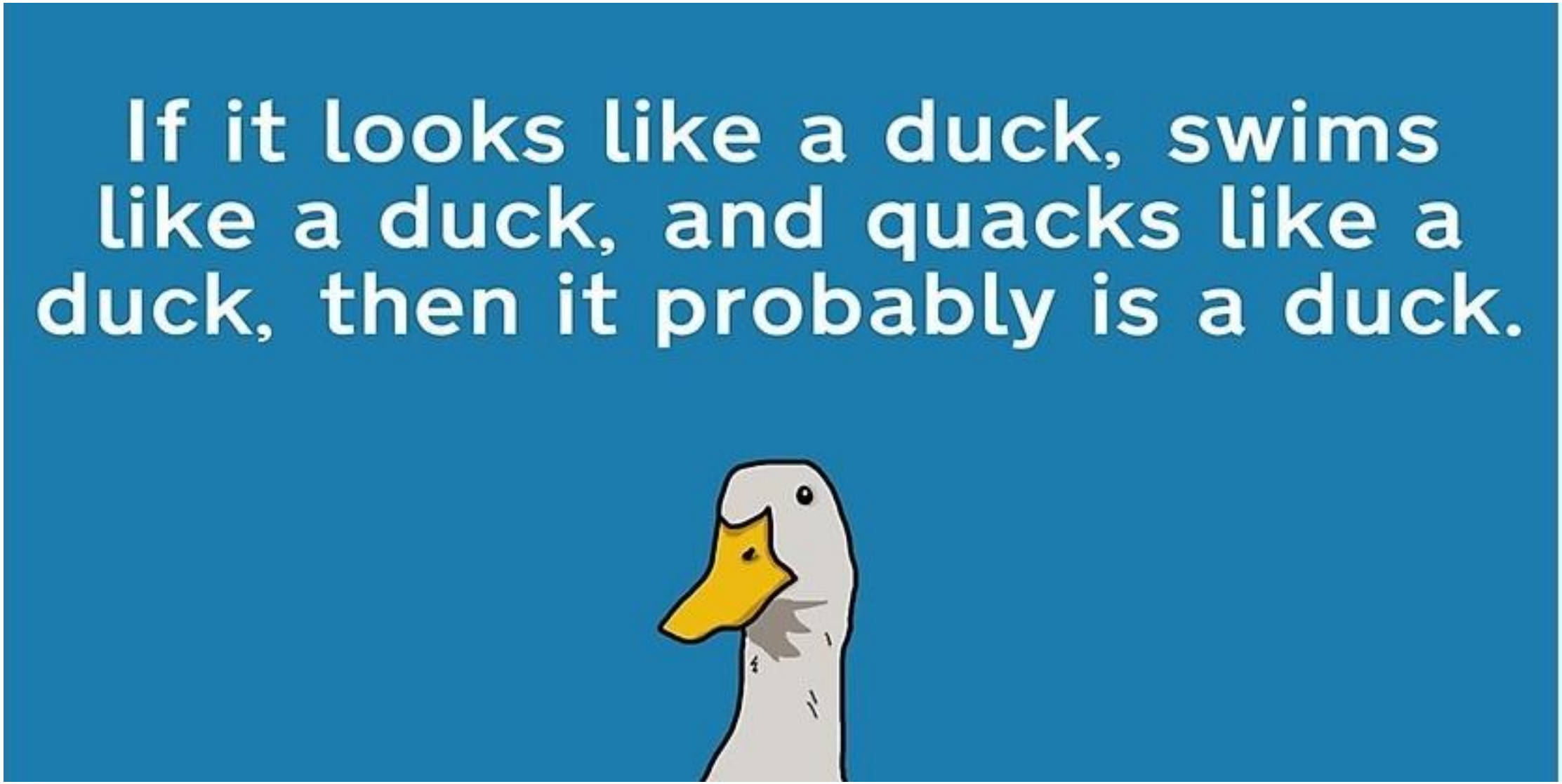
MRI defecography



What would you do?

