W9: Pelvic floor defecatory dysfunction: Management or cure?

Workshop Chair: Alexis Schizas, United Kingdom
13 September 2016 13:30 - 16:30

Start	End	Topic	Speakers
13:30	13:35	Introduction to the workshop	Alexis Schizas
13:35	13:50	Pathophysiology of PFDD	Alexis Schizas
13:50	14:05	Evaluation and Imaging of PFDD	Alison Hainsworth
14:05	14:20	PFDD in Urogynaecology and Urology Clinics	Heidi Brown
14:20	14:35	Psychological evaluation of patients with PFDD	Anton Emmanuel
14:35	15:00	Biofeedback in patients with PFDD	Doreen McClurg
15:00	15:30	Break	None
15:30	16:05	Hands on Training of Rectal Irrigation	Carlene Igbedoh
16:05	16:15	Pharmacological treatment of PFDD	Anton Emmanuel
16:15	16:25	Surgical treatment of PFDD	Alexis Schizas
16:25	16:30	Discussion	All

Aims of course/workshop

Aim:
The aim of this course is to learn how to evaluate and manage pelvic floor defecatory dysfunction (PFDD).

Objectives:
At the end of the workshop the participants should be able to:

- Understand the pathophysiology of pelvic floor defecatory dysfunction (PFDD)
- Recognise and classify types of PFDD
- How to evaluate PFDD
- Understand the role of imaging in patients with PFDD
- Understand the impact of PFDD in urinary and sexual function and what to do if patients present to a Urogynaeocology or Urology clinic and when to liaise with the Colorectal team
- Understand the role of biofeedback in the management of PFDD
- Learn how to use Rectal Irrigation as part of the management of PFDD
- Understand the pharmacological man

Learning Outcomes

At the end of the workshop the participants should be able to:

- Identify Pelvic floor disorders that affect defecation
- Understand the assessment of pelvic floor defecatory dysfunction and the necessity before embarking onto any treatment
- Urologists and Urogynaecologists need to be aware of PFDD when these patients present to their clinics with urinary and/or sexual symptoms
- Identify Biofeedback as first line management in patients with PFDD and be able to provide basic advice
- Able to understands the principle of Rectal Irrigation use in patients with PFDD
- Understand the pharmacological treatment of PFDD and how to escalate the different medication of PFDD
- Understand that surgery should be considered for management of PFDD but only when the underlying pathophysiological dysfunction has been corrected
- Understand the impact of mental health and the relationship to bowel dysfunction and when to refer to a specialist
- At the end of the workshop, the speakers will do a quiz where the participants should be able to demonstrate the newly acquired knowledge

Target Audience

Colorectal Surgeons, Urogynecologist, Urologists, Nurses, Physiotherapists, Clinical Psychologists

Advanced/Basic

Advanced

Suggested Learning before workshop attendance

- Anatomy and physiology of the pelvic floor complex, including the pelvic floor muscles, the external and internal anal sphincters and the endopelvic fascia
- Normal bowel function and defecation dynamics

Suggested Reading

See online handout for references and reading suggestions

Alexis Schizas

Introduction to the Workshop

Defecatory dysfunction of the pelvic floor includes both mechanical and functional anorectal disorders. This workshop will not only evaluate the most upto-date evidence regarding the recognition of pelvic floor defecatory dysfunction (PFDD), the assessment and treatment of PFDD, but the importance of collaborative work amongst the multidisciplinary team. We hope that you will find this workshop stimulating and that it will add to your clinical practice ensuring a safe and effective assessment and treatment of this group of patients.

Biofeedback

Biofeedback should be the first line management for pelvic floor defecatory dysfunction due to the minimal risk and the higher rate of success with completion of therapy. Biofeedback is based on behavior modification by using "operant conditioning techniques" to restore a normal pattern of defecation. The government principle is that any behavior when reinforced repeatedly can be learned and perfected.

Biofeedback retraining usually involves correcting the underlying pelvic floor dyssynergia by teaching patient to defecate effectively using bracing of the abdominal wall muscles and effective relaxation of the pelvic floor muscles with or without attempts to improve rectal sensory perception. There are three main methods of monitoring the function of the anus and providing biofeedback to patients. These methods include electromyography (EMG) biofeedback, manometry biofeedback and balloon sensory training.

During biofeedback sessions patients may also be given instruction on gut, rectal and pelvic floor muscle anatomy and function, as well as behavioral advice about frequency and length of toilet visits, posture on the toilet, increasing fiber and fluid intake and physical activity.

Pelvic floor muscle rehabilitation has become also an integral part of the treatment of these patients due to the higher incidence of other pelvic floor disorders associated with PFDD such as urinary incontinence and pelvic organ prolapse.

As an adjunct to Biofeedback, rectal irrigation has become rapidly an effective intervention in nearly half of the patients with pelvic floor defecatory dysfunction.

Although there is some debate in the literature about the degree of effectiveness of biofeedback, success rates range between 30 and 90% and preferred to by patients when compared to chronic laxative use. Poor prognosis of biofeedback includes those patients with eating disorders and untreated mental health disorders and they should be identified during initial evaluation, and referred to a psychologist or psychiatrist.

Take home message

- Biofeedback and/or conservative measures should be first line management in patients with PFDD
- Biofeedback is an established intervention for patients with PFDD that helps 30 to 90% of patients with PFDD

Pathophysiology of PFDD

PFDD occur in about 18% of the population and have a considerable impact on health costs and quality of life. PFDD encompasses both functional and mechanical causes. Before defaecation occurs the rectum dispense and the somatic sensation leads to a relaxation of the internal anal sphincter and if it is an appropriate time defaecation occurs. If it is not an appropriate time there is voluntary contraction of the external anal sphincter and pelvic floor muscles until the sensation to defecate passes and an appropriate time. In order to defecate the recto-anal angel straightens by squatting and correct defecatory dynamics are required (using the abdominal muscles and diaphragm).

Pelvic floor defecatory dysfunction is the difficulty in evacuation of the rectum. It can be classified into several groups:

1. Functional outlet obstruction (Inefficient relaxation of the anal sphincters, Internal anal sphincter, External anal sphincter and pelvic floor muscles, Neurological causes)
2. Mechanical outlet obstruction (Intrarectal intussusception/rectal prolapse, Enterocoele)
3. Defaecatory force and direction (Rectocoele, Perineal descent, Poor propulsive effort)
4. Colorectal Compliance (Mega rectum, Rectal hyposensitivity, Slow transit)

Patients with defecatory difficulties complain of symptoms of straining, feeling of incomplete evacuation, pain, digital assistance during defecation and unsuccessful attempts. They may also send an extended time on the toilet, have decreased bowel frequency; complain of post defecation soiling and fragmented defecation. They often complain of concomitant urinary and/or sexual symptoms.

Surgical management of PFDD
Conservative treatment is the initial treatment for defecatory dysfunction and correct defecatory technique is essential following surgery to prevent recurrence of symptoms and pathology.

Surgery can assist in correcting anatomical pathology and several surgical procedures are available.
1. Rectal prolapse surgery:
    - Transvaginal rectocoele repair and levatoplasty
    - Ventral mesh rectopexy
    - Stapled transanal resection of rectum
2. Full thickness rectal prolapse
    - Perineal procedures – Delorme's/ Altemeier's
    - Abdominal procedures – ventral mesh rectopexy, posterior mesh rectopexy, resection rectopexy, sutured rectopexy.
3. Intussusception
    - Ventral mesh rectopexy
    - Stapled transanal resection of rectum
4. Enterocoele
    - Transvaginal rectocoele repair, enterocele repair and levatoplasty
    - Ventral mesh rectopexy

Complications of surgery must be fully discussed and all patient's symptoms may not be corrected by surgery. Correcting anatomical abnormalities may not necessarily correct symptoms. Unfortunately, surgery can sometimes make pelvic floor symptoms worse.

Often rectal anatomical abnormalities are not found in isolation, patient may often have symptoms and pathology in the middle and anterior pelvic floor compartments.

A full pelvic floor assessment is required a combined colorectal/urology/urogynaecology approach may be required to achieve the best results for patients.

Take home message
A clear understanding of pathology is required to make an appropriate decision with each patient if any surgical options are available and which will be the most appropriate for their symptoms.

<u>Alison Hainsworth</u>
Evaluation and Imaging of Pelvic Floor Defaecatory Dysfunction
Robust assessment is required for optimal treatment planning of PFDD. There is no gold standard assessment tool but a combination of clinical, physiological and radiological tools are used.

Clinical Assessment
Pelvic floor defecatory dysfunction includes incomplete evacuation, post defecatory soiling, faecal urgency and incontinence. These may occur in those with malignancy, which must be excluded first. Incomplete evacuation, incontinence, constipation and symptoms attributable to anterior and middle compartmental dysfunction often co-exist and so it is difficult to diagnose pathology based on symptoms alone. Moreover, the association between symptoms and anatomical abnormalities is not absolute.

Treatment aims to reduce the 'bother' of symptoms and therefore a series of standardised questionnaires exist to objectively measure 'bother', quality of life and treatment outcomes. The obstructed defaecation syndrome (ODS) score is the only scoring system designed specifically for use with patients with pure outlet obstruction.

Examination includes digital rectal examination and vaginal examination.

Anorectal Physiology
The function of the anal canal and rectum is assessed by a catheter and includes rest and squeeze anal pressures; vectograms; first, urge and maximal sensation; rectal compliance and balloon evacuation. There is conflicting evidence on the association of rectal compliance with obstructive defaecation. Some demonstrate normal compliance and sensation in all subjects (with/ without a rectocele) whilst others show reduced rectal compliance and impaired sensation.

Defaecation Proctography
Defaecation Proctography is a dynamic investigation of rectal emptying involving the voluntary expulsion of barium paste recorded on cineradiography or fluororadiography. It is regarded as gold standard for the morphological assessment of posterior compartment pelvic floor disorders with the advantages of assessing defecatory dynamics. It provides structural and functional assessment of; rectocele, intussusception, rectal prolapse, enterocele, sigmoidocoele, perineal descent and the anorectal angle

along with anismus and evacuation. Pathological findings in asymptomatic volunteers have thrown into question proctographic parameters.

Defaecation MRI
Numerous techniques for MR defecography are described including the use of closed configuration magnets in the supine position or vertically open configuration magnets in the sitting position. MRI can distinguish between enterocele, sigmoidocoele and peritoneocoele without additional contrast but supine imaging underestimates pathology and open configuration magnets are inaccessible.

Integrated Total Pelvic Floor Ultrasound (endoanal, transvaginal, transperineal)
Endoanal, transvaginal and transperineal ultrasound are routinely used for anterior and middle compartmental assessment and the integrity of the anal sphincters. Its' use in the assessment of enterocele, rectocele, intussusception, rectal prolapse and anismus are being explored.

Endoanal ultrasound assesses the integrity of the internal and external sphincters and associated defects, sepsis, obstetric trauma or sphincter thickening.

Transperineal ultrasound is more likely that defaecation Proctography to make multiple diagnoses. It has a high positive predictive value and low negative predictive value for abnormalities compared to defaecation Proctography. It may provide a suitable screening tool for symptomatic patients though there remains insufficient evidence to adopt this as routine practice.

Take home message
Physiologic tests such as anorectal manometry and imaging such as Proctography and MRI play a key role in objective diagnosis and may assist in planning treatment for this group of patients.

Heidi Brown
Pelvic floor defecatory dysfunction: The Urogynecologist's Perspective
The urologist or urogynecologist's approach to defecatory dysfunction is similar to that of the colorectal surgeon but also often includes evaluation and investigation of concomitant urinary symptoms. Complaints of urinary urgency, frequency, or sensation of incomplete bladder emptying often prompt further investigation of bowel symptoms. Our approach to defecatory dysfunction includes: (1) clarification of patient symptoms; (2) consideration of underlying causes; (3) recommendation of conservative management as first-line therapy; and (4) pursuit of surgical repair when it is likely to improve symptoms.

According to ICS/IUGA terminology, **straining to defecate** refers to a patient's complaint of the need to make an intensive effort (by abdominal straining or Valsalva) to initiate, maintain, or improve defecation. **Feeling of incomplete (bowel) evacuation** is the complaint that the rectum does not feel empty after defecation, while **diminished rectal sensation** refers to diminished or absent sensation in the rectum. **Constipation** incorporates the Rome II criteria and encompasses complaints that bowel movements are infrequent and/or incomplete and/or there is a need for frequent straining or manual assistance to defecate [2]. **Splinting** refers to the need to digitally replace vaginal prolapse or otherwise apply manual pressure to the vagina or perineum, while **manual evacuation** refers to placement of fingers in the rectum to evacuate stool.

The pathophysiology of defecatory dysfunction is covered elsewhere in this workshop, but referral to a gastroenterologist may be helpful if you suspect systemic or motility disorders contributing to symptoms. The Pelvic Organ Prolapse Quantification (POP-Q) system [3] is used to quantify support defects in the posterior compartment, which may result in prolapse of the anterior rectal and posterior vaginal wall into the lumen of the vagina ('rectocele,') prolapse of the small bowel into the lumen of the vagina ('enterocele,') or perineal descent (perineum descending greater than or equal to 2 cm below the level of the ischial tuberosities at rest or at straining). Posterior compartment prolapse may be associated with splinting or manual evacuation symptoms, but most studies do not show a correlation between prolapse stage and defecatory symptoms.

First line management includes optimization of stool consistency through adjustments in fluid and fiber intake with additional pharmacologic therapy if necessary and referral to pelvic floor physiotherapy for muscle coordination, biofeedback, and behavioural coaching, including toileting behaviours. If symptoms persist following conservative management, surgical intervention is considered. Urogynecologists often approach posterior compartment prolapse with native tissue vaginal posterior repair with or without levator plication, which has success rates for anatomic restoration of 76–98% for traditional posterior colporrhaphy and 56–100% for site-specific repairs. Existing literature does not support the placement of biological or synthetic grafts in the posterior compartment, as they do not improve anatomic and symptomatic outcomes. If underlying concomitant reasons for defecatory dysfunction are not addressed prior to surgical repair, prolapse is likely to recur due to persistent straining. Transanal and transabdominal approaches to correct anatomic defects are more commonly performed by our colleagues in colorectal surgery.

Take home message

- Many women that present to the Urogynaecology/Urology clinics with urinary symptoms will have concomitant bowel dysfunction so an understanding of investigations, treatment options and when to seek further opinion once simple measures have failed is important.
- A multidisciplinary approach including dietetics, physiotherapy, gastroenterology, colorectal surgery, and urogynaecology is preferred to ensure patients receive individualized and appropriate therapy.

Anton Emmanuel

Psychological evaluation

Patients with functional colorectal problems often have symptoms related to other aspects of pelvic floor function. In addition, they often have non-pelvic comorbidity in the form of other functional disorders (such as fibromyalgia, chronic back pain). The multiplicity of symptoms, and the nature of symptoms being often related to intimate or taboo functions mean that there is often an associated psychological dimension to be considered. In turn, these psychological symptoms can cause exacerbation of pelvic floor dysfunction.

The spectrum of psychological morbidity ranges from low-grade anxiety to fullblown mood disorder. As such it is little surprise that purely focussing on the surgical aspects of management of pelvic dysfunction is likely to result in poor outcomes for the patient. Psychological evaluation is key to optimising treatment outcomes with other modalities, but also key to help explain the complexity of symptoms to patients and validate why they may have emotional complaints alongside the physical. The family drawing test has been used in children and adults to assess cognitive, interpersonal and psychological functioning. It has been investigated in patients with pelvic floor dysfunction and may be an alternative to obtaining a formal psychiatric or psychological opinion. This is a test for somatisation which can also be assessed by the PHQ-15 or the modified for GI patients PHQ-12. In terms of clinic assessment without needing referral to a psychological service, anxiety and depression can be identified by use of the HAD questionnaire and there is an extensive literature of this instrument being used to identify cases as well as reflect progress with therapies. Pain questionnaires and maintaining a bowel diary are also helpful assessment tools, which can aid by pointing to possible trigger factors and cyclical patterns.

