Surgery for constipation

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Constipation is a common complaint in medicalpractice. The vast majority of affected patients eitherhave identifiable reasons for there constipation orhave no evidence of organic di.sease, but can beeasily managed with simple measures.Asmall, but currently undefined proportion haveconstipation that is more severe and persistent,which is unresponsive to fiber and mild laxatives,and for which no cause is evident and is called”Idiopathicconstipation”.Patients With idiopathic constipation can bediVided into two main categories. Patients withcolonic origin for their constipation, and patient Withoutlet obstruction. It is important to establish theorigin of chronic constipation as either a colonicsource or anorectal obstruction.A colonic source of dysmotility would direct anoperation towards the colon istself, while anorectalsource of osbtruction implies an outlet obstructionfor which a different surgical approach is indicated.This study was done as regards etiology,pathology, classification, investigation and propermanagement of cases with constipation eithersecondly constipation or idiopatihic constipation.Idiopathic constipation of colonic origin is due toa pathology in the colonic smooth muscle, themesyenteric plexus or both. It can affected the wholecolon or rectum only.Transit studies for these patients showed:retention of radio- opaque markers Withinthe colon.Silver staining showed decreases number ofagryophnio neurons and missing neurons.These finding have been suggested to bepathognomonic primary-colonic dysmotility.The besttreatment is abdominal colectomy With -ileorectalanastomosis. the reported experience With thisprocedure showed very good results.Idiopathic constipation due to outlet obstruction:Normal defecation requires co-ordination ofabdominal and pelvic muscles. Many studies havedemonstrated various and often mix:edabnormalitiesof this mechanism.Patients under this category can be divided intothree groups: Patients With defect in muscles ofdefecation, Patinets With defect in muscles ofcontinence, and Patients Withoutlet fibrosis.Defect in muscles of defecation which includeLevator dysfunction syndrome: Changes in thelevator plate and its ligaments which interfere Withthe normal defecation mechanism, With ultimatedevelopment of the ”levator dysfit.lnctionsyndrome”.Thus on straining at stool, the contraction of boththe sagging atrophic levator plate and thesublaxated suspensory sling is too weak to effectrectal neck opening in front of the descending faecalmass, and the Treatment is by surgical repair of thelevator ani muscle.Or Defect in muscles of continence: As thepuborectalis muscle is considered to be one of themajor contributes to the mechaniism of continence.Its failure to relax during defecation causes impairedevacuation, which can be expressed as paradoxicalcontraction of

the pelvicfloor striated muscle duringdefecation that blocks movements of rectal contents.Lateral division of the puborectalis muscle inmanagement of severe idiopathic constipation andcases Withmegarectum was perfonned as to diVidethe puborectalis muscle and the upper 1/2 ofexternal anal sphincter in the lateral quadrant.Patients with outlet fibrosis: This group ofpatients have straining Withbulky and soft stools.Most of them have Anorectal neck lesion(haemorrhoids, chronic anal fissure). All of thepatients has a fibrous tube located in the rectal necksubmucosa below the pectinate line. This fibrousband and associated rectal neck stenosis elevate therectal neck pressure and hinder full rectal neckexpansion at defecation with a resulting partialobstruction.:and Treatment is by Bandotomy.