8.1 Introduction

Much has changed in the last three decades, since surgery for rectocele is no longer carried out by gynecologists alone and the term “obstructed defecation” is now well known even among non-specialists. Prior to 1980, only a few surgeons even considered the puborectalis muscle and very few radiologists had performed a defecography. Moreover, in this age of Internet medicine, you might receive a telephone call from a worried patient saying: “Doctor, please help me, I have a rectocele, I spend hours on the toilet and strain all the time!”

As far as rectal internal mucosal prolapse is concerned, its relationship with defecation and its endoscopic/radiologic grading were previously almost unknown. Solitary rectal ulcer syndrome was likely to be interpreted as a neoplasm or colitis, and psychologists were aware of “vaginismus” not “anismus.” Thus, progress in knowledge and technology is most welcome, provided it does not result in surgical overtreatment. Indeed, surgery for obstructed defecation is rarely carried out at St. Mark’s Hospital, to mention a well-known institution, as was the case 30 years ago.

Professor Phillips, Director of St. Mark’s, in his Invited Commentary to the paper of Boccasanta et al. (2004) on the STARR procedure, wrote that for those who think that constipation is mainly a functional disease, to resect the rectum for constipation is like removing a lung from a patient with asthma. Professor Nicholls, at the Educational Meeting of the Italian Society of Colo-Rectal Surgery, held in Rome in 2008, reported that at St. Mark’s almost no patients with constipation are treated surgically. At our unit, only 14% of patients with obstructed defecation (OD) undergo surgery (Pescatori et al., 2006). The rest are treated using conservative measures, with satisfactory outcome based on the following findings:

1. As reported in the literature, regardless of the operation, about half of the patients will have persisting or recurrent OD in the long term.
2. Any operation for OD is associated with the risk of postoperative complications. Some of them are severe, such as rectal ischemia following a Delorme procedure or pelvic sepsis after a STARR procedure (references will be quoted).
3. Any surgery for OD may be followed by the need for re-intervention, which is burdensome for the patients and for the hospital.
4. At our unit alternative measures are available as well as expert consultants who are able to treat functional associated disease, as described in the diagram of the “iceberg syndrome” (Fig. 8.1), which we follow when dealing with OD.
5. Conservative treatment is frequently offered to OD patients, such as psychotherapy, pelvic floor rehabilitation, high fiber diet, hydrocolon-lavage, yoga, and hypnosis, all of which have been reported in the literature as effective in over 50% of the patients.
6. Our liaison with industry is not so close that it forces us to use technological innovations instead of other, non-surgical procedures.
7. We are well aware of the financial limitations of public healthcare. In Italy, there are regions where the healthcare budget is low, hospitals are being closed, and doctors and nurses are being dismissed.
8. We know that surgery often restores anatomy but not function, as demonstrated by Vermeulen et al. (2005) and confirmed by Wexner (2005) in a series of patients operated on for rectocele and OD.
9. We are in favor of the holistic approach, which
takes into consideration the whole entity, psyche and body, and not just the affected organ.

10. We believe in the PNEI system, which considers the Psychological, Neurological, Endocrine and Immunological Systems, their relationships, and their feedback with both the large bowel and the pelvic floor. According to the PNEI system, surgery has a limited role in the management of these patients.

There are colleagues, with great expertise but more surgery-inclined, who follow different criteria. Here are three examples: In one year, Bocasanta et al. (2011) operated on 100 patients, out of 150 seen for OD, performing 50 STARR and 50 Transtar procedures. Within a 2-year period, Schwandner (2011) carried out 52 stapled rectal prolapsectomies in his patients with OD. We described this operation in 1997 (Pescatori et al., 1997, www.ucp-club.it/medici_articolo.asp) but have performed it in not more than 25 selected cases in 15 years. Gario and Trompetto carried out about 150 internal Delormes in OD patients (personal communication), whereas we have performed this procedure in fewer than 10 patients. The long-term outcome of the procedures was not mentioned in any of these three studies (i.e. outcome at over 3 years after surgery). It should also be noted that, unfortunately, there are other colleagues, more often general than colorectal surgeons, who prefer to operate rather than to use conservative measures, even when surgery is not indicated.

The following case involves a 75-year-old woman who was seen in my outpatient clinic. She suffered from severe constipation and had experienced a mild TIA when straining at defecation. She had had three vaginal deliveries, her perianal sensation was impaired, the anal reflex was nearly absent bilaterally, and she had undergone hysterectomy. Therefore, she presumably had a pudendal neuropathy and rectal hyposensation. She was moderately depressed. Defecography showed a non-relaxing puborectalis muscle on straining, a small anterior rectocele, and a modest sigmoidocele. There was no sign of recto-rectal intussusception or rectal internal mucosal prolapse. Large bowel transit was markedly slow at a transit times study with radio-opaque markers. Based on these findings, I would have suggested conservative therapy, e.g., high residue diet, psyllium, bulking laxatives, biofeedback, and maybe hydrocolon lavage; perhaps, in case of failure, a mini-invasive surgical procedure, such as sacral neuromodulation. Instead, another surgeon had proposed a STARR as the first approach, which in my opinion would have been surgical overtreatment.

Here is another example, even more impressive: The patient was a 57-year-old multiparous woman who had undergone seven operations for OD in the last 3 years. Earlier, she had lost a baby; she was divorced, had troubles with her son, and lived alone, but her psychological pattern was never investigated. She complained that she had fragmented evacuation and had to strain, and that defecation was not possible without self-digitations. She also had a dolichosigmoid, but her intestinal transit times were normal. She previously underwent a PPH to excise a rectal internal mucosal prolapse, then an anterior levatorplasty to correct a rectocele, both performed by the same surgeon. Sacral neuromodulation and biofeedback training had also been attempted. Due to worsening symptoms, she underwent a laparoscopic sigmoidectomy. After an episode of intestinal obstruction, the sigmoidorectal anastomosis was dilated, but she still had constipation. A STARR was then carried out, but OD persisted. An enterocoele was found by a radiologist, who thought that it was not the cause of symptoms; nevertheless, another surgeon carried out an obliteration of the pouch of Douglas, which was unsuccessful. Finally, the same surgeon constructed a diverting ileostomy. She had a poor quality of life with the stoma and complained of abdominal pain and urinary retention, which prompted her to see another surgeon, who suggested an anterior resection of the rectum.

I examined her in my office and performed both proctoscopy and endoanal/vaginal ultrasound (US), plus the “draw-the-family” psychological test (Miliacca et al., 2010). In addition, rectal capacity and sensation were measured using a latex balloon. She had a non-relaxing puborectalis muscle on straining, the rectal capacity was markedly decreased; she had a diversion proctitis, and was anxious and depressed. Her anal canal was short; she had a cystocele, an injured internal sphincter, a recto-rectal intussusception, and an internal rectal mucosal prolapse with a post-STARR (ear-pocket) rectal diverticulum. Thus,