Descending-perineum Syndrome

Causes for abnormal Descending Perineum/Pelvic Floor:

1) Chronic straining constipation 90%
2) Childbirth/labor prior to C-section 9%
3) Hysterectomy 1%

Straining Constipation

Traction Injury to Pudenal Nerves

Weak Bulging Pelvic Floor/Perineum

More Straining Needed to Evacuate

Denervation (nerve loss) of Perineum

Fecal/Bowel Incontinence

YOU NEED TO AVOID STRAINING!

30 grams FIBER (pick one below):

1. Konsyl - 2 Tablespoons 2 x day
2. Metamucil - 2 Tablespoons 2 x/day
3. Metamucil Clear – 2 Tablespoons 2x/day

Drink 6-8 glasses of water or juice per day

OR

Fiber Bars (ex. Fiber One) -2-3 bars/day

BEST CEREAL COMBO – 20-30 GRAMS

Mix ½-¾ cup of Bran Buds with your favorite cereal, milk and sugar or oatmeal. Pick a cereal you really like (Cheerios, Fruit Loops, Frosted Flakes, etc.) The Bran Buds will make your cereal or oatmeal taste even better and you will get 100% of your daily fiber needs. This combo TASTES GREAT and is good for you!!!

Note: All-Bran has many cereal types. You want All-BRAN BUDS.

Bowel Irrigation for Fecal Incontinence and Outlet Constipation

1. High fiber diet—30-35 grams/day
2. Tap water enema—500-1000 cc warm tap water each morning after breakfast and morning bowel movement (will need to buy enema bag)
3. One (1) Imodium capsule each morning (Imodium AD is over-the-counter) **For Incontinence Only**
4. Use Kleenex Cottonell in place of toilet paper to clean after bowel movement. When possible, wash after bowel movement with warm water, minimal or no soap. Dry perianal area well. Use hand held hair dryer if possible.
5. Apply Calmoseptine or Destin as directed.
DESCENDING PERINEUM/PELVIC FLOOR PROLAPSE SYNDROME

Constipation also occurs in patients with “descending perineum syndrome”. Such patients strain endlessly at stool but the rectum empties completely. The perineum is seen to bulge well below the plane of the ischial tuberosities. This abnormal perineal descent is probably secondary to injury to the sacral nerves from either childbirth or chronic straining at stool. Incomplete evacuation leads to more straining, more traction on the nerves, and progressive denervation of the external anal-sphincter and puborectalis. In time, this scenario leads to fecal incontinence and thereby compounds the patient’s misery. Surgery cannot correct this problem, which is best treated with biofeedback, although success is only about 50%.

The descending perineum syndrome consists of excessive ballooning down of the perineum usually as a result of years of straining, vaginal deliveries, prior rectal or perineal surgical procedures. Rectoceles and enteroceles (dilation/hernia of areas of the intestine/rectum/colon) may also be present with the descending perineum and contribute to outlet obstruction.

Descent of the pelvic floor on straining may be present with complete prolapse but may also occur on its own. Tenesmus—difficulty having a bowel movement and eventual incontinence are associated. “Evacuation proctography” may be helpful in diagnosing the problem.

Constipation caused by descent of pelvic floor defines the difficulty in expelling stools due to an excessive lowering of the pelvic floor while pushing forcefully, or due to the lowering of the pelvic floor beyond the bi-ischiatic line at rest.
DESCENDING PERINEUM SYNDROME
Clinical Findings
Symptomatology

Abdominal straining is such a potent inhibitor of pelvic muscle tone that if the individual persists in straining at stool over many years, the effectiveness of the post defecation reflex will be reduced considerably. As a result, during the straining effort of defecation, stool is passed, followed by the anterior rectal wall mucosa. Further straining then follows in an effort to pass it. In advanced cases prolapsing anterior rectal mucosa becomes so large that it occludes the upper end of the anal canal, giving a feeling of anal blockage and preventing further defecation through straining. The patient typically relates that after partial emptying of the rectum a sense of obstruction develops that cannot be overcome except by ceasing all straining. Indeed, some of these patients develop frank anal obstruction and may pass a finger into the anal canal to temporarily reduce this obstruction and allow defecation. If straining is repeated and prolonged, the anterior rectal wall mucosa ultimately will protrude.

A vague, dull aching pain in the perineum and sacral region may follow defecation because of the anterior rectal wall mucosa’s presence in the upper anal canal, and the patient may continue straining fruitlessly in an endeavor to relieve it. The sensation of incomplete evacuation ensues. Mucosa that prolapses becomes irritated and secretes mucus, causing perineal moisture, soreness, and irritation. The prolapsing mucosa may bleed, and anal leakage with soiling of the clothes and secondary pruritus may occur. Partial incontinence also may be present.

TREATMENT
The chief aim is to prevent further damage by eliminating all straining during defecation. Laxative use is of limited value because many of these patients have persistently liquid stool; a combination of liquid stool with lax sphincters causes soiling and sometimes partial incontinence. Those patients in whom the stool is hard are instructed to use bulking agents (Metamucil), high fiber diet, and plenty of fluids. Usually the most successful method of facilitating rectal emptying is use of an irritant suppository such as glycerine or bisacodyl. Suppositories are inserted daily, and the patient is instructed to stop the straining efforts. The origin of these repeated calls to stool is explained to the patient, who is told that once the bowel has emptied, all further calls should be ignored. Muscle weakness may be corrected partially by sphincteric exercises, but many weeks may pass before any effect is noted. Submucosal injection of sclerosants such as phenol in oil or a PPH Mucoproctoplasty may relieve symptoms and hopefully will stop the bleeding and mucous discharge and relieve the sensation of tenesmus.

In patients with large hemorrhoids a PPH stapled hemorrhoidectomy done to remove the redundant lower rectal mucosa may be of benefit, but the results are rarely sustained.

RECTAL DESCENT a.k.a. OCCULT RECTAL PROLAPSE
(only one part of “Descending Perineum Syndrome”)
Some people have great difficulty emptying their rectum due to what is called rectal descent. Rectal descent is a problem that appears to be related to childbirth. When women give birth, the normal attachments of the rectum to the lower backbone may get stretched or torn. This tearing allows the rectum to fall into the pelvis where it assumes a horizontal position. The front of the rectum can fall into the top of the anal canal and block the anal opening.