Ultimately there will be a small group of patients who may be suffering with significant psychiatric disease. This includes, but is not limited to, atypical eating disorders. The clinician needs to keep an open mind and keen eye and ear to detect language and features that point to this. It is critical to identify these patients early and not subject them to both intrusive and surgical therapies or to behavioural therapies, which are not likely to succeed and rather defer the patient's access to correct psychiatric therapies.

Pharmacological therapy

Drug therapy of pelvic floor dysfunction mostly relates to managing bowel function. Optimising bowel frequency and consistency is a key component of behavioural or surgical therapies in this patient group.

In terms of constipation there is a rational approach to laxatives and rectal therapies that needs to be developed. These are potent drugs and they are not mutually interchangeable. Rather it is important that the clinician understands how to choose the right agent according to the particular symptom profile of the patient. Equally it is important to understand how laxatives may need to be used in terms of regular or as required use in order to get the best effect of these medications. Such an understanding arises from understanding the differing mechanisms of actions of laxatives. Newer generation prokinetic and secretagogue agents have emerged which offer an effective option for a proportion of patients who are refractory to laxatives.

For diarrhoea the standard has been to use non-centrally acting opioid agonists in titrated fashion. Tricks of optimising this therapy can help some patients in order to avoid the adverse effects of agents that have adverse brain and dependence effects. New agents are emerging for such patients with diarrhoea, but a key part of the clinical work up of patients is to look for common (and overlooked) comorbidities, which may be causing diarrhoea (such as bile acid malabsorption, pancreatic insufficiency and coeliac diseases).

Finally there is a role of managing pain in many patients with pelvic floor dysfunction and the role of tricyclic agents and anti-epileptics is central to this.

Take home message

- Occasionally there is an underlying psychological problem that needs to be addressed when treating PFDD
- Managing stool consistency and bowel frequency as well as treating pain when necessary is a key component of managing this group of patients

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Pelvic floor defecatory dysfunction: Management or cure?

46th ICS Annual Scientific Meeting
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Welcome! Kon'nichiwa!

Thank you for attending our workshop

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Pelvic floor defaecatory dysfunction: Management or cure?

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16:25	16:30	Discussion	All

Pelvic floor defaecatory dysfunction: Management or cure?

Aim: The aim of this course is to learn how to evaluate and manage pelvic floor defaecatory dysfunction (PFDD)

The objectives for this workshop are:

- Pathophysiology
- Recognise and classify types
- Learn how to evaluate
- Understand the role of imaging

Pelvic floor defaecatory dysfunction: Management or cure?

- Understand the impact of PFDD
  - urinary and sexual function
- Present to a Urogynaeocology or Urology
  - when to liaise with the Colorectal team
- Role of biofeedback
- Rectal irrigation
- Pharmacological management
- Surgical management
- Importance of psychological assessment

Pelvic floor defaecatory dysfunction: Management or cure?

At the end of the workshop the participants should be able to:

- Identify pelvic floor disorders that affect defecation
- Assessment
- Awareness of PFDD
- Biofeedback
- Provide basic advice
- Pharmacological treatment
- Escalation of the different medications
- Surgery should be considered after underlying pathophysiological dysfunction has been corrected
- Impact of mental health

Pathophysiology of PFDD

Alexis Schizas
Consultant Colorectal Surgeon

Affiliations to disclose†:

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Pathophysiology of PFDD

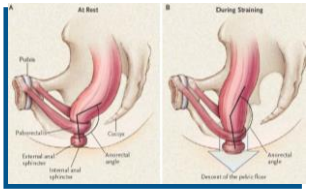
- PFDD occur in about 18% of the population
- Considerable impact on health costs
- Quality of life
- Functional and mechanical causes

Pathophysiology of PFDD

- Before defaecation occurs
  - rectum dispense and the somatic sensation
  - relaxation of the internal anal sphincter
  - if it is an appropriate time defaecation occurs
  - if not there is voluntary contraction
    - until the sensation to defecate passes

Pathophysiology of PFDD

- To defecate
  - the recto-anal angle straightens by squatting
  - correct defaecatory dynamics are required
  - abdominal muscles and diaphragm



Pathophysiology of PFDD

- Patients with defaecatory difficulties complain of:
  - symptoms of straining
  - feeling of incomplete evacuation
  - pain
  - digital assistance during defecation
  - unsuccessful attempts
  - spend an extended time on the toilet
  - decreased bowel frequency
  - complain of post defecation soiling
  - fragmented defecation
- Often complain of concomitant
  - urinary and/or sexual symptoms

Ano rectal physiology made simple

PFDD

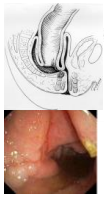
- PFDD is the difficulty in evacuation of the rectum
- Classified into several groups:
  - Functional outlet obstruction
    - (Inefficient relaxation of the anal sphincters, Paradoxical sphincter contraction (anismus), neurological causes)
  - Mechanical outlet obstruction
    - (itrarectal intussusception/rectal prolapse, enterocoele)
  - Defaecatory force and direction
    - (rectocoele, perineal descent, poor propulsive effort)
  - Colorectal Compliance
    - (mega rectum, rectal hyposensitivity, slow transit)
  - Pelvic pain syndromes
    - (levator syndrome, coccygodynia, proctalgia fugax, pudendal neuralgia)

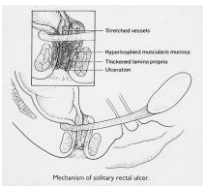
PFDD

- PFDD is the difficulty in evacuation of the rectum
- Classified into several groups:
  - Functional outlet obstruction
    - inefficient relaxation of the anal sphincters
    - paradoxical sphincter contraction (anismus)
    - neurological causes

PFDD

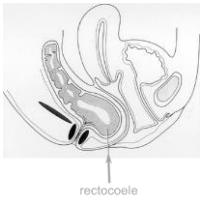
- Classified into several groups:
  - Mechanical outlet obstruction
    - intrarectal intussusception
    - SRUS
    - rectal prolapse
    - enterocoele





PFDD

- Classified into several groups:
  - Defaecatory force and direction
    - rectocoele
    - perineal descent
    - poor propulsive effort



PFDD

- Classified into several groups:
  - Colorectal Compliance
    - mega rectum
    - rectal hyposensitivity
    - slow transit

PFDD

- Classified into several groups:
  - Pelvic pain syndromes
    - levator syndrome
    - coccygodynia
    - proctalgia fugax
    - pudendal neuralgia

PFDD

- Causes of Constipation
  - Dietary
    - Low fibre, dieting, dementia, depression, anorexia, fluid depletion
  - Metabolic
    - Diabetes mellitus, hypercalcaemia, hypokalaemia, hypothyroidism, porphyria
  - Neurological
    - Parkinson's disease, spinal cord pathology, multiple sclerosis
  - Iatrogenic
    - Antacids that contain aluminium, iron, anticholinergics, antidepressants, opiates for analgesia
    - Post-operative
  - Painful anorectal conditions
    - Anal fissure, haemorrhoids, abscess, fistula
    - Toilet avoidance

PFDD

- Complex problem of rectal evacuation
- Severity variable
- Symptoms difficult to describe
- Defined by a combination of symptoms
- Pathophysiology not clear
  - Widening of the pelvic floor hiatus
  - Descent of pelvic
    - obesity
    - menopause
    - pregnancy
    - childbirth
    - inherited collagen deficiency
    - congenitally weak connective tissue

Alison Hainsworth

Affiliations to disclose†:

BK Medical

† All financial ties (over the last year) that you may have with any business organisation with respect to the subjects mentioned during your presentation

Funding for speaker to attend:

- [ ] Self-funded
- [x] Institution (non-industry) funded
- [x] Sponsored by: BK Medical

Evaluation and Imaging of PFDD

Alison Hainsworth
Colorectal Surgical Registrar/ Research Fellow

Aims of Presentation

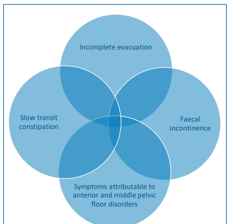
Assessment of pelvic floor defaecatory dysfunction -

- Clinical Assessment
  - History
  - Symptom Severity Scores
  - Clinical Examination
- Anorectal Physiology
- Barostat
- Radiological Investigations
  - Colonic Transit Studies
  - Defaecatory Imaging (proctogram/ MRI)
  - Integrated Total Pelvic Floor Ultrasound

Clinical History

- Rule out organic disease
- Symptoms

difficulty initiating rectal emptying
incomplete evacuation,
a feeling of obstruction
pelvic pressure
digitation (rectal/ vaginal)
straining
rectal pain/ bleeding
post defaecatory soiling
faecal incontinence



Not possible to distinguish between pathologies based on symptoms alone [1]

(1) Mertz H, Naliboff B, Mayer EA. Symptoms and physiology in severe chronic constipation. American Journal of Gastroenterology 94, 131-138. 1999.

Clinical History

- Link between symptoms & structural abnormalities not absolute.

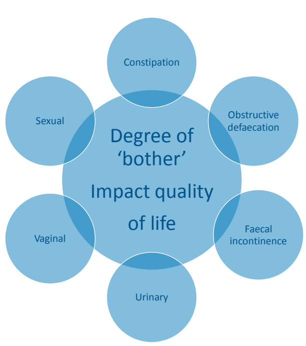
Is incomplete evacuation due to a rectocoele? [1]
Overlap between rectocoele & intussusception?[2;3]
Enterocoele symptoms vague[4]

- Not clear which symptom characteristics predict optimal treatment outcomes?

Vaginal digitation may predict improvement after rectocoele repair [5;6]
Evacuatory difficulty may predict optimal results with biofeedback[7]

(1) Zbar AP, Lienemann A, Fritsch H, Beer-Gabel M, Pescatori M. Rectocele: pathogenesis and surgical management. Int J Colorectal Dis 2003 Sep;18(5):369-84.
(2) Collinson R, Cunningham C, D'Costa H, Lindsey I. Rectal intussusception and unexplained faecal incontinence: findings of a proctographic study. Colorectal Dis 2009 Jan;11(1):77-83.
(3) Dvorkin LS, Knowles CH, Scott SM, Williams NS, Lunniss PJ. Rectal intussusception: characterization of symptomatology. Dis Colon Rectum 2005 Apr;48(4):824-31.
(4) Beer-Gabel M, Assoulin Y, Amitai M, Bardan E. A comparison of dynamic transperineal ultrasound (DTP-US) with dynamic evacuation proctography (DEP) in the diagnosis of cul de sac hernia (enterocele) in patients with evacuatory dysfunction. Int J Colorectal Dis 2008 May;23(5):513-9.
(5) Murthy VK, Orkin BA, Smith LE, Glassman LM. Excellent outcome using selective criteria for rectocele repair. Dis Colon Rectum 1996 Apr;39(4):374-8.
(6) Van Laarhoven CJ, Kamm MA, Bartram CI, Halligan S, Hawley PR, Phillips RK. Relationship between anatomic and symptomatic long-term results after rectocele repair for impaired defecation. Dis Colon Rectum 1999 Feb;42(2):204-10.
(7) Chiarioni G, Salandini L, Whitehead WE. Biofeedback benefits only patients with outlet dysfunction, not patients with isolated slow transit constipation. Gastroenterology 2005 Jul;129(1):86-97.

Symptom Scoring



Questionnaires - Symptom Scoring

- Symptom severity, treatment outcomes
- The International Consultations on Incontinence (ICI)
  - universally applicable questionnaires, international populations
  - clinical practice and research
  - bowel, urinary, bladder, sexual,
  - quality of life [1]
- Obstructed defaecation syndrome (ODS) score
  - pure outlet obstruction
  - statistically validated
  - clustering of symptoms associated with different subtypes [2]

(1) Abrams P, Avery K, Gardener N, Donovan J. The International Consultation on Incontinence Modular Questionnaire: www.iciq.net. J Urol 2006 Mar;175(3 Pt 1):1063-6.
(2) Altomare D.F, Spazzafumo M, Rinaldi M, Dodi G, Ghiselli R, Piloni V. Set-up and statistical validation of a new scoring system for obstructed defaecation syndrome. Colorectal Disease 10, 84-88. 2007.

Questionnaires - Symptom Scoring

Questionnaire	Purpose	Validation
ICIQ – BS **ICIQ – VS** **ICIQ – UI Short form**	Symptoms Bother	Validated - protocol
Obstructed defaecation syndrome (ODS) score	Symptom Treatment	Reliable Repeatable
Cleveland Constipation Score	Diagnosis	Correlates
The Knowles Eccersley Scott Symptom (KESS) score - constipation	Diagnosis Subgroups	Cross validation
Patient Assessment of Constipation Symptom (PAC – SYM) **Patient Assessment of Constipation Quality of Life (PAC – QOL)**	Treatment Burden	Consistent, reproducible, valid, responsive
Wexner Continence Grading Scale **St Marks' Faecal Incontinence score**	Symptoms	Reliable Sensitive to change
Bladder control self-assessment questionnaire (B-SAQ)	Screening	Psychometrically robust

Clinical Examination

- Inspection
- Digital Rectal Examination
  - Muscle tone
  - Ask patient to expel the examining finger
    - **Anismus**
    (sensitivity 77%, specificity 87%[1]).
    - **Intussusception**
    (detects a third of intussusception[2])
    - **Rectocoele**
- Vaginal Examination

1) Tantiphlachivan, Rao F, Attaluri A, Rao SS. Digital rectal examination is a useful tool for identifying patients with dyssynergia. Clin Gastroenterol Hepatol 2010 Nov;8(11):998-60.
2) Felt-Bersma RJ, Ludi WJ, Janssen JJ, Meuwissen SG. Defecography in patients with anorectal disorders. Which findings are clinically relevant? Dis Colon Rectum 1990 Apr;33(4):277-80.

Anorectal Physiology

The function of the anal canal & rectum is assessed

Anorectal manometry –
- rest
- squeeze
- push

RAIR

Sensory testing –
- Balloon inflation

Balloon evacuation –
- Timing & ability

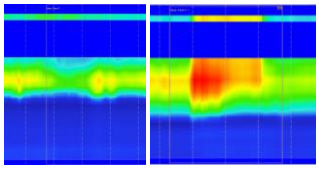
Barostat
- Compliance & capacity

Anorectal Physiology and Anismus

Dyssynergy has four patterns during anorectal manometry[1];

	Anal Pressure	Rectal Pressure
Type I	Paradoxical ↑	Adequate ↑
Type II	Paradoxical ↑	No adequate ↑
Type III	Failure to ↓	Adequate ↑
Type IV	Failure to ↓	No adequate ↑

Normal relaxation on pushing | Paradoxical contractions on pushing



1) Rao SS. Dyssynergic defecation and biofeedback therapy. Gastroenterol Clin North Am 2008 Sep;37(3):569-86, viii.

Anorectal Physiology and Anismus

Little agreement on optimal method of diagnosis

- Anorectal manometry

  Grossi et al.
  170 women, functional constipation vs age matched controls.
  90% of healthy volunteers had an 'abnormal' pattern ? use of manometry for diagnosis [1]

- Sphincter electromyography (EMG) during voiding

- Balloon expulsion (timing and ability) during voiding

  Chiarioni et al.
  286 patients and 40 controls
  good agreement
  balloon expulsion & anorectal manometry
  balloon expulsion & EMG [2]

  Palit et al.
  100 patients
  considerable disagreement
  balloon expulsion & anorectal manometry
  & evacuation proctography [3]

1) Grossi U, Carrington EV, Bharucha AE, Horrocks EJ, Scott SM, Knowles CH. Diagnostic accuracy study of anorectal manometry for diagnosis of dyssynergic defecation. Gut 2016 Mar;65(3):427-35.
2) Chiarioni G, Kim DM, Vantini I, Whitehead WE. Validation of the balloon evacuation test: reproducibility and agreement with findings from anorectal manometry and electromyography. Clin Gastroenterol Hepatol 2014 Dec;12(12):2099-56.
3) Palit S, Thin N, Knowles CH, Lunniss PJ, Bharucha AE, Scott SM. Diagnostic disagreement between tests of evacuatory function: a prospective study of 100 constipated patients. Neurogastroenterol Motil 2016 May 7.

