Letter to the Editor

Tailored treatment for obstructed defecation

Dear Professor Dodi,

I read the editorial LANGUAGE AND COMMUNICATION published in Pelviperineology 2011;30:101-103 By Dodi, Stocco and Petros, titled " Why is it so difficult to define constipation?" The authors should be commended for their provocative efforts to clarify this difficult subject.

There are two terms: *the placebo effect*, mentioned by the authors, and the *honeymoon period*, proposed by James Church at the Cleveland Clinic, i.e. the short interval of time during which the patients tries to please the surgeon meeting his expectations after the treatment.

Both of them seem to demonstrate that the psychological dynamics (not only of the patient, but also between the patient and the doctor) may play a major role in influencing the outcome of a surgical procedure.

Therefore *success* and *failure* of any operation may well depend upon factors which are unlikely to be categorized and may present with a broad spectrum, such as *lifestyle*, *character* and *personality*, difficult to be scheduled and interpreted.

If one agrees on that, it is not surprising why it is extremely difficult carry out a prospective randomized trial on *obstructed defecation*, comparing, for instance, different operations such as retrograde enema, internal Delorme, Starr or Transtar, resection rectopexy, entero-rectocele repair, Express and ventral rectopexy, and looking for the "gold standard"

The reason being that so many factors which cannot be categorized are also involved, such as anxiety and depression or rectal hyposensation or slow bowel transit due to a previous sexual arrassement, or even the abuse of chocolate and glycerine suppositories, which are know to alter the viscoelastic properties of the stool and their evacuation.

The number of potential bias is unlikely to be taken under control by the researcher and therefore the results of the study may be misleading.

As an example, only a small proportion of the Starr-Transtar studies take under account the psychological pattern of the patient candidate to surgery,[1] despite we know that two-thirds of the subjects suffering from obstructed defecation have either anxiety or depression.[2]

When facing with such a complex and wide range of variables, the average surgeon tends to consider as a goal of his treatment something which may be easily evaluated by means of simple tests, such as defecography, i.e. the restoration of the normal anatomy.

Unfortunately restoring the anatomy does not mean restoring function, as nearly half of the patients who had their rectocele repaired and disappeared at defecograpfhy, are still severely constipated.[3]

That is why is a nonsense to perform a Starr to *all* or *most* of the patients with constipation and just rectal intussusception-rectocele diagnosed at x-ray: half of them will still be constipated after 18 months.[4] I strongly suspect that the same concept is true for other manual operations.

The authors of this stimulating Editorial are in favour of the *holistic approach* and so am I. We should take under consideration both the mind and the body when evaluating our patients, as they are a unique entity.

Also, we should bear in mind the concept of obstructed defecation as a kind of an *iceberg syndrome*: all these patients have *at least two occult underlying lesions*, mainly functional.[2] If neglected, they are likely to cause symptoms' recurrence.

In conclusion, I take the liberty to suggest that less time and energy might be dedicated to comparative studies aimed at establishing *which is the best operation* for these complex patients.

A wise and evidence-based eclecticism is preferable and each specialist should be able to perform more than one procedure and select it on the basis of three criteria:

a. the *patient* (man, woman, young, elderly, fit, fragile)

b. the *targeted* lesion (e.g. dealing with a rectocele the rectovaginal septum should be reinforced, in case of pudendal neuropathy better not to fire staples close to the puborectalis muscle)

c. the *associated occult* lesions (e.g. anismus and rectal hyposensation have to be corrected with bio-feedback and depression with psychotherapy).

In two words, what I suggest for obstructed defecation is not the "gold-standard", but the "*tailored treatment*", like the one widely accepted for rectal external prolapse.

REFERENCES

1. Pescatori M. Prevention and treatment of complications in proctological surgery. Foreword by S Goldberg. Chapter 8: Obstructed defecation and related diseases. Springer-Verlag 2012, pp.135-163.
2. Pescatori M, Spyrou M, Pulvirenti d'Urso A. A prospective evaluation of occult disorders in obstructed defecation using the "Iceberg diagram". Colorect Dis 2006;8: 785-789.
3. Vermeulen J, Lange JF, Sikkenk AC, van der Haarst E. Anterolateral rectopexy for corrections of rectoceles leads to good anatomical but poor functional results. Tech Coloproctol 2005; 9:35-41.
4. Gagliardi G, Pescatori M, Altomare DF et al. Italian Society of Colo-Rectal Surgery (SICCR) Results, outcome predictors, and complications after stapled transanal rectal resection for obstructed defecation. Dis Colon Rectum 2008; 51:186-195.

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