1. Straight to surgery, rectopexy is the solution
2. Straight to surgery, colporraphy posterior is the solution
3. Straight to surgery, fix UI by colporraphy anterior
4. Straight to the PF physiotherapist
5. Start enema therapy

Case 2, 50y old female



ODS case 3
“a pain in the ass”

Let’s go →

Case 3, 65y old female

History

- Medical history
  - Chronic fatigue syndrome
  - TIA
  - Obstetric: G2P2A0, uncomplicated

- Medication
  - Zolpidem
  - Asaflow

Case 3, 65y old female

History

- Obstructive defecation, Bristol 1-2, fragmentation, periods of diarrhea with fecal soiling
- Abdominal pain and bloating, partial improvement after defecation
- Urinary urge incontinence

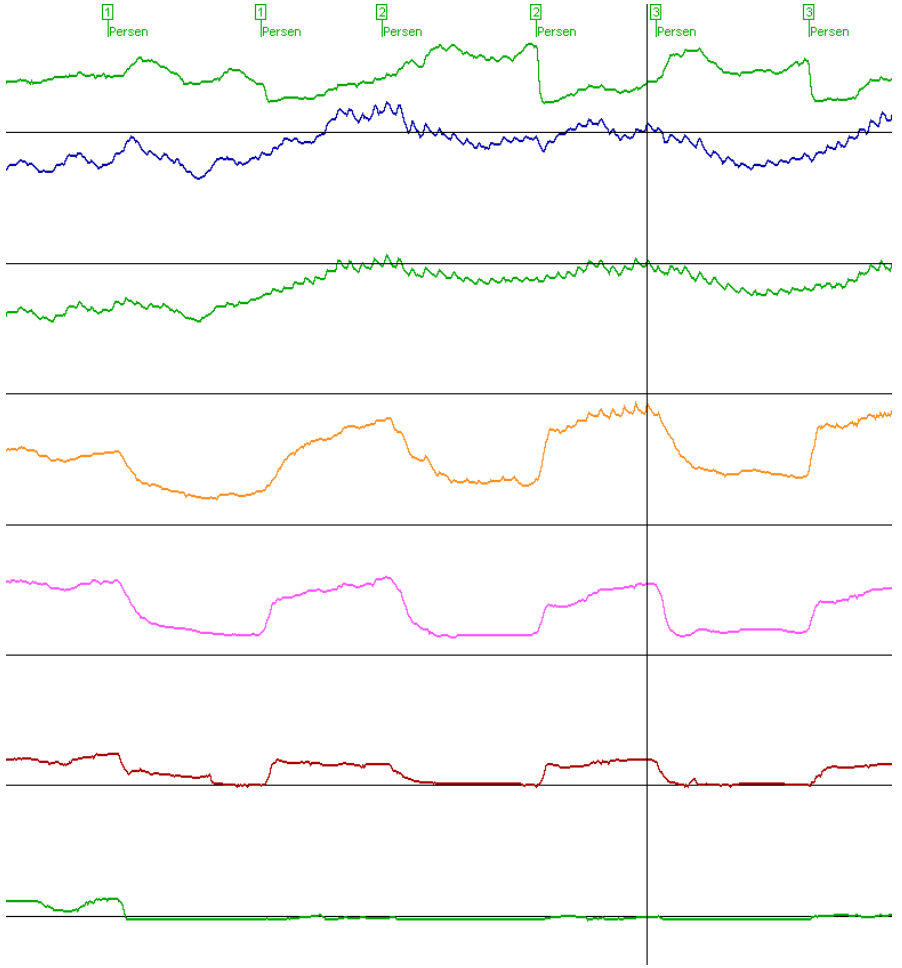
Clinical examination

- Hard stools in rectum
- Normal sfincter function
- After biofeedback perfect relaxation of sphincter and levator

