

The lazy gut - let's take it out!

Words of caution and surgical algorithm

By

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X "Twitter": @mostafashalaby

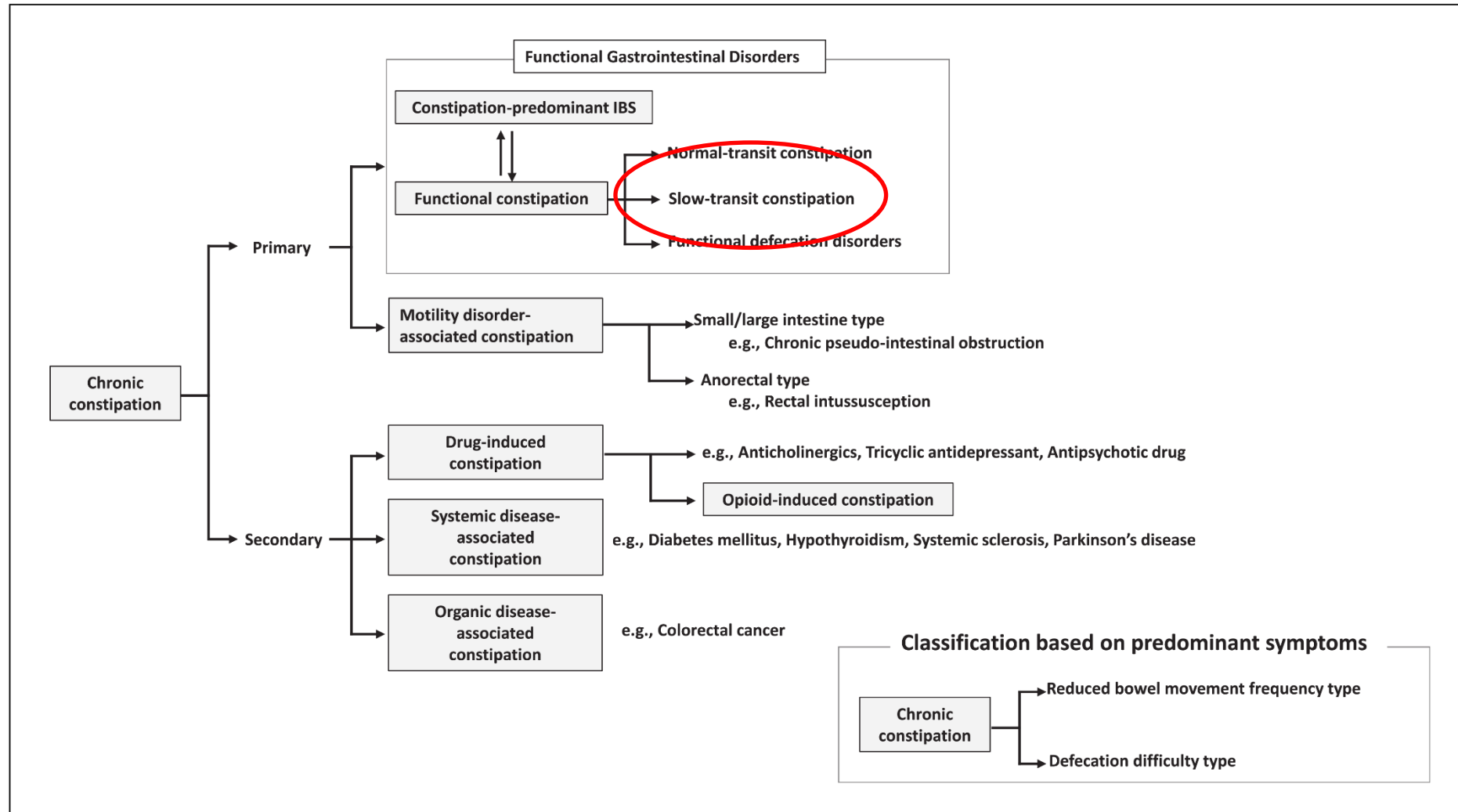


Email: mostafashalaby@mans.edu.eg

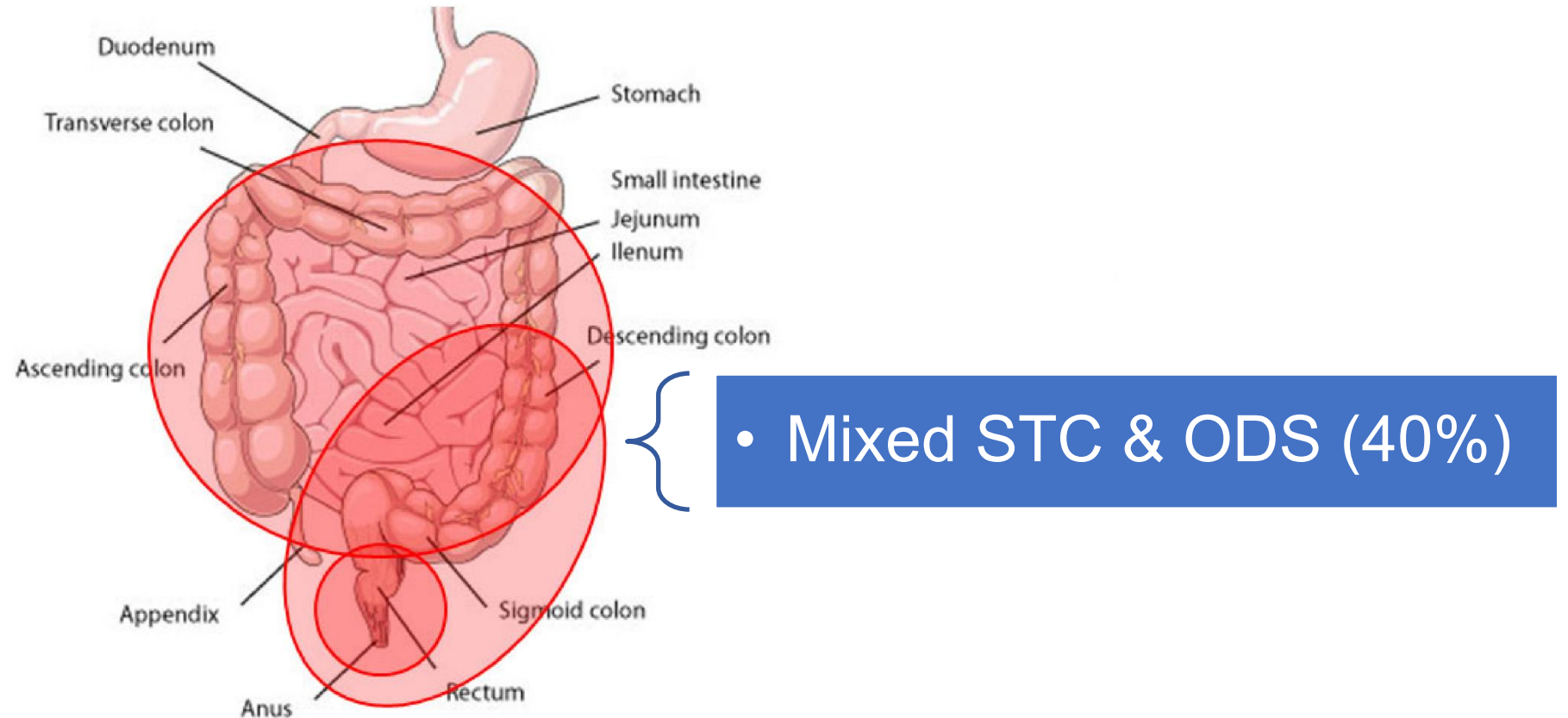
DISCLOSURE

- I have nothing to disclose

CLASSIFICATION



CLASSIFICATION



STC

1908

- Arbuthnot Lane
- Chronic intestinal stasis & autointoxication

1982

- Drossman et al
- Bowel dysfunction

1986

- Preston & Lennard-jones
- Slow transit-constipation

W. Arbuthnot Lane (1908). BMJ; Drossman (1982). Gastroenterology; Preston & J E Lennard-jones (1986). Gut

STC

- Several definitions according to radiographic, scintigraphic, and manometric.
- Rome IV Criteria are symptoms-based only and are not useful when discussing STC.
- STC might be defined by:
 - I. severe functional constipation (according to Rome Criteria);
 - II. absence of outlet obstruction;
 - III. delayed transit with markers distributed throughout the colon.
- Less common than NTC, however represents 15-30% in tertiary motility clinics.
- Up to 60% of women with refractory constipation show delayed colonic transit.

Bassotti et al., (2004). World J Gastroenterol; Vlismas et al. (2024). Medicina (Kaunas); Syllaïos et al., (2026). J Dig Dis

DIAGNOSTIC APPROACH

- The diagnosis of constipation can be made mainly on symptoms alone.
- Patients who fail to improve with 1st line therapy should be evaluated.

American Gastroenterological Association 2026

The Italian Unitary Society of Colon-Proctology 2026

Japan Gastroenterological Association 2026

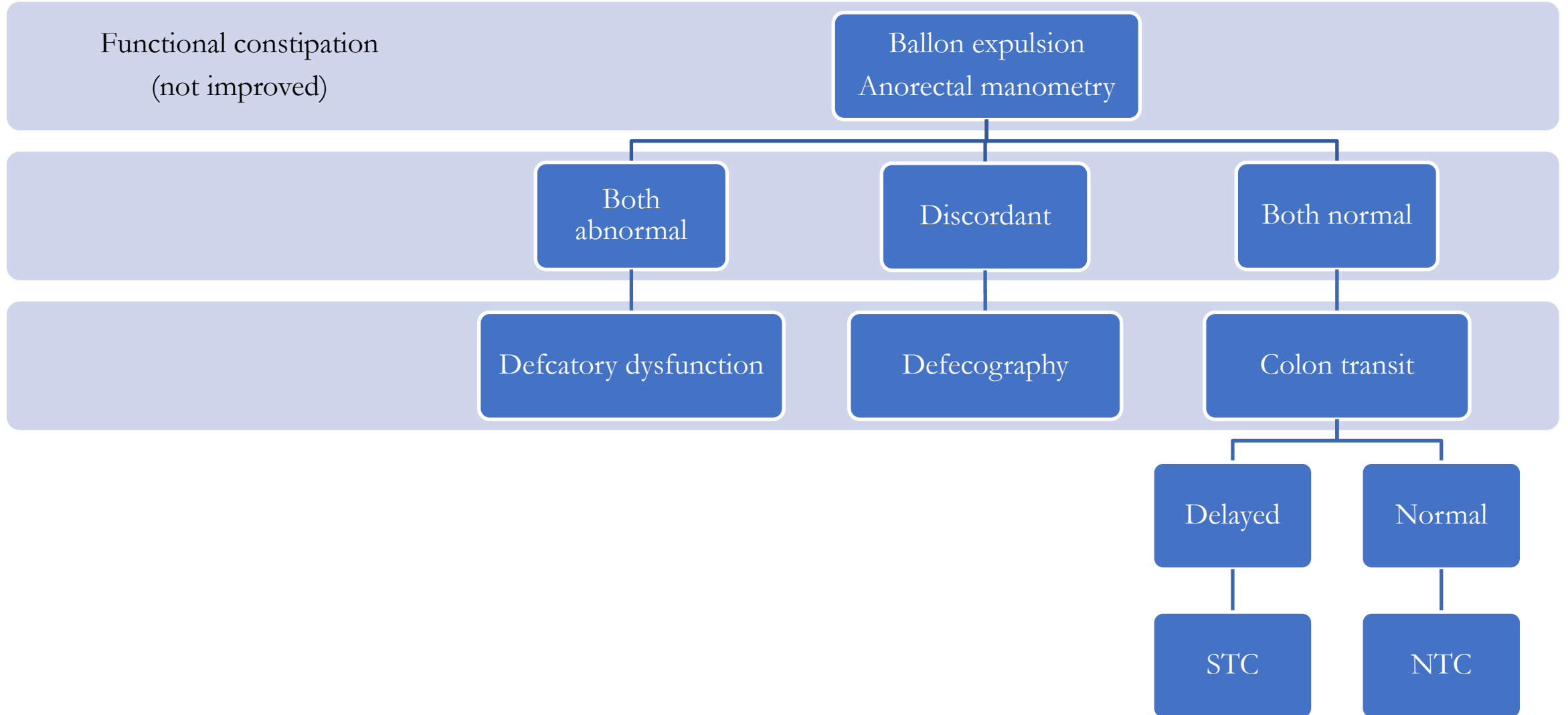
American Society of Colon and Rectal Surgeons 2024