Barostat

- Rectal compliance & capacity
- Not routine practice
- Conflicting evidence

Gosselink et al.
Normal compliance and sensation in all (with/ without rectocoele)[1]

Schouten et al.
Reduced rectal compliance
Impaired sensation[2]

Hicks et al.
Rectal compliance and capacity higher with rectocoele[3]

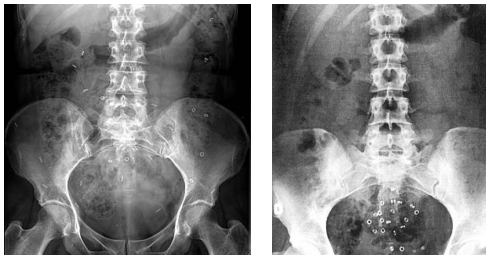
Sloots et al.
Rectal compliance unaltered after rectocoele repair[4]

1) Gosselink, M.J., Hop, W.C., & Schouten, W.R. 2001b. Rectal compliance in females with obstructed defecation. *Dis.Colon Rectum*, 44, (7) 971-977 available from: PM:11496077
2) Schouten, W.R., Gosselink, M.J., Boerma, M.O., & Ginai, A.Z. 1998. Rectal wall contractility in response to an evoked urge to defecate in patients with obstructed defecation. *Dis.Colon Rectum*, 41, (4) 473-479
3) Hicks CW, Weinstein M, Wakamatsu M, Pulliam S, Savitt L, Bordeianou L. Are rectoceles the cause or the result of obstructed defaecation syndrome? A prospective anorectal physiology study. Colorectal Dis 2013 Aug;15(8):993-9.
4) Sloots, C.E., Meulen, A.J., & Felt-Bersma, R.J. 2003. Rectocele repair improves evacuation and prolapse complaints independent of anorectal function and colonic transit time. *Int.J.Colorectal Dis.*, 18, (4) 342-348

Radiology

- Colonic Transit Studies
- Defaecatory Imaging
- Integrated Total Pelvic Floor Ultrasound

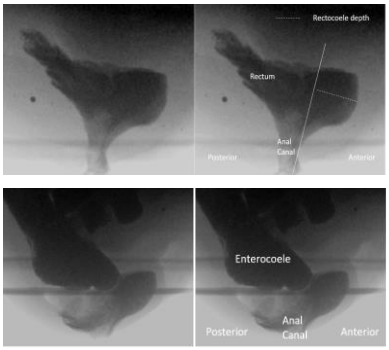
Colonic Transit Study



Fluoroscopic Defaecation Proctography

- Fluoroscopic defaecation proctography/ evacuatory proctography/ defaecography
- Dynamic investigation - rectal emptying
- Structural & functional
- Multi-compartmental

Fluoroscopic Defaecation Proctography



Fluoroscopic Defaecation Proctography

What is normal?

- Shorvon et al.
- 47 volunteers
- Rectocoele - 17/20 nulliparous women
- Intussusception – over half ≥ grade IV[1]

- Palit et al.
- 46 volunteers
- Rectocoele - up to 3.9cm may be asymptomatic
- Intussusception – ≥ 20% grade III[2]

1) Shorvon PJ, McHugh S, Diamant NE, Somers S, Stevenson GW. Defaecography in normal volunteers: results and implications. Gut. 1989 Dec;30(12):1737-49
2) Palit S, Bhan C, Lumnis PJ, Boyle DJ, Gladman MA, Knowles CH, et al. Evacuation proctography: a reappraisal of normal variability. Colorectal Dis. 2014 Jul;16(7):538-46

Fluoroscopic Defaecation Proctography

- Rectocoele & barium trapping
  - More common in larger rectocoeles[1]

- Debate
  - Is barium trapping truly associated with symptoms?[2]
  - More complete evacuation after evacuation in private[3]
  - No association - barium trapping & response to surgery[4]
  - Response of vaginal splinting may predict clinical significance[5]

(1) Mellgren A, Bremmer S, Johansson C, Dolk A, Uden R, Ahlback SO, et al. Defecography. Results of investigations in 2,816 patients. Dis Colon Rectum. 1994 Nov;37(11):1133-41.
(2) Halligan S, Bartram CI. Is barium trapping in rectoceles significant? Dis Colon Rectum. 1995 Jul;38(7):764-8.
(3) Greenberg T, Kelvin FM, Maglinte DD. Barium trapping in rectoceles: are we trapped by the wrong definition? Abdom Imaging. 2001 Nov;26(6):587-90.
(4) Stojkovic SG, Balfour L, Burke D, Fissan PJ, Sagar PM. Does the need to self-digitate or the presence of a large or nonemptying rectocoele on proctography influence the outcome of transanal rectocoele repair? Colorectal Dis. 2003 Mar;5(2):169-72.
(5) Murthy VK, Orkin BA, Smith LE, Glassman LM. Excellent outcome using selective criteria for rectocele repair. Dis Colon Rectum. 1996 Apr;39(4):374-8.

Fluoroscopic Defaecation Proctography

Intussusception and constipation

- Dvorkin et al.
- 896 patients
- no symptoms predict obstructing intussusception on proctogram[1]

Intussusception and faecal incontinence

- Plays important role in faecal incontinence[2]

- Hawkins et al.
- 147 patients
- ↑ grade of intussusception - ↑ severity of incontinence[3]

(1) Dvorkin LS, Knowles CH, Scott SM, Williams NS, Lunniss PJ. Rectal intussusception: characterization of symptomatology. Dis Colon Rectum 2005 Apr;48(4):824-31.
(2) Collinson R, Cunningham C, D'Costa H, Lindsey I. Rectal intussusception and unexplained faecal incontinence: findings of a proctographic study. Colorectal Dis 2009 Jan;11(1):77-83.
(3) Hawkins AT, Olariu AG, Savitt LR, Gingipally S, Wakamatsu MM, Pulliam S, et al. Impact of Rising Grades of Internal Rectal Intussusception on Fecal Continence and Symptoms of Constipation. Dis Colon Rectum 2016 Jan;59(1):54-61.

Fluoroscopic Defaecation Proctography

Substantial diagnostic and therapeutic effect and benefit regarding

- diagnostic confidence,
- resolving diagnostic conflict
- determining intended management[1,2]

BUT should not solely be relied upon for treatment planning

(1) Harvey CJ, Halligan S, Bartram CI, Hollings N, Sahdev A, Kingston K. Evacuation proctography: a prospective study of diagnostic and therapeutic effects. Radiology 1999 Apr;211(1):223-7.
(2) Bartram C. Dynamic evaluation of the anorectum. Radiol Clin North Am 2003 Mar;41(2):425-41.

Defaecation MRI

Dynamic conditions or expulsion of USS gel

Sitting or supine

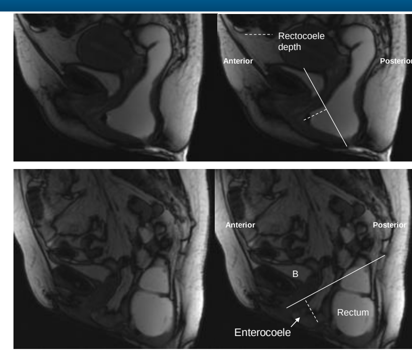
Structural and functional assessment of

- Anterior
- Middle
- Posterior

compartments

NB: Levator plate, anal sphincter complex if necessary

Defaecation MRI



Defaecation MRI

Sitting vs supine MRI (small studies) –

Sitting	Supine
Greater degree of pelvic floor laxity during dynamic imaging	All intussusceptions missed (though dynamic imaging only)
Significant difference in position of bladder, vagina and anorectal junction during dynamic imaging	
BUT no difference in position of anorectal junction in defaecatory imaging	
More enterocoeles seen	Less enterocoeles seen
Small rectocoeles seen	Small rectocoeles missed
BUT not necessarily superior for depicting clinically relevant findings	

Bertschinger, K.M., Hetzer, F.H., Roos, J.E., Treiber, K., Marincek, B., & Hilfiker, P.R. 2002. Dynamic MR imaging of the pelvic floor performed with patient sitting in an open-magnet unit versus with patient supine in a closed-magnet unit. *Radiology*, 223, (2) 501-508
Fielding, J.R., Griffiths, D.J., Versi, E., Mulkern, R.V., Lee, M.L., & Jolesz, F.A. 1998. MR imaging of pelvic floor continence mechanisms in the supine and sitting positions. *AJR Am J Roentgenol.*, 171, (6) 1607-1610
Iacobellis, F., Brillantino, A., Renzi, A., Monaco, L., Serra, N., Feragalli, B., Iacomino, A., Brunese, L., & Cappabianca, S. 2016. MR Imaging in Diagnosis of Pelvic Floor Descent: Supine versus Sitting Position. *Gastroenterol.Res.Pract.*, 2016,

Defaecation MRI vs Defaecation Proctography

Author	n	Position	Rectal evacuation	Conclusions
Pilkington et al.	42	Supine	Yes	MRI - ↓intussusception -↑anismus
Pannu et al.	82	Supine	Yes (35) No (47)	With contrast – similar Without contrast – MRI↓ abnormalities
Kelvin et al.	10	Supine	Yes	Similar detection rates – prolapse
Vanbeckevoort et al.	35	Supine	No	MRI lower sensitivity
Schoenenberger et al.	15	Sitting	Yes	MRI superior
Healy et al. a	24	Supine	No	MRI more organ decent
Healy et al. b	10	Supine	No	MRI no rectal intussusception/ prolapse
Lienemann et al.	44	Supine	Yes	MRI more accurate prolapse & descent
Delemarre et al.	51	Prone	No	Examination for rectocoele corresponds with defaecation proctography but not MRI

- MRI underestimates posterior pathology
- Contrast **expulsion is the key** to detection of pathology
- Reason for underestimation probably difficulty evacuating contrast when supine

Defaecation MRI

What is normal?

(asymptomatic subjects – rectocoele, pelvic floor hypermobility[1]).

Decision making

Small studies - has clinical impact

Rentsch et al.
20 patients
77.3% - confirmed clinical diagnoses
34% - revealed combined pelvic floor disorders[2]

Kaufman et al.
22 patients
41% - changed operative plan[3]

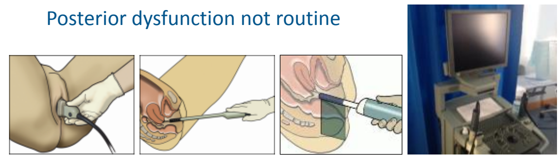
(1) Schreyer AG, Paetzel C, Furst A, Dendl LM, Hutzel E, Muller-Wille R, et al. Dynamic magnetic resonance defecography in 10 asymptomatic volunteers. World J Gastroenterol 2012 Dec 14;18(46):6836-42.
(2) Rentsch M, Paetzel C, Lenhart M, Feuerbach S, Jauch KW, Furst A. Dynamic magnetic resonance imaging defecography: a diagnostic alternative in the assessment of pelvic floor disorders in proctology. Dis Colon Rectum 2001 Jul;44(7):999-1007.
(3) Kaufman HS, Buller JL, Thompson JR, Pannu HK, DeMeester SL, Genadry RR, et al. Dynamic pelvic magnetic resonance imaging and cystocolpoproctography alter surgical management of pelvic floor disorders. Dis Colon Rectum 2001 Nov;44(11):1575-83.

Integrated Total Pelvic Floor Ultrasound

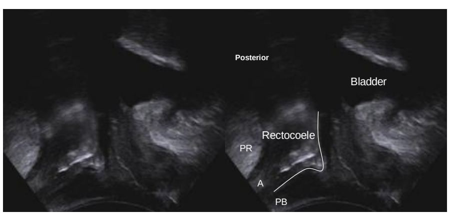
Endoanal, transperineal and transvaginal ultrasound

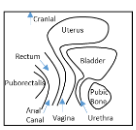
Routine
- anterior/ middle dysfunction
- endoanal - anal sphincters

Posterior dysfunction not routine



Integrated Total Pelvic Floor Ultrasound





Transperineal Ultrasound vs Defaecation Proctography

Author	n	Findings
Beer Gabel et al.	105	Sensitivity good/ excellent & specificity high for rectocoele, intussusception, enterocoele, rectal prolapse.
Martellucci et al.	54	Agreement substantial/ perfect for rectocoele, intussusception, enterocoele No significant difference for anorectal angle
Steensma et al.	75	Agreement moderate/ good - rectocoele/ enterocoele, fair - intussusception.
Beer Gabel et al.	62	Both methods accurate for cul-de-sac hernia Ultrasound more readily diagnoses peritoneocoele, upgrades enterocoele
Perniola et al.	37	High positive predictive value for rectocoele, intussusception, rectal prolapse Poor agreement for rectocoele (& depth), intussusception, anorectal angle
Grasso et al.	43	Moderate agreement for rectocoele, excellent agreement for intussusception, excellent concordance for ARA straining / rest ratio
Brusciano et al.	114	High specificity - intussusception and rectocoele. Transperineal ultrasound confirm rectocoele, intussusception and enterocoele
Beer Gabel et al.	33	Good agreement for rectocoele, intussusception, rectal prolapse. Ultrasound more likely to make multiple diagnoses No difference in measurement of anorectal angle, anorectal junction position

- Ultrasound is a suitable screening tool for defaecatory dysfunction

Anorectal Physiology

Advantages	Useful in diagnosis of…	Disadvantages	Unhelpful in diagnosis of…
• Bedside test • Minimally invasive • Physiology and function • Biofeedback tool	• Neurological conditions • Muscle tone, sphincter injury, fistulas • Anismus • Increased rectal capacity	• Debate - no international standardisation for techniques and normal values - anismus - rectal compliance • Left lateral	• Structural problems

Fluoroscopic Defaecation Proctography

Advantages	Useful in diagnosis of…	Disadvantages	Unhelpful in diagnosis of…

• Available, practical
• Cost
• Functional & anatomical assessment of defaecatory dynamics
• Sitting
• Expulsion contrast
• Visual biofeedback
	• Posterior compartmental dysfunction
	• Barium trapping in a rectocoele
	• Effect of vaginal splinting & correct defaecatory techniques
		• No consistency in technique
		• Debate
		  • normal parameters
		  • implications of findings
		• Radiation
		• Multicompartmental assessment – contrast
			• Anterior and middle compartmental prolapse (unless contrast)

Defaecation MRI

Advantages	Useful in diagnosis of…	Disadvantages	Unhelpful in diagnosis of…
• Functional & anatomical assessment of defaecatory dynamics • Open configuration magnets – sitting • Expulsion of contrast • Multicompartmental • Soft tissue • No radiation	• Multicompartmental • Trapping of gel in rectocoele • Effect of vaginal splinting and correct defaecatory techniques	• Expense • Limited access to open configuration magnets • Pathology may be underestimated due to; - Supine - No expulsion of rectal contrast	• If no rectal expulsion - intussusception

Integrated Total Pelvic Floor Ultrasound

Advantages	Useful in diagnosis of…	Disadvantages	Unhelpful in diagnosis of…
• Dynamic multicompartmental assessment without contrast • Safe, cheap, portable, • One stop clinic • Visual biofeedback • ?Screening tool	• Multicompartmental assessment • Screening tool for obstructed defaecation	• User dependent, training, experience • Gynaecological/ left lateral position • Expulsion of rectal gel not routine • May underestimate pathology • Splinting effects of probe ?distort anatomy/ prevent Valsalva	• Completeness and pattern of evacuation • Effects of vaginal splinting and correct defaecatory techniques

Summary

No one perfect assessment tool

Combination

- **clinical review**
- physiological examination
- radiological investigation

} determine pathophysiology, treatment planning

MDT

Future developments - ? imaging with simultaneous physiological assessment.

