ANORECTAL DISORDERS:

FUNCTIONAL ANORECTAL PAIN AND FUNCTIONAL DEFECTION DISORDERS

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Anorectal Disorders

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DIAGNOSTIC PROCEDURES

- History:
- Digital rectal examination
- Endoscopy
- Imaging: Endosonography, (MR-)defecography, MRI
- Anorectal manometry
1. **Resting anal pressure:** 70% attributable to internal anal sphincter function

2. **Squeeze pressure:** the strength and duration of voluntary external anal sphincter and puborectalis contraction

3. **Internal anal sphincter inhibitory reflex**

4. **Threshold volume of rectal distention**
   - first sensation of distention,
   - a sustained feeling of urgency to defecate,
   - Maximum tolerable volume

5. **Attempted defecation**
   - increased intra-abdominal pressure and relaxation of the pelvic floor muscles (normal),
   - or by paradoxical contraction of the pelvic floor muscles, which may be relevant to symptoms

(6. **Rectal compliance** can be evaluated by assessing the pressure volume relationship during stepwise distention of a latex balloon. Barostat preferable. )
FUNCTIONAL ANORECTAL PAIN

Definition?
FUNCTIONAL ANORECTAL PAIN

Levator ani syndrome:
  Vague, dull ache or pressure sensation high in the rectum, worse with sitting than with standing or lying down.
  Physical examination may reveal spasm of levator ani muscles and tenderness on palpation.
  Overlap with dysynergic defecation disorder

Proctalgia fugax:
  Sudden, severe pain in the rectal area, lasting for a few seconds to several minutes (rarely up to 30 minutes).
  Pain is localized to the rectum in 90% of cases.
  Attacks are infrequent, typically occurring fewer than 5 times per year
FUNCTIONAL DEFECATION DISORDERS

Definition and diagnostic procedures?
FUNCTIONAL DEFECAITION DISORDERS

Diagnostic Criteria for Functional Defecation Disorders

1. The patient must satisfy diagnostic criteria for functional constipation and/or irritable bowel syndrome with constipation

2. During repeated attempts to defecate, there must be features of impaired evacuation, as demonstrated by 2 of the following 3 tests:
   a. Abnormal balloon expulsion test
   b. Abnormal anorectal evacuation pattern with manometry or anal surface EMG
   c. Impaired rectal evacuation by imaging
Rectal pressure

Anal pressure

A
Pretreatment:
• No change in intrarectal pressure
• Paradoxical anal contraction

B
• Improved pushing
• Paradoxical contraction remains

C
• Increased intrarectal pressure
• Coordinated relaxation in anal sphincter
FUNCTIONAL DEFECATION DISORDERS

1. Patient education: Explain to patients that they inadvertently squeeze or fail to relax their anus when they are straining.

2. Enhance push effort: Teach the patients to effectively push, when straining, by appropriately increasing the intra-abdominal pressure;

3. Train to relax pelvic floor muscles: Biofeedback

4. Practice simulated defecation