By "holistic approach" (greek "olos" = "all") we mean a clinical approach which is not only confined to the diseased segment of the body, say the inert large bowel or the spastic pelvic floor in case of constipation, but takes under consideration the whole "mind and body complex", which is a unique indivisible entity.

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Key words: holistic, constipation, treatment

INTRODUCTION

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Ira Kodner, one of the past presidents of the ASCRS (American Society of Colon and Rectal Surgeons) wrote in the late seventies in International journal Colorectal Disease that he would never operate on a patient with rectal intussusception, prior to perform a complete psychological assessment.

Mike Keighley, in the late eighties, found that his patients with recurrent constipation following colectomy and ileorectal anastomosis had significantly more preoperative psychological disturbances when compared to those who did well after surgery.

Not only psyche (P) is involved in the etiology of chronic constipation. Some patients are constipated due to neurological (N) defects, e.g. an impairment of colonic peristalsis caused by a deficient myenteric plexus in the distal large bowel, or to endocrine (E) disease, e.g. hypothyroidism, or decreased plasma levels of PYY, peptide-tyrosine-tyrosine, a hormone mainly secreted by the large bowel to slow the ileal transit, also called "ileal brake", or to immunological (I) disease, e.g. scleroderma or collagenesis or dysbiosis due to alterations between cytokine defensive lamina and pathogenic bacteria of the intestinal flora.

The so-called PNEI (Psycho-Neuro-Endocrine-Immunological) system is like a cybernetic system which "surrounds" the diseased organ, in our case the large bowel with the pelvic floor. The target organ and each single apex of the surrounding PNEI rhomb are strictly connected by a bidirectional system of mutual control, by means of receptors, nerves, neurotransmitters, cytokines, lymphocytes, circulating hormones, all in perfect harmony when the individual is healthy.

The symptom "constipation" may therefore be just an unconscious "shout of alarm" of the patient to let us know that this complex balance is in danger. Our task in this case is not simply to treat the symptom, but to take care of the whole entity of the patient with an holistic approach and to understand how and why and when and where this balance has broken and try to restore it in the interest of the patient.

Often, in case of a complex functional disorders such as chronic constipation TO CUT IS NOT TO CURE. In such circumstances, as stated by Robin Phillips from St Mark's Hospital in Diseases of the Colon and Rectum 2004 when commenting the STARR stapled rectotomy procedure for obstructed defecation, "to resect a piece of rectum in a constipated patient is like to resect a piece of lung in a patient with asthma or the cut an arm in a patient with high blood pressure".
That is why most of surgical operation for chronic constipation are followed by early recurrence of symptoms. As examples, I might quote the STARR procedure itself, followed by recurrence of at least three symptoms of obstructed defecation in 51% of the cases 19 months after surgery (Gagliardi et al, Diseases of the Colon and Rectum 2006) or the endorectal rectocele repair, followed by 50% of recurrence after 6 years (Michot, Diseases of the Colon and Rectum 2005) or the transanal both manual and stapled prolapsectomy, followed by 52% of recurrences after 3 years (Pescatori et al, International Journal Colorectal Diseases 2006) or the resection-rectopexy, followed by 50% of recurrences after 4 years (Brown et al, Colorectal Disease 2004).

All the above mentioned procedures are aimed at restoring normal anatomy in patients with either rectal intussusception or internal mucosal prolapse or rectocele, but the restoration of anatomy not always leads to restoration of function, unless the treatment is holistic and takes under consideration the management of the occult functional lesions frequently associated with either rectal intussusception or internal mucosal prolapse and rectocele. Such occult functional lesions, e.g. psychoneurosis, rectal hyposensitivity, pudendal neuropathy, non relaxing puborectalis muscle and slow-transit may affect up to two-thirds of the constipated patients and need to be correctly diagnosed and then managed by non surgical procedures, i.e. psychotherapy, high residue diet, transanal electrostimulation, hydrocolontherapy, pelvic floor rehabilitation or injection of botulin toxin. Or even minimally invasive surgeries, such as spinal cord neurmodulation, aimed at increasing sigmoid propulsive motor activity, firstly reported by us in 1982 for the treatment of two neurological constipated patients (Pescatori et al, GI Motility Disorders, ed Wienbeck, Raven Press) and then successfully used in the clinical practice after 2000 by Matzel, Baeten, Gianio, Kamm and others using the Medtronic pace maker, which may be implanted under local anesthesia and also videoassisted (Demartines et al, Techniques in Coloproctology, 2006).

