United European Gastroenterology Journal

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GUIDELINE OPEN ACCESS

European Guidelines on Multidisciplinary Management of Obstructed Defecation Syndrome—ESCP, UEG, ESGAR, EAGEN, ESGENA, ESNM and ESPCG

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Received: 3 October 2025 | **Revised:** 14 September 2026 | **Accepted:** 28 September 2026

Keywords: biofeedback | clinical guidelines | constipation | diagnosis | GRADE | obstructed defecation syndrome | pelvic floor disorders | rectal prolapse | rectocele | treatment

ABSTRACT

Introduction: The goal of this project was to develop a joint European clinical practice guideline for the diagnosis and treatment of obstructed defecation syndrome (ODS), based on the best available evidence. These guidelines are intended to support all healthcare professionals involved in the care of patients with ODS, such as general practitioners, colorectal surgeons, gastroenterologists, gynecologists, radiologists, physiotherapists, and psychologists, as well as to provide accessible information for patients themselves.

Methods: A multidisciplinary Guideline Development Group representing seven European scientific societies and including patient representatives formulated PICO-based clinical questions. Evidence was identified through a systematic literature review

Marta Goglia and Agnese Dezi contributed equally to this study.

Arcangelo Picciariello shares senior authorship.

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and assessed using the GRADE approach. Recommendations were formulated according to the available evidence and, where evidence was insufficient, as expert opinions.

Results: The final guideline includes 28 statements (1 moderate grade evidence, 2 low grade evidence, 3 very low grade evidence, 22 expert opinion) covering the diagnosis, conservative and surgical management of ODS, including indications for various imaging modalities, functional tests, and both transanal and transabdominal surgical approaches. Multidisciplinary assessment is recommended throughout the diagnostic and therapeutic pathway. Conservative treatment represents the initial management strategy, with biofeedback recommended before surgery in patients with ODS and dyssynergic defecation who fail dietary and laxative treatment. Surgery should be reserved for selected patients with persistent symptoms after conservative treatment and considered following multidisciplinary pelvic floor evaluation.

Conclusion: These multidisciplinary European guidelines offer a comprehensive and evidence-based framework for the diagnosis and management of ODS. They are intended to promote standardized, high-quality care across Europe and to improve outcomes and quality of life for individuals affected by this complex condition. Given the limited quality of evidence supporting many interventions, individualized decision-making within a multidisciplinary setting remains central to ODS management.

Domain	Recommendation	Evidence level
History taking		
4.1.1. Diagnosis and history taking	A thorough history taking is pertinent and specific elements that may contribute to obstructed defecation syndrome should be covered, including prior anorectal surgery, and child-bearing trauma.	Expert opinion
4.1.2. Psychological assessment	Anxiety, depression, psychological distress and history of sexual abuse should be taken into consideration when assessing patients with obstructed defecation syndrome.	Expert opinion
Physical examination and diagnostics		
4.2.1. Digital rectal examination	Digital rectal examination could be used for diagnosing dyssynergic defecation.	Expert opinion
4.2.2. Scoring systems	Obstructive defecation syndrome score and Cleveland Chronic constipation score could be used for an objective assessment of symptoms and quality of life as well as to evaluate response to treatment. Any other validated disease-specific score may be considered according to the patient's clinical characteristics and associated pelvic floor disorders.	Expert opinion
4.2.3. Oxford classification	The oxford classification can be considered in assessing the severity of prolapse and consequently in the choice of a tailored approach.	Expert opinion
4.2.4. Endoanal ultrasound	Endoanal ultrasound, anorectal physiology, and transit and shape studies can be considered to diagnose and assess any potential functional and/or organic diseases.	Expert opinion
4.2.5. Radiological diagnosis:	Evacuation proctography is recommended as first line tool in the detection of functional and structural abnormalities in patients with symptoms of	Low level of evidence

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Domain	Recommendation	Evidence level
	obstructed defecation. If available, MR-defecography and transperineal ultrasound could be used as triage tests in the evaluation of women with symptoms of obstructed defecation, especially when a multicompartmental prolapse is suspected.	
4.2.6. Multidisciplinary decision on multicompartmental issues	Evacuation proctography and MR-Defecography are useful means for multidisciplinary decision making and of confirming the consequences of obstructed defecation syndrome surgical treatment. However, both the pre- and post-operative findings may not always be correlated with patients' symptoms.	Expert opinion
4.2.7. Balloon expulsion test	The balloon expulsion test cannot be considered as a screening test, especially when used in the left lateral position.	Expert opinion
4.2.8. Multidisciplinary approach need	The management of obstructed defecation syndrome requires a multidisciplinary approach that integrates the expertise of colorectal surgeons, gastroenterologists, radiologists, pelvic floor physiotherapists, urogynecologists, nurses, general practitioners and psychologists.	Expert opinion
Conservative treatment		

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Domain	Recommendation	Evidence level
4.3.1. Dietary modification	Fiber-rich diet, increase in liquid uptake and bulking laxatives can be used as first-line treatment.	Expert opinion
4.3.2. Biofeedback	Biofeedback therapy should be considered before surgery in patients with obstructed defecation syndrome and dyssynergic defecation who have failed conservative treatments (diet, laxatives).	Moderate level of evidence
4.3.3. Botulinum injection and electrostimulation	Botulinum injection and bilateral posterior tibial nerve stimulation can be considered in patients with obstructed defecation syndrome and dyssynergic defecation.	Very low level of evidence
4.3.4. Emptying strategies	Rectal emptying strategies, including enemas and transanal irrigation, may be considered in selected patients with obstructed defecation syndrome who continue to experience impaired rectal emptying despite optimization of stool consistency and conservative measures.	Expert opinion
Surgery-indication		
4.4.1. Surgery	Surgery can be considered in patients affected by obstructed defecation syndrome who fail conservative treatment. The guideline development group recommends a step-wise approach from conservative to medical to surgical	Expert opinion

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Domain	Recommendation	Evidence level
	after pelvic floor multidisciplinary meetings.	
Surgical approaches: Transabdominal approach		
4.5.1. Ventral mesh rectopexy	Ventral mesh rectopexy could be offered to patients with ODS caused by posterior pelvic floor anatomical dysfunctions.	Very low level of evidence
4.5.2. Robotics and laparoscopic ventral mesh rectopexy	Both robotic and laparoscopic ventral mesh rectopexy can achieve good anatomical correction. Robotic ventral mesh rectopexy should be considered because of the better functional results, significantly shorter length of hospital stay, lesser intraoperative blood loss, and lower postoperative complication rate, when both robot and laparoscopic approaches are available.	Low level of evidence
4.5.3. Resection rectopexy	Resection rectopexy could be considered in patients with obstructed defecation syndrome associated with internal rectal prolapse.	Expert opinion
4.5.4. Type of suture to be used	Absorbable sutures can be used to fix mesh during ventral mesh rectopexy because of the lower risk of mesh erosion.	Very low level of evidence
4.5.5. Solitary rectal ulcer	Ventral mesh rectopexy could be considered in patients with solitary rectal ulcers and obstructed defecation syndrome. The combination with a transanal approach may lead to better results.	Expert opinion
4.5.6. Sacrocolpopexy	Sacrocolpopexy could be combined with ventral rectopexy to achieve short- and long-term successful results in patients with obstructed defecation syndrome due to rectal prolapse, rectocele, or enterocele and associated multicompartment prolapse (anterior, apical, middle and posterior compartment prolapse).	Expert opinion
Surgical approaches: Transanal/transperineal approach		
4.6.1. Internal delorme's	Internal Delorme's can be considered as the transanal procedure of choice due to the low rate of complications, especially in patients with impaired anal function and with a risk of post-operative fecal incontinence. Biofeedback can be performed in the post-operative period of those patients to improve the functional outcomes.	Expert opinion
4.6.2. Transperineal/ transvaginal	Transperineal or transvaginal repair can be used in patients with symptomatic simple rectocele.	Expert opinion
4.6.3. Stapled transanal rectal resection	Stapled transanal rectal resection and its variations can be considered for patients with good anal sphincter function. However, high complication and reintervention rates highlight the	Expert opinion

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Domain	Recommendation	Evidence level
	need for cautious patient selection, thorough preoperative assessment, and surgical expertise.	
Safety and special considerations		
4.7.1. Complications and informed consent	Patients should be informed and adequately counseled regarding all mesh benefits and potential harm. A patient-tailored approach discussed throughout this guideline should be adopted and the procedures should be performed by adequately trained surgeons.	Expert opinion
Surgical failure		
4.8.1. Surgical failure	Small rectal diameter, low anal sphincter squeeze pressure, increased pelvic floor descent at rest, redundant colon, and connective tissue disorders and pre-existing constipation are potential predictors of unfavorable outcomes after stapled transanal rectal resection or ventral mesh rectopexy procedures.	Expert opinion
4.8.2. Enterocele as a risk factor for transanal procedures	The radiologic presence of an enterocele is not predictive of surgical failure nor does it represent an absolute contraindication to surgery.	Expert opinion
Redo surgery		
4.9.1. Safety of redo following ventral mesh rectopexy	Redo-surgery for obstructed defecation syndrome following ventral mesh rectopexy can be considered a feasible and safe approach.	Expert opinion
4.9.2. Redo for mesh erosion and chronic pelvic pain	Redo-surgery for mesh erosion and chronic pelvic pain may present significant morbidity risks and may often be less effective.	Expert opinion

Note: Green, expert opinion; Blue, very low level of evidence; Orange, low level of evidence; Red, moderate level of evidence.

1 | Introduction

Obstructed Defecation Syndrome (ODS) is a distressing condition characterized by difficulty or inability to empty the rectum despite a normal urge to defecate and often normal stool consistency. It results from anatomical or functional abnormalities that impair anorectal emptying, reducing lumen caliber without an identifiable mechanical obstruction. Many patients require manual assistance (e.g., digital evacuation or perineal/vaginal pressure), and dependence on adjuncts such as pessaries, laxatives, suppositories, or enemas is common. Typical symptoms include repeated unsuccessful defecation, anorectal pain, hard or pellet-like stools, and occasional rectal bleeding due to straining.

Patients commonly report anorectal blockage or heaviness, pelvic floor pain, tenesmus, or slow transit; fecal incontinence (FI) and post-defecatory soiling may also occur. These symptoms can significantly impair quality of life (QoL), requiring comprehensive, individualized management [1–10]. More than 30% of patients with chronic constipation report straining, incomplete evacuation, perineal heaviness, and the need for self-digitation [1, 9, 11]. In the general population, ODS affects 7%–18%, rising to up to 50% among patients with chronic constipation in specialized colorectal or gastroenterology settings. It is likely underreported in primary care [12], and prevalence varies with population and diagnostic criteria [7].

ODS is more prevalent in women, particularly those who are multiparous or have had vaginal deliveries, reflecting compromise of the pelvic floor and anal sphincter complex. Prevalence is approximately 18% in adult women and 12.3% in middle-aged women, increasing to 23% in postmenopausal women [1, 7, 8, 13, 14].

Functional abnormalities are a major cause of ODS. This guideline uses the term dyssynergic defecation (DD) to encompass pelvic floor incoordination disorders, including paradoxical puborectalis contraction and anismus [1, 3, 6, 15–17]. A concise overview of definitions and pathophysiology is provided in Appendix S1.

This guideline presents recommendations on the value of multidisciplinary management of ODS and is structured as follows:

- History taking and symptom evaluation

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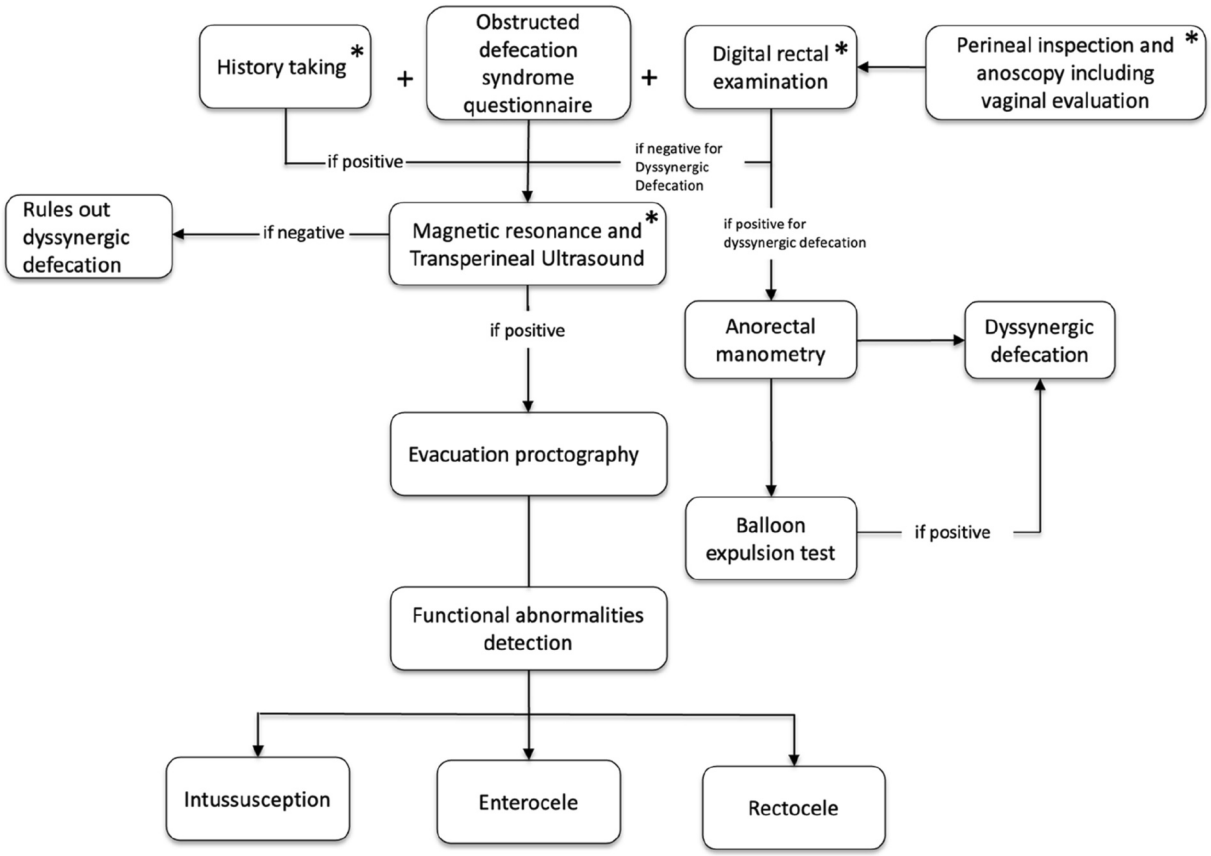


FIGURE 1 | Diagnostic algorithm. * In case of multicompartmental involvement (referred symptoms or clinical/radiological signs) a multidisciplinary assessment is recommended.