Psychological Evaluation of PFDD

Anton Emmanuel

Biofeedback in Pelvic Floor Defaecatory Dysfunction

Doreen McClurg

Heidi Wendell Brown, MD, MAS

Affiliations to disclose†:

Consultant: Grand Rounds, Inc.

Research Funding: Wisconsin Multidisciplinary K12 Urologic Research Career Development Program (NIH K12DK100022

† All financial ties (over the last year) that you may have with any business organisation with respect to the subjects mentioned during your presentation

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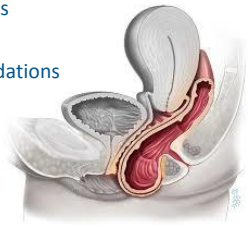
Urology /urogynaecology perspective

Overview

- Definitions
- Concomitant Symptoms
- Evaluation (POP-Q)
- Treatment Recommendations



www.iuga.org

Joint Terminology

- **Straining to defecate:** need to make intensive effort (by abdominal straining or Valsalva) to initiate, maintain, or improve defecation
- **Splinting:** need to digitally replace vaginal prolapse / apply manual pressure to vagina / perineum
- **Manual evacuation:** placement of fingers in the rectum to evacuate stool
- **Feeling of incomplete evacuation:** rectum does not feel empty after defecation
- **Diminished rectal sensation:** decreased / absent sensation of contents in the rectum

Abrams P, Cardozo L, Khoury AAD, Wein A (2013) 5th International Consultation on Incontinence. ICUD-EAU. ISBN : 978-9953-493-21-3

Functional Constipation (Rome III)

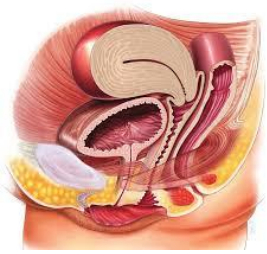
1. ≥2 symptoms w/ ≥ 25% of defecations over last 3 mo:
   - Straining
   - Lumpy or hard stools
   - Sensation of incomplete evacuation
   - Sensation of anorectal obstruction / blockage
   - Manual maneuvering required (vaginal or rectal)
   - Fewer than 3 defecations / week
2. Loose stools rarely present without use of laxatives
3. Insufficient criteria for irritable bowel syndrome

http://www.romecriteria.org/assets/pdf/19_RomeIII_apA_885-898.pdf

When you have a hammer…

Concomitant Symptoms

- Urinary incontinence
- Urinary urgency
- Urinary frequency
- Urinary retention
- Fecal incontinence
- Pelvic organ prolapse



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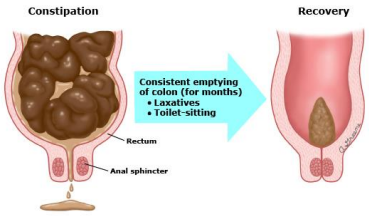
Urinary Symptoms & Bowel Dysfunction

Roommates in a small apartment

- Stool in rectum can press on bladder → urgency, frequency
- Incontinence can be related to pressure, retention, loss of pelvic floor muscle coordination
- Retention from urethral occlusion or underlying nerve dysfunction

http://www.mountnittany.org/articles/healthsheets/11940

Fecal Incontinence and Defecatory Dysfunction



- Child holds in stool because of pain
- Stretched out nerves and muscle that don't work well
- Buildup of hard stool
- Soft stool may move around hard stool and leak out

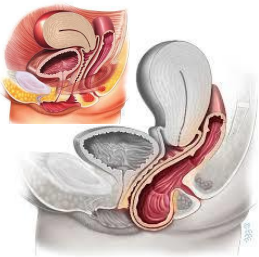
- Thicker, stronger muscle that works well
- Nerves able to sense need to go
- Sphincters able to prevent leaking

www.utdol.com

Prolapse and defecatory dysfunction

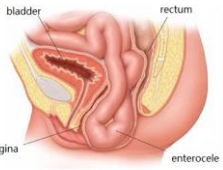
Posterior or apical vaginal support defects can cause defecatory dysfunction.

Rectocele



www.iuga.org

Enterocele



http://colorectalsurgeonssydney.com.au/?page_id=1281

Defecatory dysfunction and prolapse

https://www.pinterest.com/pin/574983077397795060/

Chronic straining damages pelvic floor support and can lead to pelvic organ prolapse in any compartment.

Urogynecologist's Evaluation

- History
  - Duration, bother, mediators and triggers
  - Prior therapies and results
  - Alarm symptoms → referral
- Validated Instruments
  - Pelvic Floor Distress Inventory (PFDI)
  - Pelvic Floor Impact Questionnaire (PFIQ)
  - Bristol Stool Scale
- Physical Exam

Pelvic Floor Distress Inventory

Patient Name: _____ Date: _____ Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6):	NO	YES — If yes, how much does it bother you?			
	No	Not at all	Somewhat	Moderately	Quite a bit
1. Usually experience *pressure* in the lower abdomen?	0	1	2	3	4
2. Usually experience *heaviness* or *dullness* in the pelvic area?	0	1	2	3	4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
5. Usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4

Colorectal-Anal Distress Inventory 8 (CRADI-8):	No	Not at all	Somewhat	Moderately	Quite a bit
7. Feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
9. Usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
10. Usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
11. Usually lose gas from the rectum beyond your control?	0	1	2	3	4
12. Usually have pain when you pass your stool?	0	1	2	3	4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4

Urinary Distress Inventory 6 (UDI-6):	No	Not at all	Somewhat	Moderately	Quite a bit
15. Usually experience frequent urination?	0	1	2	3	4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of need to go to the bathroom?	0	1	2	3	4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
19. Usually experience difficulty emptying your bladder?	0	1	2	3	4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1	2	3	4

Pelvic Floor Impact Questionnaire (PFIQ):

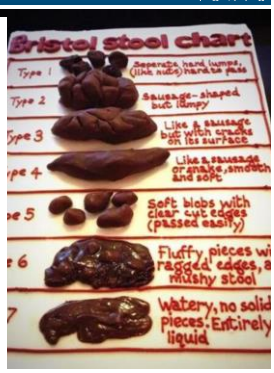
A validated, condition-specific Quality of Life instrument

How do symptoms or conditions relate to the following → usually affect your ↓	*Bladder or urine*	*Bowel or rectum*	*Vagina or pelvis*
1. Ability to do household chores (cooking, housecleaning, laundry)?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit
3. Entertainment activities such as going to a movie or concert?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit
5. Participating in social activities outside your home?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit
6. Emotional health (nervousness, depression, etc)?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit
7. Feeling frustrated?	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit	□ Not at all □ Some what □ Moderately □ Quite a bit

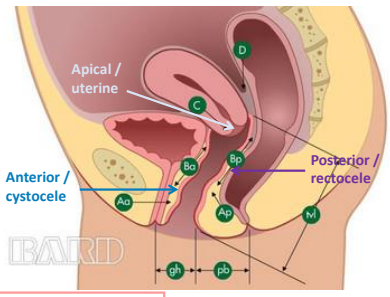
Assessment of Stool Consistency

Bristol Stool Chart

Type 1	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear-cut edges (passed easily)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. **Entirely Liquid**



Urogyn Physical Exam: POP-Q



http://www.bardmedical.com/POPQ

Prolapse Reduction Cough Stress Test

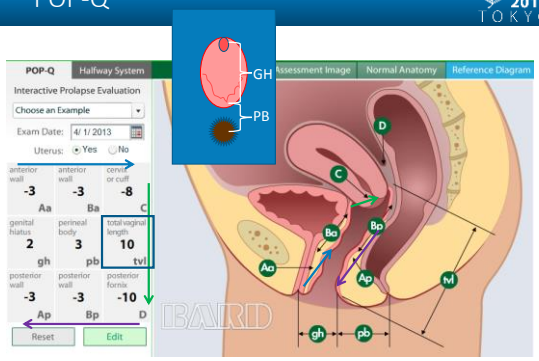
If bulge, reduce with large Q-tip(s)

Have patient valsalva x 3

Have patient cough x 3

Enterocele and rectocele can be preventing urine leakage.

POP-Q



http://www.bardmedical.com/POPQ

POP-Q Helpful Hints

1. Inside the hymen, measurements are negative
2. Outside the hymen, measurements are positive
3. At the hymen, measurement is 0
4. If symptoms are out of proportion to exam findings, have patient STAND and observe prolapse with valsalva in standing position.

POP-Q Measurement Sites

Points	Description	Range of Values
Aa	Anterior vaginal wall 3 cm proximal to the hymen	-3 cm to + 3 cm
Ba	Most distal position of the remaining upper anterior vaginal wall	-3 cm to + tvl
C	Most distal edge of cervix or vaginal cuff scar	- tvl to + tvl
D	Posterior fornix (N/A if post hysterectomy)	
Ap	Posterior vaginal wall 3 cm proximal to the hymen	-3 cm to + 3 cm
Bp	Most distal position of the remaining upper posterior vaginal wall	-3 cm to + tvl

Additional Measurements:

Genital hiatus (gh) – Measured from middle of external urethral meatus to posterior midline hymen

Perineal body (pb) – Measured from posterior margin of gh to middle of anal opening

Total vaginal length (tvl) – Depth of vagina when point D or C is reduced to normal position

http://www.bardmedical.com/POPQ

POP-Q Staging Criteria

Stage	POP-Q measurements
Stage 0	Aa, Ap, Ba, Bp = -3 cm and C or D ≤ - (TVL – 2) cm
Stage I	Stage 0 criteria not met and leading edge < -1 cm
Stage II	Leading edge ≥ -1 cm but ≤ +1 cm
Stage III	Leading edge > + 1 cm but < + (TVL – 2) cm
Stage IV	Leading edge ≥ + (TVL – 2) cm

Reference: Bump RC, Mattiasson A, Bo K, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol. 1996;175:13.

http://www.bardmedical.com/POPQ

Baden-Walker Halfway System

About the Baden-Walker Halfway System

The Baden-Walker Halfway System is designed to measure the most distal portion of the prolapse site in relationship to the hymen. The halfway system does not require site-specific measurements of the vagina and the perineal body in relation to the hymen.

Grade	Position of most distal prolapse site
0	No prolapse
1	Halfway to hymen
2	To hymen
3	Halfway past hymen
4	Maximum descent

Reference: Baden WF, Walker TA, Lindsay HJ. The vaginal profile. Tex Med J. 1968;64:56-58.

http://www.bardmedical.com/POPQ

Physical Exam

Bimanual exam:
- Uterine size, position, mobility, tenderness
- Adnexal masses / tenderness

Levator spasm / tenderness (pain)

Brink Scale to assess pelvic floor strength

Rectal exam – r/o masses, assess sphincter
- Anal sphincter tone at rest and with squeeze
- Intact anal sphincter? (place thumb in vagina while index finger is in rectum and palpate muscle)

Physical exam: Brink Scale (3-12)

Vaginal pressure or muscle force
- 1 - no response
- 2 - weak squeeze
- 3 - moderate squeeze
- 4 - strong squeeze

Elevation/vertical displacement of examiner's fingers
- 1 – none
- 2 – fingertip moves anteriorly
- 3 – whole length of fingers move anteriorly
- 4 – whole fingers move anteriorly, are gripped and pulled in

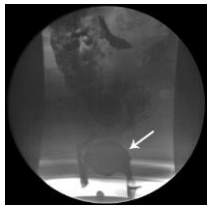
Duration of contraction
- 1 - none
- 2 - <1 second
- 3 - 1–3 seconds
- 4 - >3 seconds

Defecography if symptoms ≠ exam

Prior to defecation

Black arrow: vagina
White arrow: rectum

With attempt to defecate:



Rectocele

http://www.mghradrounds.org/index.php?src=gendocs&link=2009_april

Urogyn Management: First Line

- If alarm signs: referral to GI
- Optimization of stool consistency through adjustments in fluid and fiber intake with additional pharmacologic therapy if necessary (referral to dietitian / nutrition)
- Referral to pelvic floor physiotherapy for muscle coordination, biofeedback, and behavioural coaching, including toileting behaviours
- Re-evaluate symptoms in 3 months

Urogyn Treatment Options

If not bothered: Nothing!

If bothered: Knee injury analogy

- Physical therapy
- Brace (pessary)
- Surgery

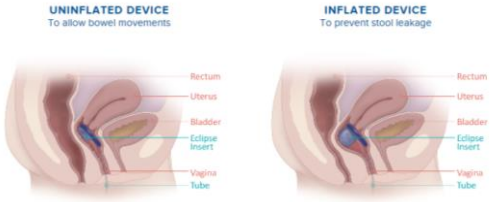
50% success with PT pessary

Can always do surgery

http://www.clinicalhealthservices.com/universalkneesupport.aspx

Eclipse vaginal bowel control system

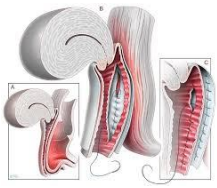
- N = 61 subjects fitted / 110 enrolled
- 6 episodes / week → 1 episode per week (1 month)
- No device-related serious adverse events
- Pelvic cramping and discomfort (esp during fitting)



Richter et al, Obstetrics & Gynecology 2015; 125(3):p 540–547

Surgical repair

1. Offered if symptoms persist after other treatments fail.
2. Posterior compartment prolapse with native tissue vaginal posterior repair has success rates for anatomic restoration of 76–98% for traditional posterior colporrhaphy and 56–100% for site-specific repairs.
3. No role for biological or synthetic grafts in the posterior compartment.



Post-op: avoid constipation / straining

http://www.evidentlycochrane.net/feet-up-constipation/

Conclusions & Recommendations

- Symptom tracking enables self-directed, personalized effort and evaluation of results
- Best outcomes involve multidisciplinary approach to optimize various mechanisms contributing to symptoms

Affiliations to disclose†:

The equipment utilised as part of this presentation has been kindly donated by the following companies:

- Coloplast
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- BBraun

† All financial ties (over the last year) that you may have with any business organisation with respect to the subjects mentioned during your presentation

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Trans-anal Irrigation Therapy (TAI)

By
Carlene Igbedioh
Clinical Nurse Specialist

Aims of this presentation

- What is Trans-anal Irrigation Therapy?
- How does it work? And Benefits
- Indications and Contraindications
- Complications of TAI
- When should TAI be considered?
- Patient selection/investigations required/initiating treatment
- What does the literature say?
- Rectal Irrigation systems
- Rectal Irrigation – Decision Matrix
- Trouble shooting

Trans-anal irrigation therapy

- Trans-anal irrigation therapy (TAI), commonly known as Rectal irrigation, involves facilitation of bowel evacuation by instilling water into the rectum via the anus, using either a balloon catheter or cone delivery system.

Emmett et al. BMC Gastroenterology (2015) 15:139
Emmanuel et al. Spinal Cord (2013) 51:732–738

History of TAI

- 1500 B.C., the 'Ebers Papyrus', an ancient Egyptian medical document, described the many benefits of colon cleansing.
  - It was designed to counteract the effects of "*autointoxication*"
- Later the Greeks and the Romans used it to treat "fevers and intestinal worms".
- Dr Ardene (English surgeon; 1307-1390) advocated that "each person should be purged 3 to 4 times a year to maintain good health".

http://www.jacemedical.com/colon_articles/The%20history%20of%20colonic%20hydrotherapy.pdf

History of TAI

- The 17th century known as the age of the enema and the use of syringes for "internal washing or lavament"
  - Reached the height of fashion during the years of the reign of Louis XIV (1638-1715) who is reported to have over 2000 'Clysters or enemas'
  - Regnier De Graaf was the first one to describe the use of enemas with syringes in his treatise De Clysteribus published in 1668.