If we look at the obstructed defecation like an Iceberg Syndrome (Pescatori et al, Colorectal Disease 2006), the above mentioned occult lesions may well represent "underwater rocks" for our "surgical ship", and cause a failure of the therapy, if directed exclusively towards the evident lesions, such as rectocele and mucosal prolapse. In our experience, only 14% of the patients with obstructed defecation may require surgery, and, according to Nyam and Pemberton of the Mayo Clinic, overall, only 5% of patients with chronic constipation may benefit from surgery (Diseases of the Colon and Rectum 1997).

The holistic approach allows a more effective management of chronic constipation, but requires a multidisciplinary team, with a colorectal surgeon, a gastroenterologist, a psychologist and/or a psychiatrist, a pelvic floor physiotherapist and a dietician, a hydrocolontherapist, and a bacteriologist expert of the bacterial flora of the gut. These are the specialists working at our Unit in Rome, where we organize courses for postgraduates teaching the holistic approach for both functional and organic large bowel diseases. These courses include also diagnostic procedures, such as anal manometry and ultrasound, and surgical sessions in highly selected patients. Instead than routinely addressing patients to a psychologist, we found more useful to use the Draw-the-Family-test, which enables us to find out patients’ mental disorders by looking at a simple drawing concerning his or her family and showing alterations such as little figures or incomplete families or poor tract without details. In this case the patients tend to keep inside the drawing details, as they keep emotions and feces, Introvert and controlled patients are more prone to have a psychogenic component of their chronic constipation (Complex anorectal disorders, eds Wexner, Zbar, Pescatori, Springer London 2005, see the chapter written in cooperation with our psychologist A. Russo).

Let me conclude this presentation, which might look as semi-philosophical or at least unusual to some extent, quoting a very concrete and really impressive case report (of course we might quote many!) which is useful to underline the importance of the holistic approach and the clinical disasters due to a lack of the holistic approach.

A 23 yrs old female presented to our Unit with severe long-standing chronic constipation, one bowel motion every two weeks, plus abdominal bloating and pain, and occasional mucus soiling per anum. She had had four surgeries (anal internal sphincterotomy, Soave pull-through, right hemicolectomy and anal stretch, all performed by pediatric surgeons) between the age of 12 and the age of 17, with progressive worsening of her symptoms. After a detailed investigation of her clinical history, our psychologist found out that she had been anally raped by her mother’s companion between the age of 6 and the age of 11. One year later she became constipated. She never told this story to any of the doctors who tried to tried her constipation and therefore she never had any psychological support after such a severe trauma! At anal manometry, her sphincters were weak and the rectoanal inhibitory reflex was markedly disordered thus rising the suspicion of a ganglion deficiency. The study of intestinal transit time showed a slowered transit of the radiopaque markers in the residual large bowel. We tried to treat her with high residue diet, bulk laxatives and psychotherapy but with no success, therefore a surgical operation was planned. We thought we had to increase the rectal capacity to provide a sufficient reservoir above her weak sphincter, but we thought we had to remove the large bowel which was quite inert and bypass the hypoganglionic distal segment of the neorectum. Therefore we carried out a total colectomy and then a Duhamel operation pulling a J-pouch of terminal ileum behind the neorectal stump and performing a transanal anastomosis, covered by a diverting ileostomy, which was successfully closed after 6 weeks. The patient did well, underwent a course of psychotherapy, married after two years and had a baby with a caesarean delivery one year later, she underwent a course of pelvic floor exercises and is continent and no more constipated after twelve years. This case report has been published in Coloproctology in the early nineties.
In conclusion, the holistic approach is to be preferred when dealing with patients with chronic constipation, the PNEI system should be beard in mind when facing a patient with large bowel disease, the Iceberg syndrome and diagram may help to improve the treatment of patients with occult diseases suffering from obstructed defecation and the assistance of a multisciplinary equipe, involving, among the others, a psychologist trained in psychosomatosis, is required to offer the best chance of cure to constipated patients. Surgery is indicated only in very few selected cases and commercially supported costly innovations should be used only if they demonstrate to achieve better results than validated manual procedures.

SUMMARY

HOLISTIČKI PRILAZ OPSTIPACIJI

Holističkim prilazom (grčki colos-svež) nazvan je klinički prilaz koji nije ograničen samo obolelim segmentom tela, kao kod inertnog kolona ili spastičnog pelvičnog poda u slučaju opstipacije, nego uzima u obzir ceo kompleks tela i duše kao jedinstvenu nerazdvojnu celinu.

Holistički prilaz opstipaciji dozvoljava efektivnije lečenje hronične opstipacije, ali zahteva multidisciplinarni tim koji se sastoje od kolorektalnog hirurga, gastroenterologa, psihologa i ili psihijatra, fizioterapeuta pelvičnog poda i dietologa, hidrokolon terapeuta i bakteriologa, eksperta za crevnu floru.

Ključne reči: holistički, opstipacija, tretman