Pelvic Physical Therapy Distance Journal Club
October 6, 2021
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References are very helpful in identifying landmark articles
1. Rome IV for bowel disorders
7. Rome IV for anorectal disorders
17. Clinical guideline on treatment of IBS and constipation
43 to 46. High level studies on biofeedback treatment

Background
Disorders of chronic constipation
- Functional constipation (FC)
- IBS-C
- Opioid-induced constipation (not discussed tonight good ref 37)
- Functional defecation disorder
  - Inadequate defecatory propulsion
  - Dyssynergic defecation (DD)

Symptoms
- Infrequent BM
- Hard or lumpy stool
- Excessive straining
- Sensation of incomplete emptying or blockage
- Use of manual maneuvers
- Acute or chronic (more than 3 months)

Prevalence of chronic constipation - 9-14%
- 6% FC
- 1.5% IBS-C
- 1.5% Opioid-induced constipation
- DD unknown
- More common in older patients, women and those with low socioeconomic status

Pathophysiology
- Not completely understood
- Hypothesis - disorder of gut-brain interaction
Assessment and Diagnosis

• Symptoms
  o Bristol stool form type 1 and 2
  o GI sx - abdominal pain, bloating, vomiting (PAC-SYM outcome)
  o Red flags - unintentional weight loss, rectal bleeding, family hx of colorectal CA or IBS
  o Neurological disorders
  o Medications

• Clinical signs (physical examination)
  o Observe externally - fissures, mass, lesion
  o Palpate internally at rest - increased tone - stricture
  o Palpation internally during bearing down
    ▪ Perineal descent desirable
    ▪ Paradoxical contraction implies DD
    ▪ Digital rectal exam for DD 75% sensitive, 87% specific

• Investigations (devices)
  o Balloon expulsion (BE)
    ▪ 50 ml of water or air expelled in 1 to 2 min
    ▪ Cannot differential between Inadequate defecatory propulsion and DD
  o Anorectal manometry (ARM)
    ▪ Type 1 - Adequate propulsion, paradoxical PFM
    ▪ Type 2 - Inadequate propulsion, paradoxical PFM
    ▪ Type 3 - Adequate propulsion, insufficient PFM relaxation
    ▪ Type 4 - Inadequate propulsion, insufficient PFM relaxation
    ▪ Ortengren AR, et al 2020 meta-analysis questions role in DD
  o Defecography - radiological study of structural abnormality and change of anorectal angle with contract and straining
  o Coloscopy - little value except to rule out cancer
  o Colonic transit studies - little value because delayed transit occurs secondary to evacuation disorder (when evacuation improves, transit will improve)

• Diagnosis - described in detail on page 42
  o IBS-C
  o Functional constipation (FC) (no abdominal pain)
  o Opioid-induced constipation
  o Functional defecation disorder
    ▪ Satisfy the criterion for FC or IBS-C
    ▪ AND (+) 2 of 3 tests - BE, ARM, Defecography (not structural)
Treatment

- **Conservative**
  - Effective practitioner patient relationship
  - Increased fluid intake - only if dehydrated
  - Exercise - 20 min walk daily - meta-analysis
  - Soluble fiber - psyllium - Metamucil (not bran), add slowly to 20 to 30 g / day

- **Pharmacological**
  - Osmotic laxatives - FC and IBS-C
    - Polyethylene glycol - Miralax - best
    - Did not change abdominal pain
  - Stimulant laxatives - FC
    - Bisacodyl - Ducolax - beneficial
    - Sodium picosulphate - ? MOM - beneficial
    - Senna - Senokot - little evidence
  - Prescriptions - Linzest.....

- **Anorectal biofeedback**
  - Rectal manometery with bearing down practice
  - EMG with relaxation practice
  - 70% response rate for DD (not for other constipation or pediatric constipation)
  - Good evidence
  - Consider home biofeedback

- **Transanal irrigation** - neurogenic bowel
- **Nerve stimulation** - little evidence
- **Surgery** - last resort

Discussion

1. Do you suggest OTC treatments for FC or IBS-C? which ones
2. Do you use rectal manometery or other forms of biofeedback for these patients
3. Any other successful treatments?