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20TH ANNUAL
GI SYMPOSIUM

A scenic view of a coastline with a large tree in the foreground, overlaid with a light blue tint. The background shows a rocky shore meeting the ocean under a clear sky. The tree's branches and leaves are visible in the upper and right portions of the frame.

Dyssynergic Defecation

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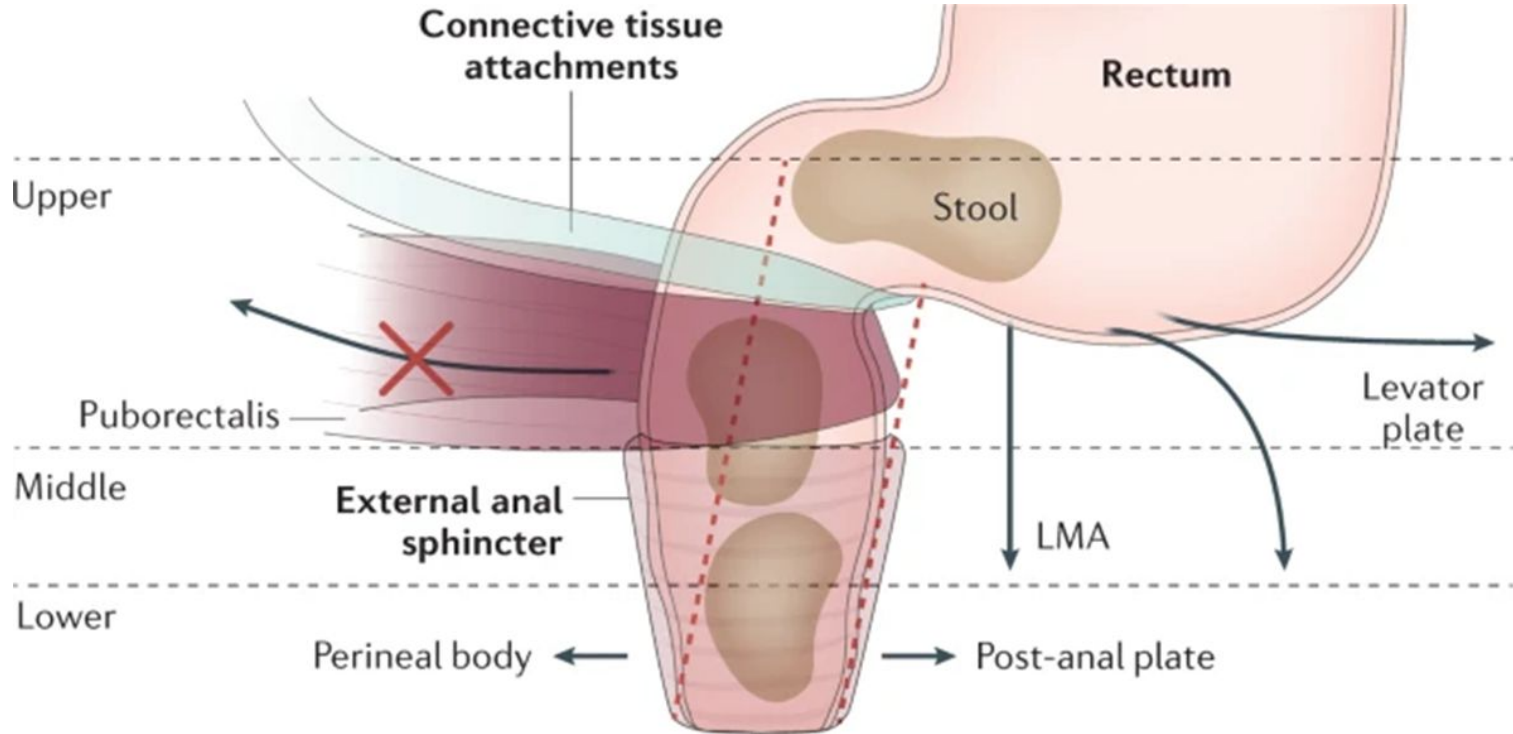
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Outline

