

Guideline on Pelvic Floor Disorders: consensus on Obstructed Defecation Syndrome (ODS)

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Abbreviations

BET – Balloon Expulsion Test
BTXA – Botulinum Toxin type A
CBC – Complete Blood Count
CCCS – Cleveland Clinic Constipation Score
CCD – Cystocolpodefecography (fluoroscopic defecography)
DGBI – Disorders of Gut–Brain Interaction
DP – Descending Perineum
DRE – Digital Rectal Examination
ECTS – European Credit Transfer and Accumulation System
EMG – Electromyography
FC – Functional Constipation
FI – Fecal Incontinence
GRADE – Grading of Recommendations, Assessment, Development and Evaluation
IBS – Irritable Bowel Syndrome
IBS-C – Irritable Bowel Syndrome with constipation
MDT – Multidisciplinary Team
MR – Magnetic Resonance
ODS – Obstructed Defecation Syndrome
POP – Pelvic Organ Prolapse
QoL – Quality of Life
RCT – Randomized Controlled Trial
SNM – Sacral Nerve Modulation
SRU – Solitary Rectal Ulcer
STARR – Stapled Transanal Rectal Resection
STC – Slow Transit Constipation
TFS – Tissue Fixation System
TSH – Thyroid-stimulating hormone

Abstract

Background and aims: Obstructed defecation syndrome (ODS) is a multifactorial condition that significantly impairs quality of life and presents diagnostic and therapeutic challenges due to the interaction of functional and anatomical factors. This initiative aimed to develop a Belgian consensus and a diagnostic–therapeutic algorithm to support effective clinical management of ODS.

Methods: A Belgian steering group of gastroenterologists and colorectal surgeons (n=6) conducted a Delphi consensus process. Based on a structured literature review, 82 statements were drafted and discussed during three online voting rounds. Consensus was defined as ≥80% agreement, and evidence strength was graded using the GRADE system.

Results: Thirty-one experts participated, including gastroenterologists, colorectal surgeons, gynecologists, and physiotherapists. Sixty-two final statements were formulated, of which 46 were endorsed. ODS was defined as a disorder of anorectal evacuation, with functional and structural components often coexisting. Symptoms overlap with functional constipation, IBS-C, and fecal incontinence, and quality of life is substantially impaired. Diagnosis requires multimodal evaluation, including digital rectal examination and anorectal testing. First-line treatment consists of conservative measures such as lifestyle optimization, laxatives, and pelvic floor re-education. Surgery is reserved for selected patients with refractory symptoms and significant anatomical abnormalities. Tailored surgical approaches are supported for rectocele, rectal prolapse, and pelvic organ prolapse, whereas sacral nerve stimulation is not routinely recommended.

Conclusion: These consensus statements provide practical guidance for the diagnosis and management of ODS. Conservative

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therapy remains the cornerstone, with surgery reserved for selected cases. Areas lacking consensus warrant further research. (*Acta gastroenterol belg.*, 2026, 89, 385-405).

Keywords: ODS, obstructed defecation syndrome, pelvic floor physiotherapy, consensus, Delphi, surgical treatment.

Introduction

Obstructed defecation syndrome (ODS) lacks a universally accepted definition, but is used as a term to describe the whole complex of mechanical and functional disorders leading to difficult or inadequate rectal emptying. By the Rome IV classification, obstructed defecation (OD) is defined as a subclass of functional constipation (FC) and/or irritable bowel syndrome with constipation (IBS-C), but must be distinguished from one another as they are managed differently (1). ODS is characterized by difficulty in defecation due to dysfunction in either the propulsion mechanism or anal relaxation (2). Functional, anatomical and psychological factors all contribute to the symptom pattern. While ODS does not affect a patient's overall prognosis, it significantly impairs quality of life (QoL) (3). Despite its high prevalence, the condition often goes unrecognized, and even when suspected, clinicians frequently encounter challenges in its diagnosis and management, largely due to its multifactorial origin. Focusing treatment on a single factor often yields unsatisfactory outcomes.

