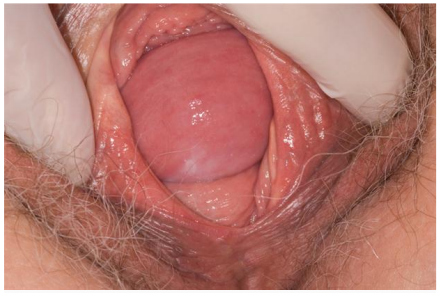
icle

Viewpoint: Obstructive defecation syndrome

18 July 2014 1 comment

Mr Andrew Hextall discusses the assessment and management of patients with bowel evacuation disorders.



Vaginal wall prolapse: a common cause of obstructive defecation (Photo: SPL)

Constipation is a common reason for women of all ages to consult their GP. Although difficulty with bowel evacuation can result from problems with the consistency of a motion, it is increasingly recognised that many women experience obstructive defecation syndrome (ODS), often as a consequence of pelvic floor damage experienced during childbirth.

Typical symptoms of ODS

- Straining to empty
- Prolonged or sometimes unsuccessful efforts to evacuate a motion
- Long periods spent in the bathroom
- The use of perineal or vaginal support - also known as 'digitation'
- Manual assistance to evacuate
- Sensation of incomplete emptying or difficulty wiping clean
- Requirement for use of laxatives or enemas

Causes

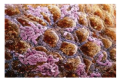
Failure to relax the anal sphincter or pelvic floor muscles while trying to defecate is a common functional cause of obstructive defecation - this is also known as anismus or pelvic floor dyssynergia. This condition often improves with pelvic floor physiotherapy and biofeedback.[1]

The mechanical causes of ODS include:

- Rectocele: a weakness in the rectovaginal septum allows the rectum to push forward against the posterior vaginal wall and herniate. Some women will become aware of a bulge in the vagina, sometimes causing problems with intercourse, while others can feel a dragging sensation, particularly towards the end of the day if they have been lifting or spent a lot of time standing.
- Intussusception: internal rectal prolapse (rectal intussusception) can obstruct the bowel lumen/passage of faeces and often coexists with a rectocele.
- Enterocele: a hernia of the small bowel or sigmoid colon through the Pouch of Douglas can obstruct defecation and cause difficulty with evacuation.

Read these next

Case study: A case of recurrent abdominal pain in an eight-year-old boy
23 May 2014



Irritable bowel syndrome: clinical review
26 April 2013

Clinical pictures: Perianal problems
12 April 2013

The Basics - Irritable bowel syndrome
1 February 2012

Clinical assessment

A detailed history will give many clues as to the possible cause of the defecatory disorder.

Red flag symptoms, such as a recent change in bowel habit or rectal bleeding, need to be excluded.

Frequency of bowel opening and the consistency of the motion passed are important, as is a description of the difficulty the patient is experiencing. Coexistent gynaecological or urological symptoms need to be considered and may help when deciding where to make a referral.

Examination should include palpation of the abdomen to exclude a pelvic mass, vaginal examination to look for prolapse or uterine enlargement, and a rectal assessment to rule out any low sinister pathology.

Investigations

History and examination may help to decide if further investigations are necessary.

Sometimes it is worth considering trying stool softeners or referring the patient to a specialist women's health physiotherapist before requesting any investigations.

For those women who do not respond to simple measures, the following studies can be useful.

Defecation proctography
Contrast medium is inserted into the rectum, then defecation is imaged, usually by X-ray. Movement of the rectum and pelvic floor can be assessed dynamically, with rectocele and intussusception being frequent findings in patients with ODS.

Some women with anismus are unable to relax their pelvic floor and anal sphincter, leading to incomplete evacuation.

Colonic transit studies
These can be useful if there is a suspicion that the patient has a slow colonic transit time and true constipation.

Dynamic MRI
As there is no irradiation and soft tissue structures can be imaged, this investigation is increasingly replacing conventional defecography.

Anorectal manometry and imaging
This is particularly useful when patients appear to have difficulty relaxing their anal sphincter or have coexistent faecal incontinence.

Multidisciplinary team

A multidisciplinary team approach is considered essential to obtain the best outcome.

Patients often complain of coexistent colorectal, gynaecological and urological symptoms, which need to be considered in context with a radiologist who has performed a defecating proctogram or other imaging.

The presence of a specialist women's health physiotherapist helps to ensure that conservative as well as surgical treatments are offered.

Where to refer?

Patients who are significantly troubled by their symptoms and fail to improve with conservative measures should be referred to the local pelvic floor service, if available, or to a urogynaecologist or colorectal surgeon with an interest in pelvic floor problems.

Clinical Re
Ulcerative
6 October

Conservative treatment

Patients should be advised to eat a healthy balanced diet and drink about two litres of water a day, depending on their activity levels and the ambient temperature.

It may be necessary to prescribe stool softeners. Particular attention should be paid to developing a regular bowel habit, especially for women with a busy lifestyle.

Pelvic floor physiotherapy is the first-line treatment for most patients and includes instruction on:

- Positioning on the toilet.
- Relaxation of the abdominal and pelvic floor muscles.
- Avoidance of straining and breath holding.
- Promoting correct techniques to allow unobstructed defecation.

Surgery

The type of surgery is usually tailored to the patient after a failed trial of conservative therapy and discussion by the pelvic floor multidisciplinary team. The most commonly performed procedures are:

- Rectocele repair: a standard posterior repair, sometimes with perineorrhaphy, is the most common procedure when patients complain of ODS and a bulge in the vagina secondary to a rectocele.
- Stapled transanal resection of rectum: a transanal approach can be used to treat a rectocele and prolapsing rectal mucosa causing intussusception.[2]
- Laparoscopic ventral rectopexy: this is particularly suitable for women with a visible external prolapse of the rectum and obstructive defecation, although the operation can also be performed for those with intussusception on defecography.[3]

Learning points

- Obstructive defecation syndrome is a common problem in women.
- Conservative measures, such as pelvic floor physiotherapy, often help.
- Consider referral to the local pelvic floor service.
- Imaging, including defecography, is useful when planning surgery.
- Most patients should be discussed by the pelvic floor multidisciplinary team before having definitive treatment.
- A number of different surgical options are available.

Conclusion

Constipation and ODS are common problems in primary care. Initial assessment and treatment using pelvic floor physiotherapy can often be undertaken without the need for referral. Investigation and discussion by a pelvic floor multidisciplinary team are increasingly seen as essential before surgery is undertaken.

- Mr Hextall is consultant obstetrician and gynaecologist/urogynaecologist, Spire Bushey Hospital and St Albans City Hospital, West Hertfordshire Hospitals NHS Trust

References

1. Ho YH, Tan M, Goh HS. Clinical and physiologic effects of biofeedback in outlet obstruction constipation. Dis Colon Rectum 1996; 39: 520-4.

2. Omner A, Albrecht K, Wenger F et al. Stapled transanal rectal resection (STARR): a new option in the treatment of obstructive defecation syndrome. Langenbecks Arch Surg 2006; 391(1): 32-7.

3. McCue JL, Thomson JP. Rectopexy for internal rectal intussusception. Br J Surg 1990; 77: 632-4.