- Physical examination and diagnostics
- Conservative treatment
- Surgery
- Surgical approaches: transabdominal
- Surgical approaches: transanal/transperineal
- Safety and special considerations
- Surgical failure
- Redo surgery

Surgical techniques are grouped by approach for clarity, with variations in availability across countries and institutions (e.g., robotics) noted in relevant sections.

This guideline is intended for healthcare professionals involved in ODS management (general practitioners, gastroenterologists, radiologists, colorectal surgeons, gynecologists, and nurses), as well as patients seeking further information.

An evidence-based treatment algorithm (Figure 1, 2, 3) summarizes the key recommendations and should be used alongside the main text to guide clinical decision-making.

The Guideline Development Group (GDG) had full editorial independence without any influence from the funding body.

Full methodological details are provided in Appendices S2–S5 (Search Strategy, Review Clinical Questions, Grading Tables, KSR evaluation).

2 | Rationale

ODS is a complex, multifactorial condition requiring a comprehensive understanding of its underlying mechanisms and an integrated management approach. Although it encompasses a range of structural and functional abnormalities, internal rectal prolapse (IRP) is a central factor in its pathophysiology and clinical presentation. The interplay between anatomical defects—such as rectocele and descending perineum syndrome (DPS)—and functional disorders, including paradoxical puborectalis contraction and pelvic floor dyssynergia, underscores the need for thorough evaluation and targeted treatment [6, 18, 19].

The complexity of ODS highlights the importance of a multidisciplinary approach to its assessment and management. It spans multiple specialties, including radiology, physiotherapy, gastroenterology, urogynecology, and surgery, requiring close collaboration across disciplines. To address this, a concerted effort was undertaken to develop a standardized and evidence-based framework for ODS care, involving seven European societies representing the key disciplines engaged in its management. Together, they provide the expertise needed to address the structural, functional, and psychosocial dimensions of the condition [6, 20].

By integrating perspectives across specialties, this initiative aims to establish unified guidelines that reflect the multifactorial nature of ODS, promote best practice, and ensure consistency in

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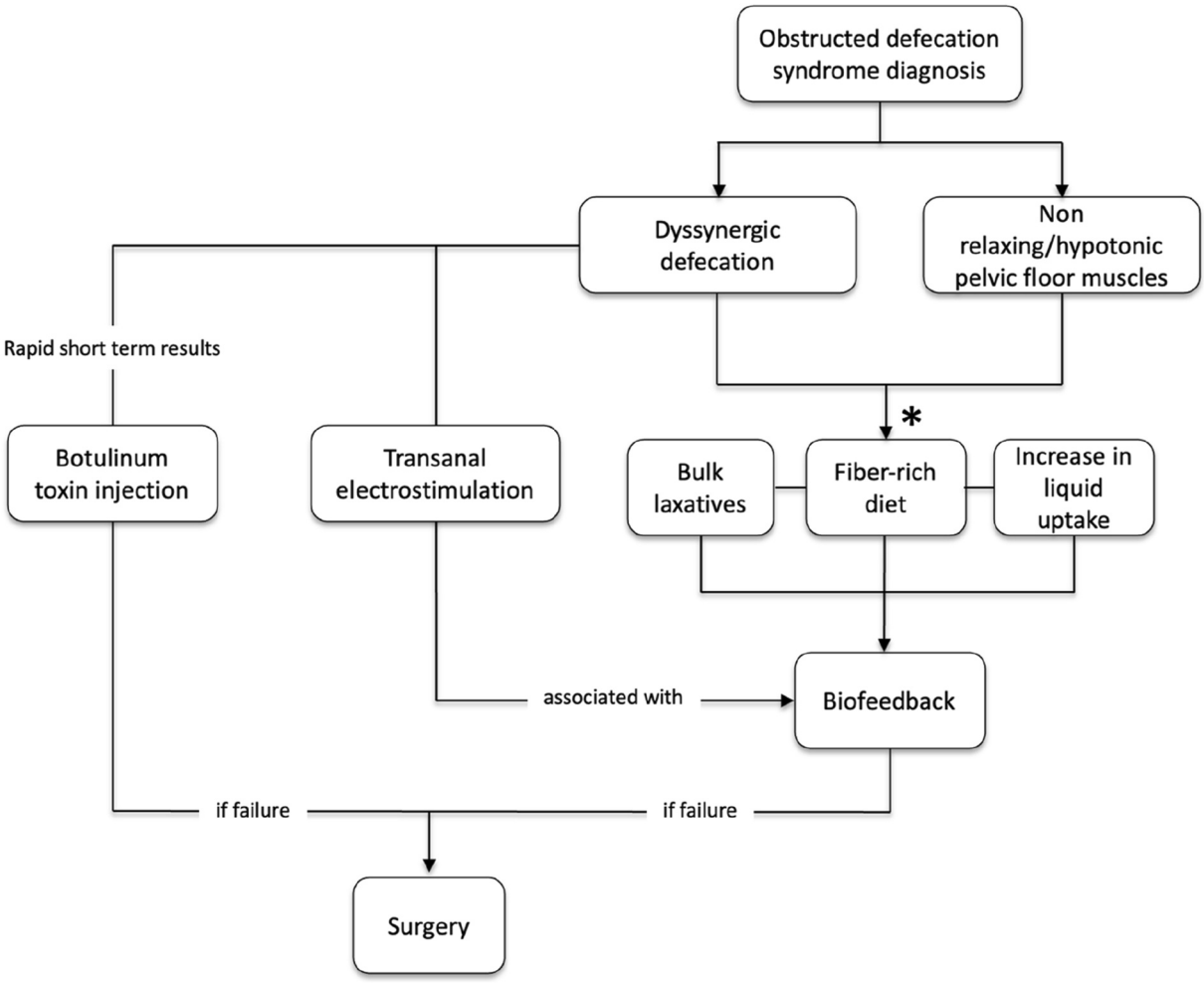


FIGURE 2 | Conservative treatment. * Biofeedback is potentially associated with the initial medical assessment.

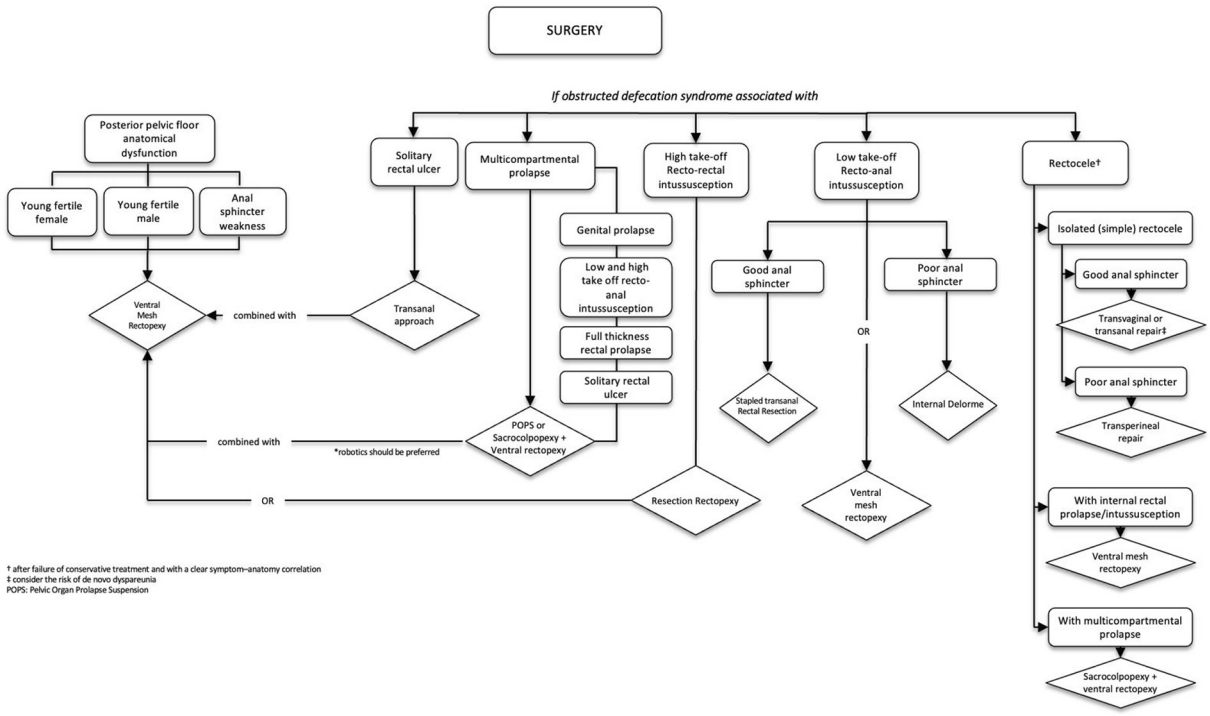


FIGURE 3 | Surgery.

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care across Europe. This collaborative approach supports clinicians in delivering patient-centered multidisciplinary care, with the goal of improving outcomes and QoL for individuals with ODS.

The primary aim of this guideline is to consolidate current evidence on the assessment and management of ODS. Previous guidelines have often focused on specific patient groups or related conditions, such as post-oncological colorectal surgery complications, leaving a gap in the management of primary anorectal and pelvic floor dysfunction. Apart from individual scientific contributions, this represents the first guideline to specifically address ODS as a multicompartmental disorder and its associated management strategies.

This joint European effort provides a focused, evidence-based framework for the evaluation and management of ODS, equipping clinicians across specialties with practical tools to manage this challenging condition effectively.

3 | Methodology

This European guideline on the multidisciplinary management of ODS was developed using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology [21] and adheres to the Appraisal of Guidelines for Research and Evaluation II (AGREE II) standards. The process was overseen by the GDG, comprising multidisciplinary experts from multiple countries, supported by United European Gastroenterology (UEG), European Society of Coloproctology (ESCP), European Society for Gastrointestinal and Abdominal Radiology (ESGAR), European Association of Gastroenterology, Endoscopy and Nutrition (EAGEN), European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA), European Society of Neurogastroenterology and Motility (ESNM), and the European Society of Primary Care Gastroenterology (ESPCG).

The scope focused on the diagnosis, assessment, and management of ODS, including clinical and radiological evaluation, conservative and surgical treatments, and patient-reported outcomes such as QoL, recurrence, and complications. Key domains included symptoms, diagnostics, therapeutic interventions, and follow-up strategies (Phase I: setting the scope).

An international GDG of 20 experts—colorectal surgeons, gastroenterologists, a radiologist, general practitioners, endoscopy nurses, and methodologists—from 12 European countries was convened. Selection prioritized expertise and geographical diversity to ensure broad applicability. Patient representatives contributed to ensure alignment with patient priorities and approved the final manuscript. Methodological support and quality assurance were provided by Kleijnen Systematic Reviews Ltd (Phase II: GDG formation) (Supporting Information S1).

Review questions were developed using Population, Intervention, Comparator, Outcome (PICO) frameworks, addressing diagnostic, therapeutic, and follow-up aspects of ODS. Outcomes (e.g., QoL, symptom resolution, complications, and recurrence) were prioritized as critical, important, or less important to guide evidence synthesis and recommendation development (Phase III: formulating review questions).

Systematic literature searches were conducted in the Kleijnen Systematic Reviews (KSR) Evidence database, MEDLINE, EMBASE, PubMed, and the Cochrane Library up to December 2025. Searches targeted predefined PICO questions using terms such as "obstructed defecation syndrome," "pelvic floor disorders," and relevant interventions (Appendix S1). Evidence prioritized systematic reviews, randomized controlled trials (RCTs), and high-quality observational studies. Data extraction was performed by methodologists with independent verification. Risk of bias was assessed using ROBIS (systematic reviews) and the Cochrane tool (RCTs). Evidence was synthesized and graded (high to very low) using GRADE, with meta-analyses updated where appropriate using ReviewManager (Phase IV: literature review). An additional search update during drafting did not identify evidence sufficient to change recommendations.

Recommendations were developed during two consensus meetings. Where evidence was available, recommendations were graded as strong or conditional; where evidence was limited, expert opinion was provided.

The draft guideline underwent a 4-week stakeholder consultation via the ESCP website. Registered stakeholders provided feedback, particularly on recommendations with potential cost implications, which was reviewed and incorporated into the final document.

Cost considerations were addressed qualitatively. Although formal cost-effectiveness analyses were not performed, the GDG considered resource use, availability, and feasibility of diagnostic and therapeutic interventions across European healthcare systems. Stakeholder feedback further informed the assessment of economic impact, particularly for resource-intensive interventions.

A detailed protocol is available at:

https://www.escp.eu.com/images/guidelines/documents/Development-Guideline-on-multidisciplinary-management-of-ODS.pdf.

4 | Diagnosis

4.1 | History Taking and Evaluation of Symptoms

4.1.1 | A Thorough History Taking is Pertinent and Specific Elements That May Contribute to Obstructed Defecation Syndrome Should be Covered Including Prior Anorectal Surgery, and Child-Bearing Trauma

Expert opinion: Comprehensive history taking plays a significant role in the initial clinical evaluation of patients affected by ODS. Women are more frequently affected by ODS because of the anatomical and physiological changes caused by childbirth, as previous vaginal deliveries can lead to rectal prolapse or intussusception, conditions closely linked to ODS [22]. However, there are no large cohort studies exploring risk factors with control groups [22–24]. The factors considered here are largely based on clinical experience and anecdotes.