The aim of this initiative was to develop a Belgian consensus to establish a diagnostic–therapeutic algorithm that can assist healthcare professionals, including gastroenterologists, colorectal surgeons, gynecologists and pelvic floor physiotherapists, in making informed clinical decisions when managing ODS.

Methods

A steering group of Belgian gastroenterologists initiated a Delphi process to develop consensus statements on various aspects of ODS, targeting Belgian healthcare professionals. The principles of the Delphi method have been published elsewhere (4). Its primary aim is to generate a reliable expert consensus through iterative questionnaires with controlled feedback (5), providing guidance where evidence from controlled trials is limited.

The process comprised several steps: (1) selection of a steering committee of four gastroenterologists and two colorectal surgeons experienced in ODS care and/or Delphi methodology; (2) recruitment of a consensus group including gastroenterologists, colorectal surgeons, gynecologists, and pelvic floor physiotherapists with clinical expertise in ODS; (3) drafting of statements tailored to the Belgian context; (4) systematic literature review to support each statement; (5) group discussion, followed by voting and revision to establish consensus; and (6) grading of evidence strength using accepted criteria.

A total of 31 experts agreed to participate (14 gastroenterologists, 10 surgeons, 2 gynecologists, and 5 physiotherapists). The steering committee drafted 82 statements, which were first discussed during a plenary meeting in February 2025. Based on feedback, the statements were revised, then allocated to six working groups of 3–5 members for literature review and narrative evidence summaries. These were shared with all participants via cloud computing by June 2025.

Consensus was pursued through two online voting rounds using a 6-point Likert scale. Physiotherapists only voted on statements in their domain ("Impact on Quality of Life (QoL)," "First-line non-pharmacological measures," and "Invasive options: general measures," including postoperative pelvic floor rehabilitation), indicated with an asterisk in Table 5, 12 and 13. Virtual meetings in June - July 2025 allowed discussion of results, after which statements were revised, omitted or expanded. Participants remained blinded to each other's votes throughout. At the end of the review process, 62 statements were retained and voted on.

In line with Delphi standards, consensus was defined as $\geq 80\%$ agreement (A+ or A) (Table 1). Evidence strength was graded using the GRADE system (Table 2). After the final voting round, a manuscript draft was circulated to all members for approval. References cited in this manuscript represent a selected subset of the literature reviewed, chosen to illustrate the discussion.

Results

An overview of the statements with voting results, GRADE of evidence and associated references is provided in their respective tables. Evidence underlying the answer to the different statements is discussed further in the next topics.

Definitions and differential diagnosis

Statements on definitions and differential diagnosis are summarized in table 3.

Within the group of chronically constipated patients, a significant subgroup can be defined as patients with obstructed defecation syndrome (ODS). The reported prevalence varies between 30 and 50%, but data may be incomplete because definitions and inclusion criteria differ. ODS is a term used to describe the whole complex of mechanical and functional disorders leading to stool entrapment or difficulties in evacuating stools, i.e. anorectal outlet obstruction. The origin of ODS can be both functional, i.e. related to abnormal coordination of pelvic floor and anal sphincter muscles during defecation, and structural, involving anatomical abnormalities, and both may be present simultaneously (7, 16, 17).

To date, there is no accepted definition of ODS. According to the Rome IV classification for functional GI disorders, (functional) ODS is defined as a subclass of

functional constipation (FC), in addition to slow transit constipation (1, 7). To meet the diagnosis of (functional) ODS, a patient must fulfil the criteria for functional constipation, as well as demonstrate failed attempts to defecate, as defined by 2/3 positive functional tests for impaired evacuation (table 4, (1, 7)). Other symptoms associated with ODS, but not mandatory to fulfil the diagnosis, may include bloating, fecal incontinence, fragmented defecation, tenesmus, urge, and abdominal pain (12-15). Functional constipation often overlaps with Irritable Bowel Syndrome with predominant constipation (IBS-C), and so does ODS (8-11). These entities are considered to be on a continuum, and patients can move between these entities over time (18, 19). A study by Bouchoucha et al. found that 84% of IBS patients reported difficult defecation according to functional constipation criteria (20). However, for ODS, abdominal pain at least once per week is not mandatory (1, 7).

