

Figure 9-1. Anorectal manometry in dyssynergic defecation. In type I dyssynergia (represented here), an increase in intrarectal pressure is observed along with a paradoxical increase in anal sphincter pressure.

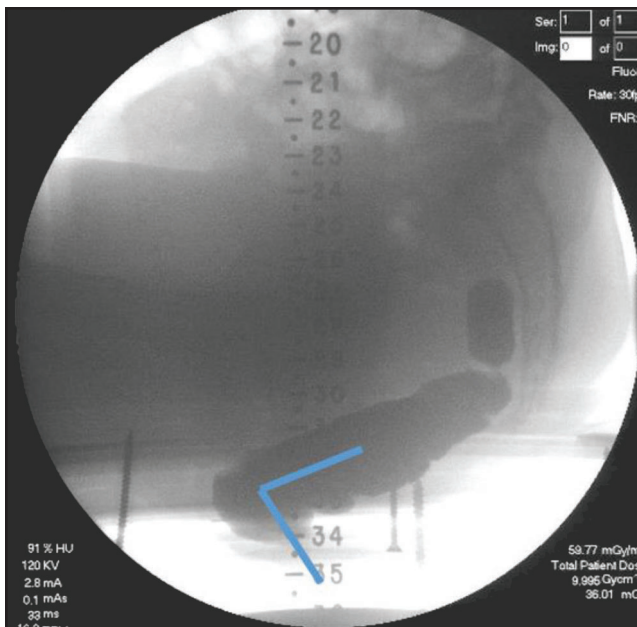


Figure 9-2. A defecogram demonstrating paradoxical contraction of the puborectalis muscle. During straining and defecation, the anorectal angle should become more obtuse to allow for opening of the anal canal and rectal evacuation. With puborectalis dyskinesia, the anorectal angle fails to widen; therefore, it becomes difficult to empty the rectal vault of stool.

Anorectal physiologic abnormalities have been reported more consistently with SRUS. When compared with case-matched groups of patients without SRUS and patients with overt rectal prolapse, patients with SRUS were noted to have significantly elevated anal squeeze pressures on anorectal manometry (Figure 9-1), whereas defecography showed paradoxical contraction of the puborectalis muscle (Figure 9-2), failure to completely empty the rectum, and a longer mean straining duration.

This suggested that despite similar symptoms, a cause-effect relationship between SRUS and rectal prolapse cannot be established.¹⁰ Two other studies comparing anorectal manometry and the balloon expulsion test between patients with SRUS and healthy controls showed statistically significant abnormal balloon expulsion tests and impaired anal relaxation in the SRUS group. Both of these studies confirmed the presence of a higher anal squeeze pressure in the SRUS group, with one of