premorbid personality, and an estimate of the patient's ability to comply with dietary restrictions. The drugs should probably not be used in patients who abuse alcohol and in those with panic and hypochondriacal symptoms who are unable to tolerate even the slightest side effect—for example, dizziness—because it causes further anxiety. For such patients a treatment such as cognitive therapy may be better,[19] but monoamine oxidase inhibitors may be particularly useful in agoraphobics and patients with phobic avoidance who are either unable or unwilling to engage in behavioural treatment.[20]

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Surgery for constipation

Sometimes justified for the idiopathic slow transit type

Surgery can usually produce a good functional result in dysfunction of the colon secondary to lesions such as aganglionosis or cancer. But its role in treating idiopathic constipation is more controversial and difficult. Patients with idiopathic constipation, particularly young women, are greatly distressed by their symptoms and in some the features are appreciably improved after operation—so we have to ask which patients should be operated on and by what procedure.

Initially, constipation was thought to be due to a colonic disorder in which the transit of faeces through the large bowel was delayed[1]; such patients might be expected to improve after colectomy. Nevertheless, later it was found that in some patients constipation was a disorder of defecation related to dysfunction in the pelvic floor musculature.[2] Such patients might be expected to benefit from pelvic floor surgery. Now the clinical picture is known to be further complicated because some patients may have both disorders.

Partial colectomy gives a poor clinical result in patients with slow transit constipation.[3] On the other hand, subtotal colectomy and ileorectal anastomosis greatly improve bowel function,[3,4] though caecorectal anastomosis is less effective.

Pelvic outlet obstruction (anismus) may result either from dysfunction of the internal sphincter (hypertonia) or from failure of the puborectalis muscle to relax normally during defecation. The first abnormality has been treated with anorectal myectomy, with mixed results,[5,6] and the second with lateral or posterior division of the puborectalis with disappointing results.[7,8]

Hence there are no clear answers to the two questions asked at the beginning. Surgery cannot be advocated for pelvic outlet obstruction at present, at least until the value of anorectal myectomy has been studied. On the other hand, patients with idiopathic slow transit constipation can be offered subtotal colectomy with ileorectal anastomosis. The decision to proceed to surgery should be made only when all medical measures have failed and preferably after the patient has had a psychiatric assessment. Surgery can restore reasonable bowel function but at a considerable cost. Many patients develop severe diarrhoea, which in turn may lead to disabling faecal incontinence, and over two thirds of them continue to complain of abdominal pain postoperatively.[4]

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