Another overlap is seen between ODS, both functional and structural, and fecal incontinence (FI) and is found in 1 out of 4 patients, as patients share common risk factors (e.g. structural pelvic floor abnormalities, disordered rectal sensation...) (21-23). However, this overlap is underreported and should actively be questioned by the treating physician or therapist (21, 24, 25). The etiology of this coexistence is multifactorial (25), but presence of FI is higher in patients with higher age, female sex, a history of anal/perineal/pelvic surgery and usage of antidepressants and/or opiates (21). Fecal incontinence was not necessarily associated with sphincter insufficiency, but rather with so-called "overflow", where impaction of stools in the rectum leads to seepage of liquid stools and passive incontinence. On the other hand, rectal hypersensitivity can lead to urgency and active incontinence (22). Presence of structural changes, such as a rectocele, is a risk factor for fecal incontinence. Untreated ODS can further aggravate pelvic floor function, leading to worsening of FI (26-28).

Impact on Quality of Life (QoL)

Statements on Quality of Life are summarized in table 5.

Quality of life is severely affected in obstructed defecation (ODS), but data on the specific symptoms and aspects impacted remain limited. However, patients with severe ODS report greater pain, distress, constipation-related impairment, and worse overall physical and mental QoL, compared to patients with slow transit constipation or colonic inertia (29). Whilst patient's experiences teach us that intra-individual symptoms can vary on a day-to-day basis due to different factors (e.g. food intake, comorbidities, social events...), these assumptions need to be validated in further research. Furthermore, presentation is often delayed due to personal reasons, including embarrassment and difficulty discussing anal pathology (30).

Etiology and pathophysiology

Statements on pathophysiology are summarized in table 6.

Correct evacuation depends on intact neuromuscular anatomy and function. The pathogenesis of ODS is multifactorial: functional impairments may lead to pelvic floor dysfunction, anatomical abnormalities can cause mechanical obstruction, neurological factors may affect motor and sensory function, and psychological factors may modulate symptom severity (31). Normal defecation is a complex process requiring effective abdominal and pelvic floor muscle activity, ligamentous support, neurological integrity and coordination, as well as a functional rectal ampulla. It involves normal rectal sensation, adequate propulsion (rise in rectal pressure) and simultaneous anal relaxation(2). This sequence is mirrored in the London classification of anorectal function, which are based on dysfunction in any of these components (10, 46).

In structural ODS, abnormal position or mobility of one or more pelvic organs and/or the perineum is contributing to ODS symptom generation, and restoration of the normal anatomy by using external support devices, or by surgical procedures can improve ODS complaints (34-36). Anatomical abnormalities that can be identified in structural ODS (clinically or through imaging) include rectal prolapse, rectocele, rectorectal/rectoanal invagination (internal rectal prolapse, intussusception), descending perineum (DP), urogenital prolapse, enterocele, sigmoidocele, elythrocele (i.e. herniation of the peritoneal sac without bowel involvement, often fluid-filled), or a combination of these (Table 7). These abnormalities of the pelvic organs can be either a cause (in structural ODS) or a consequence (in functional ODS) of ODS (37). The most comprehensive hypothesis on ODS is the 'iceberg concept' (47), describing ODS as an overlap syndrome of functional and organic abnormalities resulting in 'emerging rocks' (e.g. rectocele...) as most easily clinically detectable vs. the lesser visible 'underwater rocks' (e.g. dyssynergia...). However, correlation between anatomical findings and severity of symptoms remains poor, and structural abnormalities alone do not necessarily justify surgical intervention, as endorsed by European consensus guidelines (15, 48, 49). This is especially the case for rectoceles. Rectoceles are classified as small (<2cm), medium (2-4cm) or large (>4cm). Small rectoceles are often asymptomatic, a rectocele depth of less than 2 cm is clinically insignificant and is considered within normal limits (50). Physiological factors, such as chronic straining during defecation, in combination with progressive atrophy of the pelvic floor due to parity (including number of vaginal and instrumental births, and fetal macrosomia), age and menopausal status, may result in structural changes (38-44). Laxity

of the pelvic floor causes traction-induced pudendal neuropathy which leads to further muscle atrophy and insufficiency of the anal sphincter, further aggravating symptoms, and influencing ODS severity. Another important contributing factor is a history of primarily hysterectomy, or surgery for pelvic organ prolapse or urinary incontinence (12, 51). Perineal descent is prevalent in patients with ODS and high symptom scores, being almost universal in the absence of paradoxical puborectalis contraction, and less pronounced in those demonstrating paradoxical contraction (52). However, other authors found that perineal descent measured in a validated way showed no correlation with typical symptoms of ODS (53). Anatomical abnormalities are found in 12% of asymptomatic young nulligravid women and in up to 40% of women postpartum (54-56).