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4.1.2 | *Anxiety, Depression, Psychological Distress, and History of Sexual Abuse Should be Taken Into Consideration When Assessing Patients With Obstructed Defecation Syndrome*

Expert opinion: Anxiety, depression, and a history of sexual abuse should be carefully considered in patients with ODS, as these factors can significantly influence both treatment decisions and surgical outcomes.

Psychological counseling may play a beneficial role [25, 26].

4.2 | Physical Examination and Diagnostics

4.2.1 | *Digital Rectal Examination Could be Used for Diagnosing Dyssynergic Defecation*

Expert opinion: The digital rectal examination (DRE) is the most routine and cost-effective method for diagnosing defecatory dysfunction. DRE allows for the assessment of anal sphincter tone, relaxation, and pelvic floor dysfunction, which are crucial in the diagnosis of DD and are relevant in the daily clinical practice of the health care system. The reported sensitivity and specificity are 77% and 80%, respectively, compared to anorectal manometry (ARM), indicating that it offers reasonably accurate results as a preliminary diagnostic tool. It may be of particular value in healthcare systems with limited access to advanced diagnostic methods.

However, DRE findings are subjective and depend on examiner expertise [6, 20, 27–30].

4.2.2 | *Obstructive Defecation Syndrome Score and Cleveland Chronic Constipation Score Could be Used for an Objective Assessment of Symptoms and Quality of Life as Well as to Evaluate Response to Treatment. Any Other Validated Disease-Specific Score May be Considered According to the Patient's Clinical Characteristics and Associated Pelvic Floor Disorders*

Expert opinion: Incorporating scoring systems both preoperatively and postoperatively will enable standardized evaluation of symptoms over time, allowing clinicians to objectively measure treatment outcomes and improvements in patients' QoL. The ODS score (ODSS) [31] and Cleveland Clinic Constipation Score (CCCS) [32] are the most frequently used tools for assessing the severity of ODS among the others [33, 34]. Both ODSS and CCCS are valued for their ability to evaluate multiple aspects of defecation disorders, including symptom severity, frequency, and impact on QoL. Although the choice of scoring system may vary based on clinician preference or specific patient characteristics, the consistent application of a validated scoring tool is universally recommended to ensure accurate symptom tracking and treatment evaluation. In patients with associated FI, validated disease-specific questionnaires, such as the Vaizey Score (VS), may complement ODS-specific Patient Reported Outcome Measures (PROMs). Although validated outcome measures for FI are available, the recent development of an international Core Outcome Set highlights the ongoing effort to standardize outcome assessment in this field. Appendix S6 summarizes the various available scoring systems.

4.2.3 | *The Oxford Classification can be Considered in Assessing the Severity of Prolapse and Consequently in the Choice of a Tailored Approach*

Expert opinion: The Oxford classification is a radiological grading of anatomical prolapse, including internal prolapse [35]. Its adoption enables stratification of internal and external rectal prolapse into discrete grades (I–V), offering a consistent framework for diagnosis, treatment planning, and outcome prediction. It provides a common language to describe prolapse severity, and is particularly relevant in complex cases involving multicompartment pelvic organ prolapse. It has been widely used in literature.

4.2.4 | *Endoanal Ultrasound, Anorectal Physiology, Transit, and Shape Study can be Considered to Diagnose and Assess Any Potential Functional and/or Organic Diseases*

Expert opinion: Endoanal (EAUS) and endovaginal (EVUS) ultrasound, anorectal physiology tests, and colonic transit studies are pivotal tools in the diagnostic work-up of patients with ODS, allowing clinicians to distinguish between functional and structural abnormalities and tailor treatment accordingly. EAUS, in particular, plays a crucial role in ruling out sphincter defects, which may have a therapeutic implication. Importantly, the presence of sphincter damage may contraindicate certain surgical approaches that involve manipulation of the anal canal, such as Stapled Transanal Rectal Resection (STARR), thereby directly informing surgical decision-making [36, 37]. Similarly, ARM helps uncover functional abnormalities such as reduced voluntary contraction pressure, abnormal straining patterns, or impaired rectal sensation—hallmarks of DD [38–41].

3D EVUS may serve as a valuable adjunct in the diagnostic pathway, especially when traditional imaging is not feasible [37, 42, 43]; whereas colonic transit studies also serve in ruling out slow-transit constipation (STC), which may not benefit from surgical correction of ODS-related anatomical defects, as STC is characterized by infrequent bowel movements without evidence of outlet obstruction according to the Rome IV criteria. It can be differentiated through radio-opaque marker studies, wireless motility capsules, or alternatively, scintigraphy [17, 44].

4.2.5 | *Evacuation Proctography is Recommended as First Line Tool in the Detection of Functional and Structural Abnormalities in Patients With Symptoms of Obstructed Defecation*

If available, MR-defecography and transperineal ultrasound could be used as triage tests in the evaluation of women with symptoms of obstructed defecation, especially when a multicompartmental prolapse is suspected.

Low level of evidence: A Cochrane review published in 2021 showed that evacuation defaecography/defaecating proctogram is better in both sensitivity and specificity in identifying anatomical abnormalities such as rectocele, enterocele, intussusception and pelvic floor descent compared to both MRI-defecography and trans-perineal ultrasound (TPUS) [37, 45]. A small comparative study showed that TPUS may be a valuable screening tool [45–47], particularly the dynamic evacuation

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proctography/defaecating proctogram remains the definitive diagnostic modality and is crucial for tailoring effective treatment strategies in ODS management.

4.2.6 | Evacuation Proctography and MR-Defecography Are Useful Means for Multidisciplinary Decision Making and of Confirming the Consequences of ODS Surgical Treatment. However, Both the Pre- and Post-Operative Findings May not Always be Correlated With Patients' Symptoms

Expert opinion: A number of studies have shown that clinical symptoms do not necessarily correlate with radiological findings. Normal defaecography and symptomatic patients, symptom improvement despite residual abnormalities post-operatively, reflecting radiological evaluation are not absolute measures that correlate with symptoms. Clinical findings and patient-reported outcomes must remain central to individualized therapeutic strategies [48–52].

4.2.7 | The Balloon Expulsion Test Cannot be Considered as a Screening Test, Especially When Used in the Left Lateral Position

Expert opinion: Balloon Expulsion Test (BET) is a simple procedure used to assess a patient's ability to expel a filled balloon [53], and failure to expel the balloon could be a sign of defaecatory disorder [54, 55]. However, the test could cause discomfort and given the lack of comparative studies and inconsistencies about the sensitivities of the test, it is unlikely to be a suitable tool for screening patients [56].

4.2.8 | The Management of Obstructed Defecation Syndrome Requires a Multidisciplinary Approach, That Integrates the Expertise of Colorectal Surgeons, Gastroenterologists, Radiologists, Pelvic Floor Physiotherapists, Urogynecologists, Nurses, General Practitioners, and Psychologists

Expert opinion: Given the multifactorial etiology of ODS, which includes both structural and functional components, its management cannot rely solely on surgical correction. A multidisciplinary evaluation is essential to identify the predominant mechanisms involved, whether anatomical, neuromuscular, or psychological, and to tailor the therapeutic strategy accordingly.

Surgical treatment should follow a multidisciplinary evaluation and should be reserved for patients with clear and complicated structural abnormalities.

A comprehensive pre-treatment assessment of patients with ODS should systematically include the evaluation of urinary, bowel, and sexual function, as well as the presence of pelvic pain and associated psychosocial symptoms, to allow clinicians to better capture the multifactorial nature of pelvic floor dysfunction and to identify overlapping disorders that may influence treatment outcomes.

The physical examination of patients with suspected ODS should include a combined anorectal and vaginal examination to ensure a comprehensive evaluation of pelvic floor anatomy and function. This assessment should systematically encompass vaginal wall integrity and the presence and extent of rectocele, pelvic floor muscle function, including the puborectalis and transversus perineal muscles, and the integrity of the perineal body and detection of levator ani defects [20].

4.3 | Conservative Treatment

4.3.1 | Fiber-Rich Diet, Increase in Liquid Uptake and Bulking Laxatives can be Used as First-Line Treatment

Expert opinion: Approximately 50% of ODS patients can achieve meaningful symptom relief through dietary and behavioral modifications alone. Given the absence of major complications with the conservative treatment, these interventions should always be prioritized over surgical approaches [57–59].

4.3.2 | Biofeedback Therapy Should be Considered Before Surgery in Patients With Obstructed Defecation Syndrome and Dyssynergic Defecation Who Failed Conservative Treatments (Diet and Laxatives)

Moderate level of evidence: The systematic review by Koh et al. analyzed RCTs evaluating the effectiveness of biofeedback therapy in adults with pelvic floor dysfunction (PFD) [60]. Biofeedback demonstrated a sixfold increase in treatment success (OR 5.861, 95% CI: 2.175–15.794) compared with other treatments and should be prioritized before more invasive approaches. The long-term effectiveness, significant symptom relief, and ability to directly address pelvic floor dysfunction make biofeedback a superior alternative to early surgical intervention [61].

4.3.3 | Botulinum Injection and Bilateral Posterior Tibial Nerve Stimulation can be Considered in Patients With Obstructed Defecation Syndrome and Dyssynergic Defecation

Very low level of evidence: Botulinum toxin (BoNT) type A injection represents a potential therapeutic option for patients with ODS associated with DD, although the current evidence remains of very low quality. Two recent systematic reviews reported variable symptomatic improvement (29.2%–100%), indicating substantial heterogeneity in treatment response. The absence of RCTs and high risk of bias limit the strength of these findings [62, 63]. In addition, BoNT's efficacy significantly declines within the first 1–2 months to reach one third of its efficacy after 12 months.

Furthermore, adverse effects-including transient FI and local discomfort-were observed in up to 70% of cases. In light of the variable efficacy and limited evidence, BoNT injection may be considered as a second-line or adjunctive treatment, especially in patients unresponsive to conservative therapy or pelvic floor biofeedback.

Bilateral tibial nerve stimulation has been explored as an option of treatment in small underpowered RCTs and may be beneficial in a selected group of patients [64, 65].

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4.3.4 | *Rectal Emptying Strategies, Including Enemas and Transanal Irrigation, May be Considered in Selected Patients With ODS Who Continue to Experience Impaired Rectal Emptying Despite Optimization of Stool Consistency and Conservative Measures*

Expert opinion: Rectal emptying strategies may represent an important component of conservative management in selected patients with ODS. Available options include digital assistance, rectal suppositories, enemas, and transanal irrigation (TAI) [66]. The choice of the most appropriate strategy should not rely on a "one-size-fits-all" approach but should be individualized according to the underlying pathophysiology, symptom severity, patient preferences, manual dexterity, and local expertise. Comprehensive counseling is essential to discuss the advantages, limitations, acceptability, and practical implications of each technique, allowing patients to actively participate in shared decision-making and select the strategy that best fits their needs and lifestyle. Among the available options, TAI is currently the most-studied technique and has shown promising results in improving bowel function, symptom burden, and quality of life in selected patients [67].

4.4 | Surgical Treatment

4.4.1 | *Surgery can be Considered in Patients Affected by Obstructed Defecation Syndrome Who Fail Conservative Treatment. The Guideline Development Group Recommends a Step-Wise Approach From Conservative to Medical to Surgical After Pelvic Floor Multidisciplinary Meetings*

Expert opinion: Surgery could be considered as the treatment of choice for ODS when conservative measures fail. Most patients with ODS and rectocele (including those with co-existing intussusception) can be effectively managed through intensive conservative treatment.

Surgical intervention should be reserved for selected cases who fail structured bowel retraining and remain symptomatic despite multiple sessions of pelvic floor rehabilitation [68]. The durability of symptom relief, high patient satisfaction rates, and improvements in QoL make it a compelling choice in appropriately selected cases [69–71]. Furthermore, surgical repair (posterior fascial repair and ventral mesh rectopexy) may improve dyspareunia associated with rectocele [72, 73].

4.5 | Surgical Approaches: Transabdominal Approach

Transabdominal approach could be considered for those who are fit to undergo abdominal procedure with full thickness prolapse or internal rectal prolapse, which may or may not have concurrent anterior and/or middle compartment issues.

4.5.1 | *Ventral Mesh Rectopexy Could be Offered to Patients With Obstructed Defecation Syndrome Caused by Posterior Pelvic Floor Anatomical Dysfunctions*

Very low level of evidence: Ventral mesh rectopexy (VMR) could improve symptoms of constipation and fecal incontinence, as well as overall QoL, with sustained benefits over time [74, 75]. Evidence also supports the use of VMR in elderly patients, as it has been shown to have comparable safety profiles and effectiveness in this population, with no significant increase in morbidity or mortality [76, 77]. A small randomized controlled study showed that it is superior to STARR in elderly patients [77].

A large case series showed sustained long-term (over 10 years) improvement in FI and obstructed defecation. The recurrence rate for external rectal prolapse (ERP) was 8.2%, while mesh-related complications were rare (4.6%) [78].

4.5.2 | *Both Robotic and Laparoscopic Ventral Mesh Rectopexy can Achieve Good Anatomical Correction. Robotic Ventral Mesh Rectopexy Should be Considered Because of the Better Functional Results, Significantly Shorter Length of Hospital Stay, Lesser Intraoperative Blood Loss, and Lower Postoperative Complication Rate, When Both Robot and Laparoscopic Approaches Are Available*

Low level of evidence: Both robotic ventral mesh rectopexy (RVMR) and laparoscopic ventral mesh rectopexy (LVMR) offer effective anatomical correction for ODS and associated pelvic floor disorders, with no significant differences observed in postoperative MR defecography. However, evidence from several studies highlights distinct advantages of RVMR over LVMR in terms of functional outcomes, postoperative recovery, and complication rates [79–83]. Compared with LVMR, RVMR provides enhanced benefits for surgeons, such as three-dimensional imaging, improved resolution, a clearer surgical field, motion scaling, and tremor elimination. Additionally, it has the potential to shorten the learning curve for performing mesh rectopexy and may be cost-effective in the long term.

