

doi.org/10.1590/S0004-2803.202302000-01

Evacuation disorders. Can we make a better job?

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Oliveira LCC. Evacuation disorders. Can we make a better job? *Arq Gastroenterol.* 2023;60(2):161-2.

Chronic constipation remains a common symptom with important consequences to patients and implications in costs. It is usually related to several factors involving complex mechanisms⁽¹⁾.

Because definition of constipation varies between patients and doctors, a definition criterion was proposed and became the most utilized tool to help in the assessment of symptoms. The Rome Criteria is in its fourth revision and defines constipation when a patient has less than three bowel movements per week and unsatisfactory stools within the last 6 months over a period of 3 months in combination with straining, incomplete evacuation, hard stools, and necessitating manual maneuvers in more than 25% of defecations⁽²⁾. It is a reliable tool that helps to understand the most important symptoms and classify patients into the two main categories: evacuation disorders or intestinal motility disorders.

Evacuation disorders can have a functional or structural origin. A functional evacuation disorder is part of an obstructed defecation syndrome (ODS) and is characterized by paradoxical contraction or inadequate relaxation of the pelvic floor muscles during attempted defecation, resulting in symptoms of impaired defecation such as incomplete evacuation, straining, and tenesmus⁽³⁾. This dissynergic pattern of evacuation is also termed anismus. These patients are typically referred to a general practitioner or gastroenterologist before a specialist is called into participate in their treatment. Unfortunately, many constipated patients often go undiagnosed and can sustain symptoms of ODS for years without proper evaluation and, more importantly, without proper treatment. Another recent tendency is to refer patients for expensive radiological examinations such as MRI defecography, without an adequate clinical evaluation.



As a colorectal surgeon specializing in anorectal physiology and anorectal dysfunction, I am seeing patients with long term symptoms of ODS without adequate diagnosis. In fact, it is crucial to correlate symptoms with some method that can demonstrate inadequate relaxation of the pelvic floor or incoordination during evacuation attempts. Anorectal physiology tests that can help in defining anismus include anorectal manometry⁽⁴⁾.

Recently, a proposed protocol for performing high resolution anorectal manometry was established by the International Anorectal Physiology Working Group (IAPWG) and termed the London Protocol⁽⁵⁾. It was an important step to standardize the method and allow comparisons among different centers. In patients with dyssynergia, high-resolution manometry is able to define four subtypes of dissynergic defecation. These technical refinements are facilitating interpretation of the problem, and thereby assisting in selecting the patient's best treatment option. In addition, high-definition manometry has been replacing electromyography for mapping and detecting a dissynergic sphincter.

Given these newer protocols and technological advances, it may be time to rethink how we best approach patients with anismus. According to pub-

lished guidelines, at least two complementary tests are necessary to establish a diagnosis, including anorectal manometry, balloon expulsion test, and one of the dynamic methods to evaluate evacuation⁽⁶⁾. With the introduction of the London protocol, association of clinical criteria with high resolution manometry and the balloon expulsion test will certainly help to identify patients with anismus who could benefit from biofeedback therapy.

In fact, biofeedback therapy, despite that it is still not widely utilized, is a well-recognized treatment method for patients with ODS, with robust evidence in the literature including clinical randomized trials (more effective than sham biofeedback or medical therapy) and therefore, recommended by several guidelines as a first-line treatment⁽⁷⁾. In addition, biofeedback is a valuable tool for other indications and problems related to the pelvic floor, such as anorectal functional pain syndromes associated with paradoxical contraction of the levator ani muscles⁽⁸⁾.

The future goal is to ensure that the next generation of anorectal manometry systems is more comparable and doctors are better trained to evaluate these patients, avoiding excessive costs and often ineffective treatments that merely prolong the patient's condition and do not help to improve their quality of life.

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