Functional evacuation disorders, or functional ODS, are considered to be the consequence of disorders in rectoanal coordination and rectal sensation (32), or a combination of these factors, which also seem to affect each other (33). These mechanisms are embedded in the London classification for disorders of anorectal function (part III and IV), highlighting their importance in the clinical spectrum of obstructed defecation. Rectoanal discoordination occurs when anal sphincter relaxation, relaxation of the puborectalis muscle (with widening of the anorectal angle) and rectal propulsion no longer occur simultaneously in a coordinated manner. According to part III of the London classification, patients with ODS can be divided in three mechanistic subgroups based on the balloon expulsion test and anorectal manometry results: abnormal expulsion with dyssynergia, abnormal expulsion with abnormal propulsion and abnormal expulsion with poor propulsion and dyssynergia (32). The exact pathophysiology of abnormal relaxation or even paradoxical contraction of the anal sphincter and/or puborectalis muscle during defecation is unclear. It is often considered a behavioral disorder as the relaxation of these muscles is in essence a voluntary process. It is associated with psychological wellbeing and can be aggravated by a history of traumatic life events (7). Rectal motor function, contraction of the diaphragm and abdominal wall musculature contribute to propulsion and have been found to be more frequently deranged in women with Rome 3 functional constipation compared to healthy controls (57). Rectal sensation is an essential part of the normal defecation reflex (58), and rectal hyposensitivity is present in up to 25% of patients with functional constipation, possibly correlating with symptom severity (33, 59-61). Rectal hypersensitivity, usually linked to IBS, is often present in ODS as well, which challenges the traditional understanding of its pathophysiology (33). Moreover, ODS can influence colonic motility in general (62), and secondary impaired transit may be a part of its pathophysiology. Documenting underlying pathophysiology using anorectal function testing is often useful to identify the mechanism of functional ODS and to guide therapy.

Correlations between functional and structural ODS are found, however, it seems impossible to conclude which is cause and which is effect (37, 63).

A history of psychological or early-life adverse events, as well as childhood constipation, may contribute to functional ODS, although the panel did not reach consensus on this point (10). In a prospective survey by Rao, 31% of patients reported that dyssynergia began during childhood, 29% following a specific event such as pregnancy, trauma, or back injury, and 40% reported no identifiable cause (10). Withholding behavior and attention-seeking behavior in children play an important role in the development and persistence of functional constipation (10, 64). The toilet-training period is considered a critical window during which constipation may arise from challenging parent-child interactions (10, 64). As a result of withholding behavior, retained stool leads to progressive rectal distension. Long-term fecal impaction can ultimately result in a dilated rectum with reduced rectal tone and contractility, contributing to delayed evacuation (64).

Genetic predisposition and low socioeconomic status can also play a role in the pathophysiology of ODS (7, 65-67). Furthermore, stress, anxiety and depressive mood represent important risk factors and are more frequently present in ODS as compared to slow transit constipation (7, 45). The presence of psychological distress not only leads to lower QoL, but also impacts the outcome of biofeedback therapy (7, 45).

Diagnostic approach

Statements on diagnostic approach are summarized in table 8.

In patients with suspected ODS, evaluation should be multimodal, beginning with patient history and detailed clinical examination. Scoring systems can support the evaluation of symptom severity and treatment outcomes (73, 74), but their use is largely confined to clinical research rather than diagnostic practice, a position reflected in the panel vote.

