Obstructive Defecation Syndrome: Answers from Experts

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Obstructive defecation syndrome (ODS) is a complicated-sounding term for chronic constipation. It involves difficulty in passing stool, hard stool, straining for more than 15 minutes, or incomplete evacuation occurring at least weekly and continually for 6 months or more. An interdisciplinary team at the University of California San Francisco (UCSF) analyzed data from the Reproductive Risks for Incontinence Study at Kaiser (a population-based cohort of racially diverse women, 40 to 69 years old) and determined a 12.3% ODS prevalence in women — i.e., ODS is a common occurrence in middle-aged women. Women in the database who had undergone laparoscopic/vaginal hysterectomies or surgery for pelvic organ prolapse or urinary incontinence had nearly twice the risk of weekly obstructive defecation, signaling a direct connection between ODS and underlying pelvic floor disorders.

The role of enterocele (defined as prolapse of the small bowel into the rectogenital space) continues to be argued. Published reports put enterocele incidence at 19% to 35% in ODS patients. Some experts, including Nichols and Randall, have maintained that an enterocele’s etiology is related to congenital factors, specifically an unusually deep Pouch of Douglas, the deep area behind the uterus in front of the rectum in women. This condition renders an individual especially susceptible to enterocele when associated with loss of pelvic floor support and chronic increased abdominal pressure, such as from obesity. Others consider the etiological classification of enterocele as primary when factors such as multiparity, advanced age, general lack of elasticity, obesity, constipation, and increased abdominal pressure are present; and secondary when it occurs after gynecological surgical procedures, especially hysterectomy. When an enterocele occurs in a patient who has undergone a hysterectomy, failure to reattach layers of the pubocervical fascia results in a defect in which the peritoneum comes into direct contact with the Pouch of Douglas. When an enterocele is diagnosed in a patient who still has her uterus, she typically is found to have an unusually deep Pouch of Douglas.

Given its relatively remote location, the Pouch of Douglas is notorious for the collection of infection and fluids that can affect spread of pathology such as tumors, endometriosis, and pus. The male anatomy has no precise equivalent to the Pouch of Douglas.

Treatment
The first line of treatment for ODS is to keep the stools soft, avoid straining, and use glycerine suppositories if found helpful. When the problem is due to function, biofeedback and physical therapy usually are recommended to enable patients to regain coordination of their pelvic floor. For symptoms related to a physical cause including those described and confirmed through sophisticated diagnostics, surgical correction may be recommended. Such procedures might include rectocele repair for patients with enterocele in conjunction with severe ODS symptoms that fail medical management.

Depending on the patient’s anatomy and the likely causal factors of ODS, another option is a recently developed, minimally invasive procedure: stapled transanal rectal resection (STARR®). STARR is a surgical procedure performed through the anus, requires no external incisions, and leaves no visible scars. Developed by Ethicon, a Johnson & Johnson company, STARR uses a surgical stapler, removes excess tissue in the rectum, and reduces the anatomical defects that can cause ODS. In a recent study of 90 patients undergoing the STARR procedure, patients were hospitalized 1 to 3 days, experienced minimal postoperative pain after the procedure, and resumed employment or normal activity in 6 to 15 days. In this study, most ODS patients experienced a significant improvement in their ODS symptoms following STARR.

Joint Commission Certification
Recognizing the trend toward minimally invasive surgery and the significance of such innovation in colorectal surgery, the Joint Commission added a new certification for hospitals in Minimally Invasive Surgery in Colorectal Surgery. This grows out of the Joint Commission’s launch of its Disease-Specific Care Certification program in 2002. The first such hospital to receive this new honor is Tenet’s East Cooper Hospital in Mount Pleasant, SC, in recognition of its adherence to patient safety and quality standards. The lead colorectal surgeons behind this honor, awarded in April 2011, are a young husband-and-wife team who trained at Detroit’s Beaumont Hospital. East Cooper delivers 1,400 of Charleston’s newborns annually in a brand new facility and recognizes the connection between obstetrical trauma and bowel health. As the leading community hospital for a rapidly growing population, East Cooper is committed to women’s health across all service lines and serves as an example of what is possible in this healthcare field.

Summary
Recognizing ODS as a common problem in middle-age women, understanding its etiology and risk factors, and bringing remedies with innovative solutions that restore
quality of life for baby boomers is exciting news. It is important to distinguish functional from anatomic defects (some women have both) and to rule out slow-transit constipation or even short segment Hirschsprung’s disease (a congenital disorder in which the short segment of the distal colon fails to relax, thereby creating obstruction). Do you have patients you suspect have this medical problem? Does your patient feel a sensation of incomplete evacuation, requiring repeat return trips to the bathroom or digitation of the posterior vagina or anal canal to have a bowel movement? Today, we have experts and answers.

References