Case 3, 65y old female

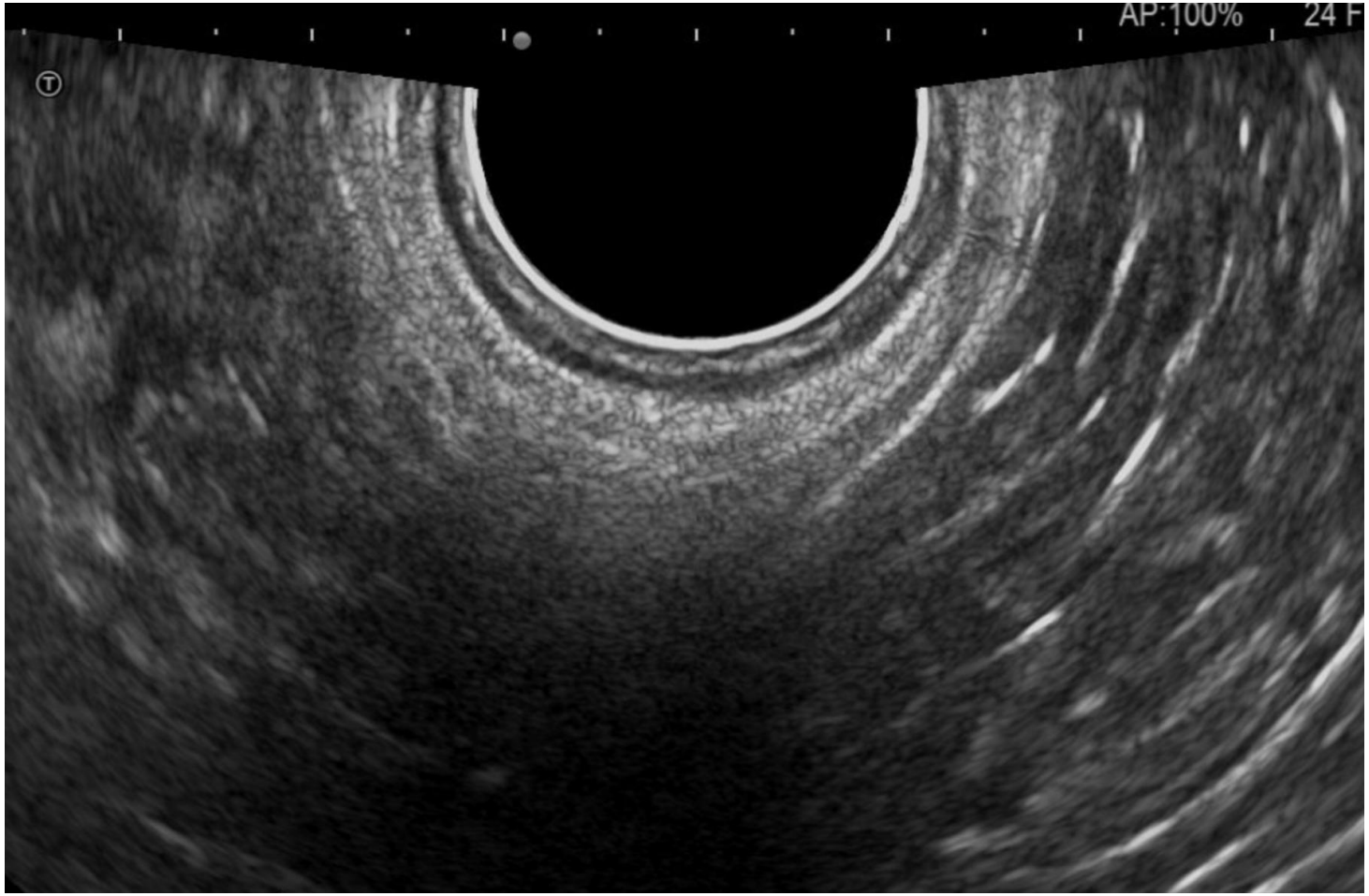
Anorectal manometry

- Low resting pressure, moderate active contraction
- Normal relaxation during straining
- Balloon expulsion succesfull
- Rectal hypersensitivity!