- In a 1917 edition of the Journal of American Medical Association (JAMA) Dr. Kellog reported that in over forty thousand gastrointestinal disease cases, he had used surgery in only twenty cases. The rest were helped as a result of **cleansing the bowels**, diet and exercise.
  - He advertised that his sanitarium had rooms "devoted to rectal and bowel applications."

http://www.jacemedical.com/colon_articles/The%20history%20of%20colonic%20hydrotherapy.pdf

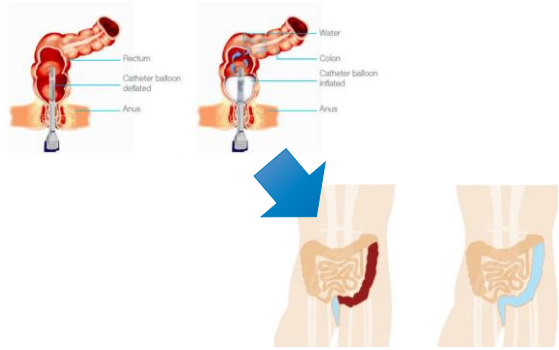
TAI in modern medicine

- Reintroduced into modern medicine in the 1980's as a treatment of neurological bowel dysfunction (Spina Bifida, MS, …)
- And more recently (early 2000's) to treat Pelvic pelvic floor defecatory dysfunction (functional bowel dysfunction)!

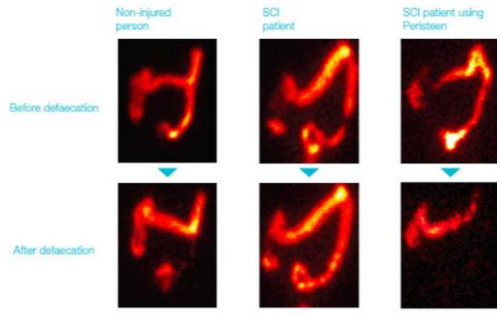


How does TAI work?

- TAI assists bowel evacuation by introducing warm water into the rectum and colon via the anus and using a balloon catheter and/or cone system;
- The balloon catheter or cone delivery system is attached via a plastic tube to an irrigation bag holding up to 1.5 liters of water although typically only 0.5–1 liter is required;
- Alternatively a low-volume system consisting of a hand pump and a cone may be employed. This will normally deliver up to 80mls of water;
- The water is subsequently evacuated into the toilet with the content of the descending colon, sigmoid colon and rectum.

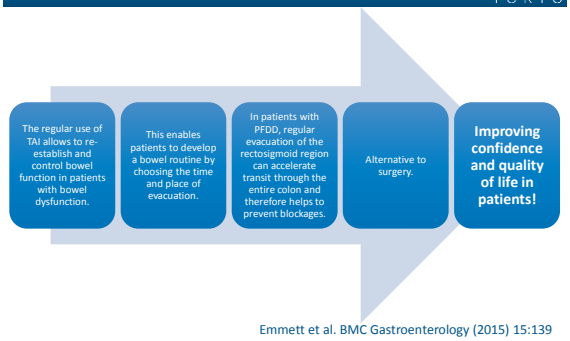


TAI



https://vimeo.com/50975672 Christensen et al. (2003) Dis Colon Rectum 46:68-76

Benefits of TAI



Emmett et al. BMC Gastroenterology (2015) 15:139
Emmanuel et al. Spinal Cord (2013) 51:732–738
Christensen et al. Gastroenterology (2006) 131(3):738-47

Indications of TAI

- Pelvic floor defecatory dysfunction: Obstructed defecation syndrome (ODS), Functional defecation disorder (FDD), Chronic idiopathic constipation (CIC), and Constipation-predominant irritable bowel syndrome (IBS-C).
- Idiopathic Post-traumatic Constipation
- Neurological Bowel dysfunction (MS, SCI, Spina bifida…)

Emmett et al. BMC Gastroenterology (2015) 15:139

Contraindications

Absolute contraindications:

- Anal or rectal stenosis
- Active inflammatory bowel disease
- Acute diverticulitis
- Colorectal cancer
- Within 3 months of rectal surgery
- Within 4 weeks after endoscopic polypectomy
- Ischaemic colitis

Relative contraindications/ Precautions:

- Severe diverticulosis
- Long-term steroid medication
- Radiotherapy to the pelvis
- Prior rectal surgery
- Faecal impaction
- Painful anal conditions
- Current or planned pregnancy
- Bleeding diathesis or anticoagulant therapy
- Severe autonomic dysreflexia
- Change of bowel habit
- The use of rectal medication
- Children below 3 years of age
- Severe heart/liver disease

Emmanuel et al. Spinal Cord (2013) 51:732–738

Complications – Bowel perforation

- Bowel perforation is a rare complication of TAI
  - DRE/Patient evaluation is mandatory pre TAI!
- The patient usually experiences:
  - Severe/sustained pain in the abdomen/back
  - Severe anal bleeding
  - Patient should be advised to seek immediate medical help!
- In order to minimize the risk:
  - Training the patient! + Discuss symptoms of bowel perforation
  - Regular contact + contact details of the health professional that provided the TAI system

Emmanuel et al. Spinal Cord (2013) 51:732–738

Tech Coloproctol (2016) 20:109–115
DOI 10.1007/s10151-015-1400-8

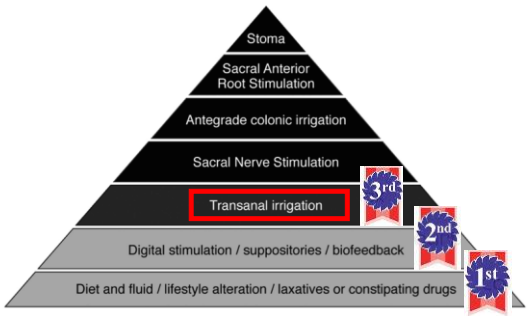
ORIGINAL ARTICLE

Global audit on bowel perforations related to transanal irrigation

P. Christensen[1] · K. Krogh[2] · B. Perrouin-Verbe[3] · D. Leder[4] · G. Bazzocchi[5] · B. Petersen Jakobsen[6] · A. V. Emmanuel[7]

Conclusion Enema-induced perforation is a rare compli-
cation to ti Irrigation,
which inc rt of the
further use is present
during trea ior pelvic
organ surg valuation
and proper e practice
of this technique.

When should TAI be considered?



Emmanuel et al. Spinal Cord (2013) 51:732–738

Patient selection and work up!

- The patient should be known to the health care professional initiating TAI
  - Pathophysiology and clinical indication of TAI
- The escalation of treatment pre TAI is an important part of deciding which method of TAI
  - Complying with clinical guidance and clinical governance
- Psyche and Motivation!
- Patient's manual dexterity

Maybe the patient has already designed her/his own TAI system!!!!

Picture taken with patient's permission.

Patient assessment pre TAI

- Review bowel management and ensure that the appropriate escalation of treatment has been completed!
- Assessment by a clinically competent TAI health care professional:
  - Symptoms up to date and comparison to the first visit with an appropriate outcome measure
  - Review PMHx, DHx and SurgHx=check contraindications!
  - Impact on QoL/ADL's
  - DRE±VE±Abdominal palpation
  - Bowel diary
  - 'Home made treatments' (coffee enemas, colonic irrigation, etc…)

Does the patient require any investigations pre TAI?

- Necessary to exclude RED FLAGS!
  - Triage clinic in our unit
- Depending on primary referrer
  - GP/Family doctor versus Colorectal Surgeon
- Bowel investigations:
  - Colonoscopy?
  - Flexible sigmoidoscopy?
  - Anorectal physiology?
  - Endoanal/Pelvic floor ultrasound?
  - Transit studies?

Initiating treatment

- PRACTICE-PRACTICE-PRACTICE-PRACTICE!!!
- Patient training
  - Explain rationale and procedure for the use of TAI
    - "Make it personal": correlation of the benefit of using TAI with the patient's symptoms and the alternative of not using TAI
    - Ensure the patient provides consent!
  - The patient should demonstrate "competence in clinic"
  - Establish a routine for the patient
    - Is there a better time? What about making use of the gastrocolic reflex?
  - Discuss frequency of TAI
    - Ideally, daily use and decrease to alternate days when patient confident with the use and experienced benefit of TAI (individual to each patient!)
  - Further encouragement of an appropriate diet and fluid intake with a reminder of defecation dynamics

- Ongoing support/adherence to the TAI
  - Follow up in person or via a telephone appointment
  - Is there a specific timeframe??
    - At GSTT, patient is contacted at two weeks via telephone and in the long term access to a group session.
- Discuss use of water and number of pumps required with each TAI system
- Set up realistic expectations
  - It may take a few weeks for an optimum benefit of TAI
- Discuss expected complications with the TAI system and how to resolve them
- Discuss the use of laxatives as an adjunct to TAI depending on initial diagnosis and indication of TAI

What does the literature say?

Scandinavian Journal of Gastroenterology, 2010; 45: 517–527

informa
healthcare

REVIEW ARTICLE

Transanal irrigation for disordered defecation: A systematic review

In patients with chronic idiopathic constipation, defecation disturbances after anorectal surgery or miscellaneous functional bowel problems, transanal irrigation can be attempted as a simple and reversible treatment, but whether it is superior to other non-surgical procedures remains to be studied. However, it seems reasonable to offer transanal irrigation before irreversible surgical procedures are considered.

Key Words: *Constipation, disordered defecation, enema, faecal incontinence, neurogenic bowel dysfunction, review, transanal irrigation*

Emmett et al. *BMC Gastroenterology* (2015) 15:139
DOI 10.1186/s12876-015-0354-7

BMC Gastroenterology

RESEARCH ARTICLE Open Access

Trans-anal irrigation therapy to treat adult chronic functional constipation: systematic

Conclusions: The reported success rate of irrigation for functional constipation is about 50 %, comparable to or better than the response seen in trials of pharmacological therapies. TAI is a safe treatment benefitting some patients with functional constipation, which is a chronic refractory condition. However findings for TAI vary, possibly due to varying methodology and context. Well-designed prospective trials are required to improve the current weak evidence base.

Methods: Evidence for effectiveness and safety was reviewed and the quality of studies was assessed. Primary research articles of patients with chronic functional constipation, treated with TAI as outpatients and published in English in indexed journals were eligible. Searching included major bibliographical databases and search terms: bowel dysfunction, defecation, constipation and irrigation. Fixed- and random-effect meta-analyses were performed.

Results: Seven eligible uncontrolled studies, including 254 patients, of retrospective or prospective design were identified. The definition of treatment response varied and was investigator-determined. The fixed-effect pooled response rate (the proportion of patients with a positive outcome based on investigator-reported response for each study) was 50.4 % (95 % CI: 44.3–56.5 %) but featured substantial heterogeneity ($I^2 = 67.1$ %). A random-effects estimate was similar: 50.9 % (95 % CI: 39.4–62.3 %). Adverse events were inconsistently reported but were commonplace and minor.

Conclusions: The reported success rate of irrigation for functional constipation is about 50 %, comparable to or better than the response seen in trials of pharmacological therapies. TAI is a safe treatment benefitting some patients with functional constipation, which is a chronic refractory condition. However findings for TAI vary, possibly due to varying methodology and context. Well-designed prospective trials are required to improve the current weak evidence base.

Received: 4 April 2016 / Accepted: 28 April 2016

Tech Coloproctol
DOI 10.1007/s10151-016-1502-y

ORIGINAL ARTICLE

Results of long-term **patients**

Abstract

Background The aim of the present study was to determine the success rate, quality of life and predictive factors of success associated with long-term rectal cleansing (RC) for defecatory disorders.

Methods All patients who started RC between January 2010 and August 2014 in our referral hospital were sent questionnaires concerning actual RC, Short Form 36 Health Survey (SF-36), Fecal Incontinence Quality of Life (FI-QoL) and the Beck Depression Inventory (BDI). In

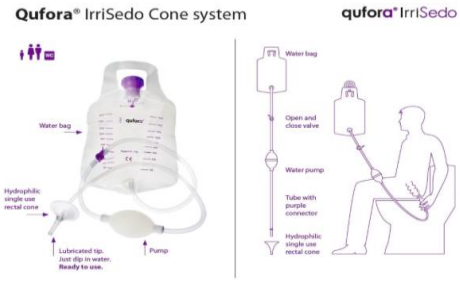
Conclusions RC is a moderately effective long-term alternative in patients who do not respond to medical therapy and biofeedback exercises. There is a high dropout rate in the first months, but a moderate rate of continuation in the period hereafter. No predictive factors for continuation were found in medical history or function tests. Those who continued RC performed better on the SF-36 subscale energy/fatigue.

Enough with the overview, lets get our hands dirty now!

TAI systems

- Peristeen – Coloplast
  - https://www.youtube.com/watch?v=M89WHE3TAZA

- Qufora IrriSedo Cone Guide
  - https://www.youtube.com/watch?v=4YLSg8RDE_I



- Qufora Balloon Irrigation system
  - https://www.youtube.com/watch?v=XV6H-AEiEb8

- Qufora IrriSedo Mini Guide
  - https://www.youtube.com/watch?v=Ar4BAwIBvUk

- Irypump® S Rectal Irrigation with Cone
  - https://www.youtube.com/watch?v=uOslfrGqZzk

TAI – Decision Matrix

	Rectal Balloon System	Cone Shape System	Pump System	Evidence	Available on prescription (UK)
Peristeen®	✓			RCT & Observational	Yes
Qufora Cone Toilet®		✓		Observational	Yes
Qufora Balloon System ®	✓			Observational	Yes
Qufora Mini System®		✓		Observational	Yes
Irypump ®			✓	Observational	Yes

TAI – Decision Matrix

	Clinical Indication	Why	Rationale
System®	soiling, post defecation soiling, rectocele	Start defecation of clear the rectum	Able to use it on the go

Cannot recommend one system over another!
Most of the time depends on clinicians clinical experience + competence with TAI systems!

Christensen et al (2003) Dis Colon Rectum 46:68-76

Emmanuel et al. Spinal Cord (2013) 51:732–738

Trouble-shooting

Consensus review of best practice of transanal irrigation in adults

Emmanuel et al. Spinal Cord (2013) 51:732–738

Bleeding	A small amount of bleeding is to be expected More copious or regular bleeding requires further investigation Haemorrhage with or without pain suggests a probable perforation, which should be treated as a medical emergency
Pain	If cramps, discomfort or pain occur while instilling the irrigation, pause instillation for a few moments and continue more slowly once the discomfort has subsided, ensure that irrigant is warm enough—at body temperature, around 36–38 1C If pain is severe/persistent stop irrigating—possible bowel perforation— medical emergency
Autonomic dysreflexia and autonomic symptoms during irrigation (sweating, palpitations and dizziness)	Instil the irrigant slowly Limit time on toilet depending on tolerance If symptoms are bothersome, ensure the patient is not alone when irrigating until symptoms at each TAI are reduced/absent If patient is at risk of AD medication should be immediately available in the home setting If AD occurs, stop irrigation immediately. Further assessment and possibly other interventions are required before continuing with TAI
Digital rectal check and removal of stool if present Increase frequency and/or volume of transanal irrigation to ensure evacuation is adequate	Digital rectal check and removal of stool if present Increase frequency and/or volume of transanal irrigation to ensure evacuation is adequate

Leakage of water around the catheter/cone	Ensure catheter/cone is properly located Check water temperature Where used, increase balloon inflation up to maximum of five pumps Instill water more slowly Reflex expulsion of the catheter, where used Check water temperature Ensure rectum empty of stool Inflate balloon more slowly Minimise inflation to avoid triggering reflexes Check for and treat constipation
Irrigant is not expelled	Repeat irrigation Use adjunctive measures as described Ensure patient is adequately hydrated Assess for constipation and treat if necessary
No stool is evacuated after transanal irrigation	Repeat irrigation or split the irrigation into two consecutive episodes, 10–15 min between episodes, using half the irrigant each time Use adjunctive measures Consider use of laxatives Check for constipation and treat as required Ensure the patient is well hydrated No stool may be present if a good result was obtained at last irrigation; if this happens regularly consider reducing frequency of irrigation If no stool for several days, suspect constipation/impaction, assess and treat accordingly

Faecal incontinence (it can also happen in patients with PFDD) between uses of transanal irrigation	Increase volume of water by small increments (100 ml) until satisfactory evacuation achieved with no faecal incontinence Split the irrigation into two consecutive episodes, 10–15 min between episodes, using half the irrigant each time Increase frequency of transanal irrigation Consider laxative use
Leakage of water between irrigations	Ensure patient allows sufficient time on toilet following transanal irrigation Encourage use of adjunctive measures to encourage emptying Reduce or decrease amount of water instilled Split the irrigation into two consecutive episodes, 10–15 min between episodes, using half the irrigant each time An Anal Plug (Coloplast) can be tried if problem persists

Conclusion

- TAI is a beneficial and effective intervention for patients with PFDD
- Escalation of the appropriate treatment and an appropriate assessment (QoL/Symptoms) pre TAI is essential in order to adhere with clinical guidelines/ governance
- Patient selection is the number 1 factor for a successful intervention!
- Patient's support is the key for the success of the intervention in the short and the long term
- Ongoing liaison with the rest of the team is essential for the ultimate benefit of the patient!!