4.5.3 | *Resection Rectopexy Could be Considered in Patients With Obstructed Defecation Syndrome Associated With Internal Rectal Prolapse*

Expert opinion: Resection rectopexy has been shown to offer improvements in the CCCS, ODSS, and VS. A systematic review and meta-analysis, that included 14 studies with 1301 patients, showed weighted mean improvement rates for obstructed defecation and FI were of 73.9% and 60.2%, respectively. Resection rectopexy demonstrated lower recurrence rates, whereas VMR was associated with better symptom improvement, shorter operative times, and lower complication rates (15%–25%) [84–87]. Careful patient selection following multidisciplinary assessment and treatment in specialized pelvic floor centers by experienced surgeons are key prerequisites to optimize outcomes and minimize the risk of failure.

4.5.4 | *Absorbable Sutures can be Used to Fix Mesh During Ventral Mesh Rectopexy Because of the Lower Risk of Mesh Erosion*

Very low level of evidence: As stated in the methodology, our literature review was updated prior to publication. The most recent systematic review by Hess et al. does not provide additional relevant evidence, as it has been assessed as having a high risk of bias [88]. A case-matched study showed an overall mesh erosion rate of 2% (6/296) in the non-absorbable suture group (four cases of rectal erosion and two cases of vaginal erosion), whereas no cases of mesh erosion were reported in the

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absorbable suture group. The type of suture, rather than the type of mesh, may play a critical role in reducing mesh-related complications, specifically erosion [89].

4.5.5 | *Ventral Mesh Rectopexy Could be Considered in Patients With Solitary Rectal Ulcers and Obstructed Defecation Syndrome. The Combination With a Transanal Approach May Lead to Better Results*

Expert opinion: VMR has emerged as an option for patients suffering from solitary rectal ulcer syndrome (SRUS) and ODS. Evidence remains limited although a case series has reported improvement in ulcer healing and functional outcomes following ventral rectopexy. Concurrent perineal repair using STARR may be beneficial in those with posterior compartment prolapse [90, 91]. A multimodal, stepwise approach, should be ideally managed in expert centers with multidisciplinary teams capable of tailoring treatment to the individual patient's functional and anatomical profile.

4.5.6 | *Sacrocolpopexy Could be Combined With Ventral Rectopexy to Achieve Short- and Long-Term Successful Results in Patients With Obstructed Defecation Syndrome Due to Rectal Prolapse, Rectocele, or Enterocele and Associated Multicompartment Prolapse (Anterior, Apical, Middle, and Posterior Compartment Prolapse)*

Expert opinion: Careful selection of candidates for combined procedures should be performed within a multidisciplinary setting, involving colorectal surgeons, gynecologists, pelvic floor specialists, radiologists, and physiotherapists, in order to tailor the surgical strategy to the dominant compartment and symptom burden.

The combination of minimally invasive sacrocolpopexy and ventral rectopexy has been shown to benefit patients in a number of case series [92–99].

The indication for combined minimally invasive sacrocolpopexy and ventral rectopexy should always derive from a patient-centered, multidisciplinary shared decision-making process, taking into account symptom severity, compartment involvement, comorbid pelvic floor disorders, patient expectations, and quality-of-life priorities.

4.6 | Surgical Approaches: Transanal/ Transperineal Approach

4.6.1 | *Internal Delorme's can be Considered as the Transanal Procedure of Choice Due to the Low Rate of Complications, Especially in Patients With Impaired Anal Function and With a Risk of Post-Operative Fecal Incontinence. Biofeedback can be Performed in the Post-Operative Period of Those Patients to Improve the Functional Outcomes*

Expert opinion: Internal Delorme's procedure, the so-called “endorectal proctopexy (ERPP)” [85, 100], can be considered in patients with impaired anal function, due to the reported low rate of complications and a low recurrence rate (6%) [100–104]. Biofeedback therapy in the postoperative period seems to aid sustained symptom relief [100, 104].

When compared to STARR, ERPP was associated with a better profile for maintaining continence, making it a preferable option for patients with impaired anal function [77, 102].

4.6.2 | *Transperineal or Transvaginal Repair can be Used in Patients With Symptomatic Simple Rectocele*

Expert opinion: Transperineal repair should be considered in patients with simple rectocele, as it offers a direct approach to reinforce the pelvic floor without the additional stress on compromised sphincter muscles. While transperineal repair remains a suitable option for patients with simple rectocele and poor sphincter function, emerging evidence suggests that in cases with preserved sphincter integrity, other approaches such as transvaginal or transanal repairs may offer anatomical and functional benefits.

There is limited evidence to guide us between transperineal or transvaginal repair. Underpowered RCT suggests that transvaginal repair may offer better results [105]. Additional transvaginal rectopexy may be beneficial according to the limited evidence [106–108].

However, the potential new onset of sexual dysfunction as de novo dyspareunia has to be considered when dealing with transvaginal repair; therefore, surgical choice has to be carefully tailored to the patient [109–112].

4.6.3 | *Stapled Transanal Rectal Resection and Its Variations can be Considered for Patients With Good Anal Sphincter Function. However, High Complication and Reintervention Rates Highlight the Need for Cautious Patient Selection, Thorough Preoperative Assessment, and Surgical Expertise*

Expert opinion: STARR can be considered an alternative treatment for patients with good anal sphincter function, particularly after the failure of conservative measures such as biofeedback training [113]. STARR has been demonstrated to be safe in appropriately selected patients [51, 114], whereas postoperative anal incontinence is reported to be an adverse symptom [77, 115–117].

Reintervention following failed or complicated STARR procedures is challenging, as issues such as proctalgia, rectal pocket syndrome, and FI are unlikely to be amenable to further surgical procedures.

The presence of psychoneurotic disorders, rectoanal intussusception (RAI), and altered rectal sensation have been identified as key predictors of poor surgical outcomes. Failure of STARR may result not only from persistent or de novo anatomical defects but also from functional disturbances such as altered rectal sensitivity or dyssynergia, which can often be undetected in standard imaging [51, 118, 119].

These findings support a selective approach to STARR, where detailed functional and psychological evaluations are performed preoperatively to minimize complications and optimize long-term results.

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Careful patient selection following multidisciplinary assessment and treatment in specialized pelvic floor centers by experienced surgeons are key prerequisites to optimize outcomes and minimize the risk of failure.

4.7 | Safety

4.7.1 | Patients Should be Informed and Adequately Counseled Regarding All Mesh Benefits and Potential Harm. A Patient-Tailored Approach Discussed Throughout This Guideline Should be Adopted and the Procedures Should be Performed by Adequately Trained Surgeons

Expert opinion: Most reported problems with the use of mesh pertain to its use in the transvaginal approach for pelvic organ prolapse (POP) and stress urinary incontinence (SUI). The reported rates of mesh erosion and chronic pain are in the region of 4%–7% [120].

The cornerstone of the high-profile issues is not the numerical complication rate but patient dissatisfaction of not being fully informed of potential complications. These concerns contributed to increased regulalatory scrutiny, culminating in the 2019 US Food and Drug Administration (FDA) order to stop the sale and distribution of synthetic mesh intended for transvaginal repair of POP.

With a much shorter history of using mesh for posterior compartments, the reported rate of complications associated with mesh during VMR is much lower (< 4%). There are a handful of studies suggestive of a low complication rate, particularly with biological meshes. However, all of the studies are either case series or not truly comparative due to practice change; hence, evidence is limited [91, 121–124].

As this topic has been extensively addressed in the ESCP guidelines, it will not be discussed in detail in this document [125].

4.8 | Surgical Failure

4.8.1 | Small Rectal Diameter, Low Anal Sphincter Squeeze Pressure, Increased Pelvic Floor Descent at Rest, Redundant Colon, Connective Tissue Disorders, and Pre-Existing Constipation Are Potential Predictors of Unfavorable Outcomes After Stapled Transanal Rectal Resection or Ventral Mesh Rectopexy Procedures

Expert opinion: The above factors were suggested as potential predictors of STARR or VMR failure in small case series [51, 126–128]. These anatomical and functional factors should be carefully evaluated preoperatively to optimize patient selection and surgical planning. Moreover, integrating postoperative rehabilitation may mitigate some of these risks and enhance long-term functional outcomes for patients with ODS.

4.8.2 | The Radiologic Presence of an Enterocele Is Not Predictive of Surgical Failure Nor Does it Represent an Absolute Contraindication to Surgery

Expert opinion: Pre-operative identification of an enterocele is essential for accurate patient selection and surgical planning. In particular, when considering STARR, the presence of enterocele may pose the risk of visceral injury [129–134]. It is common to see radiological persistence of enterocele despite symptom improvement post-VMR [131, 133].

4.9 | Redo Surgery

4.9.1 | Redo-Surgery for ODS Following Ventral Mesh Rectopexy can be Considered a Feasible and Safe Approach

Expert opinion.

4.9.2 | Redo-Surgery for Mesh Erosion and Chronic Pelvic Pain May Present Significant Morbidity Risks and May Often be Less Effective

Expert opinion: Multiple studies have evaluated the safety and efficacy of redo surgery for rectal prolapse and ODS. LVMR has been widely accepted as an effective technique for treating posterior pelvic floor disorders, yet recurrence rates range between 5% and 15% [135]. The primary indications for redo surgery include recurrent rectal prolapse, mesh erosion, and therapy-resistant pelvic pain. Redo VMR has demonstrated favorable outcomes in treating recurrent prolapse and does not carry significantly higher morbidity than primary VMR [136]. Recurrence rates following redo VMR are acceptable, with reported success rates exceeding 75% [137]. In some cases, additional sacrocolpopexy is necessary to ensure long-term stability [138].

However, redo surgery for mesh-related complications—such as erosion and infection—is associated with significantly higher morbidity. Mesh erosion can result in rectovaginal fistulas, chronic infections, and severe functional impairments, often requiring complex reconstruction or stoma creation. Similarly, redo surgery for chronic pelvic pain—though sometimes indicated—is only effective in about 50% of patients and carries a notable risk of complications [139].

Several technical and patient-related factors influence the risk of recurrence. These include insufficient distal fixation, mesh detachment from the sacral promontory, and inadequate mid-rectal support [140], as well as the use of synthetic mesh instead of biological grafts [135].

While redo VMR is justified for recurrent prolapse, the decision to reoperate for mesh erosion or pelvic pain should be carefully weighed, ideally involving a multidisciplinary team and performed in high-volume centers with specific expertise [136, 139]. Reintervention is more technically challenging and should be performed in specialized centers with multidisciplinary expertise. Moreover, outcomes may be less favorable in patients with underlying functional disorders or connective tissue disease, underlining the importance of individualized planning and long-term follow-up in this complex cohort [141].

5 | Discussion

This is the first European guideline specifically dedicated to the multidisciplinary management of ODS, developed through the collaboration of seven leading scientific societies, including ESCP, UEG, ESGAR, EAGEN, ESGENA, ESNM, and ESPCG. It integrates the perspectives of colorectal surgeons, gastroenterologists, radiologists, general practitioners, physiotherapists,

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and specialized nurses to provide a comprehensive and evidence-based framework for the diagnosis and treatment of ODS. Unlike previous recommendations that often addressed isolated aspects of pelvic floor dysfunction or were limited to post-oncological or surgical sequelae, this guideline offers a structured, stepwise approach that reflects the multifactorial nature of ODS. It emphasizes the importance of integrating anatomical, functional, and psychosocial dimensions of the syndrome, acknowledging that treatment success depends not only on correct diagnosis but also on personalized, often combined therapeutic strategies.

Conservative management should always be the first-line strategy for ODS management. Beyond improving pelvic floor function, preoperative rehabilitation and defecatory training may also reduce recurrence risk by correcting behavioral patterns, such as inappropriate straining or any other functional diseases that can compromise long-term surgical success. Furthermore, functional outcomes are strongly influenced by anatomical complexity: multicompartment prolapse requires a multidisciplinary assessment and often a combined surgical strategy tailored to each compartment. Pelvic floor MR, dynamic defecography, and anorectal physiology testing are essential tools to assess sphincter function, which in turn plays a decisive role in selecting the most appropriate surgical technique. As Reichert et al. showed, anatomical improvements after VMR were paralleled by functional recovery and increased QoL, but success was contingent on accurate diagnosis and comprehensive preoperative work-up [142]. TAI, among the conservative treatment options, has demonstrated benefits in the management of chronic constipation and FI. However, several studies report limited long-term adherence, with only about one-third of patients with slow-transit constipation or ODS continuing TAI over time [143]. Moreover, the literature suggests that outcomes in patients treated for ODS are generally less favorable compared with those observed in patients undergoing TAI for low anterior resection syndrome (LARS) [144, 145]. The same considerations apply to sacral neurostimulation, the role of which in ODS has never been fully established [146]. Sexual function was not included in the original search strategy or predefined scope of this guideline and was therefore not specifically assessed. The GDG nevertheless acknowledges the relevance of accompanying sexual dysfunction in patients with ODS and pelvic floor disorders as an important area for consideration in future research and guideline updates.

Surgery should only be considered in patients with a clear symptom–anatomy correlation. In asymptomatic individuals, incidental findings such as rectocele or intussusception on imaging do not warrant surgical correction. Indeed, despite numerous attempts to classify RAI and correlate radiological findings with clinical severity or surgical indication, no universally accepted standard exists. Some authors defined inclusion criteria based on quantitative thresholds, such as an RAI greater than 10 mm or an RAI exceeding 10 mm, but these parameters have not been validated in prospective trials. As a result, while such measures may support surgical decision-making, they should be interpreted in conjunction with clinical symptoms and functional impact. The lack of standardized diagnostic criteria complicates patient selection and contributes to the variability of outcomes reported in the literature [109].

Experts agree that restoring normal anatomy is not equivalent to curing the patient, and that a standardized, multidisciplinary, and stepwise approach is the cornerstone for durable and meaningful outcomes in ODS management [11, 50, 96, 142].

Lastly, managing complications after surgical treatments for ODS is challenging and for this reason, the role of surgeon and center experience and careful patient selection are crucial. As discussed in Section 4.9, redo surgery for recurrent prolapse after VMR can schieve favourable outcomes, whereas reoperation for mesh-related complications or chronic pelvic pain carries significantly higher morbidity and should be performed in high-volume centers with multidisciplinary expertise [136, 139]. These findings reinforce the necessity for high expertise in any surgical approach, whether abdominal, transanal, transvaginal, or perineal [11].

