Summary

Pelvic floor disorders in which colorectal surgeons are usually interested are conditions causing constipation due to Pelvic outlet obstruction: nonrelaxation or paradoxical contraction of the puborectalis, rectoceles, enterocele/sigmoidoceles, rectal intussusception/ prolapse, solitary rectal ulcer syndrome (SRUS), descending perineum syndrome, etc., or fecal incontinence.

Obstructed defecation occurs in about 7% of the adult population. Different pathophysiological mechanisms, either functional, mechanical or anatomical, eventually lead to obstructed defection Chronic constipation is a common symptom in clinical practice. Definition of constipation includes abnormal bowel frequency, difficulty during defecation and abnormal stool consistency.

Constipation is divided into two main categories; defective propulsion and defective expulsion with mixed and overlap cases. Defective propulsion occurs when there is colonic dysmotility or collapsed aganglionic segment Defective expulsion occurs when one does not feel the defecatory urge as in rectal inertia or when voluntary straining becomes ineffective because of anal achalasia, anismus or descending perineum syndrome.

The clinical approach of obstructed defecation depends upon the history, the examination and the investigations, proctosigmoidoscopy, radio-contrast transit

study, barium enema, defecating proctography for assessment of anorectal angle and the degree of the perineal descent, anorectal manometry , perineometry, rectal biopsy.

Evaluation of patients with pelvic floor complaints begins with a thorough history and physical examination, but the degree and presence of pelvic organ prolapse may not always be apparent on clinical examination. Furthermore, surgical correction of pelvic floor disorders is a common treatment plan, and accurate preoperative assessment of the entire pelvis is important to guide an optimal surgical repair in an effort to avoid the need for repeat surgery. Therefore, many patients benefit from further assessment with adjunctive tests, including imaging. There are a variety of options for imaging these patients including ultrasound, fluoroscopy, and MRI examinations.

The treatment of obstructed defecation includes medical and surgical. The medical treatment includes life style modification, laxatives, prokinetic drugs and biofeedback. Surgical treatment indicated in selected patients who may not respond to medical treatment.

Management of (Defective expulsion):

1. Initial conservative measures.
2. Biofeedback retraining.
3. Surgical correction of internal rectal prolapse, perineal descent or rectocele.

Management of (Defective propulsion):

1. Initial medical treatment & conservative measures.
2. Psychotherapy.
3. Segmental or subtotal colectomy.

Comparing the complications of STARR procedure and the contour transtar procedure found that there was no significant statistical difference between post-operative bleeding, acute urinary retention and post-operative pain.

Comparing satisfactory score between patients of STARR procedure and contour transtar operation showed there was no big difference between results of both groups when reviewing the literatures. And the statistical analysis between the results of these literatures showed that there was no statistical significant difference between these results.

So, in selected patients with obstructed defecation, after failure of all conservative measures, surgery appears to be the proper treatment especially when diagnostic studies showed correctable anatomic or functional disorder.