Pharmacological treatment of PFDD

Anton Emmanuel

Surgical treatment of PFDD

Alexis Schizas
Consultant Colorectal Surgeon

Surgical treatment of PFDD

Conservative
- maximal medical treatment
- biofeedback or pelvic floor retraining, rectal irrigation

Surgery
- failed conservative treatments
- underlying structural abnormality – e.g. rectocoele
- vaginal, transanal, abdominal or laparoscopic
- Significant recurrence and complication rates

Surgical treatment of PFDD

- Surgery
  - Vaginal
    - Transvaginal rectocoele repair
  - Perineal
    - Transperineal rectocoele repair
  - Anal
    - Prolapse repair
    - STARR
  - Abdominal or laparoscopic
    - Prolapse repair
    - Ventral mesh rectopexy

Surgical treatment of PFDD

Surgery for Rectocoele

Transvaginal
Posterior repair
+/- Levatoplasty
Site specific repair

Transanal
STARR
Intra-anal Delormes

excision / reduction of redundant tissue

Perineal

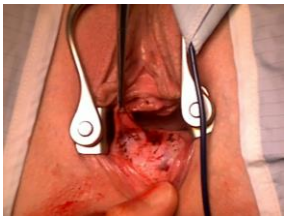
Trans-abdominal
Ventral mesh Rectopexy
Laparoscopic

buttressing the R/V septum
+ / - sphincteroplasty / repair

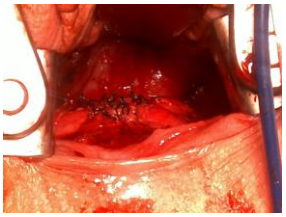
Trans-vaginal Rectocoele Repair

Trans-vaginal Rectocoele Repair

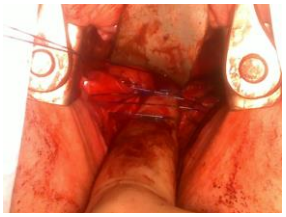
Trans-vaginal Rectocoele Repair



Trans-vaginal Rectocoele Repair



Trans-vaginal Rectocoele Repair



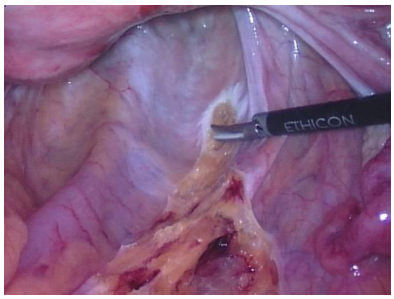
Trans-vaginal Rectocoele Repair

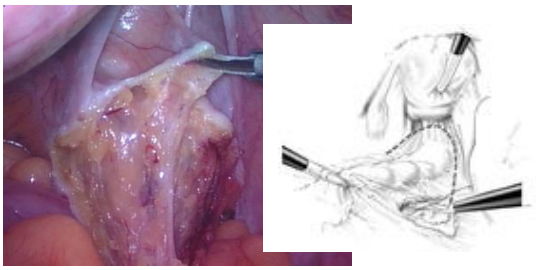
Results of Rectocoele Repair

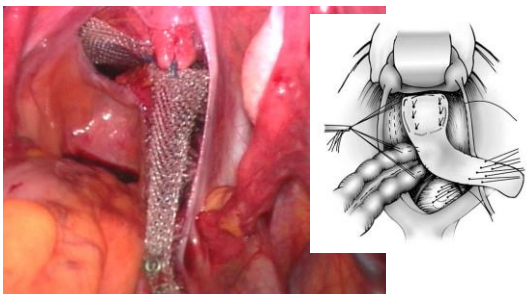
Author	n	Improved	
Khubchandani et al (1983)	59	63%	Overall 73%
Siproudhis et al (1993)	26	76%	
Janssen & van Dijke (1994)	76	50%	
Mellgren et al (1995)	25	52%	
Van Dam et al (1996)	75	71%	
Karlbom et al (1996)	34	79%	
Khubchandani et al (1997)	105	82%	
Van Laarhoven et al (1999)	22	73%	
Lamah et al (2001)	24	75%	
Boccasanta et al (2002)	30	80%	
Murthy et al (1996) (Selective policy)	31	92%	

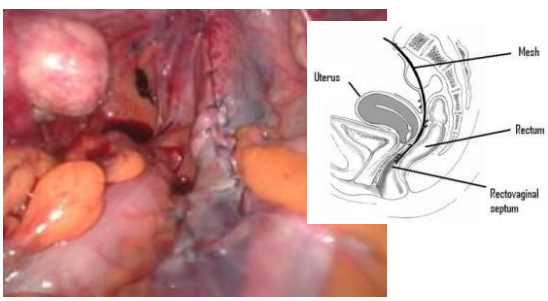
Ventral Mesh Rectopexy

- External rectal prolapse
- Internal organ prolapse / descent
- Intra rectal intussusception
  - ? Incontinence
  - ? SRUS
  - ? Pelvic pain









VMR

- Rectocoele
  - Improvement in vaginal discomfort 66%
- Reduction in ODS score 40%
  - 86% patients improvement
- Ext Rectal Prolapse
  - Recurrence 2% - 4%
- Resolution / Improvement constipation 72% - 84%
- New Constipation 2%

Prolapse Surgery

- Abdomial procedure
  Ventral Mesh Rectopexy
  Sutured Rectopexy
  Resection Rectopexy
- Perianal procedures
  Delorme's procedure
  Altmeier's

Types of prolapse

Full Thickness External Prolapse

- Low Take Off
- High Take Off

(external protrusion of intra-rectal intussusception)

Intra-rectal Intussusception

Rectal wall prolapse (rectocoele)

Perineal approaches

Delorme's operation	Perineal proctosigmoidectomy
Described in 1900	1933 Miles 1971 Altemeier
Resection of sleeve of mucosa with plication of remaining muscle and suture of bowel mucosa to anal mucosa	Full thickness excision of rectum and portion of sigmoid colon

Delorme's procedure

No. of studies (1979-2003)	No. pts	Recurrence (%)	Continence improved (%)
14	487	21	71

Perineal rectosigmoidectomy (Altmeier's)

No. of studies (1971-1999)	No. pts	Recurrence (%)	Continence improved (%)
11	558	17	61

STARR - Indications

Anatomical changes

- STARR (surgery) corrects anatomical abnormality
- in presence of symptoms

STARR: symptomatic patients with abnormality

STARR - Indications

- Prolonged evacuation or repeated straining
- Excessive time spent on the toilet
- Frequent calls to defaecate prior to or following evacuation
- Incomplete evacuation
- Laxative and or suppositories/enema use
- Digitation
- Pelvic pressure, rectal discomfort, and perineal pain

Exclusion Criteria

External full-thickness rectal prolapse

Perineal infection (abscess, fistula)

Recto-vaginal fistula

Inflammatory bowel disease (including proctitis)

Radiation proctitis

Anal incontinence (Cleveland Clinic Florida; Wexner Score > 7)

Anal stenosis precluding insertion of the stapling device

Enterocoele at rest

Significant gynaecological or urinary pelvic floor abnormality requiring combined treatment

Presence of foreign material adjacent to the rectum (e.g. mesh)

Absence of anatomical or physiological abnormality associated with ODS

Intra-operative technical factors which preclude the safe execution of the operation

Significant rectal or peri-rectal fibrosis

Prior rectal anastomosis

STARR - Outcome

Improvement ODS and structure in >90% of patients

European STARR registry

- 2,224 patients, 12-month follow-up
- significant improvement
  - obstructive defaecation score (15.8 vs. 5.8, P<0.001)
  - symptom severity score (15.1 vs. 3.6, P<0.001)
  - quality of life

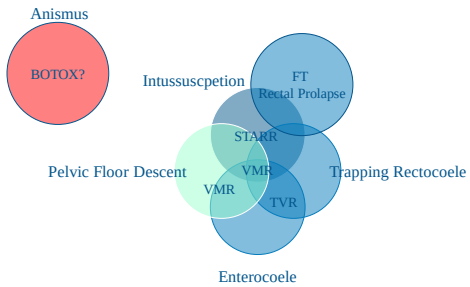
Jayne DG et al. Stapled transanal rectal resection for obstructed defecation syndrome: one year results of the European STARR Registry. Dis Colon Rectum 2009 July;52(7):1205-12.

STARR - Complications

Overall - 36%

• Urgency	20%
• Bleeding	5%
• Sepsis	4.4%
• Staple line complications	3.5%
• Incontinence	1.8%
• Pain	<2%
• rectal necrosis	<1%
• rectovaginal fistula	<1%

Surgical treatment of PFDD



Surgical treatment of PFDD

- Clear understanding of pathology
- Appropriate decision with each patient
- If any surgical options are available
- Most appropriate for their symptoms

Thank you!

Any questions?

Doreen McClurg

Affiliations to disclose†:

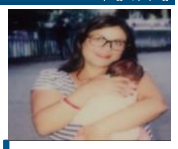
Chair of the ICS Physiotherapy Committee

Chair of the UK Pelvic, Obstetric and Gynaecological Physiotherapy sub-committee of the Chartered Society of Physiotherapy.

† All financial ties (over the last year) that you may have with any business organisation with respect to the subjects mentioned during your presentation

Funding for speaker to attend:

- ☐ Self-funded
- ☒ Institution (non-industry) funded
- ☐ Sponsored by:



Biofeedback

On behalf
Paula Igualada-Martinez
Clinical Specialist Physiotherapist

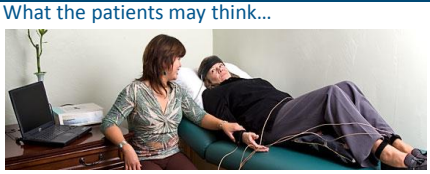
Guy's and St Thomas' NHS
NHS Foundation Trust

Aims of this presentation

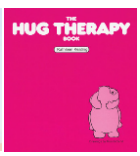
- What is Biofeedback Therapy?
- What does the literature say?
- Assessment pre Biofeedback
- Biofeedback therapy techniques
- Outcome of Biofeedback
- Conclusion

What is Biofeedback?

What the patients may think…



What my colleagues may think…



ICS definition

'The technique by which information about a normally unconscious physiologic process is presented to the patient and/or therapist as a visual, auditory or tactile signal.'

nmahp-ru

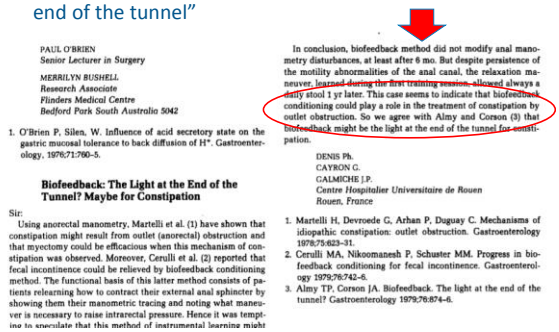
What is Biofeedback?

- Biofeedback (BFB) therapy is an instrument-based learning process that is based on "operant conditioning" techniques.

- The governing principal is that any behavior when reinforced its likelihood of being repeated and perfected increases several fold.

Rao (2011) Best Pract Res Clin Gastroenterol. 25(1): 159–166.

- Biofeedback first described in 1981 as the "Light at the end of the tunnel"



PAUL O'BRIEN
Senior Lecturer in Surgery

MERRILYN BUSHELL
Research Associate
Flinders Medical Centre
Bedford Park South Australia 5042

1. O'Brien P, Silen, W. Influence of acid secretory state on the gastric mucosal tolerance to back diffusion of H+. Gastroenterology, 1976;71:760–5.

Biofeedback: The Light at the End of the Tunnel? Maybe for Constipation

Sir:

Using anorectal manometry, Martelli et al. (1) have shown that constipation might result from outlet (anorectal) obstruction and that myectomy could be efficacious when this mechanism of constipation was observed. Moreover, Cerulli et al. (2) reported that fecal incontinence could be relieved by biofeedback conditioning method. The functional basis of this latter method consists of patients relearning how to contract their external anal sphincter by showing them their manometric tracing and noting what maneuver is necessary to raise intrarectal pressure. Hence it was tempting to speculate that this method of instrumental learning might

In conclusion, biofeedback method did not modify anal manometry disturbances, at least after 6 mo. But despite persistence of the motility abnormalities of the anal canal, the relaxation maneuver, learned during the first training session, allowed always a daily stool 1 yr later. This case seems to indicate that biofeedback conditioning could play a role in the treatment of constipation by outlet obstruction. So we agree with Almy and Corson (3) that biofeedback might be the light at the end of the tunnel for constipation.

DENIS Ph.
CAYRON G.
CALMICHE J.P.
Centre Hospitalier Universitaire de Rouen
Rouen, France

1. Martelli H, Devroede G, Arhan P, Duguay C. Mechanisms of idiopathic constipation: outlet obstruction. Gastroenterology 1978;75:623–31.
2. Cerulli MA, Nikoomanesh P, Schuster MM. Progress in biofeedback conditioning for fecal incontinence. Gastroenterology 1979;76:742–6.
3. Almy TP, Corson JA. Biofeedback. The light at the end of the tunnel? Gastroenterology 1979;76:874–6.

What is Biofeedback Therapy nowadays?

A combination of all of these therapies will help the patient to defecate effectively. Also, evacuating regularly may also stimulate gut transit.

Denis P. (1996) *European Journal of Gastroenterology and Hepatology.* 8(6). p.530–3.

Goals of Biofeedback

- To restore a normal pattern of defecation
- To correct the dyssynergia or incoordination of the abdominal, rectal, puborectalis and anal sphincter muscles
- To enhance rectal sensory perception in patients with impaired rectal sensation
- To strengthen the pelvic floor musculature

Rao et al (2015) *Neurogastroenterol Motil.* 27(5): 594–609
Heymen et al (2009) *Dis Colon Rectum.* 52(10)

What does the literature say?

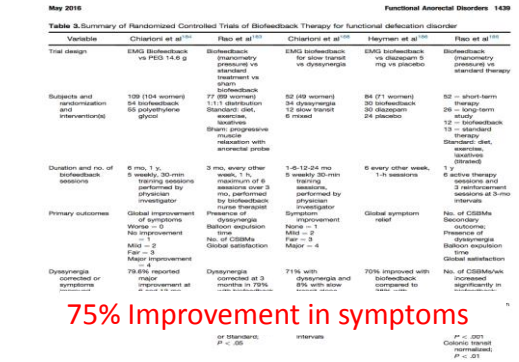
- Currently there is insufficient regarding the efficacy and safety of biofeedback for the management of people with pelvic floor defecatory dysfunction (PFDD).
- There is low or very low quality evidence from single studies to support the effectiveness of biofeedback for the management of PFDD.
- However, the majority of trials are of poor methodological quality and subject to bias.
- Further well-designed RCT's with adequate sample sizes, validated outcome measures and long-term follow-up are required to allow definitive conclusions to be drawn.

What does the literature say?

- Biofeedback therapy is recommended:
  - For the short term and long term treatment of constipation with dyssynergic defecation **(Level I, Grade A).**

- Biofeedback therapy may be useful in:
  - The short-term treatment of Levator Ani Syndrome with dyssynergic defecation **(Level II, Grade B)**, and solitary rectal ulcer syndrome with dyssynergic defecation **(Level III, Grade C)**, but the evidence is fair.