Digital rectal examination (DRE) is central, assessing resting tone, squeeze, push, coordination and rectal content, thus covering both structural and functional aspects. When performed by an experienced clinician, it shows high diagnostic accuracy (PPV 97%) (75, 76). However, bedside performance is often limited by inadequate training, practitioner discomfort, or patient refusal (30, 87-89).

Because symptoms alone do not reliably predict pelvic floor dysfunction, anorectal function tests are recommended when DRE is inconclusive (7, 8, 11). Functional ODS requires objective demonstration of impaired rectal evacuation in at least two modalities: balloon expulsion test (BET), anorectal manometry, or imaging (77). Anorectal manometry combined with BET is the preferred initial technical evaluation. During BET,

patients attempt to expel a rectal balloon filled with 50 mL of air or water while seated on a commode; inability to expel the balloon within 1-2 minutes suggests pelvic floor dysfunction but does not distinguish dyssynergia from weak propulsion, nor does it provide information on structural factors (77, 90). Manometry complements this by assessing pushing effort, paradoxical anal contraction, rectal pressure and rectal sensory function through balloon distension (27, 32, 91). Propulsion refers to the adequacy of the increase in rectal pressure during a push, whereas dyssynergia refers to failure of anal relaxation or paradoxical contraction during the maneuver. The London Classification standardizes findings from high-resolution manometry, BET and sensory testing into four categories: recto-anal inhibitory reflex abnormalities, anal tone/contractility disorders, coordination deficits and rectal sensory dysfunction (91). However, its diagnostic utility is debated, since up to 90% of healthy controls exhibit patterns currently labelled as abnormal (92). Manometry should therefore not be interpreted in isolation, but rather integrated with complementary diagnostic tests.

When functional tests are inconclusive, when structural causes are suspected, or when functional ODS fails to respond to first-line therapy, pelvic floor imaging is indicated (27). Fluoroscopic defecography (Cystocolpodefecography, CCD) offers evaluation in a physiologic sitting position, while MR defecography provides superior soft-tissue contrast and multicompartiment visualization, especially valuable in complex cases involving prior surgery or multi-organ dysfunction (78, 93-96). Information from supine MR defecography does not significantly differ from conventional defecography, except in some clinical situations, such as the suspicion of an intussusception, which is more easily visualized on Cystocolpodefecography (78, 97-104). Conventional defecography is more intrusive, requiring urinary, vaginal, and rectal contrast and involving radiation exposure, whereas MR requires only rectal contrast (105). Dynamic ultrasound, performed transperineally, endo-anally, or endovaginally, offers a radiation-free, low-cost method to assess functional and structural causes of ODS. However, it was not endorsed by the consensus panel due to the low quality of available evidence and several practical limitations. (78, 79).

Screening for concomitant IBS and/or fecal incontinence is essential, given the high overlap with ODS. In patients with new-onset ODS, secondary causes such as neurological or mucosal disease should be considered, as they may mimic ODS. Further evaluation is mandatory in the presence of alarm symptoms (16, 17, 26, 80, 81), including recent onset (<3 months), weight loss, rectal bleeding, family history of colorectal cancer or inflammatory bowel disease, abnormal findings on DRE, severe refractory constipation, iron deficiency anemia, or positive fecal occult blood (1, 27, 106, 107). All patients >45 years without recent colorectal cancer

screening, and any patient with alarm features, should undergo colonoscopy. Endoscopy is not routinely indicated in ODS without alarm features (81, 82).

In refractory ODS, a colon transit study can help rule out concomitant slow transit constipation (STC), guiding management toward medical therapy when present (83). Rectal stool retention may also contribute to STC by triggering recto-colonic inhibitory reflexes (84, 85), and abnormal transit may normalize after biofeedback therapy (108, 109). Limited biochemical tests (CBC, electrolytes, calcium, glucose, TSH) may be considered, but rarely provide meaningful diagnostic insights (86).

When and whom to treat

Statements on when and whom to treat are summarized in table 9.

Treatment of ODS should aim to improve quality of life rather than correct anatomical or proctographic abnormalities, given the poor correlation between imaging findings and symptoms (54, 110). Imaging results should therefore always be interpreted in conjunction with clinical presentation. First-line, non-invasive therapy should be initiated once ODS is suspected, while surgical interventions are reserved for refractory cases with a structural basis not responding to conservative management (111). Importantly, surgery directed at specific anatomical defects may induce new or worsened dysfunction in other pelvic compartments (112, 113).