- Pathophysiology of pelvic floor disorders
- Approach to patients with dyssynergic defecation
 - Testing
 - Treatment
- Questions

Defecatory Disorders



Key history and risk factors

Anxiety

Advancing age

Lower back injury

Abuse

Depression

Maladaptive learning behavior

Endometriosis

Trauma

Disorders of brain gut interaction

Spinal nerve injury

Surgical or obstetric trauma causing muscular pain

Hypermobility /EDS

Degenerative neuromuscular disease

Diagnosis of Functional Defecatory Disorders

Digital rectal
exam

Anorectal
Manometry

Balloon
expulsion test

Defecography

Types of Dyssynergic Defecation

Type 1

- Paradoxical increase in anal sphincter pressure during attempted defecation with normal adequate pushing force

Type 2

- Inadequate pushing force with paradoxical anal contraction

Type 3

- Adequate pushing force, but absent or incomplete sphincter relaxation

Type 4

- Inadequate rectal push effort and inadequate anal sphincter relaxation

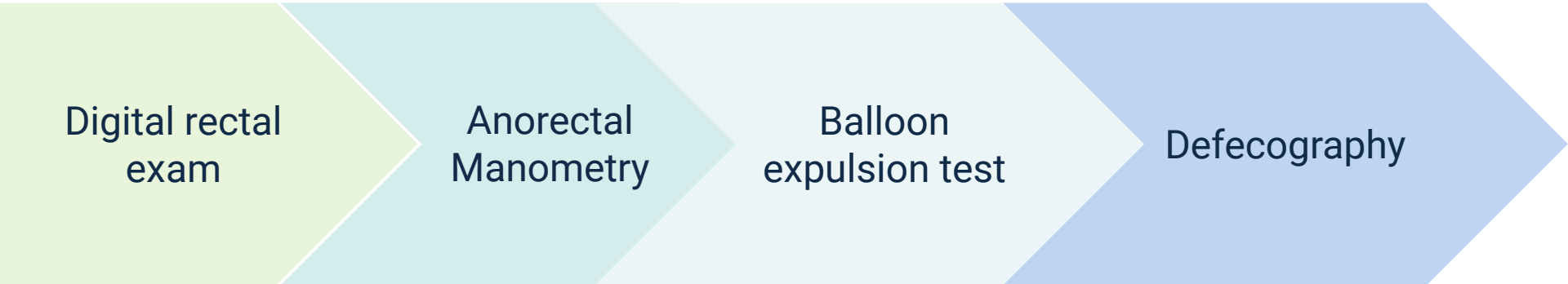
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Management of Functional Defecatory Dysfunction

**Stool Form
Optimization**

**Habit
Training**

**Pelvic Floor
Physical
Therapy +/-
Biofeedback**

Habit Training Interventions

Education training

- Education on dynamics of defecation
- Diet/fiber

Scheduled Toileting

- Follow daily routine
- Attempt defecation after meals / when urge felt
- Urge suppression techniques

Defecation techniques

- Seated training (defecation positioning / posture)
- Splinting (vaginal digitation perineal support)
- Avoid digitation

Pelvic floor relaxation

- Diaphragmatic breathing

Response to Biofeedback Therapy

- Digital maneuvers
- Harder stool
- High anal tone
- Prolonged BET
- Willingness to participate
- Success rate 60-70%
- Lasting effects >2 years

Pelvic floor botulinum toxin? Refer to colorectal surgery?

- Evidence for botulinum toxin in dyssynergic defecation is poor
- Consider surgical referral in patients who:
 - have persistent symptoms after maximizing pelvic floor physical therapy
 - have Oxford grade III-V rectal prolapse on defecography
 - Grade I-II rectal prolapse considered clinically insignificant

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