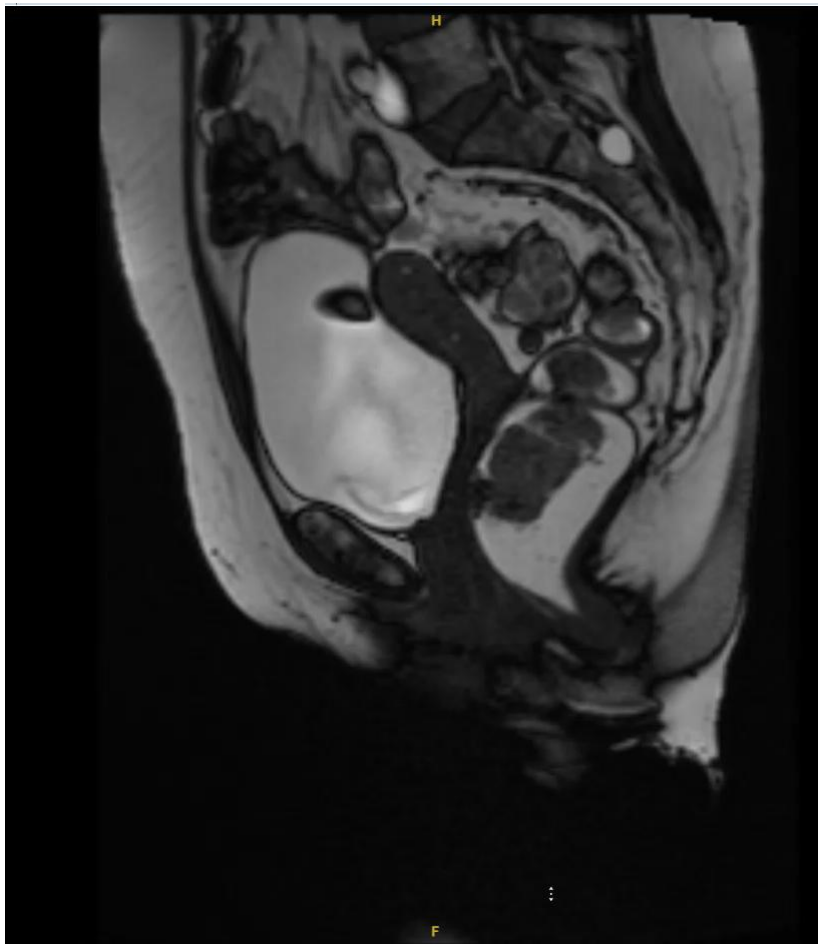
Case 3, 65y old female

Transrectal ultrasound



Case 3, 65y old female

MRI defecography

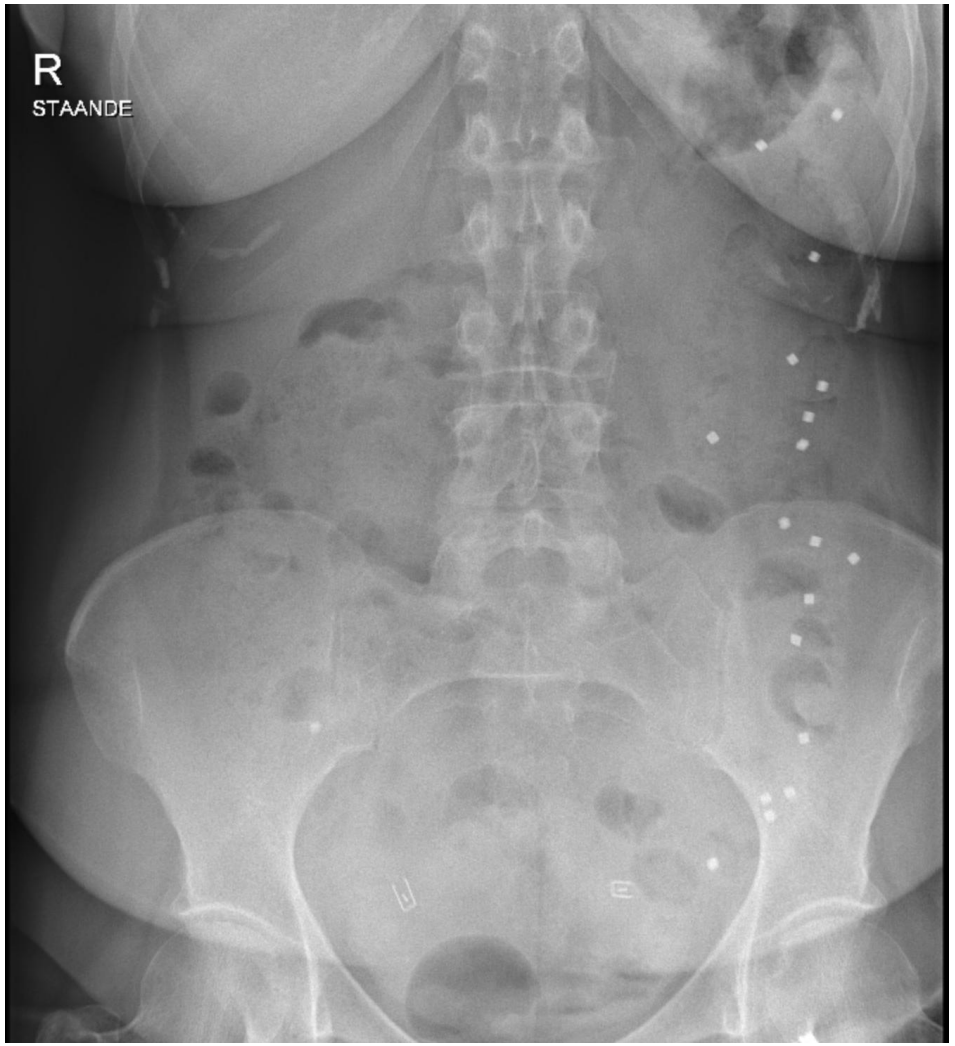


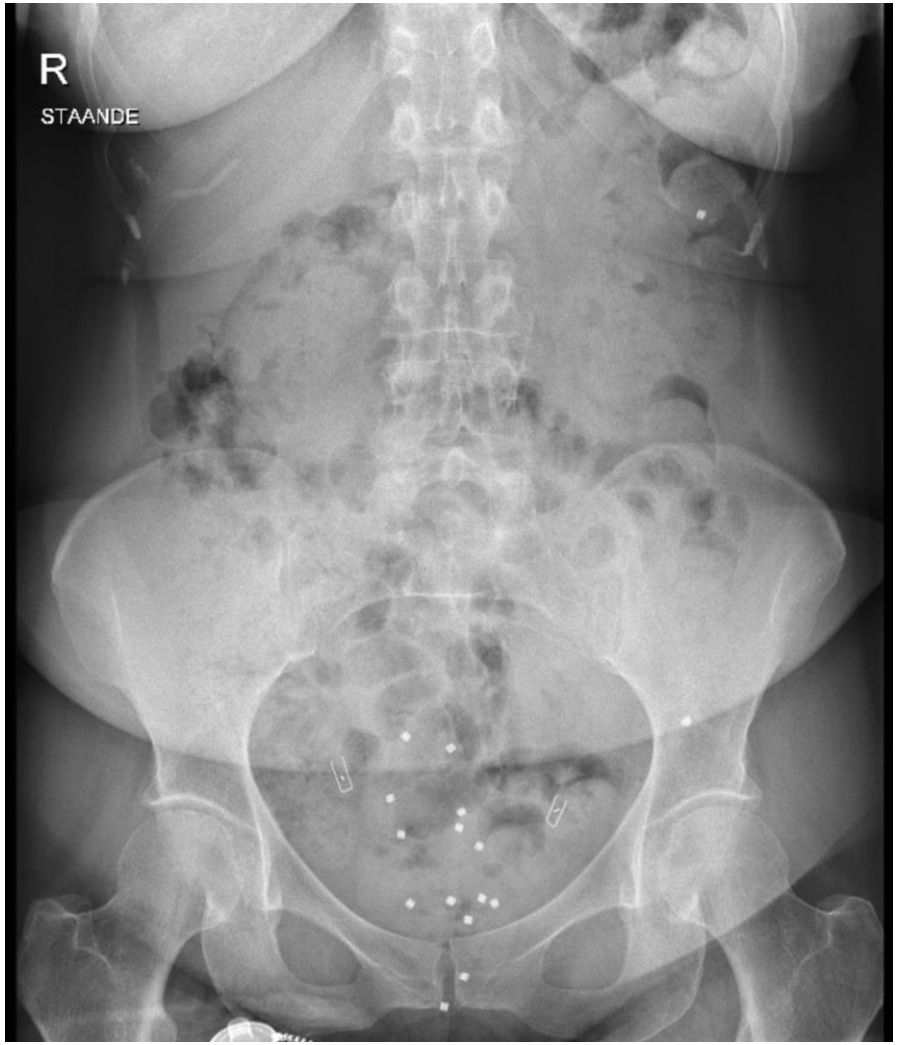
What would you do?

1. Straight to surgery, rectopexy is the solution
2. Straight to surgery, colporraphy posterior is the solution
3. Start enema therapy
4. Other examinations are needed

Case 3, 65y old female

Colon marker transit examination





Case 2, 50y old female

What we did

- MDT
  - Functional evacuation is ok
  - POP posterior not dominant
  - Abdominal pain and bloating in the picture: IBS-C with slow transit

