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Summary

Panel discussion: A topic we don't talk about - Evacuation disorders

UEG Week Vienna 2024 | Presentation

Colorectal | Primary Care | Surgery

October 14, 2024

This Q&A session addressed practical management strategies for obstructive defaecation syndrome and chronic constipation, emphasizing conservative treatment approaches, medication selection, and careful surgical decision-making.

KEY POINTS

- The speaker starts prucalopride at one milligram for 15 days to assess tolerance, then two milligrams for 15 days, letting the patient decide the optimal dose, and reports using it long term in many patients with good satisfaction when it works
- Prucalopride and bisacodyl have complementary colonic responses based on the speaker's high resolution manometry study in healthy subjects, so the speaker adds bisacodyl if patients tolerate but do not respond to prucalopride alone
- The speaker advises thinking multiple times before surgery for obstructive defaecation because some patients return with unchanged symptoms or develop difficult-to-treat rectal pain and urgency, and unlike medication, surgery cannot be reversed
- A UK national endoscopy database study reportedly showed 80% of colonoscopies even for alarm symptoms are negative, with only rectal bleeding and anaemia predictive of cancer and large polyps, and constipation does not appear to be a cancer risk factor
- For obstructive defaecation syndrome, the speaker uses biofeedback as first-line non-pharmacological treatment, frequently combines rectal irrigation with medication or uses it for refractory patients, and in the UK trains patients via nurse then continues at home
- The speaker uses amitriptyline frequently for obsessive bowel syndrome patients described as anxious and obsessed about toileting with rectal hypersensitivity

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