First-line treatment, general measures

Statements on first-line treatment, general measures are summarized in table 10.

Functional, physiological and behavioral factors can contribute to anatomical abnormalities and should be addressed as much as possible before considering surgery (15, 16, 47, 49, 66, 79, 110, 114-118). Surgery without addressing these factors is associated with poorer outcomes; hence, the consensus panel advises against routine surgical repair of anatomical anomalies identified on imaging. These contributing factors should be managed as much as possible before considering surgery, especially since imaging abnormalities do not reliably predict the presence of ODS symptoms (54, 110). Moreover, any surgical decision should follow multidisciplinary team (MDT) discussion, taking into account all three pelvic compartments to ensure patient-tailored treatment. A recent retrospective study showed that MDT review altered diagnostic work-up and technical investigations in the majority of cases (42).

Initial management should target lifestyle factors. Correcting toilet habits, including seating position, may facilitate stool expulsion (119). The squatting position is preferred because it increases the anorectal/recto-

anal angle (ARA $\sim 126^\circ$) compared with the seated posture ($\sim 100^\circ$), suggesting that less effort is required for defecation (125). Increasing intake of soluble fibers, such as psyllium or inulin/maltodextrin mixtures, is beneficial in chronic idiopathic constipation, helping to normalize bowel habits and stool consistency, facilitate evacuation, and support volumetric rehabilitation during biofeedback (120-123). IBS and FI should be actively searched for (screened) and appropriately managed, since targeted management may improve treatment efficacy (21, 106, 126-131).

In patients with psychological comorbidities or a history of adverse or early life events, psychological support should be offered to enhance the efficacy of both invasive and non-invasive treatments (66, 124).

First-line treatment, pharmacological measures

Statements on first-line treatment, pharmacological measures are summarized in table 11.

The consensus panel endorsed the use of oral and rectal laxatives for ODS. While several guidelines recommend these agents for chronic constipation (26, 106, 136-138), evidence specifically in ODS is limited; nonetheless, their use is considered reasonable (15, 132). In patients with slow transit constipation, prucalopride may be effective (133). Data on spasmolytics or probiotics (135) are lacking, and these agents are not considered effective for ODS.

First-line treatment, non-pharmacological measures

Statements on first-line treatment, non-pharmacological measures are summarized in table 12.

Pelvic floor re-education (also called pelvic floor physiotherapy) is the cornerstone of ODS treatment. It includes a set of procedures aimed at improving pelvic floor muscle strength, rectal distension perception and coordinated defecation. Techniques include education on anatomy, physiology and coordination as well as pelvic floor muscle training, biofeedback, balloon training and electrostimulation (139). Therapy should be provided by a physiotherapist with specialized training in pelvic floor disorders, as recommended by the consensus panel. Typically, 4–6 sessions are delivered once or twice weekly, each lasting 30–60 minutes. Patients should also perform home exercises involving squeezing and relaxing the pelvic floor with diaphragmatic breathing 2–3 times daily for 15–20 minutes (27, 126). Randomized trials estimate the efficacy of biofeedback therapy in patients with functional ODS at 70–80%, showing it to be more effective than sham therapy, polyethylene glycol or diazepam (10, 141, 142).

Since January 2015, physiotherapists in Belgium can obtain a formal qualification in pelvic re-education and perinatal physiotherapy (Ministerial Decree 2014-04-

22/05)(140). This requires completion of a recognized training program (minimum 45 European Credit Transfer and Accumulation System (ECTS) theory + 6 ECTS internship) and at least one year of clinical experience. Although this qualification is not legally required to perform pelvic treatments (e.g., internal examinations, biofeedback, rectal balloon training), the panel strongly recommends that ODS patients be treated by physiotherapists holding this ECTS-credited certification (138).