European society of neurogastroenterology and motility 2019

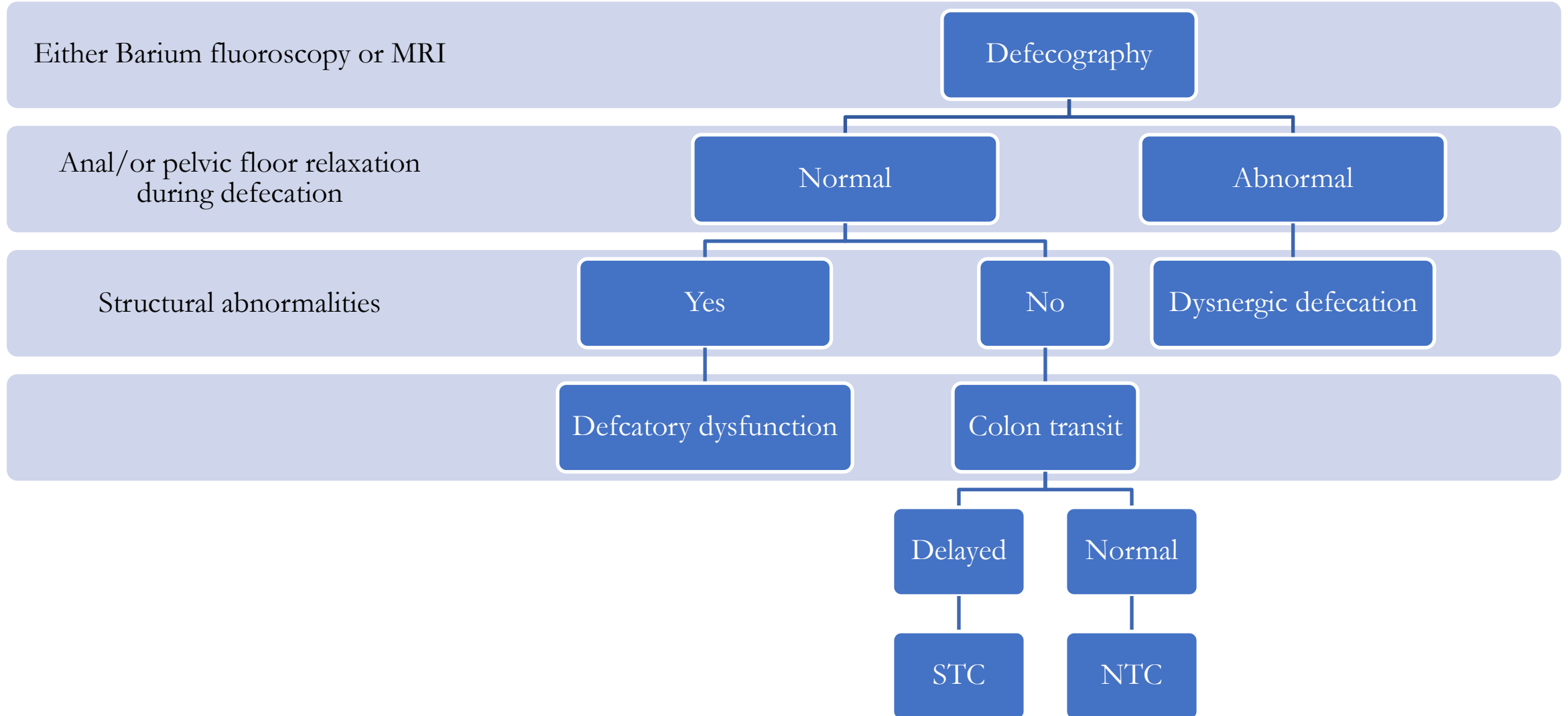
Spanish Gastroenterology Association 2017

World Gastroenterology Organization 2011

DIAGNOSTIC WORK-UP



DIAGNOSTIC WORK-UP



COLON TRANSIT

- No uniform methodology to perform the colonic transit study.
- The interpretation is variable; slow transit as retention of $\geq 20\%$ - 44% of markers.
- Retained markers does not correlate with symptom severity or QoL
- There are differences due to age, gender, and race.
- Also, it depends on dietary habits (dietary restrictions during the test, liquid vs solid)
- Older patients have prolonged rectosigmoid transit.
- Women has a longer maximal colon transit time (even menstrual cycle influence).

Rao et al., (2005). Am J Gastroenterol; Staller et al., (2018). Neurogastroenterol Motil; Evans et al., (1998). J Am Geriatr Soc; Kim & Rhee (2012). J Neurogastroenterol Motil

COLON TRANSIT

- Colon transit times are generally shorter in Asian populations than in Westerners.
- These differences may be attributed to dietary differences (fiber or spicy foods).
- In Western studies, mean transit time was 30-40 hours.
- In studies from Korea, mean colon transit time was 20-30 hours in normal subjects.
- Colon transit in Chinese is significantly faster than Western populations.
- Reference values for small-bowel and colonic transit in the Indian population.

Kim & Rhee (2012). J Neurogastroenterol Motil; Jiang et al., (2021). J Gastroenterol Hepatol; Kumar et al., (2023).

Indian J Nucl Med

REFRACTORY CONSTIPATION



META ANALYSIS AND SYSTEMATIC REVIEW

Searching for a definition for pharmacologically refractory constipation: A systematic review

Alex Yu Sen Soh,*  Jin-Yong Kang,^{†,‡} Kewin Tien Ho Siah,* Carmelo Scarpignato[§] and Kok-Ann Gwee[‡]

*Department of Gastroenterology and Hepatology, National University Hospital, [‡]Department of Medicine, Yong Loo Lin School of Medicine, National University of Singapore, Singapore; [†]Department of Gastroenterology, St George's Hospital, London, UK; and [§]Clinical Pharmacology and Digestive Pathophysiology Unit, Department of Clinical and Experimental Medicine, University of Parma, Parma, Italy

Most of the studies did not include specific details of previous treatments

Drug/drugs

Dosage

Basis (daily vs intermittent)

Duration at least 12 weeks

Previous studies

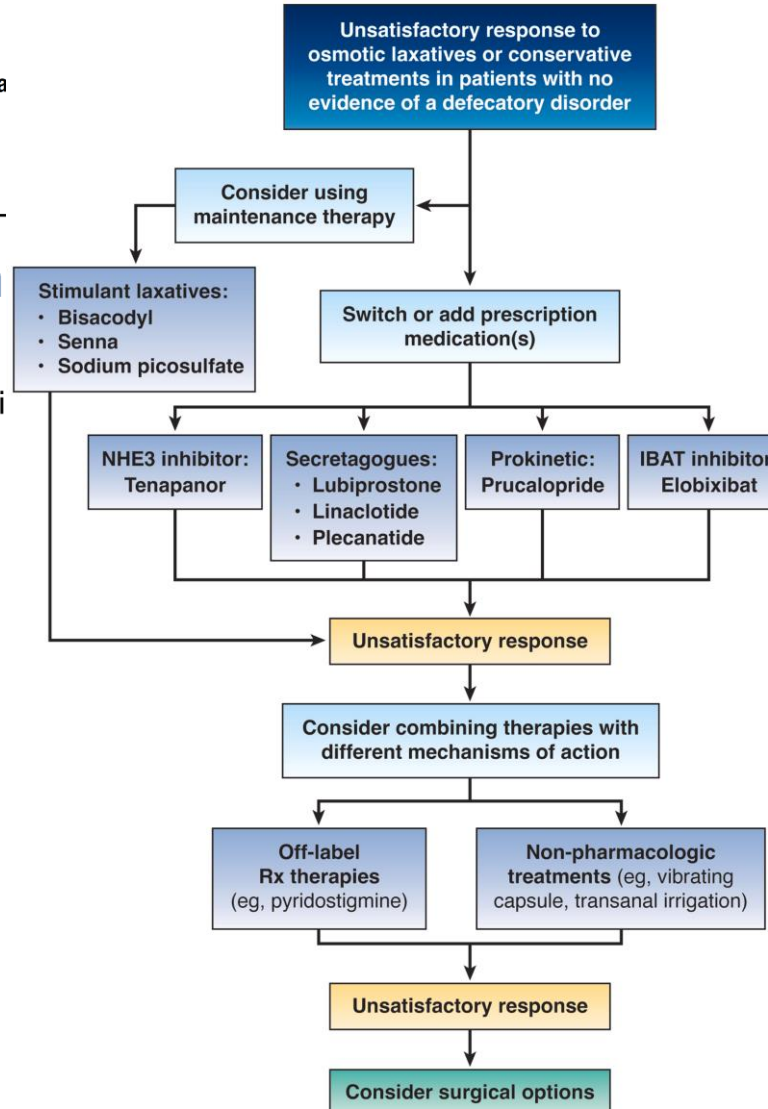
LAST RESORT PHARMACOTHERAPY

CLINICAL PRACTICE UPDATES

AGA Clinical Practice Update on Evaluation of Refractory Constipation: Expert Review

Kyle Staller,¹ Leila Neshatian,² Anthony Lembo,³ and Adi

Clinica



FURTHER EVALUATION

- Repeat colon transit time
- Isotopic scintigraphy
- Upper GIT manometry
- Psychological evaluation

Knowles et al., (1999). Ann Surg; Staller et al., (2026). Clin Gastroenterol Hepatol; Serra et al., (2020).
Neurogastroenterol Motil

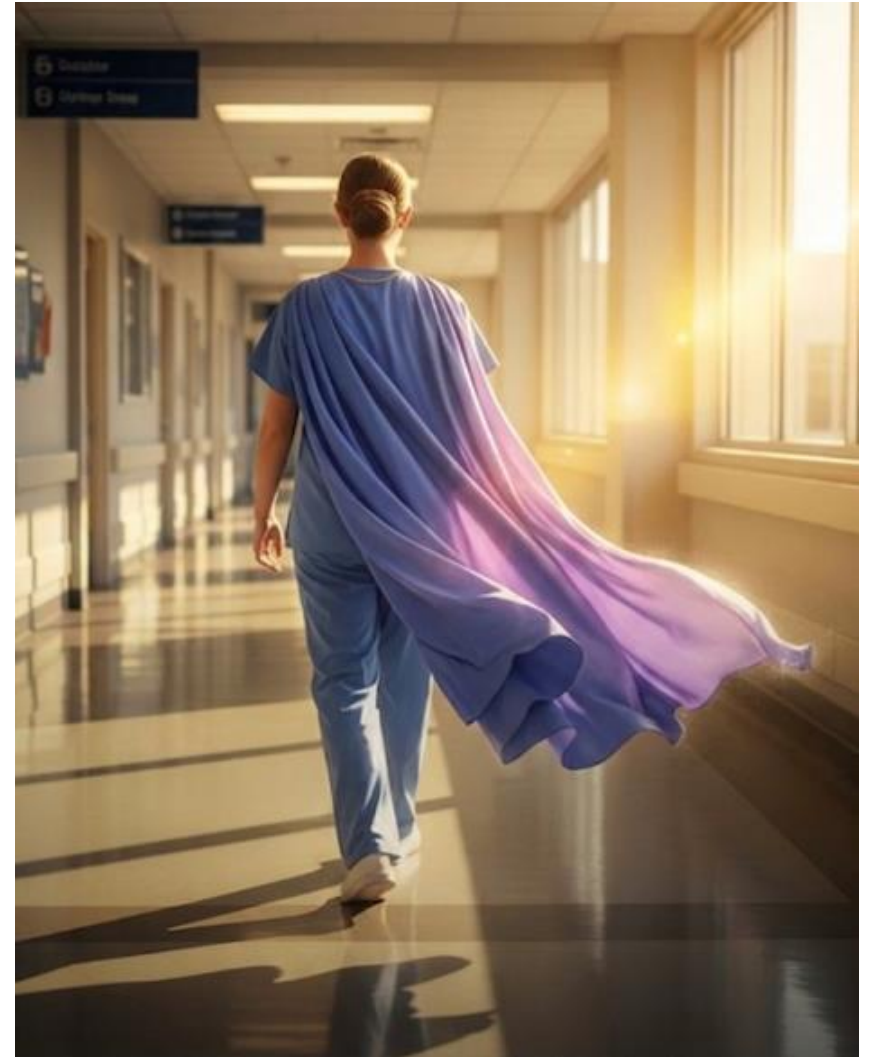
FURTHER EVALUATION

Precautions for colonic transit time

- Off treatments to document slow-transit constipation.
 - Stop laxatives for at least one week.
 - Stop medications that delay colon transit for at least 2 weeks.
- On a maximal laxative regimen to document the refractory nature of symptoms.
 - In patients with DD or colonic inertia.
 - Normal transit suggests DD, visceral hypersensitivity, or laxative side effects.
 - Slow transit suggests colonic dysmotility.