The methodology followed international standards (AGREE II, GRADE) and included rigorous literature review, structured PICO-based review questions, and multi-stakeholder consensus. The development process involved a wide geographical representation and included patient representatives to ensure alignment with real-world needs and values. This guideline also addresses relevant clinical challenges such as the differentiation between slow-transit constipation and outlet obstruction, the role of psychological comorbidities, the management of surgical failures, and the appropriate use of diagnostic imaging and scoring systems. A key strength is the inclusion of an evidence-based treatment algorithm to support clinical decision-making and improve the standardization of care across Europe. In future updates, the guideline should integrate evolving areas such as AI-assisted diagnostic tools, patient-reported outcomes, and stratified treatment pathways based on phenotyping. Moreover, we suggest that national societies adapt the recommendations to local contexts through specific implementation tools, audits, and training programs, as outlined in the “Implementation” section.

5.1 | Patient Forum

The development of this guideline actively involved patient representatives to ensure that the recommendations reflect the real-life needs, concerns, and expectations of those living with ODS. Patients contributed to discussions regarding symptom burden, diagnostic experiences, and the physical and emotional impact of various treatment options. The Patient Forum emphasized the importance of clear communication, early recognition of symptoms, and access to multidisciplinary care. Contributors highlighted frequent delays in diagnosis and the psychological distress often associated with ODS, including embarrassment, anxiety, and reduced QoL. These perspectives informed several key recommendations, such as the integration of psychological assessment into the diagnostic process and the prioritization of non-invasive treatments whenever appropriate. Patients also expressed a strong preference for shared decision-making, tailored to individual lifestyle, values, and expectations. In response, the guideline emphasizes personalized care plans and encourages clinicians to involve patients in every step of the diagnostic and therapeutic journey. Educational materials tailored to the lay public should be developed in parallel with this guideline to help patients better understand the nature of ODS, available diagnostic tests, and the range of conservative

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and surgical treatment options. Improved patient engagement is expected to enhance adherence, satisfaction, and clinical outcomes. Moving forward, continued patient involvement in future updates of this guideline will remain a priority, ensuring that the voices of those affected by ODS continue to shape the direction of care.

5.2 | Implementation

To ensure the practical adoption of this guideline, structured implementation strategies are recommended at both national and institutional levels. Professional societies and healthcare systems should promote the integration of these recommendations into routine clinical workflows through the development of local protocols, multidisciplinary care pathways, and educational materials tailored to their context. Audit tools, benchmarking systems, and key performance indicators should be established to monitor adherence and identify areas for quality improvement. Regular clinical audits will facilitate tracking of outcomes such as symptom resolution, QoL, reintervention rates, and patient satisfaction, while also supporting research and registry-based data collection. Training programs and workshops should be developed to disseminate core concepts across specialties, particularly focusing on standardized diagnostic criteria, appropriate use of imaging, and conservative versus surgical treatment algorithms. These initiatives will help bridge variations in practice, foster interdisciplinary collaboration, and ultimately improve patient outcomes.

Future revisions of the guideline should consider implementation feedback and real-world data to refine recommendations and address potential barriers to adoption. We encourage institutions to use this guideline as a foundation for continuous improvement and harmonization of care in the management of ODS.

Acknowledgments

The authors thank Seona Hamilton for her assistance in updating the literature and Yasuko Maeda for her guidance and leadership.

Evidence search: obstructive defecation syndrome, papers published between 1 January 2024–31 December 2025, and inclusion criteria were: (1). Systematic literature review (2). Randomized controlled study (3). Large observational study (more than 50 patients). Date search completed: 25/2/2026. NHSGGC Library Network.

Funding

The development of this guideline was made possible by a grant from United European Gastroenterology («UEG Activity Grant 2022»). The funding source had no involvement in the design, conduct, or reporting of the research.

Ethics Statement

The authors have nothing to report.

Consent

The authors have nothing to report.

Conflicts of Interest

Dr. Daniel Pohl reports honoraria from Schwabe Pharma and Medtronic and travel support from Schwabe Pharma. Dr. Katarina Karlović reports leadership roles as President of the Croatian Association of Nurses and Technicians in Gastroenterology and Endoscopy and Board Member of ESGENA. All the other authors declared no conflict of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Disclaimer

These guidelines were developed with due diligence and based on the best knowledge available to the authors at the time of preparation. They are intended to serve as an educational resource for medical doctors and allied healthcare professionals, offering information that may support them in patient care. Patients or other community members should only use these guidelines in consultation with a qualified healthcare professional, and should not interpret them as a substitute for professional medical advice. These guidelines are not intended to replace the need for seeking medical advice from a licensed professional.

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References

1. J. Bunni and M. J. Laugharne, "Pathophysiological Basis, Clinical Assessment, Investigation and Management of Patients With Obstructed Defecation Syndrome," *Langenbeck's Archives of Surgery* 408, no. 1 (2023): 75, https://doi.org/10.1007/s00423-023-02755-1.

2. H. P. Dietz and A. Korda, "Which Bowel Symptoms are Most Strongly Associated With a True Rectocele?," *Australian and New Zealand Journal of Obstetrics and Gynaecology* 45, no. 6 (2005): 505–508, https://doi.org/10.1111/j.1479-828X.2005.00486.x.

3. M. Jain, R. Baijal, M. Srinivas, and J. Venkataraman, "Clinical Predictors and Gender-Wise Variations in Dyssynergic Defecation Disorders," *Indian Journal of Gastroenterology* 37, no. 3 (2018): 255–260, https://doi.org/10.1007/s12664-018-0856-7.

4. D. Kremel, S. Riss, C. Müller, et al., "Adverse Obstetric History is not a Risk Factor for Poor Outcome After Ventral Rectopexy for Obstructive Defaecation Syndrome," *Journal of the Association of Coloproctology of Great Britain and Ireland* 20, no. 12 (2018): 1125–1131, https://doi.org/10.1111/codi.14392.

5. S. M. Murad-Regadas, L. V. Rodrigues, D. C. Furtado, et al., "The Influence of Age on Posterior Pelvic Floor Dysfunction in Women With Obstructed Defecation Syndrome," *Techniques in Coloproctology* 16, no. 3 (2012): 227–232, https://doi.org/10.1007/s10151-012-0831-8.

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6. Pescatori M., Spyrou M., Pulvirenti d'Urso A., "A Prospective Evaluation of Occult Disorders in Obstructed Defecation Using the 'Iceberg Diagram'," *Journal of the Association of Coloproctology of Great Britain and Ireland* 9, no. 5 (2007): 452–456, https://doi.org/10.1111/j.1463-1318.2006.01094.x.

7. C. Tan, J. Geng, J. Tang, and X. Yang, "The Relationship Between Obstructed Defecation and True Rectocele in Patients With Pelvic Organ Prolapse," *Scientific Reports* 10, no. 1 (2020): 5599, https://doi.org/10.1038/s41598-020-62376-2.

8. J. R. Thompson, A. H. Chen, P. D. m Pettit, and M. D. Bridges, "Incidence of Occult Rectal Prolapse in Patients With Clinical Rectoceles and Defecatory Dysfunction," *American Journal of Obstetrics and Gynecology* 187, no. 6 (2002): 1494–1499, https://doi.org/10.1067/mob.2002.129162.

9. A. Tsunoda, T. Takahashi, and H. Kusanagi, "Reappraising the Role of Enterocele in the Obstructed Defecation Syndrome: Is Radiological Impaired Rectal Emptying Significant in Enterocele?," *Journal of the Anus, Rectum and Colon* 6, no. 2 (2022): 113–120, https://doi.org/10.23922/jarc.2021-064.

10. Y. Yin, Z. Xia, M. Luan, and M. Qin, "Improvement in Outlet Obstructive Constipation Symptoms After Vaginal Stent Treatment for Rectocele," *Surgical Innovation* 28, no. 5 (2021): 634–641, https://doi.org/10.1177/1553350620975616.

11. A. Picciariello, M. Rinaldi, U. Grossi, et al., "Time Trend in the Surgical Management of Obstructed Defecation Syndrome: A Multicenter Experience on Behalf of the Italian Society of Colorectal Surgery (SICCR)," *Techniques in Coloproctology* 26, no. 12 (2022): 963–971, https://doi.org/10.1007/s10151-022-02705-x.

12. S. Eustice, R. Endacott, J. Morris, R. Shankar, and B. Kent, "Women's Experiences of Managing Digitation: Do we Ask Enough in Primary Care?," *JRSM Open* 9, no. 8 (2018): 2054270418783616, https://doi.org/10.1177/2054270418783616.

13. A. Hotouras, J. Murphy, D. J. Boyle, M. Allison, N. S. Williams, and C. L. Chan, "Assessment of Female Patients With Rectal Intussusception and Prolapse: Is This a Progressive Spectrum of Disease?," *Diseases of the Colon & Rectum* 56, no. 6 (2013): 780–785, https://doi.org/10.1097/DCR.0b013e31827ba32c.

14. L. G. Bordeianou, J. C. Carmichael, I. M. Paquette, et al., "Consensus Statement of Definitions for Anorectal Physiology Testing and Pelvic Floor Terminology (Revised)," *Diseases of the Colon & Rectum* 61, no. 4 (2018): 421–427, https://doi.org/10.1097/DCR.0000000000001070.

15. P. M. Cavallaro, K. Staller, L. R. Savitt, et al., "The Contributions of Internal Intussusception, Irritable Bowel Syndrome, and Pelvic Floor Dyssynergia to Obstructed Defecation Syndrome," *Diseases of the Colon & Rectum* 62, no. 1 (2019): 56–62, https://doi.org/10.1097/DCR.0000000000001250.

16. S. Ascanelli, M. Portinari, M. Canella, et al., "Obstructed Defecation Syndrome Associated With Paradoxical Puborectalis Contraction: Osteopathic Treatment Versus Anal Biofeedback. Results of a Pilot Study," *Techniques in Coloproctology* 25, no. 5 (2021): 589–595, https://doi.org/10.1007/s10151-020-02381-9.

17. D. A. Drossman and W. L. Hasler, "Rome IV-Functional GI Disorders: Disorders of Gut-Brain Interaction," *Gastroenterology* 150, no. 6 (2016): 1257–1261, https://doi.org/10.1053/j.gastro.2016.03.035.

18. M. Pescatori, A. P. Zbar, and S. M. Ayabaca, "Tailoring Surgery for Obstructed Defecation Syndrome to the 'Iceberg Diagram': Long-Term Results," *Surgery* 172, no. 6 (2022): 1636–1641, https://doi.org/10.1016/j.surg.2022.05.030.

19. G. Gallo, M. Trompetto, A. Realis Luc, et al., "Anatomo-Functional Outcomes of the Laparoscopic Frykman-Goldberg Procedure for Rectal Prolapse in a Tertiary Referral Centre," *Updates in Surgery* 73, no. 5 (2021): 1819–1828, https://doi.org/10.1007/s13304-021-01114-3.

20. S. Rachaneni, I. K. Atan, K. L. Shek, and H. P. Dietz, "Digital Rectal Examination in the Evaluation of Rectovaginal Septal Defects," *International Urogynecology Journal* 28, no. 9 (2017): 1401–1405, https://doi.org/10.1007/s00192-017-3285-8.

21. J. L. Brozek, E. A. Akl, P. Alonso-Coello, et al., "Grading Quality of Evidence and Strength of Recommendations in Clinical Practice Guidelines. Part 1 of 3. An Overview of the GRADE Approach and Grading Quality of Evidence About Interventions," *Allergy* 64, no. 5 (2009): 669–677, https://doi.org/10.1111/j.1398-9995.2009.01973.x.

22. A. Hotouras, J. Murphy, A. Abeles, et al., "Symptom Distribution and Anorectal Physiology Results in Male Patients With Rectal Intussusception and Prolapse," *Journal of Surgical Research* 188, no. 1 (2014): 298–302, https://doi.org/10.1016/j.jss.2013.12.008.

23. A. Giri, K. E. Hartmann, J. N. Hellwege, D. R. Velez Edwards, and T. L. Edwards, "Obesity and Pelvic Organ Prolapse: A Systematic Review and Meta-Analysis of Observational Studies," *American Journal of Obstetrics and Gynecology* 217, no. 1 (2017): 11–26.e3, https://doi.org/10.1016/j.ajog.2017.01.039.

24. L. Ferrari, K. Cuinas, A. Hainsworth, et al., "Preoperative Predictors of Success After Transvaginal Rectocoele Repair," *Techniques in Coloproctology* 27, no. 10 (2023): 859–866, https://doi.org/10.1007/s10151-023-02822-1.

25. C. Miliacca, G. Gagliardi, and M. Pescatori, "The 'Draw-the-Family Test' in the Preoperative Assessment of Patients With Anorectal Diseases and Psychological Distress: A Prospective Controlled Study," *Journal of the Association of Coloproctology of Great Britain and Ireland* 12, no. 8 (2010): 792–798, https://doi.org/10.1111/j.1463-1318.2009.01985.x.

26. M. P. J. Nicolai, H. H. Fidder, J. J. H. Beck, et al., "Sexual Abuse History in GI Illness, How do Gastroenterologists Deal With it?," *Journal of Sexual Medicine* 9, no. 5 (2012): 1277–1284, https://doi.org/10.1111/j.1743-6109.2012.02683.x.

27. K. Tantiphlachiva, P. Rao, A. Attaluri, and S. S. C. Rao, "Digital Rectal Examination is a Useful Tool for Identifying Patients With Dyssynergia," *Clinical Gastroenterology and Hepatology* 8, no. 11 (2010): 955–960, https://doi.org/10.1016/j.cgh.2010.06.031.

28. A. C. Caetano, A. Santa-Cruz, and C. Rolanda, "Digital Rectal Examination and Balloon Expulsion Test in the Study of Defecatory Disorders: Are They Suitable as Screening or Excluding Tests?," *Chinese Journal of Gastroenterology and Hepatology* 2016 (2016): 8654314–8654318, https://doi.org/10.1155/2016/8654314.