Pelvic floor re-education can correct functional ODS and improve symptoms in patients with structural ODS (141, 142, 155). Although it does not correct anatomical abnormalities, it may reduce or eliminate the need for surgery. The therapy aims to correct dyssynergia or dyscoordination of the abdominal and pelvic floor musculature; strengthen or relax the pelvic floor muscles, including the external anal sphincter; maintain rectal emptying; address rectal hypersensitivity or hyposensitivity; and empower patients to self-manage anorectal dysfunction (156-159). Interventions include intravaginal and/or intrarectal techniques for stretching, release and neuromuscular re-education (139, 160). Biofeedback therapy employs EMG biofeedback, manometry and rectal balloon training to monitor voluntary striated muscle activity, provide feedback on anal and rectal pressures, and train patients to recognize the sensations associated with pelvic floor relaxation. It also teaches the effective use of abdominal muscles to generate adequate pushing force for defecation (139). Long-term studies indicate that benefits of biofeedback therapy can be maintained for more than two years (161).

The panel did not reach consensus on whether the onset of pelvic floor re-education should be guided by anorectal manometry, as a properly performed DRE already provides useful information and evidence on optimal timing is lacking (143). Although manometry is not required to begin pelvic floor re-education, it is extremely valuable for guiding management, helping to distinguish whether therapy should focus on rectal sensitivity, propulsion, or dyssynergia. Nonetheless, manometry results may not always align with a physiotherapist's clinical evaluation, since factors like test environment, stress, time constraints or patient discomfort can influence performance. The panel did not formally reject transanal botulinum toxin type A (BTXA) injections as an adjunct to biofeedback, but a moderate consensus was reached against their use given the limited supporting evidence (144-148). Furthermore, the panel did not endorse pelvic floor support (34, 149), transanal irrigation (150, 151) or antegrade colonic irrigation (152, 153) because of insufficient evidence. Similarly, cognitive-behavioral therapy (CBT) and gut-directed hypnotherapy did not reach consensus as adjunctive treatments, despite functional ODS being part of the DGBI spectrum (154). Nevertheless, aside from antegrade colonic irrigation, these interventions

may be considered on an individual basis in selected patients, e.g. transanal irrigation as second-line therapy in patients with neurological disease and ODS (162).

Invasive options: general measures

Statements on invasive options, general measures are summarized in table 13.

The panel agreed that surgery should be considered in patients with major anatomical abnormalities and evident symptoms but only after conservative first-line treatments have failed or proven insufficient (36, 111). The primary goal should be to restore function and quality of life, rather than focusing solely on anatomical correction based on imaging findings (110). Functional problems should be treated first, as they may negatively impact surgical outcomes (47, 117, 164-166). However, the presence of functional disorders does not in itself preclude surgery, particularly when a major anatomical defect is present (167, 168). Furthermore, up to a quarter of patients experience persistent or worsening ODS symptoms despite the absence of anatomical failure (169). The panel did not reach consensus on the need for post-operative pelvic floor re-education. In cases of combined functional and structural ODS, this should be considered (15, 163). Although evidence is limited, expert opinion among panelists supports offering one or two sessions of pelvic floor re-education focusing on toilet posture and pushing behavior to patients after surgery.

Invasive options: surgery

Statements on invasive options, surgery, are summarized in table 14.

A systematic review comparing six types of Pelvic Organ Prolapse (POP) repair (laparoscopic sacrocolpoperineopexy, transvaginal posterior colporrhaphy with graft or mesh, site-specific defect repair, native-tissue posterior colporrhaphy, transanal approaches, and STARR) found that, apart from laparoscopic sacrocolpoperineopexy, which shows worsening defecatory symptoms, all were associated with variable improvements in ODS symptoms (170). These findings were later confirmed in a large nationwide cohort study, which showed ODS symptom improvement proportional to the baseline degree of prolapse (201). POP repair is effective for ODS only in the absence of anorectal dyssynergia, which should be investigated and treated prior to surgery. However, most studies do not assess functional issues at baseline or exclude such patients from intervention, and evidence supporting the need for absence of dyssynergia before surgery is lacking, apart from some smaller studies (168, 171).