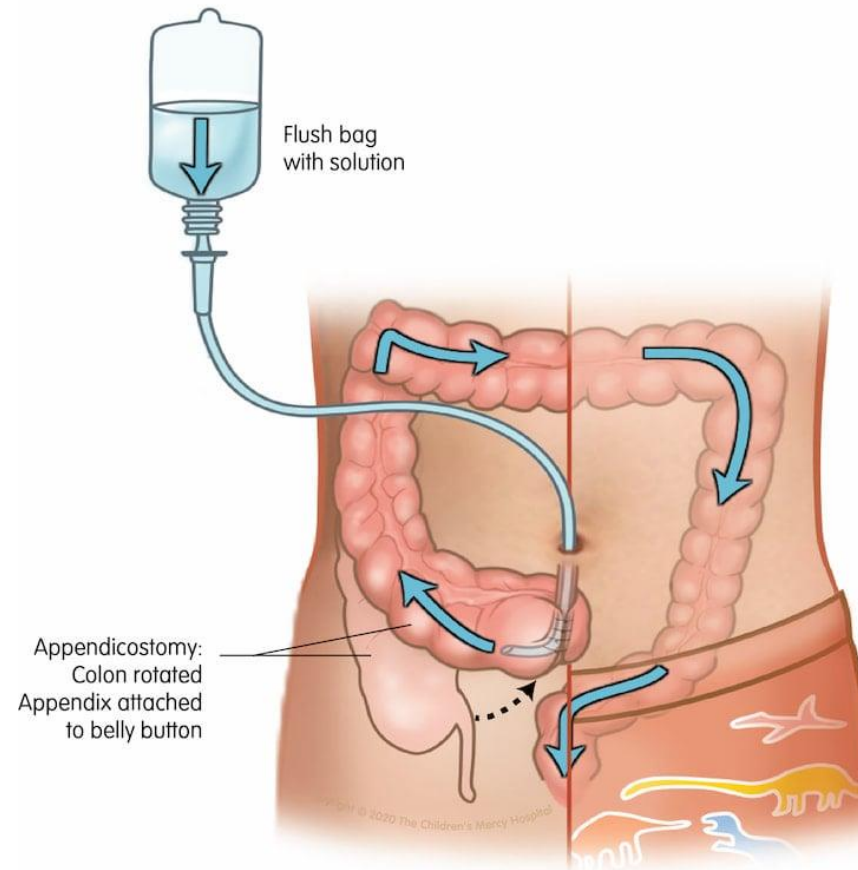
SURGICAL OPTIONS

- Antegrade enema
- Neuromodulation
- Ileostomy
- Bypass
- Colectomy



ANTEGRADE COLONIC ENEMA

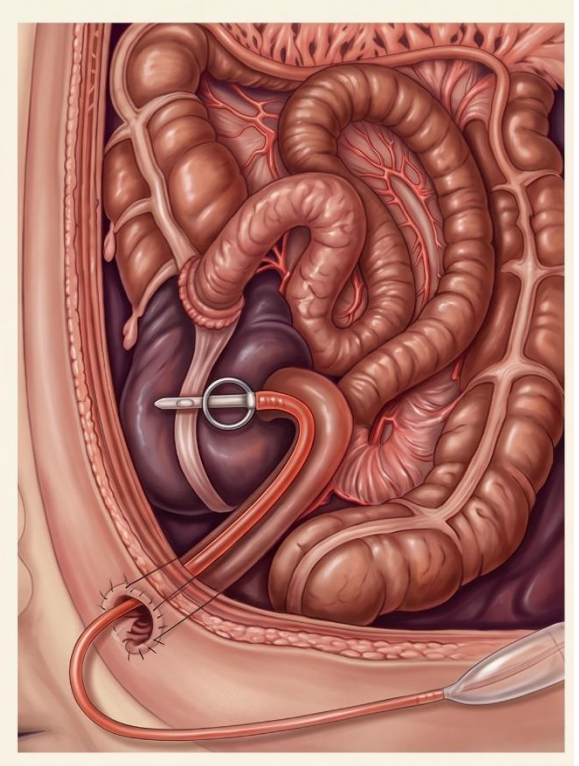
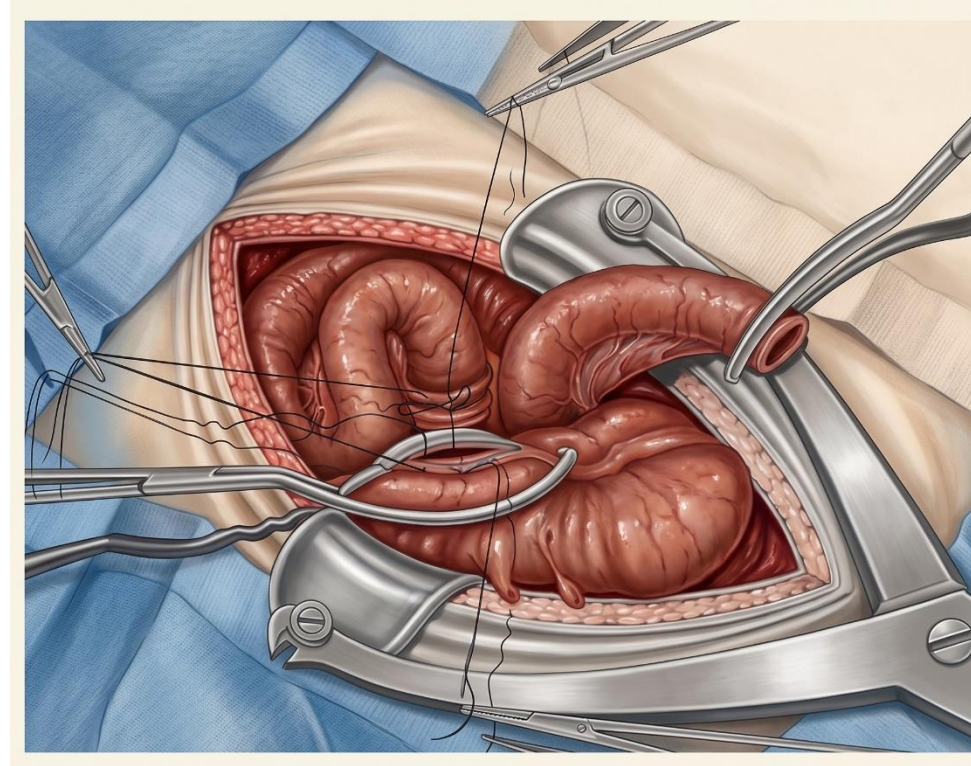
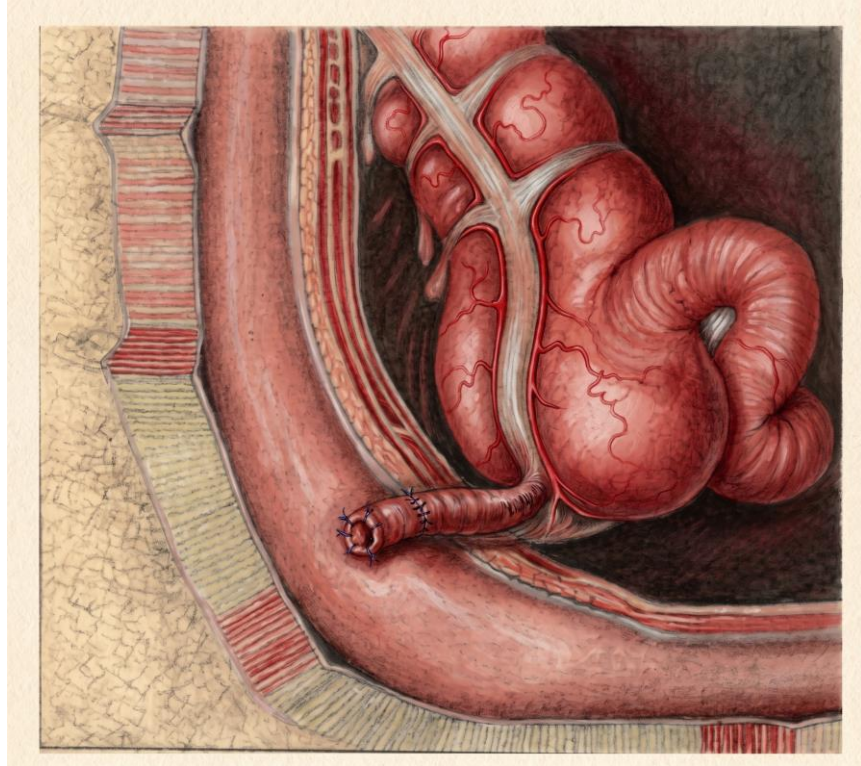
MACE/MALONE/APPENDICOSTOMY WITH FLUSH