What does the literature say?



May 2016 — Functional Anorectal Disorders 1439

Table 3. Summary of Randomized Controlled Trials of Biofeedback Therapy for functional defecation disorder

Variable	Chiarioni et al[184]	Rao et al[183]	Chiarioni et al[185]	Heymen et al[186]	Rao et al[180]
Trial design	EMG Biofeedback vs PEG 14.6 g	Biofeedback (manometry pressure) vs standard treatment vs sham biofeedback	EMG biofeedback for slow transit vs dyssynergia	EMG biofeedback vs diazepam 5 mg vs placebo	Biofeedback (manometry pressure) vs standard therapy
Subjects and randomization and intervention(s)	109 (104 women) 54 biofeedback 55 polyethylene glycol	77 (69 women) 1:1:1 distribution Standardized diet, exercise, laxatives Sham: progressive muscle relaxation with anorectal probe	52 (49 women) 34 dyssynergia 12 slow transit 6 mixed	84 (71 women) 30 biofeedback 30 diazepam 24 placebo	52 — short-term therapy 26 — long-term study 12 — biofeedback 13 — standard therapy Standard: diet, exercise, laxatives (titrated)
Duration and no. of biofeedback sessions	6 mo, 1 y; 5 weekly, 30-min training sessions performed by physician investigator	3 mo, every other week, 1 h, maximum of 6 sessions over 3 mo performed by biofeedback nurse therapist	1-6-12-24 mo 5 weekly 30-min training sessions, performed by physician investigator	6 every other week, 1-h sessions	1 y 6 active therapy sessions and 3 reinforcement sessions at 3-mo intervals
Primary outcomes	Global improvement of symptoms Worse = 0 No improvement = 1 Mild = 2 Fair = 3 Major improvement = 4	Presence of dyssynergia Balloon expulsion time No. of CSBMs Global satisfaction	Symptom improvement None = 1 Mild = 2 Fair = 3 Major = 4	Global symptom relief	No. of CSBMs Secondary outcome: Presence of dyssynergia Balloon expulsion time Global satisfaction
Dyssynergia corrected or symptoms	79.6% reported major improvement at	Dyssynergia corrected at 3 months in 79%	71% with dyssynergia and 8% with slow	70% improved with biofeedback compared to	No. of CSBMs/wk increased significantly in

or Standard; $P < .05$ — intervals — $P < .001$ Colonic transit normalized; $P < .01$

75% Improvement in symptoms

Rao et al. (2016) Gastroenterology 150:1430–1442

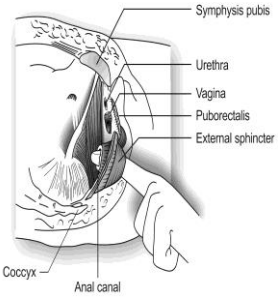
Assessment pre BFB

- History taking
  - Standardized assessment tools
  - Outcome measures
  - Bowel diary
- Observation and Physical examination
  - Digital Rectal Examination
    - Sensitivity of 75%
    - Specificity of 87% for detecting dyssynergia!
  - Pelvic floor muscle assessment via PV or PR
    - PERFECT Scheme
    - International Continence Society Pelvic Floor Score
    - PFMF assessment scheme
- Further tests and investigations
  - When basic treatment has failed e.g. education, fluid and fibre intake, review of medication, etc…

Digital ano-rectal assessment

Laycock J and Jerwood D (2001) Physiotherapy 87 (12):631-642
Messelink B et al. (2005) Neurourology and Urodynamics 24:374-380
Slieker-ten Hove et al (2009) Neurourology and Urodynamics 28:295-300
Tantiphlachiva et al (2010). Clin Gastroenterol Hepatol. 8:955–960

Sphincter assessment: PERFECT scale and modified Oxford grade -



Median saggital section of the pelvis,showing examining finger in the anal canal (J Lang)

- Observe inappropriate muscle activity e.g. breath holding
- Ask patient to 'bear down'
- Assess any paradoxical contraction of puborectalis.

Finger in the anal canal – EAS assessment Modified Oxford Scale

Defaecation mechanisms

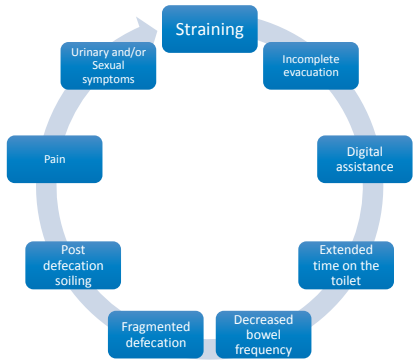
Ask patient bear down, assess for:

Paradoxical contraction PR and EAS

Relaxation of anal canal (normal response)

Propulsive effort (feeling of downward pressure and the examining digit being expelled)

What are the main symptoms to treat in BFB?



So, what do we do during Biofeedback sessions?

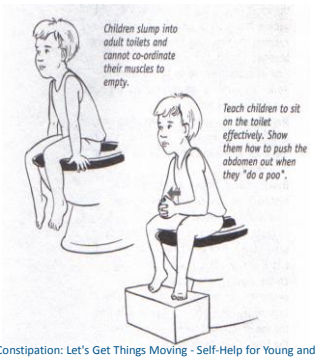
Biofeedback Therapy

- Education
- Defecation dynamics
- Dietary advice
- Physical Activity
- Medication
- Pelvic floor Rehabilitation
- Neuromuscular electrical stimulation
- EMG Biofeedback
- Rectal sensation and balloon expulsion training
- Perineal splinting/support
- Abdominal muscle rehabilitation
- Correct diaphragmatic breathing patterns
- Abdominal massage
- Emotional support and Behavioural Therapy

Education is the key to success!!!

- Discussion of digestive tract, function and the defecation process
  - If possible with models/pictures
- Normalize bowel frequency according to patient's symptoms and pathology
  - Demystify the myth of the 'once a day rule'
- Discuss previous treatments and failures
- Discuss results of investigations and the relationship to patients symptoms

Constipation : Let's get things moving



Markwell S (2003) Constipation: Let's Get Things Moving - Self-Help for Young and Old - A New Approach

Defecation dynamics: what should happen?

- Defecation technique:
- Aim for most functional position
  - Puborectalis (anorectal angle) release, 'paying out'
  - Other PFM activity (rectal support)
- Forward lean position with forearm support
- Neutral spine / foot support for lumbar stability
- Co-ordination between diaphragm and abdominals
- Co-contraction pelvic floor/abdominals
- Waist widens and braces
- Abdominal bulging (Sapsford et al., 1996)

Squatty potty

Bowel training

- Regular attempt following breakfast (stimulation of gastro-colic reflex) or after exercise
- Privacy and time
- Avoid ignoring the urge to defecate
- Strain for no more than 5 minutes
- During attempted defecation, they must be instructed to push at a level of 5 to 7, assuming level 10 as their maximum effort of straining

Dietary Advice

- Trials evaluating the effect of increased liquid intake in patients with PFDD are lacking, and there is no evidence that bowel evacuation difficulties can be improved by increasing oral fluid intake, unless the patient is dehydrated.
- Recent studies concluded that psyllium, a natural fiber supplement increases stool frequency and gave this compound a grade B recommendation, but there was insufficient data to make a recommendation for the synthetic polysaccharide methylcellulose, or calcium polycarbophil or bran in patients with bowel evacuation difficulties.
- Any eating disorder should be managed accordingly

Bove et al (2012) World J Gastroenterol. 28; 18(36): 4994-5013
Rao (2011) Best Pract Res Clin Gastroenterol. 25(1): 159–166

Physical Activity

- Physical activity can increase colonic transit time and reduce bowel evacuation symptoms in elderly subjects

However…

- Despite the recommendation to patients with PFDD of regular physical activity there is no evidence that bowel evacuation difficulties can be improved by an increased in physical activity.

Rao et al. (1999)*Am J Physiol.* 276: G1221-G1226.

De Schryver et al (2005) *Scand J Gastroenterol.* 40: 422-429.

Medication

- Laxatives
  - Stool softners, stimulant laxatives, osmotic compounds such as polyethylene glycol, magnesium compounds and lactulose and a chloride channel activator such as lubiprostone
  - Good adjuncts in the initial management of patients when regularizing their bowel habit and establishing a bowel regimen.
  - IDEALLY THEY SHOULD BE DISCONTINUED!!
- Review medication that may aggravate bowel dysfunction (e.g. pain medication/narcotics)
- Initial stages of biofeedback therapy the use of glycerin or bisacodyl suppositories can be used as an evacuatory aid

Brandt et al. (2005) Am J Gastroenterol. 2005; 100(Suppl 1):S5–S21.

Pelvic floor muscle training

- Chronic straining ➔Pudendal Neuropathy ➔Pelvic floor weakness
- PFMT should involve fast and slow twitch muscle fibres and be performed in a variety of positions
- Exercise programs should follow the principles of:
  - Specificity, Overload, Progression, Maintenance and reversibility
- For a minimum of **5 months**
- Include strategies to adhere to the exercise regime

Bø K *Int Urogynecol J* 1995; **6:** 282–91.

Bø et al (2007) Evidence-Based Physical Therapy for the Pelvic Floor

American College of Sports Medicine (ACSM) (1998) Med Sci Sports Exer 30: 975-991

Neuromuscular Electrical Stimulation (NMES)

- NMES is aimed at training the pelvic floor and external anal sphincter muscles by producing a series of electrically induced contractions, to improve strength, sensation and function
- NMES is a treatment for women who demonstrate a grade 0, 1 on the modified Oxford scale and would otherwise be unable to re-educate their pelvic floor muscles
- Patients should join in with the electrically induced contraction.

Vonthein et al (2013) Int J Colorectal Dis 28:1567-1577

Rectal Sensation Training

- Insert balloon into rectum
- (via anal canal - 3 – 4cm)

- Slowly inflate balloon to 'onset' of sensation
- Teach patient to 'defer' urgency
- Gradually increase amount of air

Rectal balloon filling

With permission POGP

Rectal Sensation testing

With permission POGP

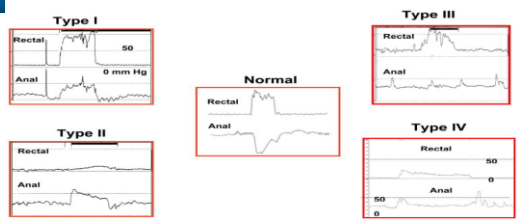
Balloon expulsion training

With permission POGP

Anorectal Manometry Biofeedback

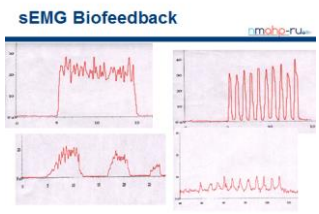
With permission POGP

Manometric Patterns: Attempted Defecation



Type 1:Here, the patient can generate an adequate pushing force, (rise in intra abdominal pressure) along with a paradoxical increase in anal sphincter pressure
Type 2:Here, the patient is unable to generate an adequate pushing force (no increase in intrarectal pressure) but can exhibit a paradoxical anal contraction
Type 3:Here, the patient can generate an adequate pushing force (increase in intrarectal pressure) but, either has absent or incomplete (<20%) sphincter relaxation (i.e. no decrease in anal sphincter pressure)
Type 4:The patient is unable to generate an adequate pushing force and demonstrates an absent or incomplete anal sphincter relaxation

EMG Biofeedback



Abdominal Massage: Cochrane Review

- 9 RCTS with 12 comparisons
- 'Chronic constipation'
- Neurological, cancer and non-comorbid conditions populations were heterogeneous
- 427 participants
- Excluded 24 studies
- Abdominal massage V Control (n=5)
- Abdominal massage V other massage (n=2)

Cochrane Review: Results

Figure 1. Forest plot comparing abdominal massage versus no treatment or usual care for primary outcome measure (number of defaecations).

Study or Subgroup	Control Mean	SD	Total	Experimental Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Gursen 2015 (i)	3.26	1.53	15	4.73	1.43	15	15.4%	-1.47 [-2.53, -0.41]
Jeon 2005	2.8	0.58	15	4.5	0.89	16	62.7%	-1.70 [-2.23, -1.17]
Lamas 2009	4.54	2.89	30	5.72	1.91	30	11.3%	-1.18 [-2.42, 0.06]
McClurg 2011	3	2	15	4.5	2	15	8.5%	-1.50 [-2.93, -0.07]
McClurg 2013	6.5	5.67	16	5.58	1.3	16	2.1%	0.92 [-1.93, 3.77]
Total (95% CI)			**91**			**92**	**100.0%**	**-1.53 [-1.95, -1.12]**

Heterogeneity: $Chi^2 = 3.56$, $df = 4$ ($P = 0.47$); $I^2 = 0\%$
Test for overall effect: $Z = 7.22$ ($P < 0.00001$)

Mean Difference IV, Fixed, 95% CI

-10 -5 0 5 10
Favours experimental Favours control

Abdominal massage

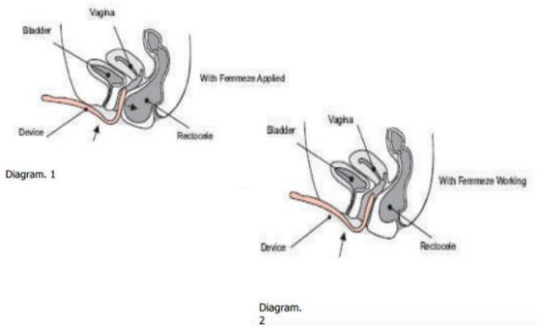
Video

- Mechanism of action – unknown
- More effective on delayed transit time
- Up to two-thirds of patients with a defecation disorder also have delayed colonic transit. Rao 2016

Perineal splinting/support: Femmeze

- No literature available regarding the effectiveness of this gadget
- Anecdotal information suggests that patients have mixed feelings about using it when PFDD is present

Femmeze



Can we predict outcome of BFB?

