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Summary

What speciality is best to handle defecatory disorders: The gastroenterologist's vs. the colorectal surgeon's perspective

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A gastroenterologist and colorectal surgeon debate the optimal management of defecatory disorders, agreeing that functional assessment and conservative therapy should precede surgery but differing on which specialty is best positioned to coordinate care.

KEY POINTS

- The gastroenterologist argued that symptoms alone cannot diagnose dyssynergic defaecation and physiological testing (anorectal manometry, balloon expulsion test, or defecography) is required per Rome Five criteria.
- The speaker stated that biofeedback therapy is efficacious in 70 to 80% of patients with dyssynergic defaecation at both short and long term, supported by five randomised controlled studies.
- Both speakers agreed that first-line therapy consists of lifestyle and dietary management with oral laxatives, and that structural abnormalities are common in 20 to 60% of constipated patients but do not always require surgery.
- The gastroenterologist emphasised that dyssynergic defaecation must be treated before surgery because there is high risk of relapse of structural abnormalities if the functional disorder is not addressed first.
- The surgeon argued that only 13% of healthy volunteers showed a normal manometric evacuation pattern in their study, and that manometry alone cannot define disease without balancing symptoms, function, and anatomy.
- The surgeon stated that certain defecography findings such as very large rectocele, deep recto-anal intussusception, enterocele, or megarectum are never seen in health and may warrant surgical consideration after conservative measures fail.

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