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Gastro-intestinal motility disorder can be intrinsic to the alimentary function, or can results from surgical manipulation of the bowel or nervous system. These disorders are difficult to diagnose and treat. Surgical therapy seldom is indicated for these disorders of motility, however, groups of patients are being identified with specific motor dysfunction of the, oesophagus, stomach small intestine colon, rectum and biliary system that may be amenable to surgical therapy.

For example: motility disorders of oesophagus include:

1ry motility disorders of oesophagus:

1- Achalasia of the cardia.

2- Nutcracker oesophagus.

3- Diffuse oesophageal spasm.

4- Non specific motility disorders.

2ry motility disorders of oesophagus:

1- Diabetes mellitus.

2- Scleroderma.

3- Amyloidosis.

Motility disorders of stomach include:

1- Functional gastric stasis.

2- Idiopathic gastric stasis.

3- Idiopathic gastroparesis.

4- Metabolic gastroparesis.

5- Neuromuscular gastroparesis.

6- Mucosal damage gastroparesis.

7- Iatrogenic gastroparesis.

8- Reflux gastroparesis.

Motility disorders of small intestine include:

1- Chronic idiopathic intestinal pseudo-obstruction.

2- Small intenstinal obstruction.

3- Post operative ileus.

4- Paralytic ileus.

5- Intestinal transaction with anastomosis.

Motility disorders of colon include:

1- Primary colonic inertia.

2- Secondary colonic inertia.

3- Generalized intestinal pseudo obstruction (acute & chronic).

4- Hirschsprung's disease.

5- Hirschsprung's related disorders.

Motility disorders of anorectal canal:

1- 1ry rectal inertia.

2- Pseudo hirschsprung's disease.

3- Idiopathic faecal impaction of the elderly.

4- 2ry rectal inertia.

5- Hirschsprung's disease.

Motility disorders of the pelvic floor muscles:

1- Descending perineal syndrome.

Motility disorders of biliary tree:

1- Gall bladder dysfunction.

2- Sphincter of oddi dysfunction.

a- Basal sphincter of oddi hypertension.

b- Sphincter of oddi dyskinesia.

Modern manometric techniques have been applied clinically to dysfunction of the sphincter of Oddi and have defined specific primary dysmotilities that can be treated using surgical or endoscopic sphincterotomy similarly, improved evaluation of colorectal motility using transit studies, pelvic floor radiography, nerve conduction studies, and anorectal manometry has led to better identification of the etiology of severe and debilitating forms of constipation and better results of targeted surgical intervention. Studies of motility in normal and abnormal states have shed light on understanding the abnormalities in gallbladder motility that predispose to gallstone formation.

Finally, although we have known that certain surgical procedures affect motility in an adverse manner, a better basic understanding of gastrointestinal physiology has led to the development of more directed physiologic operations.