ANTEGRADE COLONIC ENEMA

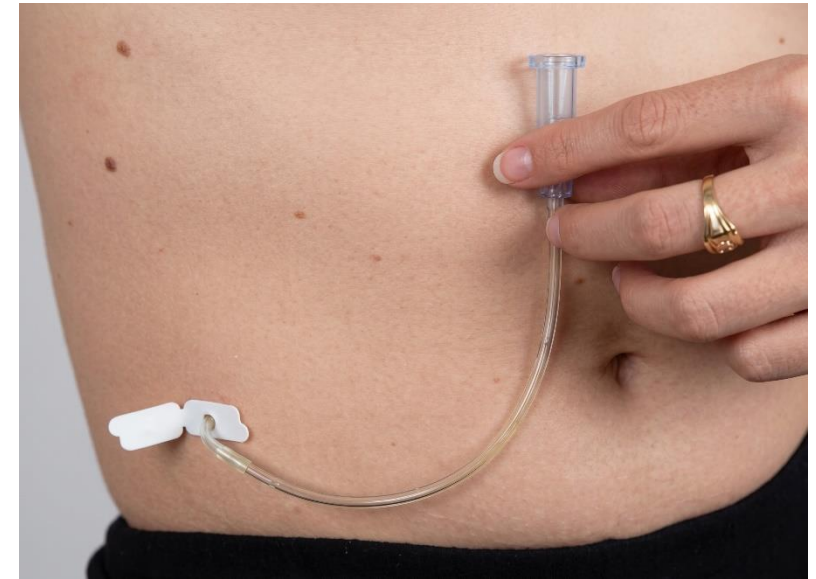
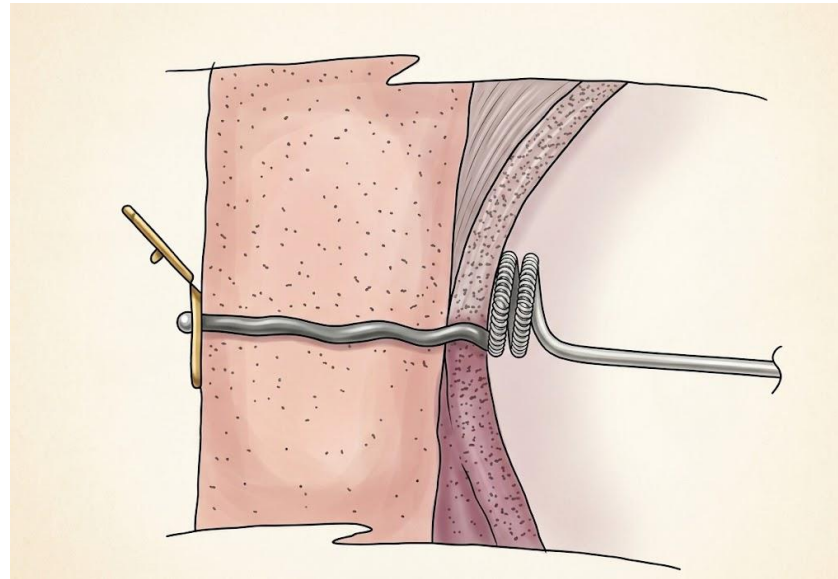
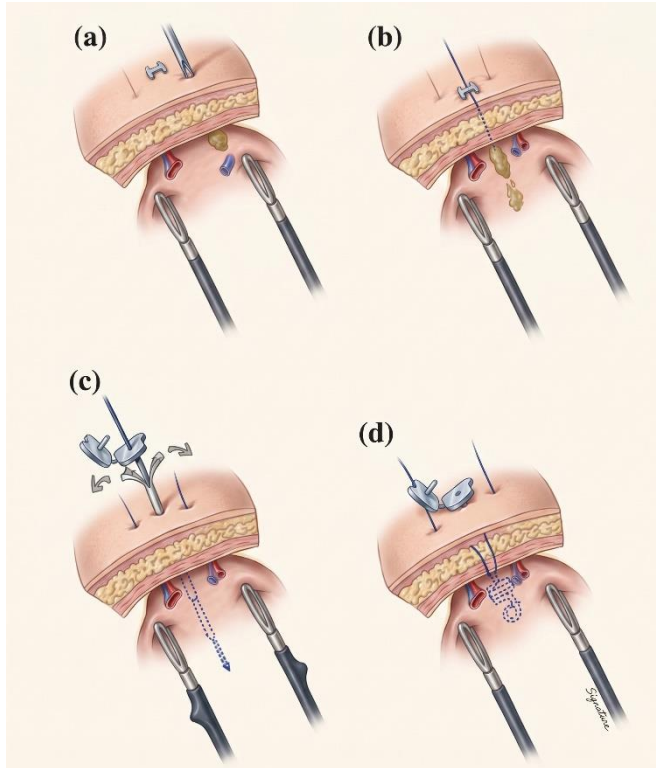
- Introduced in 1990 by Malone for myelomeningocele or imperforate anus cases.
- In functional constipation, it increase defecation frequency, reduce soiling frequency, and improvement QoL.
- Surgical options:
 - Appendicostomy
 - Ileocecostomy (Ileal neoappendicostomy)
 - Cecostomy Button “Chait Trapdoor cecostomy”

ANTEGRADE COLONIC ENEMA



Rongen et al., (2001). Dis Colon Rectum;

ANTEGRADE COLONIC ENEMA



Chait et al., (1997). J Pediatr Surg; Yamout et al., (2009). Pediatr Surg Int

ANTEGRADE COLONIC ENEMA

International Journal of Colorectal Disease
https://doi.org/10.1007/s00384-025-0502-

(2026) 41:4

RESEARCH

The Malone antegrad
constipation and feca
of the literature

Gaetano Gallo¹ · Veronica De Sin
Giuseppe Clerico⁴ · Roberto Sor

Leakage,

Table 5 Long-term outcomes. *MACE*, Malone antegrade continence enema; *MACE success*, patients still performing irrigation out of the total patients available for the assessment at the end of follow-up. *CCIS*, Cleveland Clinic Incontinence Score; *BRQ*, Bowel-Related Questionnaire. *SF-36*, Medical Outcomes Study 36-Item Short Form

Health Survey. *AMS*, American Medical Score; *CCCS*, Cleveland Clinic Constipation Score; *GIQLI*, Gastrointestinal Quality of Life Index; *KESS*, Knowles Eckersley Scott Symptoms Score; *FIQL*, Fecal Incontinence Quality of Life score; *QOL*, quality of life

Study	Follow-up (months)	MACE success, n (%)	Definite colostomy, n (%)	Functional scores/questionnaires used	Functional results
Hill et al. [15]	15	-	-	-	4 pts. resolved, 2 improved
Krogh et al. [21]	17 (1–39)	10/16 (62.5%)	0	Overall satisfaction, generic bowel function	75% reported satisfaction
Rongen et al. [31]	18 (12–23)	8/12 (66.6%)	2 (16.7%)	CCCS, State-Trait Anxiety Inventory, Zung Depression Scale, Beck Depression Inventory, Nottingham Health Profile	Improvement CCCS, depression and anxiety
Lees et al. [32]	36 (13–140)	15 (46.9%)	9 (29.0%)	-	-
Hirst et al. [22]	6 (3–51)	13/15 (86.7%)	0	CCIS, BRQ for ODS, SF-36	Improvement CCIS, BRQ. No improvement SF-36
Portier et al. [28]	27–35	26/28 (92.9%)	0	-	-
Lefèvre et al. [29]	26 (10–85)	18/22 (81.8%)	1/22 (4.5%)	Overall satisfaction, SF-36	Improved social function, role emotional and mental health 64% reported excellent satisfaction
Uno [23]	9 (1–18)	-	-	-	-
Altomare. et al. [27]	44 (33–66)	9/11 (81.8%)	1/11 (9.1%)	AMS, CCCS, GIQLI	All scores improved
Meurette et al. [30]	55 ± 36	13/25 (52.0%)	5/25 (20%)	KESS, GIQLI	KESS similar, GIQLI improved
Chéreau et al. [24]	48 (4–110)	64/70 (91.4%)	0	CCIS, GIQLI, SF-36	CCIS improved, GIQLI and SF-36 in normal ranges
Duchalais E. et al. [13]	12	11/18 (61.1%)	-	KESS, GIQLI	All scores improved
Sturkenboom R. et al. [14]	43 ± 26	22/30 (73.3%)	8/30 (26.7%)	Malone continence scale, CCCS, SF-36, Karnofsky, VAS, Vaizey survey	Malone: 61.1% full-partial success Vaizey: 60% partial success CCCS: 61.5% full-partial success SF-36: no difference with general pop
Ricard J et al. [20]	-	50/67 (74.6%)	5/67 (7.5%)	KESS, CCIS, GIQLI	All scores improved
Brinas P. et al. [25]	33 (0.7–126)	16/23 (69.6%)	5/23 (21.7%)	KESS, CCIS, FIQL	KESS and CCIS unchanged FIQL improved
Spinelli M. et al. [26]	14, 84, 121	3/3 (100%)	0/3 (0%)	-	-

a previous



Median follow-up was 28.5 months

75.1% continued to use colonic irrigations

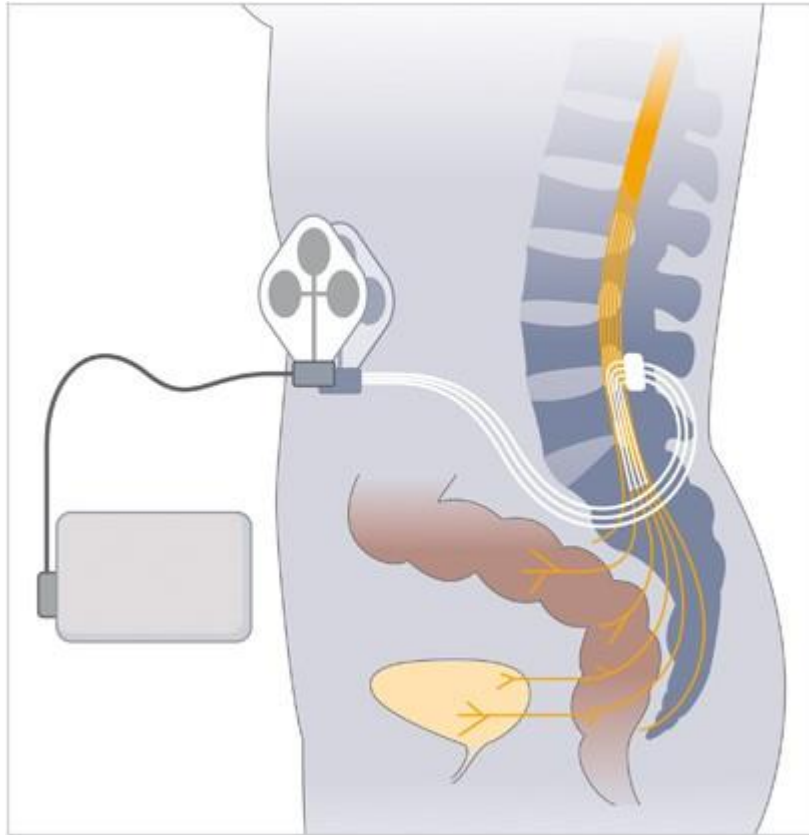
Satisfactory outcomes (improved function & QoL) in 60%–83%

MACE failure, defined as conversion to permanent colostomy, was reported in 9.8%

Stoma stenosis in

neoappendicostomy

NEUROMODULATION



2025

Efficacy and Safety of Noninvasive Electrical Neuromodulation for Treatment of Functional Constipation: A Systematic Review and Meta-Analysis of Randomized Controlled Trials

Sidan Long, MD; Shuangshuang Ji, MD; Borko Nojkov, MD;
Jiande D. Z. Chen, PhD



Relieves symptoms

Improves QoL

Reduce use of remedies

SNS

Neuromodulation: Technology at the Neural Interface

Received: December 12, 2024 Revised: February 11, 2025 Accepted: March 3, 2025

<https://doi.org/10.1016/j.neurom.2025.03.001>

2025



Meta-analysis of Randomized Controlled Trials on the Efficacy of Sacral Neuromodulation in Chronic Constipation

Sameh Hany Emile, MBBCh, MSc, MD^{1,2}; Justin Dourado, MD¹; Anjali Wignakumar, MBBS, BSc (Hons)¹; Nir Horech, MD^{1,3}; Zoe Garoufalia, MD¹; Rachel Gefen, MD^{1,4}; Marylise Boutros, MD¹

The effectiveness, safety and cost-effectiveness of SNM for patients with refractory idiopathic STC remains inconclusive

Received: 5 September 2023 Revised: 24 November 2023 Accepted: 10 December 2023

DOI: 10.1111/codi.16876

SYSTEMATIC REVIEW

2024



Meta-analysis was not associated with any tangible consequences for QoL.



