

Title:
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DIAGNOSTIC AND THERAPEUTIC CHALLENGES IN THE MANAGEMENT OF OBSTRUCTIVE DEFECATION

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Dear Editor,

Chronic constipation is a very common disease in daily clinical practice with significant deterioration in quality of life that is increased when associated with obstructive defecation. For this reason, we believe that this case can improve our knowledge for these problems.

A 53-year-old woman reported life-long constipation defined as difficulty to evacuate with excessive straining and sensation of incomplete evacuation.

The rectal examination showed an incomplete opening of the anal canal with defecation manoeuvre and an anterior rectocele. Colonoscopy showed a 3-cm rectal ulcer, without specific signs neither histological nor microbiological analysis.

High-resolution anorectal manometry (HRAM) with a 12-sensor solid state catheter was performed with mild hypotonic internal anal sphincter; type III dyssynergy pattern (fig 1A) and rectal hypersensitivity. Balloon expulsion test(BET) was expelled in 12 seconds (1).

A fluoroscopic defecography was performed with adequate rectum-anal angle opening during straining, moderate anterior rectocele(2.6 cm); and enterocele grade III(fig 1B). The diagnosis was chronic constipation due to obstructive defecation and a secondary solitary rectal ulcer(SRU).

This case reflects the diagnostic doubts and the complex management of these patients, which must be addressed by a multidisciplinary team.

HRAM showed type III dyssynergia (DD). However, the BET didn't support that diagnosis. When there is a discrepancy between HRAM and BET, defecography is required. However, our patient only presented one of the three radiological criteria to define DD. The presence of SRU could also interfere in our results as these patients usually have hypersensitivity and paradoxical contraction of the puborectal during pushing(2).

Most guidelines currently assume that there is no gold standard for the diagnosis of DD, having to meet criteria in at least 2 techniques. However, the current evidence shows a poor concordance between them(3).

Regarding treatment, these patients do not usually respond to conventional treatments for constipation. Sucralfate enemas demonstrated a remarkable improvement for the SRU (fig 1B) (4). The patient was treated initially with biofeedback(5) and pelvic floor rehabilitation. However, the important structural alterations may require surgical repair, with the aid of rehabilitative techniques that help to carry out an adequate defecatory maneuver.

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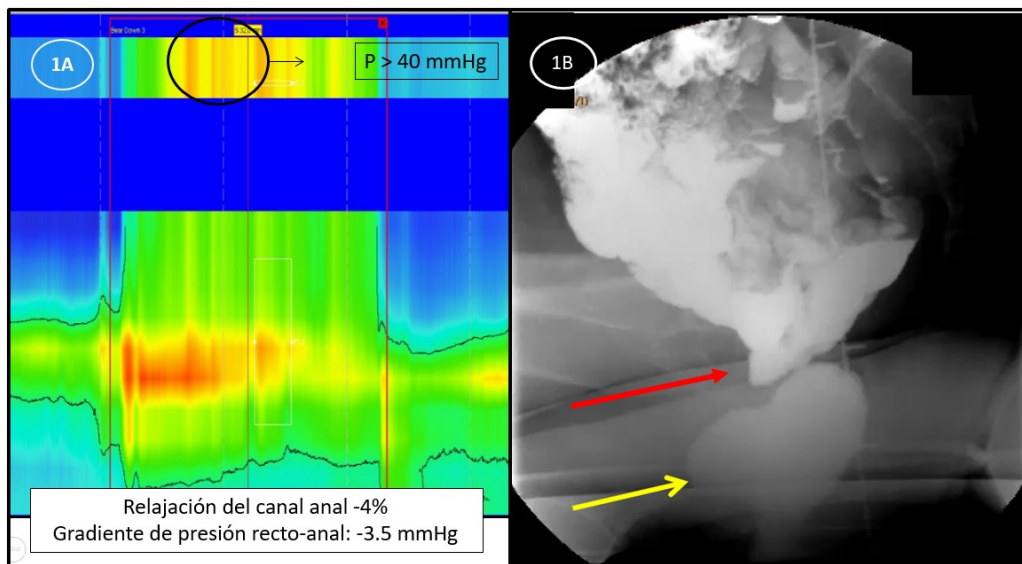


Figure 1. 1A Simulated evacuation without rectal distention with High-resolution anorectal manometry (HRAM). It can be seen that there is an adequate propulsive force (> 40 mmHg) but there is an inadequate ($\leq 20\%$) relaxation of anal sphincter. 1B. Simulated defecation by defecography. An anterior rectocele of moderate size was observed (yellow arrow) and a severe enterocele (red arrow), the intestinal loops exceeded the coccyx line and remain situated anterior to the rectum.