The chronic constipated patient and role for Rectal Inertia

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Chronic constipation

• There are various definitions of chronic constipation, and the apparently small differences between them.

• One of the most widely used is based on the Rome III criteria Whether the combination of two or more different symptoms identifies different subsets of patients.

• It remains unclear . as whether a bowel diary is needed to over-come the discrepancy between recalled and recorded bowel habits

Rome III criteria for diagnosis of constipation

Criteria must be present for at least 3 months with symptom onset at least 6 months prior to diagnosis:

1. **Must include two or more of following:**
   - < 3 bowel movements / week.
   - Straining at ≥25% of defecations.
   - Lumpy or hard stools at ≥25% of defecations.
   - Sensation of anorectal obstruction at ≥25% of defecations.
   - Sensation of incomplete evacuation at ≥25% of defecations.
   - Manual disimpaction at ≥25% of defecations.

2. **Absence of loose stools without laxatives.**

3. **Inadequate criteria to diagnose constipation-predominant irritable bowel syndrome (IBS-C).**

Constipation

- **Primary versus secondary constipation**

  Patient with symptoms of impaired evacuation must be evaluated for 2ry causes for constipation such as :

  - **Mechanical causes** e.g. Rectal or colon cancer
  - **Endocrine or metabolic disorders** e.g. Hypothyroidism, diabetes, hypercalcemia
  - **Neurologic diseases** e.g. Multiple sclerosis, parkinson's disease
  - **Medications** e.g. Opiates, analgesics, antidepressants
  - **History of sexual abuse** should be considered in women with anismus

Subtypes of primary constipation

❑Normal transit constipation

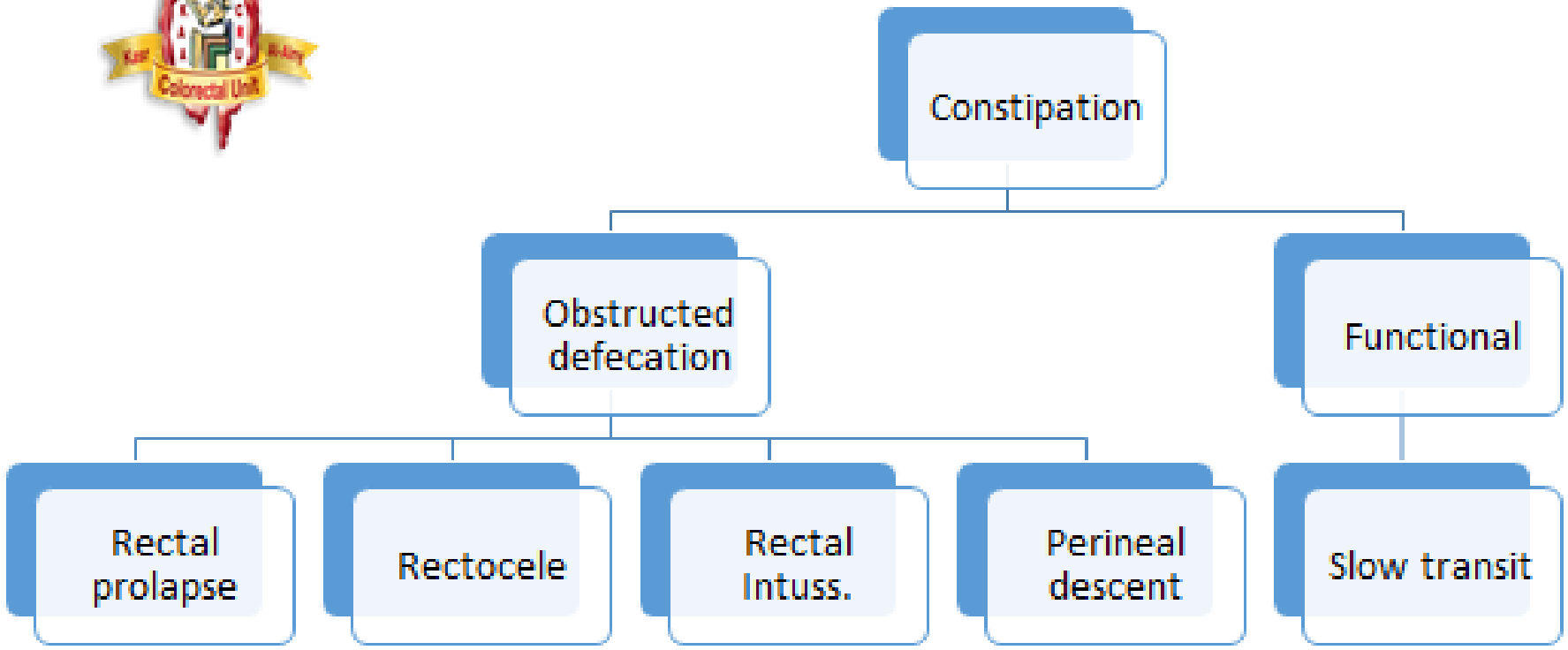
Patients have normal transit times through colon but have perception of constipation due to evacuation difficulties or due to hard stool (i.e outlet problem, i.e pelvic floor disorder).

❑Slow transit constipation

Propulsion of intraluminal contents is delayed in portions of colon or throughout entire colon.

❑Pelvic floor disorders

- Functional disorders → Dyssynergic Defecation (Anismus)
- Structural disorders:
  - ✓ Rectocele
  - ✓ Rectal intussusception
  - ✓ Enterocele
  - ✓ Descending Perineum Syndrome


Constipation
Obstructed defecation
Functional
Rectal prolapse
Rectocele
Rectal Intuss.
Perineal descent
Slow transit

Work up for a case of chronic constipation

- Exclude secondry causes of constipation
- Evaluate ano rectum and pelvic floor

ANORECTUM AND PELVIC FLOOR EVALUATION

Anatomical

- Conventional defecography
- MRI defecography
- Echo defechography
- Endo FLIP

Functional

Anorectal manometry

Colonic transiet time

Work up for a case of chronic constipation

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Ano rectal manometry

- **Anal canal evaluation**

Rest and sqeeze pressures

- Reflexes

RAIR

Rectal evaluation

- Sensation First sens 20 Urge 50 Intense urge 180
- Compliance 6- 9 delta v :delta p
- Mean intra rectal pressure less than 20 from 20 to 30 from 30 to 40
- balloon expulsion test

Diagnosis of rectal inertia

- Pressures
- Compliance
- Balloon expulsion

Management

- Mild
- Moderate
- Severe or atonic rectum

Medical managements

- Prokinetics
- Botox if associated with anismus
- Biofeed back

Atonic rectum

Fixing an atonic rectum aggravates the out flow problem

Atonic rectum

- When to resect

Manometry

Failed conservative

- How to resect

Perineal

Trans anal

Laparoscopic

- Perineal

Altemiere in rectal prolapse with atonic rectum

Trans anal

Trans STARR internal prolapse

STARR

Laparoscopic

Low anterior resection

THANK YOU