

## Perspective

# Obstructed Defecation Syndrome in Young Women

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## Introduction

Obstructed Defecation Syndrome (ODS) is characterized by excessive straining at stool, incomplete rectal evacuation, and needing for perineal splinting. This condition is prevalent in young women suffering from constipation, approximating 7-15% [6]. ODS is refractory to laxative use. Typically, the block is found in the rectosigmoid portion. The main causes are divided into mechanical and functional. Mechanical causes interfere with stool passage, as can be found for instance in rectal prolapse. Functional causes include various neurologic or behavioral disorders, leading to pelvic floor dysfunction, discoordination of the defecatory process, and impaired rectal sensation. In dyssynergic defecation, that affects many young women with chronic constipation, there is an inability to coordinate the abdominal and pelvic floor muscles to evacuate stools. Paradoxical contraction of the pelvic floor muscles during defecation hinders evacuation [10-12]. ODS is characterized by persistent sensation of rectal fullness and painful prolonged or excessive straining, accompanied by a sensation of incomplete evacuation and clustering, often, digital manipulation. Hemorrhoids and fissures are also related to functional ODS due to the psychological condition to avoid pain during defecation.

A holistic approach is needed for patients with ODS, considering that most of these young women present with psychological distress, either anxiety or depression. Anismus affects many ODS patients [8].

## Assessment

Symptoms of prolonged or excessive straining, feelings of incomplete evacuation, application of perineal or vaginal pressure, or direct digital evacuation of stool (including soft stool) may be indications of anorectal outlet abnormality [13] which after a thorough history taking should be followed-up with a Pelvic Floor Muscle (PFM) functional assessment [2]. Signs of no- or insufficient perineal descent during observation and anorectal digital examination indicate pelvic floor dysfunction such as paradoxical contractions of the PFM and external anal sphincter. Medical data based on physiologic studies (colonic-transit tests, anorectal manometry, balloon expulsion tests, and defecography) can be helpful for the physical therapist before start of the physical therapeutic diagnostic consultation to further evaluate the consequences of the health problem ODS in order to determine if and to what extent physical therapy is warranted for the individual patient under assessment and evaluation [2,7]. Realistically, in most cases results of these tests are not (yet) available for the physical therapist. Frequently, they only will be performed until dietary and lifestyle changes, trials of fiber and laxatives and physical therapy have produced no improvement [7].

## Treatment

Most conservative treatment modalities for young women with ODS up to now lack sufficient or convincing scientific or

clinical evidence. We use in our clinical practice general exercises or physical activity, behavioral changes regarding fluid intake and bowel habit and – regimen. Next to this, PFM training, Bio Feedback (BF), behaviour therapy, and Electrical Stimulation (ES) are provided to these women with ODS (Camilleri, 2010). BF supports PFM and anal sphincter muscle training by converting intracavity electronic signals or pressure, captured with a small intra-rectal balloon or electronic probe to a computer screen which makes it possible for the young women to see (and/or hear) if and to what extent the pelvic floor is used adequately during PFM contractions and relaxations during physical activities. It is used to train them to relax their PFM while straining and to coordinate relaxation and pushing to achieve defecation [3]. Our experience is that BF may be helpful in young women with symptoms or physical examination findings that suggest pelvic floor dysfunction, or who have diagnostic test results indicative of this disorder.

Defective expulsion is commonly investigated by asking our patient to defecate a 50mL water-filled rectal balloon. Patients with functional defecation disorders usually fail this test. In these cases, as part of our behavioral therapy, we first explain the anorectal dysfunction and discuss its relevance with the patient before approaching the treatment. We train on a more effective use of the abdominal muscles and instructions on diaphragmatic breathing technique to enhance the push effort. Our patients will next be shown anal manometry or EMG recordings displaying their anal function and are taught through trial and error to relax the PFM and anal muscles during straining. By increasing the intra-abdominal/intra-rectal pressures with synchronized relaxation of the anal sphincters using visual and verbal feedback from manometry, we seek to improve recto-anal coordination. Visual feedback on PFM relaxation and contraction is continuously encouraged. When our patient has learned to relax the PFM during straining, the visual and auditory help can be discontinued.

Another kind of training we use is an air-filled balloon attached to a catheter, which is slowly withdrawn from the rectum while the young woman concentrates on the evoked sensation and tries to facilitate its passage [1]. Then she should defecate the balloon spontaneously without any assistance. Also, in case of a hyposensitive rectum we use the rectal balloon for sensory retraining. Usually, this kind of BF training is safe, has no side-effects and will last up to 6 intensive supervised sessions of 30 to 60 minutes each [5].

Physical therapy for ODS aims to improve or restore normal bowel function and relieve symptoms such as abnormal or excessive straining during defecation, bloating, and feelings of incomplete evacuation. In case of pelvic floor dyssynergia we offer PFMT with BF, alone or in combination with prescribed medication, to stimulate coordination, timing and selective contractions/relaxation of the PFM including the external anal sphincter [7,9]. It is important to offer intense home and office training and checking and following up on adherence to the protocols.

## To Conclude

In young women with ODS physical therapy is an essential part of the patient-centred multidisciplinary team. In that sense it is paramount that this kind of treatment should be provided by a well-trained, experienced but also empathic physical therapist.

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