29. J. Liu, C. Lv, Y. Huang, et al., "Digital Rectal Examination is a Valuable Bedside Tool for Detecting Dyssynergic Defecation: A Diagnostic Study and a Meta-Analysis," *Chinese Journal of Gastroenterology and Hepatology* 2021, no. 1 (2021): 5685610, https://doi.org/10.1155/2021/5685610.

30. L. Dekker, D. A. van Reijn-Baggen, I. J. M. Han-Geurts, and R. J. F. Felt-Bersma, "To What Extent are Anorectal Function Tests Comparable? A Study Comparing Digital Rectal Examination, Anal Electromyography, 3-Dimensional High-Resolution Anal Manometry, and Transperineal Ultrasound," *International Journal of Colorectal Disease* 38, no. 1 (2023): 12, https://doi.org/10.1007/s00384-022-04304-6.

31. D. F. Altomare, L. Spazzafumo, M. Rinaldi, G. Dodi, R. Ghiselli, and V. Piloni, "Set-up and Statistical Validation of a New Scoring System for Obstructed Defaecation Syndrome," *Journal of the Association of Coloproctology of Great Britain and Ireland* 10, no. 1 (2008): 84–88, https://doi.org/10.1111/j.1463-1318.2007.01262.x.

32. F. Agachan, T. Chen, J. Pfeifer, P. Reissman, and S. D. Wexner, "A Constipation Scoring System to Simplify Evaluation and Management of

20506414, 2026, 9, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/ueg2.70303 by CochraneItalia, Wiley Online Library on [07/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Constipated Patients," *Diseases of the Colon & Rectum* 39, no. 6 (1996): 681–685, https://doi.org/10.1007/BF02056950.

33. C. H. Knowles, A. J. Eccersley, S. M. Scott, S. M. Walker, B. Reeves, and P. J. Lunniss, "Linear Discriminant Analysis of Symptoms in Patients With Chronic Constipation: Validation of a New Scoring System (KESS)," *Diseases of the Colon & Rectum* 43, no. 10 (2000): 1419–1426, https://doi.org/10.1007/BF02236639.

34. A. Renzi, A. Brillantino, G. Di Sarno, and F. d'Aniello, "Five-Item Score for Obstructed Defecation Syndrome: Study of Validation," *Surgical Innovation* 20, no. 2 (2013): 119–125, https://doi.org/10.1177/1553350612446354.

35. R. Collinson, C. Cunningham, H. D'Costa, and I. Lindsey, "Rectal Intussusception and Unexplained Faecal Incontinence: Findings of a Proctographic Study," *Journal of the Association of Coloproctology of Great Britain and Ireland* 11, no. 1 (2009): 77–83, https://doi.org/10.1111/j.1463-1318.2008.01539.x.

36. A. Albuquerque and G. Macedo, "Anal Sphincters Evaluation by Endoanal Ultrasound in Obstructed Defecation," *Journal of Ultrasound in Medicine* 36, no. 12 (2017): 2519–2524, https://doi.org/10.1002/jum.14300.

37. I. M. van Gruting, A. Stankiewicz, R. Thakar, G. A. Santoro, J. IntHout, and A. H. Sultan, "Imaging Modalities for the Detection of Posterior Pelvic Floor Disorders in Women With Obstructed Defaecation Syndrome," *Cochrane Database of Systematic Reviews* 9, no. 9 (2021): CD011482, https://doi.org/10.1002/14651858.CD011482.pub2.

38. F. Pucciani and M. N. Ringressi, "Obstructed Defecation: The Role of Anorectal Manometry," *Techniques in Coloproctology* 16, no. 1 (2012): 67–72, https://doi.org/10.1007/s10151-011-0800-7.

39. A. Bove, F. Pucciani, M. Bellini, et al., "Consensus Statement AIGO/SICCR: Diagnosis and Treatment of Chronic Constipation and Obstructed Defecation (Part I: Diagnosis)," *World Journal of Gastroenterology* 18, no. 14 (2012): 1555–1564, https://doi.org/10.3748/wjg.v18.i14.1555.

40. A. Bove, M. Bellini, E. Battaglia, et al., "Consensus Statement AIGO/SICCR Diagnosis and Treatment of Chronic Constipation and Obstructed Defecation (Part II: Treatment)," *World Journal of Gastroenterology* 18, no. 36 (2012): 4994–5013, https://doi.org/10.3748/wjg.v18.i36.4994.

41. H. Heinrich, M. Sauter, M. Fox, et al., "Assessment of Obstructive Defecation by High-Resolution Anorectal Manometry Compared With Magnetic Resonance Defecography," *Clinical Gastroenterology and Hepatology* 13, no. 7 (2015): 1310–1317.e1, https://doi.org/10.1016/j.cgh.2015.01.017.

42. D. O'Leary, G. Rostaminia, L. H. Quiroz, and S. A. Shobeiri, "Sonographic Predictors of Obstructive Defecatory Dysfunction," *International Urogynecology Journal* 26, no. 3 (2015): 415–420, https://doi.org/10.1007/s00192-014-2515-6.

43. G. Rostaminia, P. Javadian, C. Awad, and S. A. Shobeiri, "Ultrasound Indicators of Rectal Support Defect in Women With Obstructive Defecatory Symptoms," *Female Pelvic Medicine & Reconstructive Surgery* 25, no. 3 (2019): 222–225, https://doi.org/10.1097/SPV.0000000000000511.

44. S. M. Scott, M. Simrén, A. D. Farmer, et al., "Chronic Constipation in Adults: Contemporary Perspectives and Clinical Challenges. 1: Epidemiology, Diagnosis, Clinical Associations, Pathophysiology and Investigation," *Neuro-Gastroenterology and Motility* 33, no. 6 (2021): e14050, https://doi.org/10.1111/nmo.14050.

45. C. Ralston, M. Reena, D. Solanki, et al., "Can we Use Integrated Total Pelvic Floor Ultrasound as a Screening Tool in Defaecatory Pelvic Floor Dysfunction? A Prospective Evaluation of the Accuracy of Integrated Total Pelvic Floor Ultrasound Compared With Defaecation Proctography," *Journal of the Association of Coloproctology of Great Britain and Ireland* 27, no. 2 (2025): e17274, https://doi.org/10.1111/codi.17274.

46. I. M. A. van Gruting, K. Kluivers, A. Stankiewicz, et al., "Evaluation of Perineal Descent Measurements on Pelvic Floor Imaging," *Journal of Clinical Medicine* 14, no. 2 (2025): 548, https://doi.org/10.3390/jcm14020548.

47. J. Li, Y. Xue, Q. Chen, et al., "Clinical Relevance of Transperineal Ultrasound Compared With Anorectal Manometry for the Evaluation of Female Patients With Obstructive Defecation Syndrome," *BMC Gastroenterology* 25, no. 1 (2025): 558, https://doi.org/10.1186/s12876-025-04171-9.

48. U. Grossi, H. Heinrich, G. L. Di Tanna, et al., "Systematic Characterization of Defecographic Abnormalities in a Consecutive Series of 827 Patients With Chronic Constipation," *Diseases of the Colon & Rectum* 64, no. 11 (2021): 1385–1397, https://doi.org/10.1097/DCR.0000000000001923.

49. A. Tsunoda, T. Ohta, Y. Kiyasu, and H. Kusanagi, "Laparoscopic Ventral Rectopexy for Rectoanal Intussusception: Postoperative Evaluation With Proctography," *Diseases of the Colon & Rectum* 58, no. 4 (2015): 449–456, https://doi.org/10.1097/DCR.0000000000000328.

50. L. Ramage, P. Georgiou, S. Qiu, et al., "Can we Correlate Pelvic Floor Dysfunction Severity on MR Defecography With Patient-Reported Symptom Severity?," *Updates in Surgery* 70, no. 4 (2018): 467–476, https://doi.org/10.1007/s13304-017-0506-0.

51. A. Picciariello, V. Papagni, G. Martines, M. De Fazio, R. Digennaro, and D. F. Altomare, "Post-Operative Clinical, Manometric, and Defecographic Findings in Patients Undergoing Unsuccessful STARR Operation for Obstructed Defecation," *International Journal of Colorectal Disease* 34, no. 5 (2019): 837–842, https://doi.org/10.1007/s00384-019-03263-9.

52. E. Xynos, "Functional Results After Surgery for Obstructed Defecation," *Acta Chirurgica Iugoslavica* 59, no. 2 (2012): 25–29, https://doi.org/10.2298/aci1202025x.

53. G. Chiarioni, S. M. Kim, I. Vantini, and W. E. Whitehead, "Validation of the Balloon Evacuation Test: Reproducibility and Agreement With Findings From Anorectal Manometry and Electromyography," *Clinical Gastroenterology and Hepatology* 12, no. 12 (2014): 2049–2054, https://doi.org/10.1016/j.cgh.2014.03.013.

54. M. Minguez, B. Herreros, V. Sanchiz, et al., "Predictive Value of the Balloon Expulsion Test for Excluding the Diagnosis of Pelvic Floor Dyssynergia in Constipation," *Gastroenterology* 126, no. 1 (2004): 57–62, https://doi.org/10.1053/j.gastro.2003.10.044.

55. Rao S. S. C., "Constipation: Evaluation and Treatment of Colonic and Anorectal Motility Disorders," *Gastrointestinal Endoscopy Clinics of North America* 19, no. 1 (2009): 117–139, https://doi.org/10.1016/j.giec.2008.12.006.

56. C. Lambiase, M. Bellini, W. E. Whitehead, S. L. Popa, R. Morganti, and G. Chiarioni, "Biofeedback Efficacy for Outlet Dysfunction Constipation: Clinical Outcomes and Predictors of Response by a Limited Approach," *Neuro-Gastroenterology and Motility* 37, no. 1 (2025): e14948, https://doi.org/10.1111/nmo.14948.

57. F. Pucciani, M. Raggioli, and M. N. Ringressi, "Usefulness of Psyllium in Rehabilitation of Obstructed Defecation," *Techniques in Coloproctology* 15, no. 4 (2011): 377–383, https://doi.org/10.1007/s10151-011-0722-4.

58. S. M. Murad-Regadas, F. S. P. Regadas, L. V. Rodrigues, G. O. da S. Fernandes, G. Buchen, and V. T. Kenmoti, "Management of Patients With Rectocele, Multiple Pelvic Floor Dysfunctions and Obstructed Defecation Syndrome," *Arquivos de Gastroenterologia* 49, no. 2 (2012): 135–142, https://doi.org/10.1590/s0004-28032012000200008.

59. S. Valiyeva, D. Tiso, P. Cerri, A. Pisciaroli, and R. Pietroletti, "Results of Medical Treatment With Psyllium, Lactobacillus, and

20506414, 2026, 9, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/ueg2.70303 by CochraneItalia, Wiley Online Library on [07/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Tryptophan (Plurilac Trio) in Obstructive Defecation Syndrome," *Frontiers in Surgery* 11 (2024): 1361049, https://doi.org/10.3389/fsurg.2024.1361049.

60. C. E. Koh, C. J. Young, J. M. Young, and M. J. Solomon, "Systematic Review of Randomized Controlled Trials of the Effectiveness of Biofeedback for Pelvic Floor Dysfunction," *British Journal of Surgery* 95, no. 9 (2008): 1079–1087, https://doi.org/10.1002/bjs.6303.

61. D. Moore and C. J. Young, "A Systematic Review and Meta-Analysis of Biofeedback Therapy for Dyssynergic Defaecation in Adults," *Techniques in Coloproctology* 24, no. 9 (2020): 909–918, https://doi.org/10.1007/s10151-020-02230-9.

62. P. Chaichanavichkij, P. F. Vollebregt, S. M. Scott, and C. H. Knowles, "Botulinum Toxin Type A for the Treatment of Dyssynergic Defaecation in Adults: A Systematic Review," *Journal of the Association of Coloproctology of Great Britain and Ireland* 22, no. 12 (2020): 1832–1841, https://doi.org/10.1111/codi.15120.

63. C. Y. Chu, Y. C. Su, P. C. Hsieh, and Y. C. Lin, "Effectiveness and Safety of Botulinum Neurotoxin for Treating Dyssynergic Defecation: A Systematic Review and Meta-Analysis," *International Society on Toxinology* 235 (2023): 107311, https://doi.org/10.1016/j.toxicon.2023.107311.

64. A. A. Abouelnasr and M. Hany, "Bilateral Posterior Tibial Nerve Stimulation as a Neuromodulation Strategy for Obstructed Defecation: A Randomized Controlled Trial," *Techniques in Coloproctology* 29, no. 1 (2025): 178, https://doi.org/10.1007/s10151-025-03231-2.

65. F. Ashoush, A. Abdelrahim, O. Ali, et al., "A Randomized Controlled Trial Comparing the Efficacy of Bilateral Percutaneous Tibial Nerve Stimulation Versus Biofeedback Pelvic Floor Muscle Training in the Management of Obstructed Defecation Syndrome," *Cureus* 17, no. 3 (2025): e80885, https://doi.org/10.7759/cureus.80885.

66. S. Eustice, A. James, R. Endacott, and B. Kent, "Identifying the Health Care–Initiated and Self-Initiated Interventions Used by Women for the Management of Rectal Emptying Difficulty Secondary to Obstructive Defecation: A Scoping Review Protocol," *JBI Evidence Synthesis* 19, no. 2 (2021): 491–498, https://doi.org/10.11124/JBIES-20-00026.

67. E. Falletto, J. Martellucci, P. Rossitti, et al., "Transanal Irrigation in Functional Constipation: Long-Term Results from an Italian National Study," *Diseases of the Colon & Rectum* 69, no. 7 (2026): 1901–1910, https://doi.org/10.1097/DCR.0000000000004224.

68. C. W. Hicks, M. Weinstein, M. Wakamatsu, L. Savitt, S. Pulliam, and L. Bordeianou, "In Patients With Rectoceles and Obstructed Defecation Syndrome, Surgery Should be the Option of Last Resort," *Surgery* 155, no. 4 (2014): 659–667, https://doi.org/10.1016/j.surg.2013.11.013.