Effectiveness, safety and cost-effectiveness of sacral neuromodulation for idiopathic slow-transit constipation: a systematic review

Stella C. M. Heemskerk^{1,2,3} | Aart A. van der Wilt³ | Bart M. F. Penninx⁴ | Jos Kleijnen⁵ | Jarno Melenhorst^{3,4,6} | Carmen D. Dirksen^{1,2} | Stéphanie O. Breukink^{3,4,6}

ILEOSTOMY



ILEOSTOMY

Received: 28 October 2020 | Revised: 7 December 2020 | Accepted: 15 December 2020

DOI: 10.1111/codi.15509

ORIGINAL ARTICLE

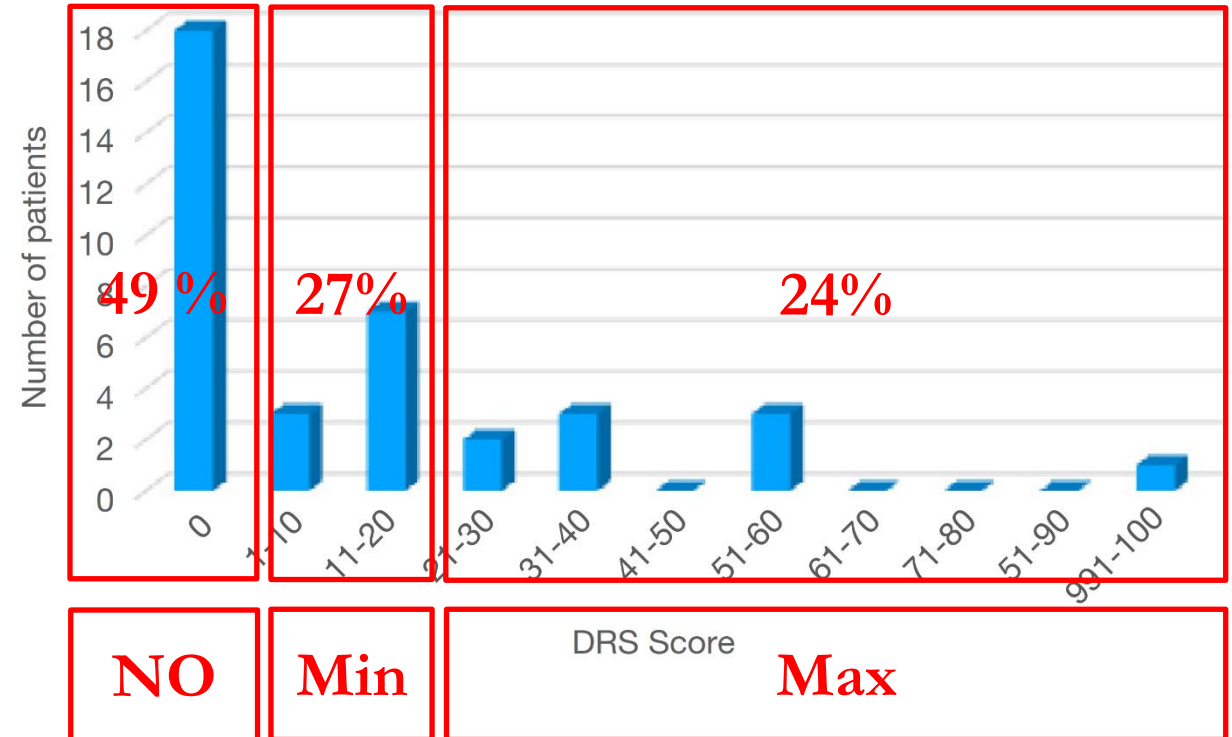
2021



Ileostomy for chronic constipation: a good idea or just asking for more trouble?

George Davis¹ | Keith Chapple¹ | Steven R. Brown²

	Patients (n = 38)	Patients (n = 38)
No further surgery	13	
Patients undergoing further operations (no. of operations)	25 (45)	49 (24 to 86)
Subtotal and ileorectal anastomosis	2	Female 100%
Subtotal and end ileostomy	6	34 (7 to 74)
Closure of ileostomy	2	37 (97%)
Proctectomy	1	
Right hemicolectomy	1	
EUA	2	31
Patients undergoing stoma-related operations (no. of operations)	19 (31)	3
Parastomal hernia repair (no. of operations)	9 (15)	1
Re-siting of stoma (no. of operations)	7 (7)	
Stomal prolapse, stomal stenosis, conversion to end (no. of operations)	8 (9)	3

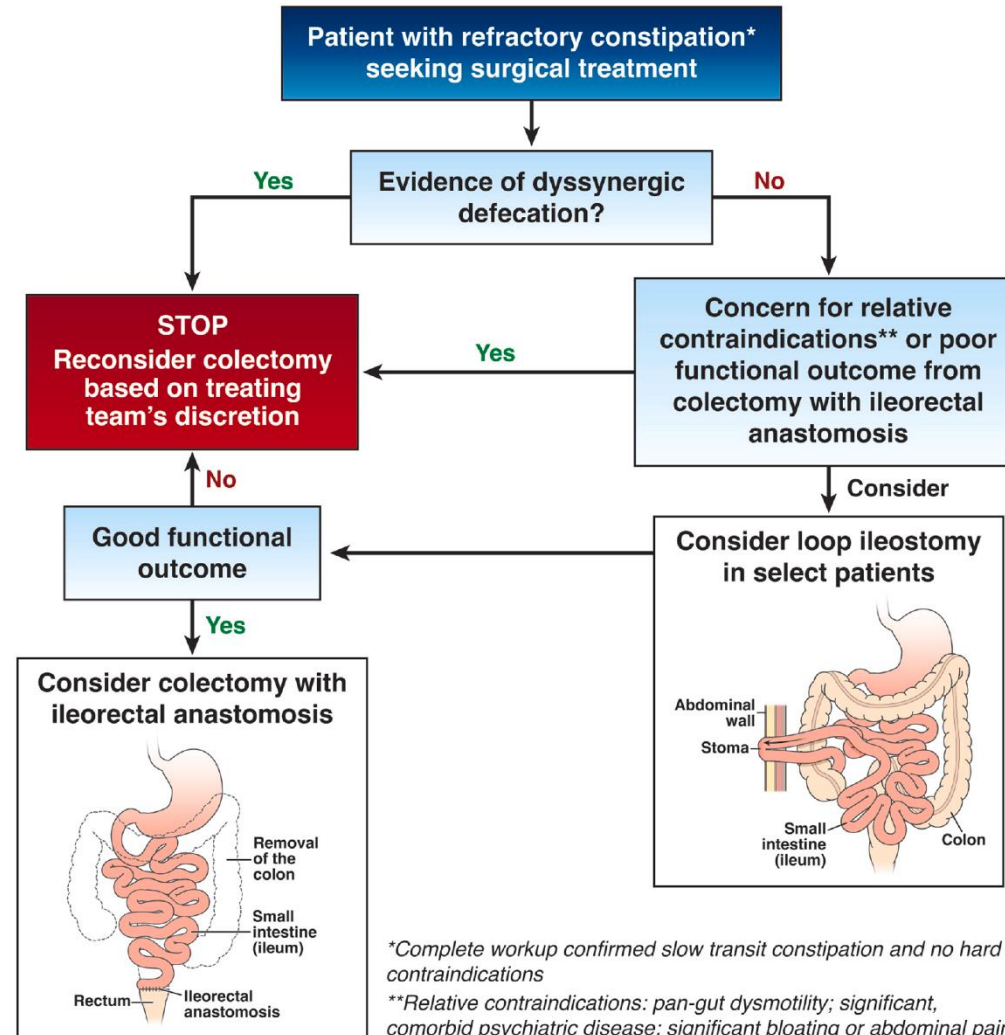


ILEOSTOMY

CLINICAL PRACTICE UPDATES

AGA Clinical Practice Update on Evaluation and Management of Refractory Constipation: Expert Panel Report

Kyle Staller,¹ Leila Neshatian,² Anthony Lembo,



BYPASS



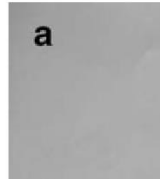
BYPASS

Int J Colorectal Dis (2010) 25:613–618
DOI 10.1007/s00384-010-0877-x

ORIGINAL ARTICLE

Retrospective series of subtotal and antiperistaltic cecoproc of slow-transit constipation

Yonggang Wang · Chunbao Zhai · Liyun Niu ·
Lijun Tian · Jianyong Yang · Zheng Hu



Proliferative and Morphologic Changes in Rat Colon Following Bypass Surgery

1985



Tech Coloproctol (2014) 18:629–634
DOI 10.1007/s10151-013-1108-6

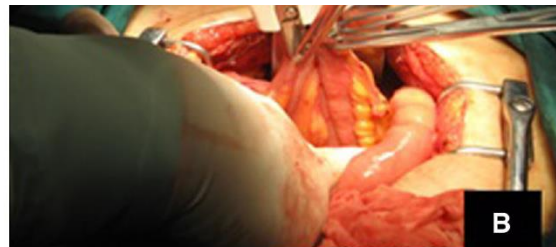
ORIGINAL ARTICLE

A modified total colonic exclusion for elderly slow transit constipation

Q. Qian · C. Jiang · Y. Chen · Z. Ding ·
Y. Wu · K. Zheng · Q. Qin · Z. Liu

DAVID H. BARKLA, MDSc, PhD, and
PETER J. M. TUTTON, MD, BS, PhD

From the Department of Anatomy, Monash University,
Clayton, Victoria, Australia



BYPASS + COLOSTOMY



World Journal of

Submit a Manuscript: <http://www.wjg.com>
DOI: 10.3748/wjg.v24.i23.

Retrospective Cohort Study
Subtotal colectomy with ileocolostomy in an aged population

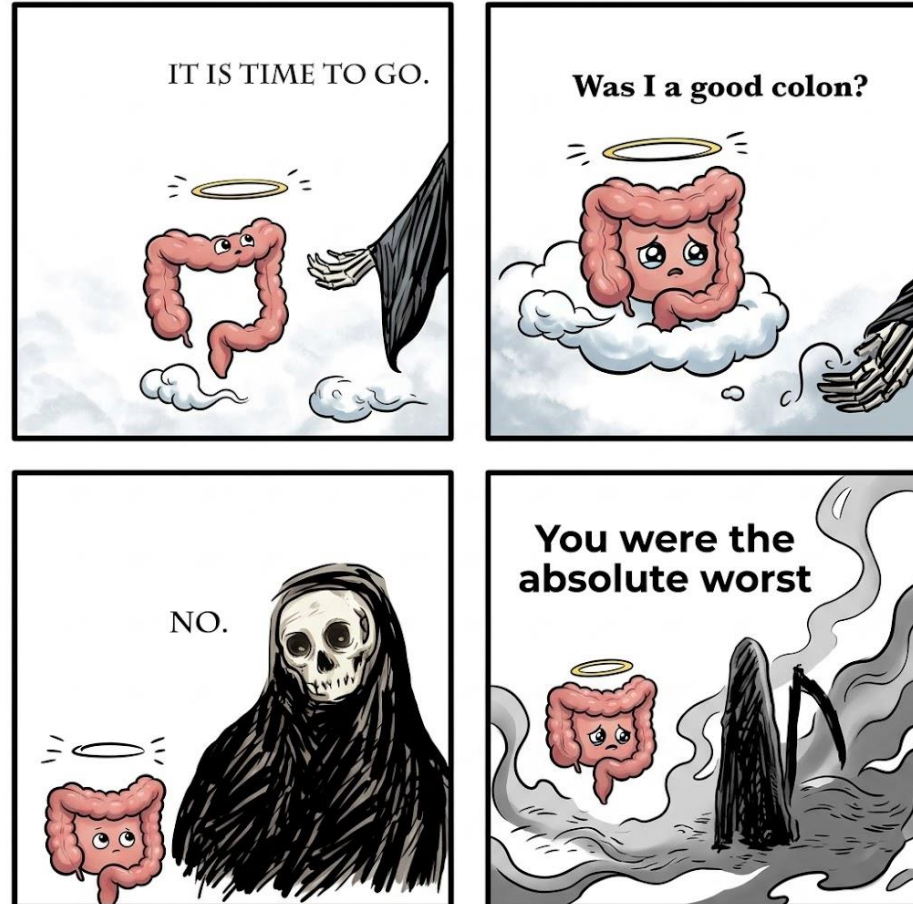
Yang Yang, Yong-Li Cao

Table 2 Preoperative and postoperative functional recovery results (mean $\pm$ SD)

	Bypass plus colostomy group (<i>n</i> = 14)				Bypass group (<i>n</i> = 15)			
	Preoperative	Postoperative	<i>P</i> value		Preoperative	Postoperative	<i>P</i> value	
WCS	16.86 $\pm$ 1.56	3 mo	2.71 $\pm$ 2.30	< 0.001	16.93 $\pm$ 1.16	3 mo	4.33 $\pm$ 3.83	< 0.001
		6 mo	2.64 $\pm$ 2.50	< 0.001		6 mo	5.07 $\pm$ 4.06	< 0.001
		12 mo	2.36 $\pm$ 2.13	< 0.001		12 mo	6.40 $\pm$ 5.16	< 0.001
		24 mo	1.86 $\pm$ 1.46	< 0.001		24 mo	6.60 $\pm$ 5.42	< 0.001
GIQLI	64.00 $\pm$ 3.51	3 mo	106.57 $\pm$ 5.79	< 0.001	63.20 $\pm$ 2.40	3 mo	88.27 $\pm$ 12.26	< 0.001
		6 mo	114.50 $\pm$ 7.59	< 0.001		6 mo	95.13 $\pm$ 14.87	< 0.001
		12 mo	119.79 $\pm$ 8.24	< 0.001		12 mo	97.60 $\pm$ 18.38	< 0.001
		24 mo	122.21 $\pm$ 6.85	< 0.001		24 mo	98.47 $\pm$ 18.09	< 0.001
ABS	2.71 $\pm$ 0.73	3 mo	1.29 $\pm$ 0.83	< 0.001	2.40 $\pm$ 0.63	3 mo	1.53 $\pm$ 0.83	0.003
		6 mo	0.86 $\pm$ 0.77	< 0.001		6 mo	1.67 $\pm$ 0.82	0.003
		12 mo	0.86 $\pm$ 0.66	< 0.001		12 mo	2.07 $\pm$ 0.88	0.207
		24 mo	0.79 $\pm$ 0.70	< 0.001		24 mo	2.27 $\pm$ 1.16	0.670
NRS	3.00 $\pm$ 1.04	3 mo	2.50 $\pm$ 1.29	0.187	2.87 $\pm$ 1.30	3 mo	3.27 $\pm$ 1.34	0.320
		6 mo	2.21 $\pm$ 1.47	0.094		6 mo	3.53 $\pm$ 2.00	0.126
		12 mo	1.14 $\pm$ 0.86	< 0.001		12 mo	3.93 $\pm$ 2.92	0.123
		24 mo	1.07 $\pm$ 0.62	< 0.001		24 mo	4.07 $\pm$ 3.04	0.105

WCS: Wexner constipation scale; GIQLI: Gastrointestinal quality of life index; ABS: Abdominal bloating score; NRS: Numerical rating scale.

