Pelvic Floor Dysfunction

Pelvic floor dysfunction is a group of disorders that change the way people have bowel movements and sometimes cause pelvic pain. These disorders can be embarrassing to discuss, may be hard to diagnosis and often have a negative effect on quality of life. Symptoms vary by the type of disorder. Many general practitioners may not be familiar with pelvic floor dysfunction, and it may take a specialist, such as a colorectal surgeon, to discover the correct diagnosis.

TYPES OF PELVIC FLOOR DYSFUNCTION

Obstructed Defecation: Obstructed defecation is difficulty getting bowel movements out of the body. Although the stool reaches the rectum, or bottom of the colon, the patient has difficulty emptying. This often makes patients feel that they need to go the bathroom more often, or that they cannot empty completely, as if stool remains in their rectum. Obstructed defecation may be caused by pelvic floor prolapse (discussed below), pain symptoms or muscles not functioning normally.

Rectocele: A rectocele is a bulge of the front wall of the rectum into the vagina. Normally, the rectum goes straight down to the anus (picture). When a patient with a rectocele strains, the stool may get caught in an abnormal pocket of the rectum which bulges into the vagina. This prevents the patient from emptying the rectum completely. Generally, rectoceles do not produce symptoms. As they grow larger, rectoceles may cause difficulty going to the bathroom, or cause leakage of stool after having a bowel movement. Rectoceles are more common in women who have given birth. Rectoceles are usually caused by thinning of the tissue between the rectum and vagina and weakening of the pelvic floor muscles.

Pelvic Floor Prolapse: The pelvic floor consists of the muscles and organs of the pelvis, such as the rectum, vagina, bladder. Stretching of the pelvic floor may occur with aging, collagen disorders or after childbirth. When the pelvic floor is stretched, the rectum, vagina, or bladder may protrude through the rectum or vagina, causing a bulge, which can be felt. In addition to a rectocele, patients may have rectal prolapse, a cystocele (prolapse of the bladder) or protrusion of the small bowel. Symptoms generally include difficulty in emptying during urination or defecation, incontinence or pressure in the pelvis.

Paradoxical Puborectalis Contraction: The puborectalis muscle is part of the control muscles that control bowel movements. The puborectalis wraps like a sling around the lower rectum. During a bowel movement, the puborectalis is supposed to relax to allow the bowel movement to pass. If the muscle does not relax or contracts during paradoxical contraction, it may feel like you are pushing against a closed door.

Levator Syndrome: Levator syndrome is abnormal spasms of the muscles of the pelvic floor. Spasms may occur after having bowel movements or without a known cause. Patients often have long periods of vague, dull or achy pressure high in the rectum. These symptoms may worsen when sitting or lying down. Levator spasm is more common in women than men.

Coccygodynia: The coccyx, or tailbone, is located at the bottom of the spine. Coccygodynia is pain is of the tailbone. The pain is usually worsened with movement and may worsen after defecation. It is usually caused by a fall or trauma involving the coccyx, although in a third of patients no cause is noted.

Proctalgia Fugax: Proctalgia fugax is a sudden abnormal pain in the rectum that often awakens patients from sleep. This pain may last up to several minutes and goes away between episodes. Proctaliga fugax is thought to be caused by spasms of the rectum and/or the muscles of the pelvic floor.

Pudendal Neuralgia: The pudendal nerves are the main sensory nerves of the pelvis. Pudendal neuralgia is chronic pain in the pelvic floor involving the pudendal nerves. This pain may first occur after childbirth, but often comes and goes without reason.

DIAGNOSIS

A complete medical history and thorough physical examination are key to evaluating pelvic floor dysfunction. The physician should ask about other pain issues in the body, as well as difficulty having bowel movements, passing urine or pain during sexual intercourse. It is important to have a full physical exam, including rectal and vaginal exams.

The function of the various nerves and muscles involved in bowel movements is complex and the physician may need additional testing to determine the cause of the problem. The tests that may be ordered by your colon and rectal surgeon can help make a diagnosis and guide treatment.

- **Endoanal/Endorectal Ultrasound**: Provides pictures of the structures of the pelvis, including the anus, rectal wall and control muscles. It may also demonstrate rectocele, rectal prolapse or enterocele (small bowel prolapse). This is generally performed in the office.
- **Anorectal Manometry**: Evaluates the ability for the control muscles and rectum to function and the strength of muscles. This is also generally performed in the office or at an endoscopy center. This test requires the patient to push and strain, so that it can correctly determine the strength of the muscles.
- **Electromyography (EMG)/ Pudendal Nerve Motor Latency Testing**: These are tests that check to determine how the nerves of the pelvic floor are working. Pudendal nerve motor latency tests evaluate just the pudendal nerve, while EMG is a more complex testing of several nerves in the anal sphincter and pelvic floor. These tests may require needles and small doses of electricity.
- **Colonic Transit Study**: A colonic transit study is a series of X-rays that evaluate the passage of stool through the colon to identify potential causes and locations of constipation. The patient takes a small pill containing metal markers, which will be seen on the X-rays over the next several days.
- **Videodefecogram**: A defogram is a special X-ray that is taken while you are having a bowel movement to test muscle movement. This test is very helpful in determining the cause of pelvic floor dysfunction. This test may include regular X-rays, fluoroscopy or an MRI machine.

TREATMENT

Treatment is based on the cause of the dysfunction and severity of symptoms. Surgical treatment is rarely needed for pelvic floor dysfunction, except for large, symptomatic rectoceles or other pelvic prolapse. In the case of prolapse, surgery may help to restore the normal location of pelvic organs. This may be performed through the abdomen or through the bottom, depending on the specific problem.

For pelvic pain syndromes, the goal of treatment is to relieve or reduce symptoms. In some cases, a combination of treatment methods helps reduce pain.

- Dietary changes such as increasing fiber and fluid intake to make bowel movements easier.
- Biofeedback, a special form of pelvic floor physical therapy aimed at improving rectal sensation and pelvic floor muscle contraction. This may include electrical stimulation of the pelvic floor muscles, ultrasound, or massage therapy. In addition, there are exercises that may be done at home which can help improve symptoms.
- Injection of a local anesthetic and/or anti-inflammatory agents.

POSTSURGERY PROGNOSIS

The success rate of prolapse surgery depends on the specific symptoms and their duration. Risks of surgical correction include bleeding, infection and pain during intercourse (dyspareunia). There is also the chance of the pelvic prolapse recurring or worsening.

WHAT IS A COLON AND RECTAL SURGEON?

Colon and rectal surgeons are experts in the surgical and non-surgical treatment of diseases of the colon, rectum, and anus. They have completed advanced surgical training in the treatment of these diseases, as well as full general surgical training. They are well versed in the treatment of both benign and malignant diseases of the colon, rectum and anus and are able to perform routine screening examinations and surgically treat conditions, if indicated to do so.

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