69. R. Collinson, N. Wijffels, C. Cunningham, and I. Lindsey, "Laparoscopic Ventral Rectopexy for Internal Rectal Prolapse: Short-Term Functional Results," *Journal of the Association of Coloproctology of Great Britain and Ireland* 12, no. 2 (2010): 97–104, https://doi.org/10.1111/j.1463-1318.2009.02049.x.

70. M. Faried, A. El Nakeeb, M. Youssef, W. Omar, and H. A. El Monem, "Comparative Study Between Surgical and Non-Surgical Treatment of Anismus in Patients With Symptoms of Obstructed Defecation: A Prospective Randomized Study," *Journal of Gastrointestinal Surgery* 14, no. 8 (2010): 1235–1243, https://doi.org/10.1007/s11605-010-1229-4.

71. L. Ferrari, K. Cuinas, A. Hainsworth, et al., "Transvaginal Rectocoele Repair for the Surgical Treatment of a 'Symptomatic' Rectocoele when Conservative Measures Fail: A 12 Year Experience of 215 Patients," *Neuro-Gastroenterology and Motility* 34, no. 11 (2022): e14343, https://doi.org/10.1111/nmo.14343.

72. S. Brandner, A. Monga, M. D. Mueller, G. Herrmann, and A. Kuhn, "Sexual Function After Rectocele Repair," *Journal of Sexual Medicine* 8, no. 2 (2011): 583–588, https://doi.org/10.1111/j.1743-6109.2010.02101.x.

73. E. Abet, P. A. Lehur, M. Wong, J. Rigaud, E. Darnis, and G. Meurette, "Sexual Function and Laparoscopic Ventral Rectopexy for Complex Rectocoele," *Journal of the Association of Coloproctology of Great Britain and Ireland* 14, no. 10 (2012): e721–e726, https://doi.org/10.1111/j.1463-1318.2012.03113.x.

74. G. Portier, S. Kirzin, P. Cabarrot, M. Queralto, and F. Lazorthes, "The Effect of Abdominal Ventral Rectopexy on Faecal Incontinence and Constipation in Patients With Internal Intra-Anal Rectal Intussusception," *Journal of the Association of Coloproctology of Great Britain and Ireland* 13, no. 8 (2011): 914–917, https://doi.org/10.1111/j.1463-1318.2010.02327.x.

75. S. Degasperi, M. Scarpa, O. Zini, et al., "Laparoscopic Ventral Rectopexy for Obstructed Defecation: Functional Results and Quality of Life," *Surgical Laparoscopy Endoscopy & Percutaneous Techniques* 31, no. 1 (2020): 14–19, https://doi.org/10.1097/SLE.0000000000000835.

76. U. Grossi, J. Lacy-Colson, S. R. Brown, et al., "Stepped-Wedge Randomized Controlled Trial of Laparoscopic Ventral Mesh Rectopexy in Adults With Chronic Constipation," *Techniques in Coloproctology* 26, no. 12 (2022): 941–952, https://doi.org/10.1007/s10151-022-02633-w.

77. K. M. Madbouly and A. D. Mohii, "Laparoscopic Ventral Rectopexy Versus Stapled Transanal Rectal Resection for Treatment of Obstructed Defecation in the Elderly: Long-Term Results of a Prospective Randomized Study," *Diseases of the Colon & Rectum* 62, no. 1 (2019): 47–55, https://doi.org/10.1097/DCR.0000000000001256.

78. E. C. J. Consten, J. J. van Iersel, P. M. Verheijen, I. A. M. J. Broeders, A. M. Wolthuis, and A. D'Hoore, "Long-Term Outcome After Laparoscopic Ventral Mesh Rectopexy: An Observational Study of 919 Consecutive Patients," *Annals of Surgery* 262, no. 5 (2015): 742–747, https://doi.org/10.1097/SLA.0000000000001401.

79. L. Ramage, P. Georgiou, P. Tekkis, and E. Tan, "Is Robotic Ventral Mesh Rectopexy Better than Laparoscopy in the Treatment of Rectal Prolapse and Obstructed Defecation?," *Techniques in Coloproctology* 19, no. 7 (2015): 381–389, https://doi.org/10.1007/s10151-015-1320-7.

80. S. Albayati, P. Chen, M. J. Morgan, and J. W. T. Toh, "Robotic Vs. Laparoscopic Ventral Mesh Rectopexy for External Rectal Prolapse and Rectal Intussusception: A Systematic Review," *Techniques in Coloproctology* 23, no. 6 (2019): 529–535, https://doi.org/10.1007/s10151-019-02014-w.

81. X. Bao, H. Wang, W. Song, Y. Chen, and Y. Luo, "Meta-Analysis on Current Status, Efficacy, and Safety of Laparoscopic and Robotic Ventral Mesh Rectopexy for Rectal Prolapse Treatment: Can Robotic Surgery Become the Gold Standard?," *International Journal of Colorectal Disease* 36, no. 8 (2021): 1685–1694, https://doi.org/10.1007/s00384-021-03885-y.

82. K. E. Laitakari, J. K. Mäkelä-Kaikkonen, J. Kössi, et al., "Mid-Term Functional and Quality of Life Outcomes of Robotic and Laparoscopic Ventral Mesh Rectopexy: Multicenter Comparative Matched-Pair Analyses," *Techniques in Coloproctology* 26, no. 4 (2022): 253–260, https://doi.org/10.1007/s10151-021-02563-z.

83. D. K. Manatakis, N. Gouvas, G. Pechlivanides, and E. Xynos, "Ventral Prosthesis Rectopexy for Obstructed Defaecation Syndrome: A Systematic Review and Meta-Analysis," *Updates in Surgery* 74, no. 1 (2022): 11–21, https://doi.org/10.1007/s13304-021-01177-2.

84. S. H. Emile, H. A. Elfeki, M. Youssef, M. Farid, and S. D. Wexner, "Abdominal Rectopexy for the Treatment of Internal Rectal Prolapse: A Systematic Review and Meta-Analysis," *Journal of the Association of Coloproctology of Great Britain and Ireland* 19, no. 1 (2017): O13–O24, https://doi.org/10.1111/codi.13574.

85. A. Durbeck, H. O. Johannessen, A. Drolsum, and E. Johnson, "Very Long-Term Outcome After Resection Rectopexy for Internal Rectal

20506414, 2026, 9, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/ueg2.70303 by CochraneItalia, Wiley Online Library on [07/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Intussusception," *Scandinavian Journal of Gastroenterology* 56, no. 1 (2021): 122–127, https://doi.org/10.1080/00365521.2020.1853221.

86. A. R. Spivak, M. Maspero, R. Y. Spivak, et al., "Quality of Life, Functional Outcomes, and Recurrence After Resection Rectopexy Versus Ventral Mesh Rectopexy for Rectal Prolapse Repair," *Diseases of the Colon & Rectum* 68, no. 1 (2025): 91–100, https://doi.org/10.1097/DCR.0000000000003467.

87. C. Rudroff, J. Madukkakuzhy, J. Otten, et al., "Improvement in Functional and Mental Outcomes After Resection Rectopexy for Obstructive Defecation Syndrome ODS," *Scientific Reports* 15, no. 1 (2025): 30184, https://doi.org/10.1038/s41598-025-15037-1.

88. G. F. Hess, F. Nocera, S. Taha-Mehlitz, S. Christen, M. von Strauss Und Torney, and D. C. Steinemann, "Mesh-Associated Complications in Minimally Invasive Ventral Mesh Rectopexy: A Systematic Review," *Surgical Endoscopy* 38, no. 12 (2024): 7073–7082, https://doi.org/10.1007/s00464-024-11369-7.

89. P. Tejedor, I. Lindsey, O. M. Jones, et al., "Impact of Suture Type on Erosion Rate After Laparoscopic Ventral Mesh Rectopexy: A Case-Matched Study," *Diseases of the Colon & Rectum* 62, no. 12 (2019): 1512–1517, https://doi.org/10.1097/DCR.0000000000001510.

90. C. Gouriou, M. Chambaz, A. Ropert, et al., "A Systematic Literature Review on Solitary Rectal Ulcer Syndrome: Is There a Therapeutic Consensus in 2018?," *International Journal of Colorectal Disease* 33, no. 12 (2018): 1647–1655, https://doi.org/10.1007/s00384-018-3162-z.

91. C. Evans, E. Ong, O. M. Jones, C. Cunningham, and I. Lindsey, "Laparoscopic Ventral Rectopexy is Effective for Solitary Rectal Ulcer Syndrome When Associated With Rectal Prolapse," *Colorectal Disease* 16, no. 3 (2014): O112–O116, https://doi.org/10.1111/codi.12502.

92. F. Jean, Y. Tanneau, I. Le Blanc-Louvry, A. M. Leroi, P. Denis, and F. Michot, "Treatment of Enterocele by Abdominal Colporectosacropexy-Efficacy on Pelvic Pressure," *Journal of the Association of Coloproctology of Great Britain and Ireland* 4, no. 5 (2002): 321–325, https://doi.org/10.1046/j.1463-1318.2002.00375.x.

93. A. Lauretta, R. E. Bellomo, F. Galanti, C. A. Tonizzo, and A. Infantino, "Laparoscopic Low Ventral Rectocolpopexy (LLVR) for Rectal and Rectogenital Prolapse: Surgical Technique and Functional Results," *Techniques in Coloproctology* 16, no. 6 (2012): 477–483, https://doi.org/10.1007/s10151-012-0918-2.

94. Y. Watadani, S. A. Vogler, J. S. Warshaw, et al., "Sacrocolpopexy With Rectopexy for Pelvic Floor Prolapse Improves Bowel Function and Quality of Life," *Diseases of the Colon & Rectum* 56, no. 12 (2013): 1415–1422, https://doi.org/10.1097/DCR.0b013e3182a62dbb.

95. A. L. Edenfield, P. J. Levin, A. A. Dieter, J. M. Wu, and N. Y. Siddiqui, "Is Postoperative Bowel Function Related to Posterior Compartment Prolapse Repair?," *Female Pelvic Medicine & Reconstructive Surgery* 20, no. 2 (2014): 90–94, https://doi.org/10.1097/SPV.0000000000000048.

96. J. K. Mäkelä-Kaikkonen, T. T. Rautio, S. Koivurova, et al., "Anatomical and Functional Changes to the Pelvic Floor After Robotic Versus Laparoscopic Ventral Rectopexy: A Randomised Study," *International Urogynecology Journal* 27, no. 12 (2016): 1837–1845, https://doi.org/10.1007/s00192-016-3048-y.

97. S. Pacquée, K. Nawapun, F. Claerhout, et al., "Long-Term Assessment of a Prospective Cohort of Patients Undergoing Laparoscopic Sacrocolpopexy," *Obstetrics & Gynecology* 134, no. 2 (2019): 323–332, https://doi.org/10.1097/AOG.0000000000003380.

98. F. van Zanten, E. M. van der Schans, E. C. J. Consten, et al., "Long-Term Anatomical and Functional Results of Robot-Assisted Pelvic Floor Surgery for the Management of Multicompartment Prolapse: A Prospective Study," *Diseases of the Colon & Rectum* 63, no. 9 (2020): 1293–1301, https://doi.org/10.1097/DCR.0000000000001696.

99. A. F. Ruffolo, T. Melocchi, C. Rubod, et al., "Anatomical and Functional Outcomes of Combined Ventral Rectopexy and Sacrocolpo/Hysteropexy for Multicompartment Pelvic Organ Prolapse: A Systematic Review and Meta-Analysis," *Techniques in Coloproctology* 30, no. 1 (2025): 6, https://doi.org/10.1007/s10151-025-03236-x.

100. G. Gallo, G. Clerico, A. Realis Luc, and M. Trompetto, "A Step-by-Step Approach to Endorectal Proctopexy (ERPP): How we Do it," *Techniques in Coloproctology* 25, no. 7 (2021): 879–886, https://doi.org/10.1007/s10151-021-02467-y.

101. K. M. Madbouly, K. S. Abbas, and A. M. Hussein, "Disappointing Long-Term Outcomes After Stapled Transanal Rectal Resection for Obstructed Defecation," *World Journal of Surgery* 34, no. 9 (2010): 2191–2196, https://doi.org/10.1007/s00268-010-0638-6.

102. N. L. Ohazuruike, J. Martellucci, C. Menconi, S. Panicucci, G. Toniolo, and G. Naldini, "Short-Term Results After STARR Versus Internal Delorme for Obstructed Defecation: A Non-Randomized Prospective Study," *Updates in Surgery* 66, no. 2 (2014): 151–156, https://doi.org/10.1007/s13304-014-0247-2.

103. W. C. Liu, S. L. Wan, S. M. Yaseen, et al., "Transanal Surgery for Obstructed Defecation Syndrome: Literature Review and a Single-Center Experience," *World Journal of Gastroenterology* 22, no. 35 (2016): 7983–7998, https://doi.org/10.3748/wjg.v22.i35.7983.

104. C. A. Leo, P. Campennì, J. D. Hodgkinson, et al., "Long-Term Functional Outcome After Internal Delorme's Procedure for Obstructed Defecation Syndrome, and the Role of Postoperative Rehabilitation," *Journal of Investigative Surgery* 31, no. 3 (2018): 256–262, https://doi.org/10.1080/08941939.2017.1300714.

105. M. Balata, H. Elgendy, S. H. Emile, M. Youssef, W. Omar, and W. Khafagy, "Functional Outcome and Sexual-Related Quality of Life After Transperineal Versus Transvaginal Repair of Anterior Rectocele: A Randomized Clinical Trial," *Diseases of the Colon & Rectum* 63, no. 4 (2020): 527–537, https://doi.org/10.1097/DCR.0000000000001595.

106. H. H. Chill, S. Gilani, A. Hadizadeh, et al., "Safety of Concurrent Transvaginal Rectopexy at Time of Transvaginal Apical Prolapse Repair: A Comparative Study," *European Journal of Obstetrics & Gynecology and Reproductive Biology* 312 (2025): 114512, https://doi.org/10.1016/j.ejogrb.2025.114512.