COLECTOMY



TRENDS

AP&T Alimentary Pharmacology and Therapeutics

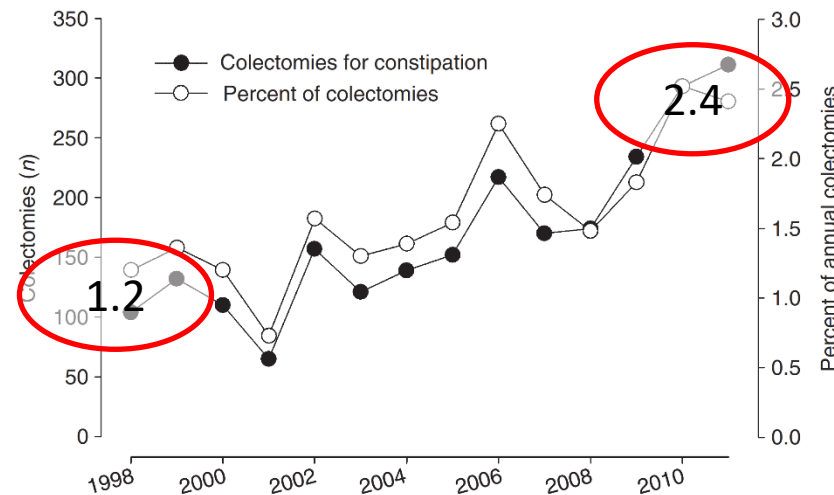


Colectomy for constipation: time trends and impact based on the US Nationwide Inpatient Sample, 1998–2011

A. Dudekula*, S. Huftless[‡] & K. Bielefeldt^{*†}

2015

Figure 1 | The total number of annual colectomies performed for constipation as primary indication was plotted as absolute number (black circles) or per cent of annual colectomies (white circles). A trend analysis showed a significant increase in the number of surgeries during the time period analysed ($P < 0.01$).



Overall rate 1.7%

No deaths

Complications 42.7%

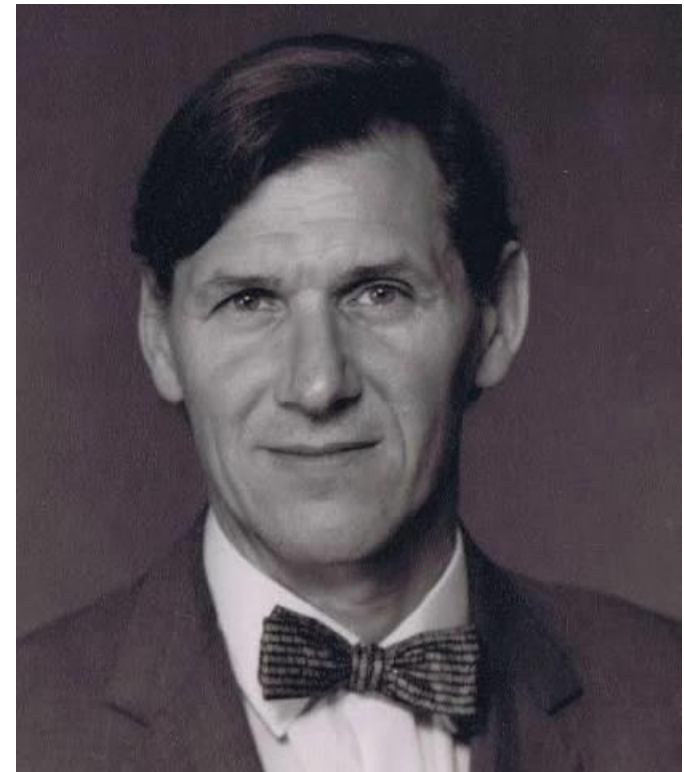
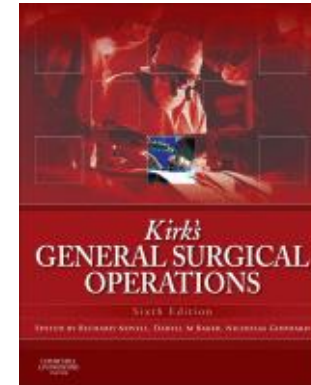
WHEN NOT TO OPERATE?

A good surgeon knows how to operate

A better surgeon knows when to operate

The best surgeon knows when not to operate

Raymond M. Kirk (Jerry Kirk; 1923-2019)



EXCLUSION CRITERIA

- Unproven prolongation of colonic transit time
- Hirschsprung's disease
- Upper GIT motility disorders
- FI and anal sphincter dysfunction
- IBS
- Untreated defecation disorders
- Chronic use of opioids
- Mental disorders
- Neurological disorders

EXCLUSION CRITERIA



Slow-transit constipation and criteria for colectomy: a cross-sectional study of 1568 patients

