# Introduction

Normal pelvic floor function involves a set of learned and reflex responses that are essential for the normal control and evacuation of stool. A variety of functional disturbances of the pelvic floor, including incontinence and constipation, are not life threatening, but can cause a significant distress to affected patients. Understanding the normal anatomy and physiology of the pelvic floor is essential to understand and treat these disorders of defecation **(Shelton & Welton., 1997)**.

The normal defecation process is associated with complete relaxation of sphincter muscles. So, failure of relaxation and paradoxical contraction of these muscles during defecation may block the passage of stools and, thus causing constipation of the outlet obstruction type (**Maria et al., 2000)**.

Constipation is a common clinical problem that comprises a constellation of symptoms that include excessive straining, hard stools, feeling of incomplete evacuation, such as metabolic problems, fiber deficiency, anorectal problems, and drugs, can cause constipation, when excluded functional constipation consists of two subtypes: slow-transit constipation and dyssnergic defecation. Some patients with irritable bowel syndrome may exhibit features of both types of constipation (**Rao, 2003)**.

Chronic constipation is usually considered idiopathic, but secondary causes shoud be excluded. In about 1% of patents with severe, intractable constipation, further diagnostic testing (e.g., endoscopy, colonic transit study) is needed. Patients with colonic inertia can be treated with judicious use of laxatives, but surgery may be necessary in few cases. Patients with outlet inertia shoud be referred for biofeedback treatment (**Wong & Kadakia, 1999)**.

Obstructive defecation occurs in about 7% of the adult population. Different pathophysiological mechanisms, either functional or anatomical, electromyography, colonic transit time measurement. Manometry plays an important role to quantify the problem (**D'Hoore & Penninckx, 2003)**.

Different mechanisms can eventually lead to Obstructive defecation. A defective rectal filling sensation as in idiopathic megarectum and/or megacolon, or impaired rectal sensation due to psychological factors or cerebral pathology can lead to Obstructive defecation. Blunted rectal sensation or rectal hyposensitivity seems to be a common finding in constipated patients (**Gladman et al., 2003)**.

Absence of relaxation or even paradoxical contraction of the striated pelvic floor muscles is noted in anismus. Comparably, spinal cord lesions and multiple sclerosis may lead to a nonrelaxing "spastic" pelvic floor. A grade lll intussusception of the rectum or enterocele can lead to mechanical outlet obstruction. Dissipation of the force vector at straining is the major cause of Obstructive defecation in patients with a rectocele, descending perineum syndrome and total rectal prolapse. A functional outlet obstruction can be acausative factor for the development of a prolapse syndrome further aggravating Obstructive defecation. In some patients impaired colonic function may develop secondary to outlet obstruction (**Karlbom et al., 1995)**.

The symptomatology of obstructive defecation may include sever prolonged straining, inability to initiate defecation, feeling of incomplete evacuation, the need for manual disimpaction, laxative or enema abuse, leakage and rectal pain (**D'Hoore & Penninckx, 2003)**.

Assessment of the complex pathophysiology behind the complaint of Obstructive defecation allows the surgeon to provid the patient with

realistic expectations. Different surgical techniques have been described and validated for treatment of prolapse of the middlr and posterior pelvic compartment (rectocele, enterocele, rectal prolapse) (**D'Hoore & Penninckx, 2003)**.