107. A. Hadizadeh, H. H. Chill, A. Leffelman, et al., "Short-Term Complications Following Transvaginal Sacrospinous Ligament Rectopexy: A Retrospective Cohort Study," *International Urogynecology Journal* 36, no. 5 (2025): 1037–1044, https://doi.org/10.1007/s00192-025-06098-x.

108. H. H. Chill, A. Hadizadeh, A. Leffelman, et al., "Long-Term Outcomes of Transvaginal Sacrospinous Ligament Suture Rectopexy," *International Urogynecology Journal* 36, no. 7 (2025): 1425–1433, https://doi.org/10.1007/s00192-025-06099-w.

109. M. Mercer-Jones, U. Grossi, D. Pares, et al., "Surgery for Constipation: Systematic Review and Practice Recommendations: Results III: Rectal Wall Excisional Procedures (Rectal Excision)," supplement, *Journal of the Association of Coloproctology of Great Britain and Ireland* 19, no. Suppl 3 (2017): 49–72, https://doi.org/10.1111/codi.13772.

110. U. Grossi, E. J. Horrocks, J. Mason, et al., "Surgery for Constipation: Systematic Review and Practice Recommendations: Results IV: Recto-Vaginal Reinforcement Procedures," supplement, *Journal of the Association of Coloproctology of Great Britain and Ireland* 19, no. Suppl 3 (2017): 73–91, https://doi.org/10.1111/codi.13781.

111. E. F. Zimmermann, R. S. Hayes, I. R. Daniels, N. J. Smart, and A. M. Warwick, "Transperineal Rectocele Repair: A Systematic Review," *ANZ Journal of Surgery* 87, no. 10 (2017): 773–779, https://doi.org/10.1111/ans.14068.

112. B. Balci, S. Leventoglu, I. Osmanov, B. Erkan, Y. Irkilata, and B. Mentes, "Laparoscopic Ventral Mesh Rectopexy Vs. Transperineal Mesh Repair for Obstructed Defecation Syndrome Associated With Rectocele:

20506414, 2026, 9, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/ueg2.70303 by CochraneItalia, Wiley Online Library on [07/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Comparison of Selectively Distributed Patients," *BMC Surgery* 23, no. 1 (2023): 359, https://doi.org/10.1186/s12893-023-02206-0.

113. P. A. Lehur, A. Stuto, M. Fantoli, et al., "Outcomes of Stapled Transanal Rectal Resection Vs. Biofeedback for the Treatment of Outlet Obstruction Associated With Rectal Intussusception and Rectocele: A Multicenter, Randomized, Controlled Trial," *Diseases of the Colon & Rectum* 51, no. 11 (2008): 1611–1618, https://doi.org/10.1007/s10350-008-9378-1.

114. L. Ripamonti, A. Guttadauro, G. Lo Bianco, et al., "Stapled Transanal Rectal Resection (Starr) in the Treatment of Obstructed Defecation: A systematic Review," *Frontiers in Surgery* 9 (2022): 790287, https://doi.org/10.3389/fsurg.2022.790287.

115. K. Adams and S. Papagrigoriadis, "Stapled Transanal Rectal Resection (STARR) for Obstructive Defaecation Syndrome: Patients With Previous Pelvic Floor Surgery Have Poorer Long-Term Outcome," *Journal of the Association of Coloproctology of Great Britain and Ireland* 15, no. 4 (2013): 477–480, https://doi.org/10.1111/codi.12054.

116. F. Borie, J. M. Bigourdan, M. H. Pissas, and F. Guillon, "Laparoscopic Ventral Rectopexy for the Treatment of Outlet Obstruction Associated With Recto-Anal Intussusception and Rectocele: A Valid Alternative to STARR Procedure in Patients With Anal Sphincter Weakness," *Clinics and Research in Hepatology and Gastroenterology* 38, no. 4 (2014): 528–534, https://doi.org/10.1016/j.clinre.2013.12.010.

117. J. Driouch, D. Bausch, and O. Thaher, "Short- and Mid-Term Functional Outcomes of STARR Procedure in Obstructed Defecation Syndrome," *Minerva Surgery* 80, no. 3 (2025): 214–223, https://doi.org/10.23736/S2724-5691.25.10863-0.

118. M. Pescatori and G. Gagliardi, "Postoperative Complications After Procedure for Prolapsed Hemorrhoids (PPH) and Stapled Transanal Rectal Resection (STARR) Procedures," *Techniques in Coloproctology* 12, no. 1 (2008): 7–19, https://doi.org/10.1007/s10151-008-0391-0.

119. M. Pescatori and A. P. Zbar, "Reinterventions After Complicated or Failed STARR Procedure," *International Journal of Colorectal Disease* 24, no. 1 (2009): 87–95, https://doi.org/10.1007/s00384-008-0556-3.

120. E. MacCraith, E. M. Cunnane, M. Joyce, J. C. Forde, F. J. O'Brien, and N. F. Davis, "Comparison of Synthetic Mesh Erosion and Chronic Pain Rates After Surgery for Pelvic Organ Prolapse and Stress Urinary Incontinence: A Systematic Review," *International Urogynecology Journal* 32, no. 3 (2021): 573–580, https://doi.org/10.1007/s00192-020-04612-x.

121. N. J. Smart, S. Pathak, P. Boorman, and I. R. Daniels, "Synthetic or Biological Mesh Use in Laparoscopic Ventral Mesh Rectopexy-a Systematic Review," *Journal of the Association of Coloproctology of Great Britain and Ireland* 15, no. 6 (2013): 650–654, https://doi.org/10.1111/codi.12219.

122. L. Franceschilli, D. Varvaras, I. Capuano, et al., "Laparoscopic Ventral Rectopexy Using Biologic Mesh for the Treatment of Obstructed Defaecation Syndrome and/or Faecal Incontinence in Patients With Internal Rectal Prolapse: A Critical Appraisal of the First 100 Cases," *Techniques in Coloproctology* 19, no. 4 (2015): 209–219, https://doi.org/10.1007/s10151-014-1255-4.

123. F. Borie, T. Coste, J. M. Bigourdan, and F. Guillon, "Incidence and Surgical Treatment of Synthetic Mesh-Related Infectious Complications After Laparoscopic Ventral Rectopexy," *Techniques in Coloproctology* 20, no. 11 (2016): 759–765, https://doi.org/10.1007/s10151-016-1538-z.

124. F. Drissi, F. Rogier-Mouzelas, S. Fernandez Arias, J. Podevin, and G. Meurette, "Moving From Laparoscopic Synthetic Mesh to Robotic Biological Mesh for Ventral Rectopexy: Results From a Case Series," *Journal of Clinical Medicine* 12, no. 17 (2023): 5751, https://doi.org/10.3390/jcm12175751.

125. Y. Maeda, E. Espin-Basany, K. Gorissen, et al., "European Society of Coloproctology Guidance on the Use of Mesh in the Pelvis in Colorectal Surgery," *Colorectal Disease* 23, no. 9 (September 2021): 2228–2285, Epub 2021 Jun 29. PMID: 34060715, https://doi.org/10.1111/codi.15718.

126. L. Boenicke, J. Reibetanz, M. Kim, N. Schlegel, C. T. Germer, and C. Isbert, "Predictive Factors for Postoperative Constipation and Continence After Stapled Transanal Rectal Resection," *British Journal of Surgery* 99, no. 3 (2012): 416–422, https://doi.org/10.1002/bjs.7837.

127. S. Solari, J. Martellucci, S. Ascanelli, et al., "Predictive Factors for Functional Failure of Ventral Mesh Rectopexy in the Treatment of Rectal Prolapse and Obstructed Defecation," *Techniques in Coloproctology* 26, no. 12 (2022): 973–979, https://doi.org/10.1007/s10151-022-02708-8.

128. S. Singh, E. Smyth, O. Jones, C. Cunningham, and I. Lindsey, "Outcomes of Rectal Prolapse Surgery in Patients With Benign Joint Hypermobility Syndrome," *Techniques in Coloproctology* 27, no. 6 (2023): 491–494, https://doi.org/10.1007/s10151-023-02770-w.

129. M. L. Corman, A. Carriero, T. Hager, et al., "Consensus Conference on the Stapled Transanal Rectal Resection (STARR) for Disordered Defaecation," *Journal of the Association of Coloproctology of Great Britain and Ireland* 8, no. 2 (2006): 98–101, https://doi.org/10.1111/j.1463-1318.2005.00941.x.

130. J. Reibetanz, L. Boenicke, M. Kim, C. T. Germer, and C. Isbert, "Enterocele is not a Contraindication to Stapled Transanal Surgery for Outlet Obstruction: An Analysis of 170 Patients," *Journal of the Association of Coloproctology of Great Britain and Ireland* 13, no. 6 (2011): e131–e136, https://doi.org/10.1111/j.1463-1318.2011.02554.x.

131. H. A. Formijne Jonkers, N. Poierrié, W. A. Draaisma, I. a. M. J. Broeders, and E. C. J. Consten, "Laparoscopic Ventral Rectopexy for Rectal Prolapse and Symptomatic Rectocele: An Analysis of 245 Consecutive Patients," *Journal of the Association of Coloproctology of Great Britain and Ireland* 15, no. 6 (2013): 695–699, https://doi.org/10.1111/codi.12113.

132. F. Guerra, F. La Torre, and M. Pescatori, "Urogynecological Prolapse and Enterocele are Predictive of Poor Functional Outcome After Failed or Complicated STARR Procedures," *Techniques in Coloproctology* 18, no. 8 (2014): 765–766, https://doi.org/10.1007/s10151-014-1140-1.

133. D. Mege, A. Sans, A. Maignan, et al., "Temporary Successful Results of Ventral Rectopexy for Enterocele Surgical Correction, About 138 Patients," *International Journal of Colorectal Disease* 32, no. 11 (2017): 1569–1575, https://doi.org/10.1007/s00384-017-2887-4.

134. S. M. M. Paim, M. Hawkins, M. Gilfeather, and J. Griffin, "Enterocele Reduction in the Prone Position: New Horizons for Safer Stapled Transanal Rectal Resections," *Surgical Technology International* 34 (2019): 156–162, https://pubmed.ncbi.nlm.nih.gov/30500977/PMID:30500977.

135. C. W. P. Fu and A. R. L. Stevenson, "Risk Factors for Recurrence After Laparoscopic Ventral Rectopexy," *Diseases of the Colon & Rectum* 60, no. 2 (2017): 178–186, https://doi.org/10.1097/DCR.0000000000000710.

136. K. E. Laitakari, J. K. Mäkelä-Kaikkonen, M. Kairaluoma, et al., "Redo Ventral Rectopexy: Is it Worthwhile?," *Techniques in Coloproctology* 25, no. 3 (2021): 299–307, https://doi.org/10.1007/s10151-020-02369-5.

137. B. Liu and S. Brown, "Redo Laparoscopic Ventral Mesh Rectopexies: A Multimedia Article on the Technical Points," *Techniques in Coloproctology* 20, no. 8 (2016): 597–598, https://doi.org/10.1007/s10151-016-1467-x.

138. D. A. van Rumpt and A. L. A. Bloemendaal, "Recurrence of Symptoms After Mesh Rectopexy: Different Reasons and Different Solutions," *Techniques in Coloproctology* 27, no. 6 (2023): 495, https://doi.org/10.1007/s10151-022-02719-5.

20506414, 2026, 9, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/ueg2.70303 by CochraneItalia, Wiley Online Library on [07/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

139. E. M. van der Schans, P. M. Verheijen, I. A. M. J. Broeders, and E. C. J. Consten, "Ninety-day Morbidity of Robot-Assisted Redo Surgery for Recurrent Rectal Prolapse, Mesh Erosion and Pelvic Pain: Lessons Learned From 9 Years' Experience in a Tertiary Referral Centre," *Journal of the Association of Coloproctology of Great Britain and Ireland* 23, no. 12 (2021): 3205–3212, https://doi.org/10.1111/codi.15979.

140. S. R. Brown, K. Pearson, A. Hainsworth, and A. Williams, "Treatment of Recurrent Rectal Prolapse After a Laparoscopic Ventral Mesh Rectopexy," *Techniques in Coloproctology* 26, no. 12 (2022): 991–995, https://doi.org/10.1007/s10151-022-02689-8.

141. W. R. G. Perry, P. Christensen, R. J. Collinson, et al., "Ventral Rectopexy: An International Expert Panel Consensus and Review of Contemporary Literature," *Diseases of the Colon & Rectum* 68, no. 5 (2025): 593–607, https://doi.org/10.1097/DCR.0000000000003656.

142. M. Reichert, A. Busse, A. Hecker, et al., "Changes in Dynamic Pelvic Floor Magnet Resonance Imaging and Patient Satisfaction After Resection Rectopexy for Obstructed Defecation Syndrome," *ROFO* 188, no. 1 (2016): 38–44, https://doi.org/10.1055/s-0041-105406.

143. C. Bildstein, C. Melchior, G. Gourcerol, et al., "Predictive Factors for Compliance With Transanal Irrigation for the Treatment of Defecation Disorders," *World Journal of Gastroenterology* 23, no. 11 (2017): 2029–2036, https://doi.org/10.3748/wjg.v23.i11.2029.

144. P. Tamvakeras, C. Horrobin, J. Chang, and M. Chapman, "Long-Term Outcomes of Transanal Irrigation for Bowel Dysfunction," *Cureus* 15, no. 7 (2023): e42507, https://doi.org/10.7759/cureus.42507.

145. J. Martellucci, E. Falletto, S. Ascanelli, et al., "Consensus-Driven Protocol for Transanal Irrigation in Patients With Low Anterior Resection Syndrome and Functional Constipation," *Techniques in Coloproctology* 28, no. 1 (2024): 153, https://doi.org/10.1007/s10151-024-03033-y.

146. J. Martellucci, "Sacral Nerve Stimulation for Constipation: History of an Unconsummated Marriage," *Techniques in Coloproctology* 21, no. 4 (April 2017): 257–258, Epub 2017 May 3. PMID: 28470364, https://doi.org/10.1007/s10151-017-1619-7.

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