P. Chaichanavichkij^{1,*}, P. F. Vollebregt¹, S. Z. Y. Tee², S. M. Scott¹ and C. H. Knowles¹

BJS Open, 2021, zrab049
DOI: 10.1093/bjsopen/zrab049
Original Article

2021

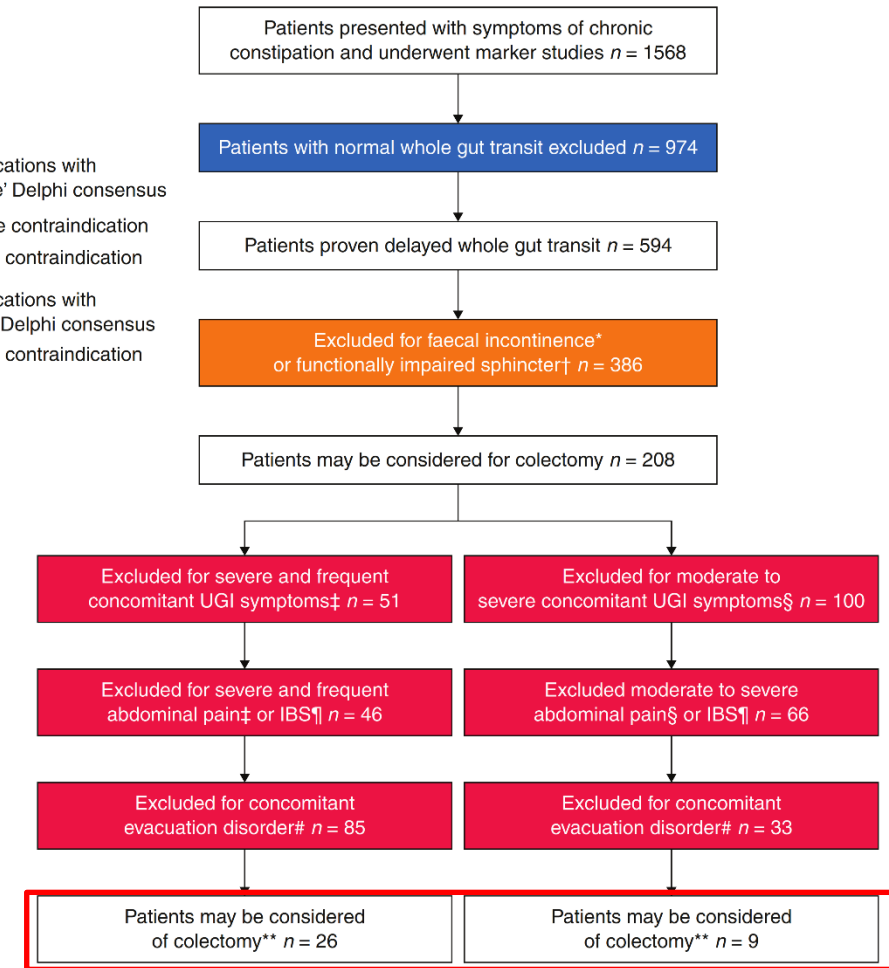


Contra indications with
'appropriate' Delphi consensus

- Absolute contraindication
- Relative contraindication

Contra indications with
"uncertain" Delphi consensus

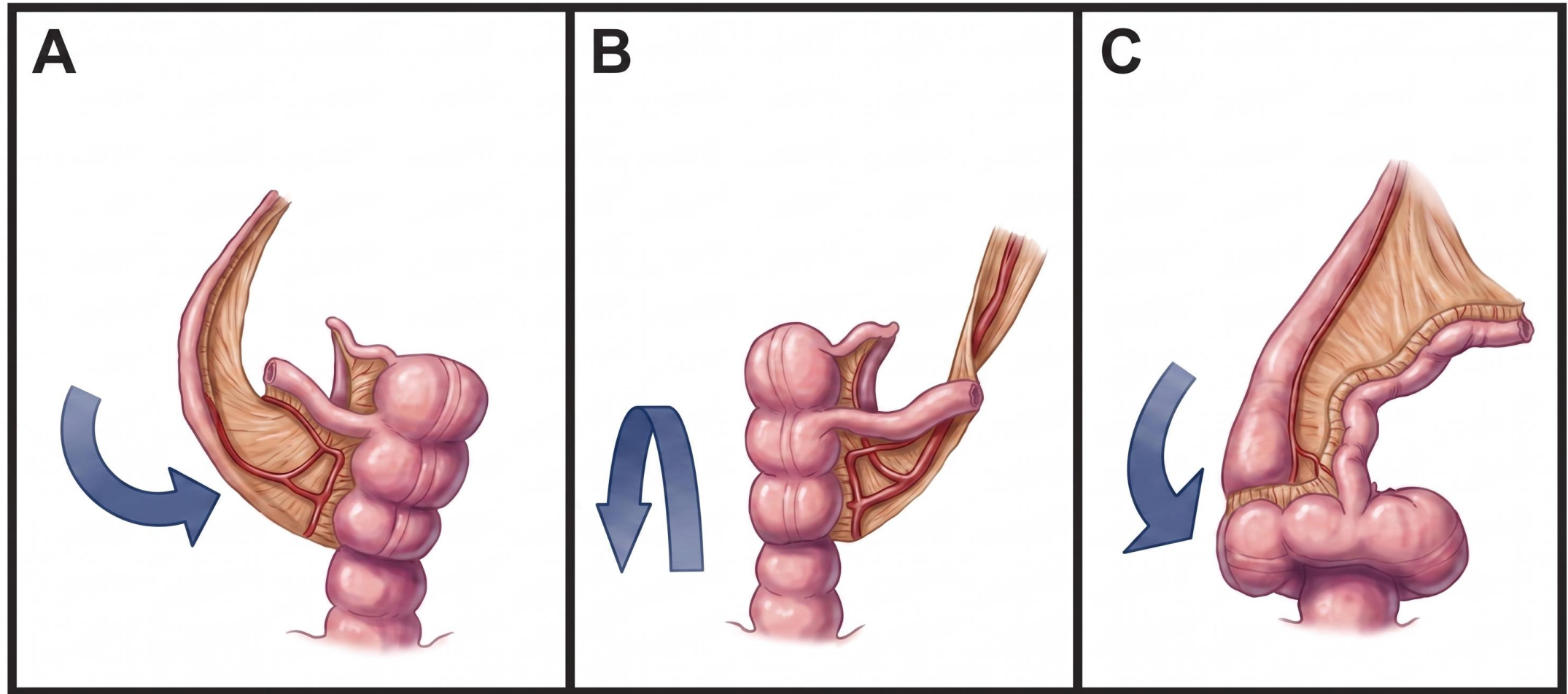
- Relative contraindication



COLECTOMY OPTIONS

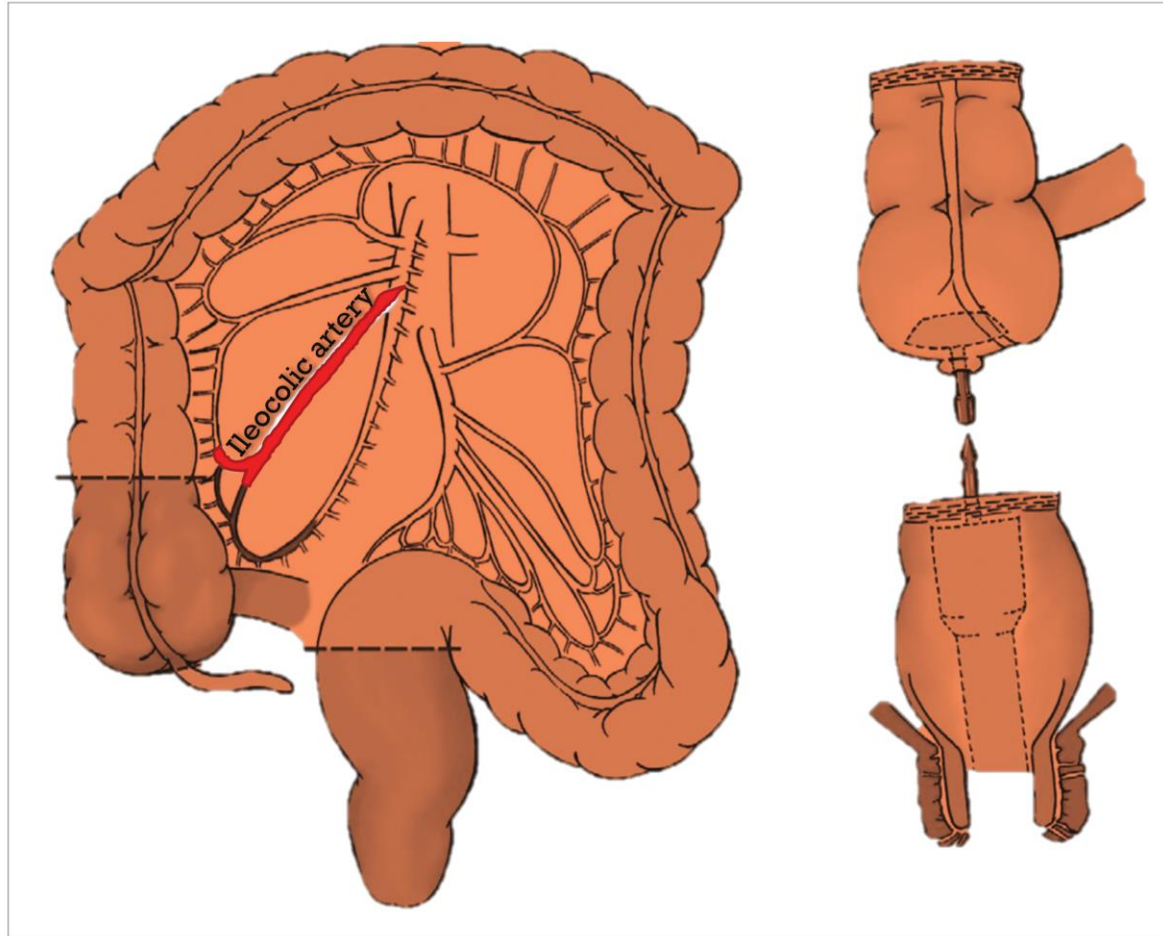
- Total colectomy with
 - Ileorectal anastomosis
- Subtotal colectomy with
 - Ileosigmoid anastomosis
 - Cecorectal anastomosis (iso peristalsis – anti peristalsis)

CECORECTAL ANASTOMOSIS



Sarli et al., (2001). Dis Colon Rectum

CECORECTAL ANASTOMOSIS



Grossi et al., (2024). Colorectal Dis

CRA vs IRA

International Journal of Colorectal Disease (2022) 37:531–539
<https://doi.org/10.1007/s00384-022-04093-y>

REVIEW

2021



Cecorectal (CRA) versus ileorectal (IRA) anastomosis after colectomy for slow transit constipation (STC): a meta-analysis

Konstantinos Perivoliotis^{1,2} · Ioannis Baloyiannis³ · George Tzovaras³



Safety	CRA	IRA				Constipation Period	Follow-up
Morbidity	✓	✓				6.75)	72(27)
AL	✓	✓	Patient satisfaction	✓	✓	✓	8.25)
SBO	✓	✓	GIQLI scores	✓	✓	✓	2(2.8)
SSI	✓	✓	Wexner scores	✓	✓	✓	42
Operative Time	✓	✓	FI	✓	✓	✓	63.9(63)
Hospitalizations	✓	✓					33.2(26.75)

CRA vs ISA vs TC-IRA

Updates in Surgery (2024) 76:411–422
<https://doi.org/10.1007/s13304-024-01762-1>

REVIEW ARTICLE

Comparing the short-term outcomes of different colectomies in patients with constipation in eastern countries

Xueyi Xue¹ · Hao Zeng^{1,2} · Dongbo Chen¹

Table 2 Characteristics of included studies

Study	Country	Type
XiaoYu Xie et al	China	RCT
CongQing Jiang et al	China	RCT
Fan Li et al	China	RCT
Ye Feng et al	China	RCT
Zhang et al	China	RCT
Ji-Wei Sun et al	China	RCT



Operative time	CRA	TC-IRA	SC-ISA
Length of hospital stay	CRA	SC-ISA	TC-IRA
Wexner constipation score	CRA	TC-IRA	SC-ISA
GIQLI	CRA	SC-ISA	TC-IRA
Small bowel obstruction	SC-ISA	CRA	TC-IRA
Abdominal pain	SC-ISA	CRA	TC-IRA
Abdominal distention	SC-ISA	CRA	TC-IRA
Incision infection	SC-ISA	CRA	TC-IRA
Therapeutical effective rate	SC-ISA	CRA	TC-IRA

1 period	
CRA	SC-ISA
13 (8.25)	
13 (8.25)	
N/A	
3.8 (5)	9.5 (5.75)
	14.5 (6.8)
3.5 (2)	11 (2.5)

RESERVOIR LENGTH

Wei et al. BMC Gastroenterology (2015) 15:30
DOI 10.1186/s12876-015-0257-7

RESEARCH ARTICLE

A prospective comparison of functional recovery after subtotal colectomy with ileocolic anastomosis and ileocolic anastomosis with a colonic reservoir

Dong Wei^{1*†}, Jian Cai^{1,2*†}, Yang Yang¹, Ting Zhao¹, Jianfeng Zhang¹ and Fengbo Cai¹

Table 3 Post-operation functional recovery comparison between the two groups (mean ± SD)

	Time		Observation group N = 41	Control group N = 40	p value
WCS	Pre-operation		16.61 ± 1.55	16.55 ± 1.30	
	post-operation	3 months	1.66 ± 1.73	3.78 ± 3.91	0.002
		6 months	1.59 ± 1.76	4.05 ± 4.23	0.001
		12 months	1.56 ± 1.61	4.38 ± 4.93	0.001
GIQLI	Pre-operation		64.61 ± 3.97	63.08 ± 4.02	
	post-operation	3 months	107.09 ± 4.80	90.93 ± 12.06	<1 × 10 ⁻⁶
		6 months	115.95 ± 6.19	98.43 ± 14.84	<1 × 10 ⁻⁶
		12 months	120.88 ± 7.39	103.43 ± 16.42	<1 × 10 ⁻⁶
APIS	Pre-operation		3.10 ± 0.9	3.00 ± 1.30	
	post-operation	3 months	1.78 ± 1.35	2.88 ± 1.87	0.001
		6 months	1.34 ± 1.35	2.45 ± 2.06	0.002
		12 months	0.88 ± 1.25	2.20 ± 2.47	0.001
APFS	Pre-operation		2.39 ± 0.49	2.30 ± 0.46	
	Post-operation	3 months	1.22 ± 0.652	1.63 ± 1.05	0.042
		6 months	0.98 ± 0.82	1.58 ± 1.15	0.009
		12 months	0.76 ± 0.83	1.35 ± 1.31	0.013
ABS	Pre-operation		2.41 ± 0.63	2.28 ± 0.51	
	Post-operation	3 months	1.05 ± 0.74	1.43 ± 0.96	0.035
		6 months	0.78 ± 0.79	1.30 ± 1.02	0.008
		12 months	0.63 ± 0.86	1.08 ± 1.16	0.025

Note: WCS: Wexner constipation scale; GIQLI: Gastro-Intestinal Quality of Life Index; APIS: abdominal pain intensity scale; APFS: abdominal pain frequency scale; ABS: abdominal bloating scale.

site

sup.

LONG-TERM

Techniques in Coloproctology

<https://doi.org/10.1007/s10151-019-02140-5>

ORIGINAL ARTICLE

2020



50%

Subtotal colectomy and ileorectal anastomosis for slow transit constipation: clinical follow-up at median c

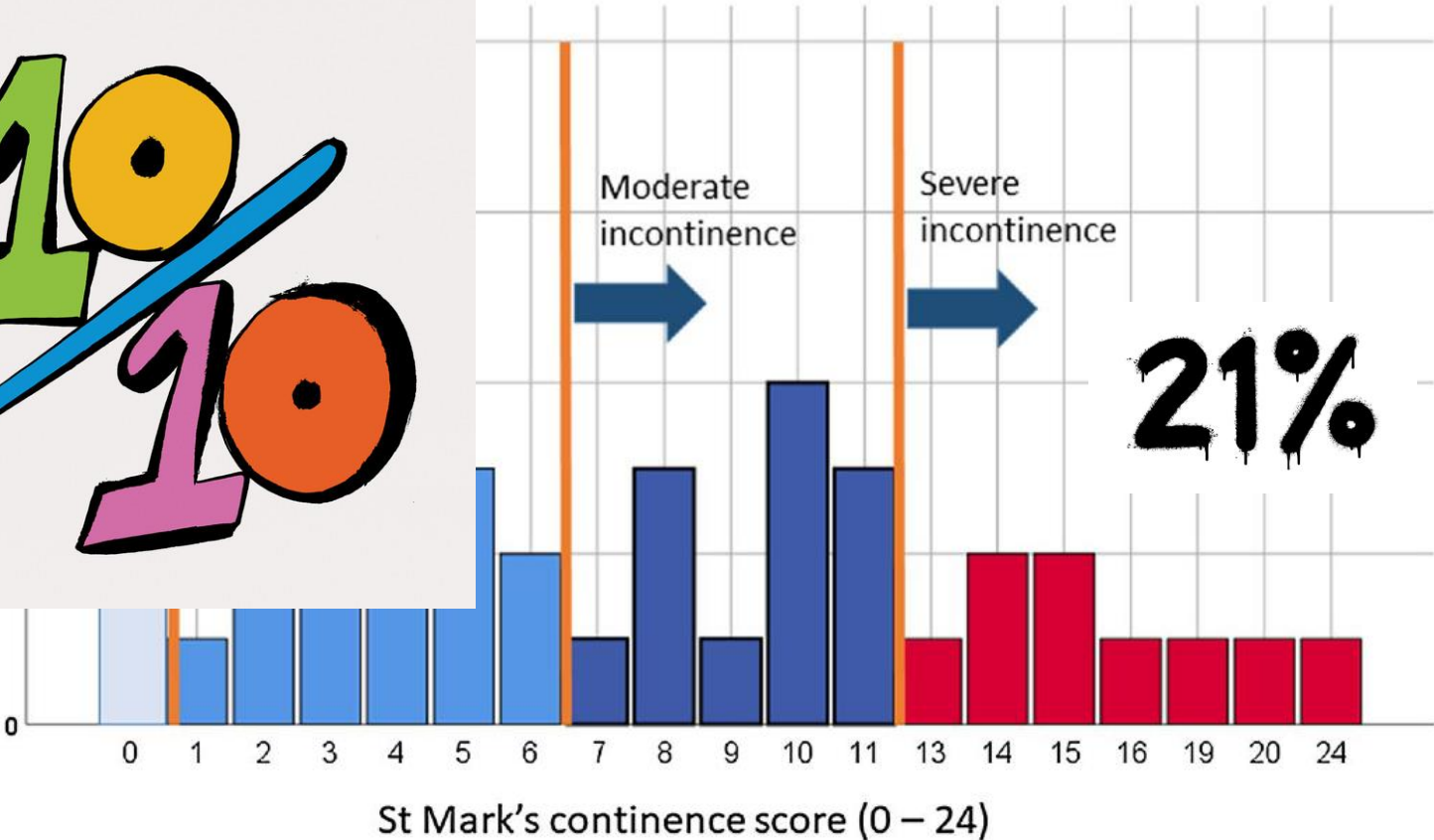
V. Patton^{1,2} · V. Balakrishnan¹ · C. Pieri¹ · P. Doherty¹ · K. C. Phan