GASTROENTEROLOGY 2005;129:86–97

Biofeedback Benefits Only Patients With Outlet Dysfunction, Not Patients With Isolated Slow Transit Constipation

GIUSEPPE CHIARIONI,* LARA SALANDINI,* and WILLIAM E. WHITEHEAD†
*Divisione di Riabilitazione Gastroenterologica, Università di Verona, Azienda Ospedaliera di Verona, Centro Ospedaliero Cliniczzato, Valeggio sul Mincio, Verona, Italy; and †UNC Center for Functional Gastrointestinal and Motility Disorders, and Division of Gastroenterology and Hepatology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Background & Aims: **Biofeedback is reported to be as effective for slow transit constipation as for pelvic floor dyssynergia and no more effective than education. We aimed to test the hypothesis that biofeedback benefits only patients with pelvic floor dyssynergia, describe the physiologic mechanism of treatment, and identify predictors of success.** ***Methods:*** **Fifty-two patients (49**

reduced numbers of high-amplitude propagating contractions[3,4] associated with decreased numbers of interstitial cells of Cajal.[5,6] Diagnosis is based on transit studies showing abnormally prolonged transit of radiopaque markers or radioisotopes through the colon.[7,8]

Outlet dysfunction–type constipation refers to diffi-

- Factors That Predict Outcome of Biofeedback Therapy in Constipation With Dyssynergic Defecation (DD)

Patcharatrakul et al (2016) AGA Abstract

	Success (n= 77)	Failure (n=50)	p-value
Age (year)	42 ± 15	40 ± 14	NS
Gender (M:F)	5:72	2:48	NS
Bowel satisfaction score (VAS 0-100), mm	9(1-21)	17(2-33)	0.002
Digital maneuvers to facilitate defecation, n(%)	20(26.6)	5(10)	0.03
Anal resting pressure (mmHg)	81.1 ± 18.3	80.8 ± 21.0	NS
Defecation index	0.5 ± 0.3	0.6 ± 0.4	NS
Balloon expulsion time (s)	73 (26->300)	54 (15->300)	NS
First sensation threshold (ml)	20 (10-30)	20 (10-30)	NS
Desire to defecate threshold (ml)	80 (70-160)	80 (60-130)	NS
Urge to defecate threshold (ml)	160 (110-240)	160 (110-240)	NS
Rectal hyposensitivity, n(%)	28(36.3)	15(28.8)	NS
Rectal hypersensitivity, n(%)	36(46.8)	26(52)	NS
Dyssynergic defecation type, n(%) -Type I -Type II -Type III -Type IV	20(26) 51(66.2) 5(6.5) 1(1.2)	13(26) 28(56) 5(10) 4(8)	NS

Background & Aims: Uncontrolled trials suggest biofeedback is an effective treatment for pelvic floor dyssynergia (PFD), a type of constipation defined by paradoxical contraction, or inability to relax, pelvic floor muscles during defecation. The aim was to compare biofeedback to laxatives plus education. *Methods:* Patients with chronic, severe PFD were first treated with 20 g/day fiber plus enemas or suppositories up to twice weekly. Nonresponders were randomized to

Conclusions: Five biofeedback sessions are more effective than continuous polyethylene glycol for treating PFD, and benefits last at least 2 years. Biofeedback should become the treatment of choice for this common and easily diagnosed type of constipation.

sensations of incomplete evacuation and anorectal blockage, use of enemas and suppositories, and abdominal pain (all $P < .01$). Stool frequency increased in both groups. All biofeedback-treated patients reporting major improvement were able to relax the pelvic floor and defecate a 50-mL balloon at 6 and 12 months. *Conclusions:*

Conclusion

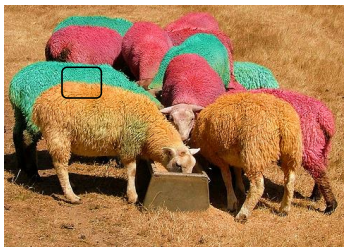
- Biofeedback therapy is a labor-intensive approach but has NO ADVERSE EFFECTS
- Identification of patients is the key to success of BFB
- Only offered in a few centers around the world
- We should aim for a standardization of protocols and equipment
  - "There is marked variation in practice, training and supervision of BFB therapists in the UK"

Etherson et al. (2016) Frontline Gastroenterology. 0:1-6.
Rao et al. (2011) Gastroenterology. 140 suppl1(5):S707–S708.

Pharmacological treatment of the patient with pelvic floor dysfunction

Anton Emmanuel
ICS, September 2016

National Hospital for Neurology & Neurosurgery



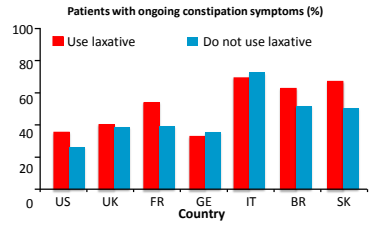
Treatment approach

Symptom-based	Constipation Diarrhoea Pain
Severity considered	Mild – Moderate - Severe
Co-morbidity -considered	

Constipation: the role of laxatives

16–40% of those with constipation use laxatives

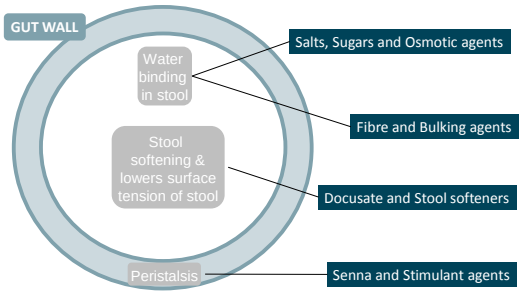
Symptoms persist despite laxative use



Approximately 2000 adults each from: United States, US; United Kingdom, UK; France, FR; Germany, GE; Italy, IT; Brazil, BR; South Korea, SK

Wald *et al. Aliment Pharmacol Ther* 2008;**28**:917

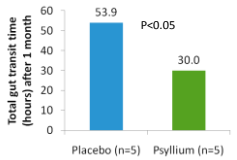
Laxatives for chronic constipation: Luminal mechanism of action



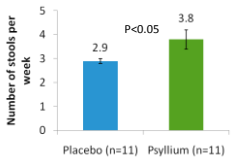
[1]Tack & Müller-Lissner. *Clin Gastroenterol Hepatol* 2009;**7**:502

Bulking agents

Decreased total gut transit time after 1 month of psyllium in patients with dyssynergic defaecation[1]



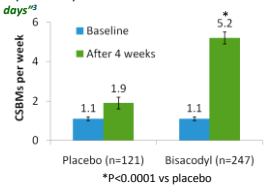
Increased stool frequency after 2 months of psyllium in patients with normal transit constipation[2]



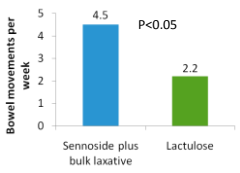
1. Ashraf et al. Aliment Pharmacol Ther. 1995;9(6):639-47
2. Cheskin et al. J Am Geriatr Soc. 1995;43(6):666-9

Stimulants

More frequent bowel movements with bisacodyl vs placebo in patients with "occasional missed days"[2]



More frequent bowel movements with sennoside plus bulk laxative vs lactulose in elderly patients (n=30)[4]

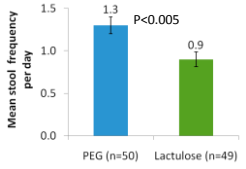


CSBM, complete spontaneous bowel movement

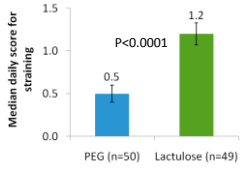
1. Pare et al. Can J Gastroenterol. 2007;21(Suppl B):3B-22B
2. Emmanuel. Ther Adv Gastroenterol. 2011;4(1):37-48
3. Kamm et al. Clin Gastroenterol Hepatol. 2011. [Epub ahead of print]
4. Kinnunen et al. Pharmacology. 1993;47 Suppl 1:253-5

Osmotic agents: macrogol

Slow transit success (needing ≤1 additional laxative during 3-week treatment period) with lactulose[1]



Less straining with PEG vs lactulose after 1 month: elderly[2]



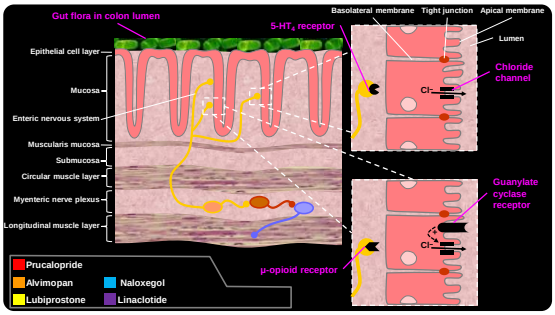
1. Attar et al. Gut. 1999;44:226-30
2. Ardonsky & Goldner. Am J Gastroenterol. 1990;85(3):261-5
3. Corazziari et al. Dig Dis Sci. 1996;41(8):1636-42
4. Di Palma et al. Am J Gastroenterol. 2007;102(9):1964-71

Constipation: tailor laxatives to dominant symptoms

Episodic hard stool	Bulk fibre[1]
Episodic reduced frequency	Stimulant[1]
Slow transit constipation	Osmotic[1]
Difficulty evacuating	Glycerine or stimulant suppository[1]
Megarectum or megacolon	Osmotic[2]

If no improvement:
- Increase dose[1]
- Rational combination e.g.
  - Stool softener and stimulant laxative[1,3,4] or bulking agent[1]

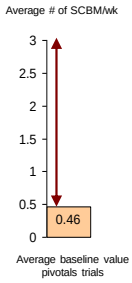
1. Emmanuel Ther Adv Gastroenterol 2011;4(1):37-48
2. Sranka & Pemberton Curr Treat Options Gastroenterol. 2006;9(4):343-50.
3. Larkin et al. Palliat Med. 2008;22(7):796-807
4. Sykes. Cancer Surv. 1994;21:137-46



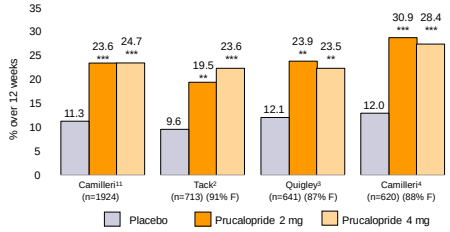
Number of SCBMs/week during the run-in

50% of the patients have 0 SCBMs at baseline

80% of the patients have a mean of ≤ 1 SCBM/week



Efficacy in chronic constipation: ≥3 SCBM/week (primary endpoint)



SCBM = spontaneous complete bowel movements

**p≤0.01 *vs.* placebo
***p≤0.001 *vs.* placebo

[1]Camilleri *et al. Gastroenterology* 2008;134:A548. [2]Tack *et al. Gut* 2009;58:357
[3]Quigley *et al. Aliment Pharmacol Ther* 2008;29:315. [4]Camilleri *et al. N Engl J Med* 2008;358:2344

Lubiprostone in chronic constipation

RCT 24mcg Lubiprostone versus placebo twice daily x4 weeks

242 patients with chronic constipation

Results

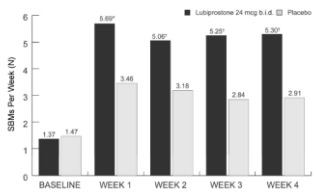
"Responders" (>3SBMs/wk) at 4 weeks = 58 v 28%

NNT= 3.3

Adverse events

Lubiprostone vs placebo

- Nausea 32% v 3%
- Headache 12% v 6%
- Discontinued 8% v 1%

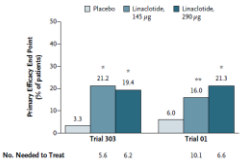


Johanson et al Am J Gastroenterol 2008; 103(1):170-177

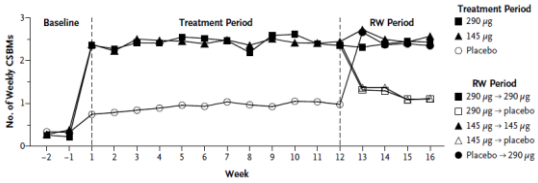
FDA statement

"Although the treatment effect is small, lack of a currently available therapy for this condition makes it important to have a treatment option available to patients ....."

Linaclotide



*not licensed in UK/EU



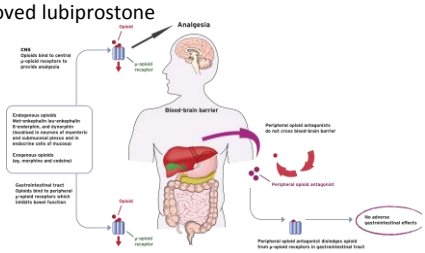
Opioid induced constipation

Minimise dose and range of opioids

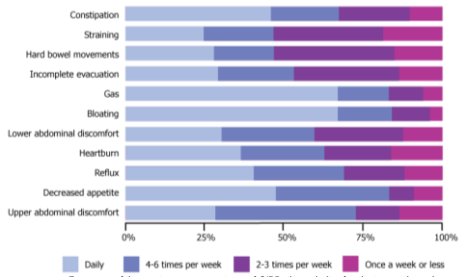
Laxatives…

FDA has approved lubiprostone

PAMORAs



OIBD occurs frequently, despite the use of laxatives, in individuals taking daily oral opioids for chronic pain



Frequency of the most common symptoms of OIBD: the majority of patients experienced most symptoms 4 times a week.

Bell et al. *Pain Med.* 2009;10:35–42.

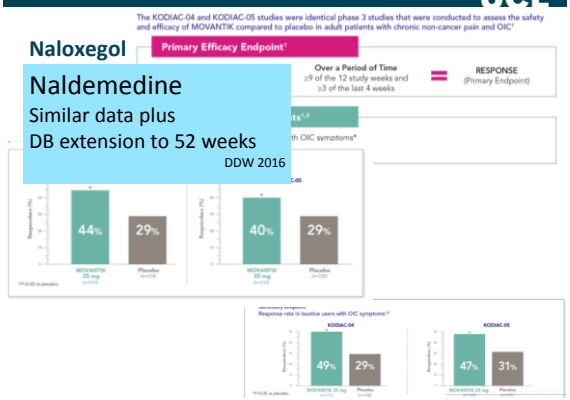
Naloxegol

Naldemedine

Similar data plus

DB extension to 52 weeks

DDW 2016



Diarrhoea - Drug treatment

Loperamide

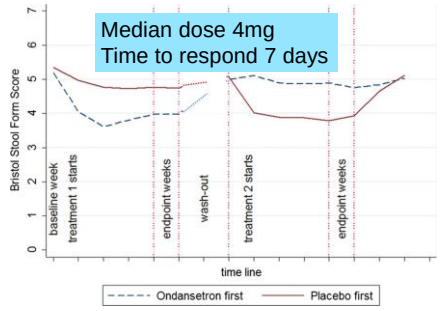
- Smooth muscle and secretion/absorption effect
- Effective in >80% long-term
- No dependence or opioid activity
- Titratable dosing and prophylactic usage
- Syrup formulation
- 2-16mg

Lomotil, codeine – less effective, less well tolerated

Amitriptyline – minor evidence in FI

NICE Clinical Guidance 2008

Diarrhoea – use of Ondansetron



Garsed et al. Gut 2014: 63:1617

Management of Faecal Soiling

The Anal Plug

14 patients with spinal injury
All 14 incontinent weekly at least

13/14 stopped liquid leak
11/14 controlled gas incontinence

Well tolerated in 11
All had attenuated anal sensation

Norton et al GI Nursing (2004)

Causes of peri-anal pain

Muscular causes

Structural causes with a lump

Structural causes without a lump

Rectal causes

Pruritus ani

Causes of peri-anal pain

Muscular causes
- levator ani syndrome
- proctalgia fugax
- myofascial syndrome
- coccygodynia

Structural causes with a lump
- thrombosed haemorrhoid
- anal abscess (may be with a fistula)
- sentinel tag (with anal fissure)
- condyloma

Structural causes without a lump
- anal fissure
- anal fistula

Rectal causes
- rectal prolapse
- proctitis

Pruritus ani

Pruritus ani

Treat cause

Dermatological condition	Faecal soiling	Dietary triggers	Infection
Dermatitis	Incontinence	Caffeine	Pinworm
Lichen planus	Fissure/fistula	Beer	Candida
Lichen sclerosis	Altered bowel function	Chilli	STD
Psoriasis	Haemorrhoids/skin tags		Abscess
Hydradenitis	Rectal prolapse		
Systemic disease	**Malignancy**	**Irritants**	**Neurogenic**
Anaemia	Squamous cancer	Deodorants	Lumbosacral radiculopathy
Diabetes	Bowen disease	Detergents	
Leukaemia		Tight clothing	
IBD			

Pruritus ani

Itch-scratch cycle
Perianal hygiene and avoid irritants
Sedating histamine (hydroxyzine)
Topical hydrocortisone

Topical capsaicin (0.0006% in white paraffin)
Biopsy?

Anal fissure

Acute vs chronic

Midline vs off-centre

Stool softeners + topical treatment

Topical GTN 0.2% / diltiazem 2%

Botox 20iu:

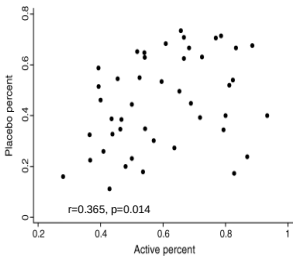
- 92% vs 70% healing (Botox vs GTN)
  Brindisa et al BJS 2007

Levator ani syndrome

Very treatable

- Digital massage } by reducing
- Hot baths (40 C)} anal pressure
- Electrogalvanic treatment – partial or complete relief 43%
- Pelvic floor biofeedback – 35% relief, unrelated to pelvic manometry
- Local injection triamcinolone – relief 40%
- Muscle relaxants } anecdotal
- Anxiolytics / analgesics } evidence

Physician-Patient interaction: the Placebo Response



Patel et al, NGM 2005