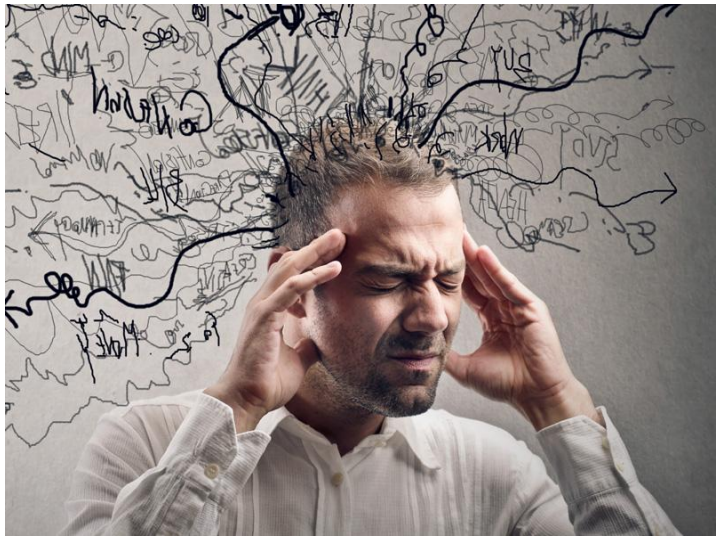
- Advice
  - No posterior POP surgery
  - Linaclotide and duloxetine to treat IBS-C
  - Enema therapy to support evacuation
  - Urinary workup ongoing (treat cystocele?)

ODS ruminations

Let’s go →

Pitfalls when approaching obstructive defecation

- Forget the functional role of the pelvic floor
  - Functional examinations matter
  - Pelvic floor physiotherapy is crucial
  - Not every POP needs surgery



Prognostic Significance of Rectocele, Intussusception, and Abnormal Perineal Descent in Biofeedback Treatment for Constipated Patients

- 108 patients with paradoxical puborectalis syndrome
- Biofeedback after defecography
  - 55% sufficient response
  - POP was frequent, both in responders and nonresponders (no significant difference)

Defecographic Findings in Patients who Completed Biofeedback Therapy

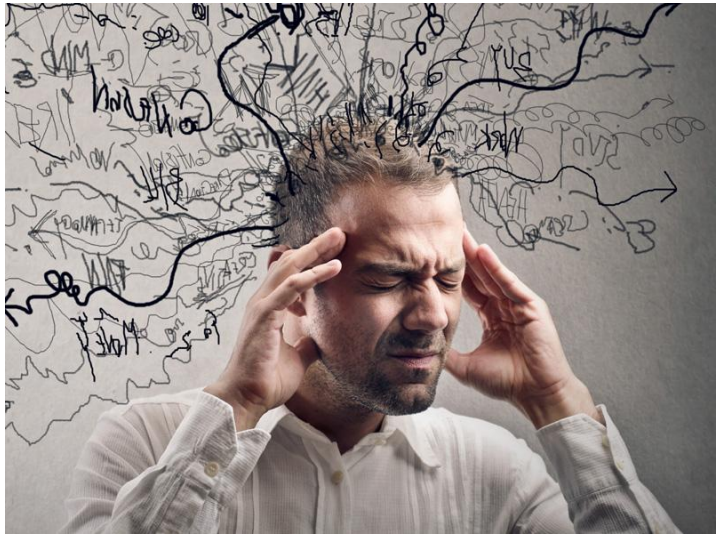
Parameter	Improved (n = 59)	Unimproved (n = 49)	Total (n = 108)	*P* Value
Rectocele (>2 cm)	14 (23.7)	9 (18.4)	23 (21.3)	0.64
Intussusception (>3 mm)	5 (8.5)	5 (10.2)	10 (9.3)	1
Sigmoidocele	5 (8.5)	2 (4.1)	7 (6.5)	0.45
Abnormal perineal descent (>5 cm)	37 (62.7)	31 (63.3)	68 (63)	1

Figures are number of patients and (percentage) unless otherwise specified.

Lau et al, Dis Colon Rectum 2000

Pitfalls when approaching obstructive defecation

- **Forget the functional role of the pelvic floor**
  - Functional examinations matter
  - Pelvic floor physiotherapy is crucial
  - Not every POP needs surgery
- **Forget there is a gut attached to the anus**
  - Slow transit can be a confounder
  - Never forget about IBS
- **Forget there are neighbours in the pelvic floor**
- **Forget the psyche**
  - Sexual abuse
  - Anxiety and depression
- **Forget to look at medication**
  - Opiates, antidepressants, …



Pitfalls when approaching obstructive defecation

- If you find posterior POP, stool regulation and functional reeducation are still crucial
- Surgery only when conservative approach fails


KEEP
CALM
AND
PUT DOWN
THE KNIFE