102 TC & IRA

42 reached

Mean follow-up 15.9 (range; 1.7–29.7) years

10%



LONG-TERM

Received: 10 October 2022 | Revised: 31 December 2022 | Accepted: 28 January 2023

DOI: 10.1111/codi.16517

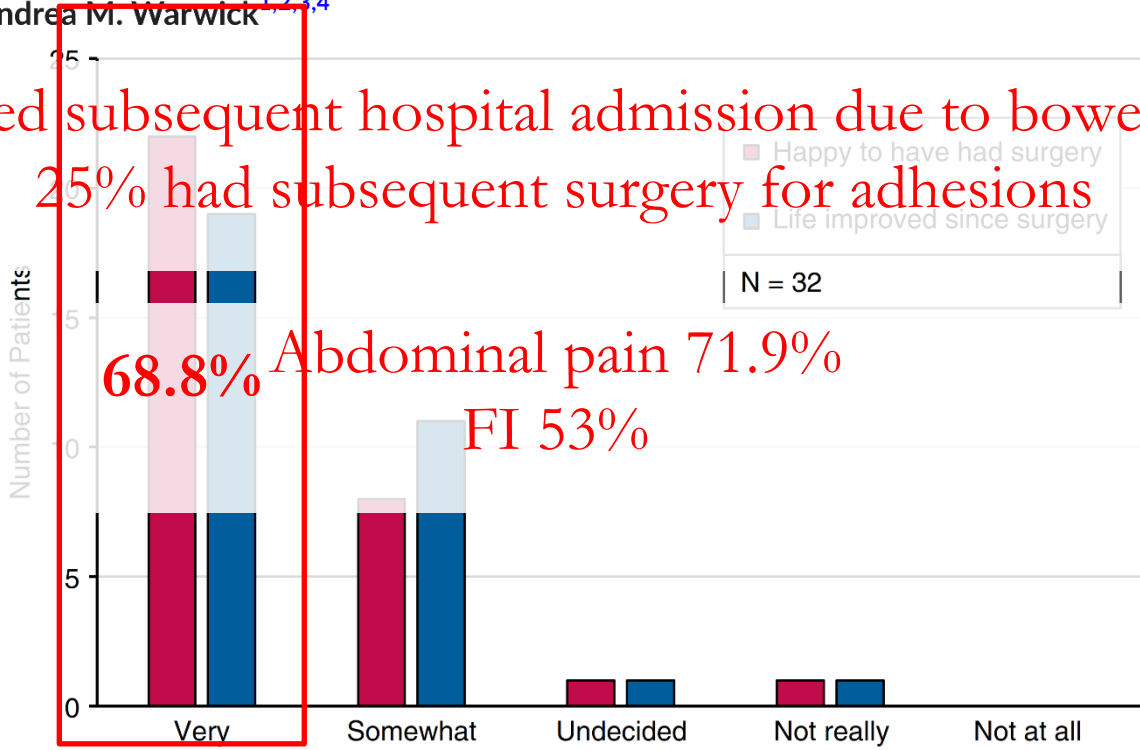
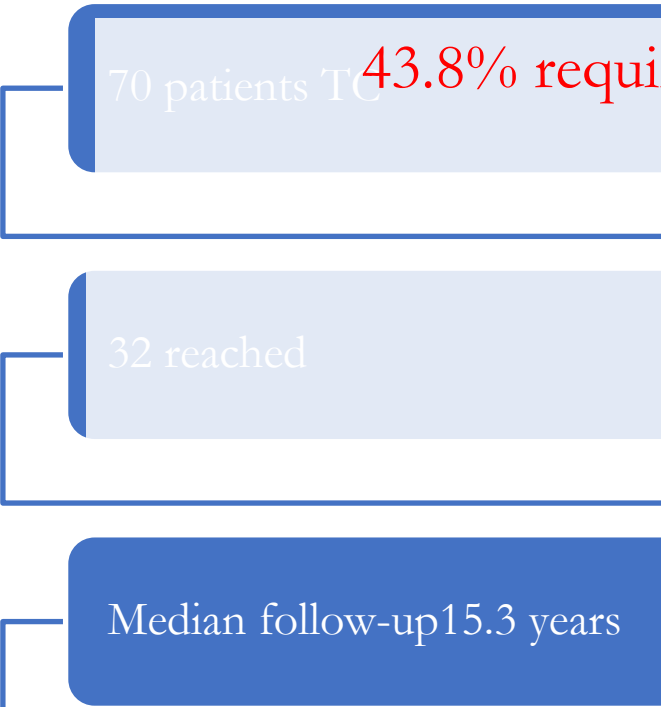
ORIGINAL ARTICLE

2023



Long-term outcomes of total colectomy for severe constipation

Ben J. Johnston¹ | David A. Clark^{1,2} | Andrea M. Warwick^{1,2,3,4}



43.8% required subsequent hospital admission due to bowel obstruction

25% had subsequent surgery for adhesions

68.8% Abdominal pain 71.9%
FI 53%

QoL

Wiadomości Lekarskie Medical Advances, VOLUME LXXVIII, ISSUE 4, APRIL 2025

WL

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ORIGINAL ARTICLE

2021

CONTENTS



Quality of life in patients with chronic slow-transit constipation according to the PAC-QOL scale one year after surgical treatment: comparison with preoperative data and reference values

Ivan M. Leshchyshyn, Leonid Yu. Markulan, Olga I. Okhotska, Yaroslav M. Susak, Pavlo L. Byk

107 (TC=57, STC=29, TPC=21)

PAC-QoL pre vs 1 year postoperative

Significant reduction of all PAC-QoL

SEGMENTAL COLECTOMY

Original article

2002



Outcome of segmental colonic resection for slow-transit constipation

E. Lundin, U. Karlbom, L. Pålman and W. Graf

28 patients

Stool frequency ↑

Median follow-up 50 months

Hard stool & straining ↓

82% pleased with outcomes

Impaired rectal sensation poor predictor

SEGMENTAL COLECTOMY

Updates in Surgery
<https://doi.org/10.1007/s13304-026-02788-3>

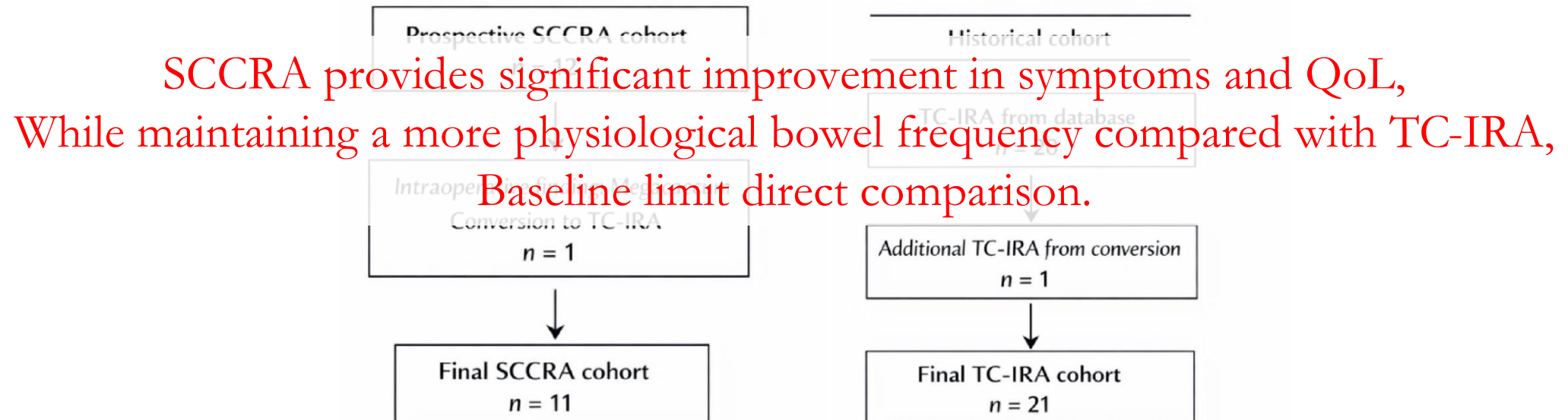
ORIGINAL ARTICLE

2026



Subtotal colectomy with antiperistaltic caecorectal anastomosis versus total colectomy with ileorectal anastomosis for refractory slow-transit constipation: a comparative analysis

Ugo Grossi¹ · Alice Pecorino² · Sayali Valiyeva³ · Nicola Passuello² · Carla Felice^{4,5} · Matteo Fassan^{5,6} · Emanuela Tessari² · Luca Faccio² · Antonio Rella² · Renato Pietroletti³ · Giacomo Sarzo²

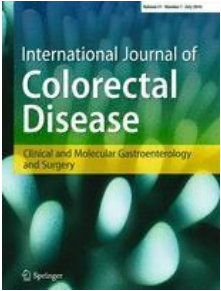


SEGMENTAL COLECTOMY

International Journal of Colorectal Disease (2019) 34:1013–1019
<https://doi.org/10.1007/s00384-019-03283-5>

ORIGINAL ARTICLE

2019



Long-term outcome after segmental colonic resection for slow transit constipation

Konstantinos E. Tsimogiannis¹ • U. Karlbom¹ • E. Lundin¹ • W. Graf¹

	Preoperative	Postoperative (long-term)	<i>p</i>	
Age at surgery				
Sex F/M ^{b,c}				
Symptom control	No laxatives	0	12	0.002 ^a
Stools frequency	Bulking agents	16	5	0.001 ^a
Straining ^{b,c}	Enemas, all types	11	2	0.004 ^a
Right hemicolectomy	Combinations	10	2	0.008
Left hemicolectomy				
Intraanal irrigation				
Transit time				

— = 11) **50**

Median follow-up 19.8 years

LIMITATIONS

- Various definitions of FC and STC
- No uniform methodology to perform and interpretate colonic transit study
- Heterogeneity in terms of study population
- Various definitions of treatment success
- Inconsistent selection criteria and clinical outcomes
- Absent of core outcome set
- Short-term follow up
- These limitations and heterogeneity hinder in between-study comparisons

Rao et al., (2005). Am J Gastroenterol; Heemskerk et al., (2023). Colorectal Dis

CONCLUSIONS

- Standardize **definition**, **diagnostic** protocol, and clinical **outcomes**
- Appropriate patients' **selection** and **counselling**
- A given treatment must be **individualized** according to patient's situation.
- Failure rates should be **discussed**, and patients should be aware of their alternatives.
- STC is **challenging**; it requires patient **education** and **multidisciplinary** approach
- Manage **expectations**
- Be aware of **exclusion criteria for colectomy**
- Both **quality** and **quantity** count

ANNOUNCEMENTS



ESCP
**21ST SCIENTIFIC
MEETING**
23-25 September 2026
Prague, Czech Republic

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COLOPROCTOLOGY

www.escp.eu.com



THANK YOU
ANY QUESTIONS
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