Isolated rectocele can be treated by abdominal, perineal, transvaginal or transanal approach and

numerous studies have compared surgical approaches (117, 170, 172-190). Surgical outcomes, including function, complications, recurrence and patient satisfaction, show no consistent significant differences between techniques, suggesting any approach is appropriate if performed by a skilled surgeon (174-176). Choice should be guided by functional symptoms, on individual patients' factors, including their overall health, anatomy and surgical expertise (179). Evidence is limited by small cohorts, short follow-up and reliance on expert opinion. For example, the STARR procedure, a minimally invasive and initially promising surgical technique for ODS with rectocele that removes redundant rectal tissue (202-206), has raised concerns regarding long-term safety and efficacy. High recurrence rates and complications, such as bleeding, fistula formation, perforation, chronic pain, stenosis, urgency and fecal incontinence (173, 207-211), make it no longer the procedure of choice for ODS. Regarding mesh placement in posterior colporrhaphy, panelists did not support the utilization of any mesh or graft materials at the time of posterior vaginal repair, which did not improve women's outcomes in terms of effectiveness, quality of life, but was more readily associated with mesh complication (195, 196). In case of combined anatomical abnormalities (e.g. enterocele, sigmoidocele, internal prolapse...) a transabdominal approach was preferred by the majority of panelists, although evidence is limited (174).

In case of full thickness rectal prolapse, laparoscopic ventral mesh rectopexy (or abdominal approach) was preferred by the panelists (188, 191-194), with some studies reporting better results in constipation and defecation scores in addition to lower recurrence rates in other studies (212-214). Both robotic and laparoscopic ventral mesh rectopexy appear safe and effective in improving ODS (215-219), and related incontinence scores (217-219). However, mesh-related complications (erosion, infection, migration), prolapse recurrence, urinary retention and chronic pelvic pain may still occur (220). Evidence on the use of biological meshes in ventral mesh rectopexy remains limited (217, 221).

There is no effective surgical treatment for pelvic descent, as the literature search was not convincing, with perineal descent usually not being mentioned, and anecdotal evidence on various surgical procedures, such as mesh reinforcement of the superficial perineal aponeurosis (197), use of Tissue Fixation System (TFS) minisling to shorten and reinforce the deep transversus perinei (DTP) ligaments, repair of damaged DTPs (198), transverse perineal support (199) and transanal stapled techniques (200).

Regarding invasive options, sacral nerve modulation (SNM) was not deemed effective in patients with functional ODS, based on available literature. The rationale behind SNM lies in the belief that functional ODS finds its origin in the presence of rectal

hyposensitivity, which can be correct by the former (222-224). While evidence for sacral nerve stimulation is already conflicting in patients with refractory idiopathic slow transit constipation (225-230), the evidence in ODS is even less clear, showing weaning of efficacy after 6 months (231-233). Therefore, the indication of SNM for functional ODS remains debatable.

Conclusion

This consensus was developed through a Delphi consensus process and provide evidence-based recommendations for the clinical evaluation and management of ODS. It is essential to engage patients in shared decision-making by discussing all potential treatment options, carefully weighing their benefits and risks in light of individual expectations. Figure 1 summarizes the statements and serves as a practical guide for treating physicians.

ODS is a highly prevalent condition that imposes a significant burden on both patients and the healthcare system. Through the Delphi process, a panel of Belgian experts reviewed current evidence on the definition, symptomatology, pathophysiology, diagnosis and treatment of ODS, with particular consideration of the Belgian healthcare context. The consensus statements offer practical guidance for clinicians in recognizing, diagnosing and managing ODS. Statements that failed to reach consensus highlight areas of uncertainty and underscore the need for further research.

Declarations

CVdB and PR take responsibility for the integrity of the work as a whole, from inception to published article.

Contributors:

CVdB, PR: concept and study design;
CVdB, HDS, MS, DVDP, SVdB, LVP, PR: statement drafting, data analysis and interpretation
CVdB, HDS, MS, DVDP, SVdB, LVP, PR: article writing;
CVdB, HDS, MS, DVDP, SVdB, KB, GB, PC, JBC, DDL, MAD, AF, IG, JG, BVG, IG, MH, SK, NK, DM, SN, NP, PP, KR, HR, AS, SS, JS, TvA, LVP, PR: critical review and correction of draft.

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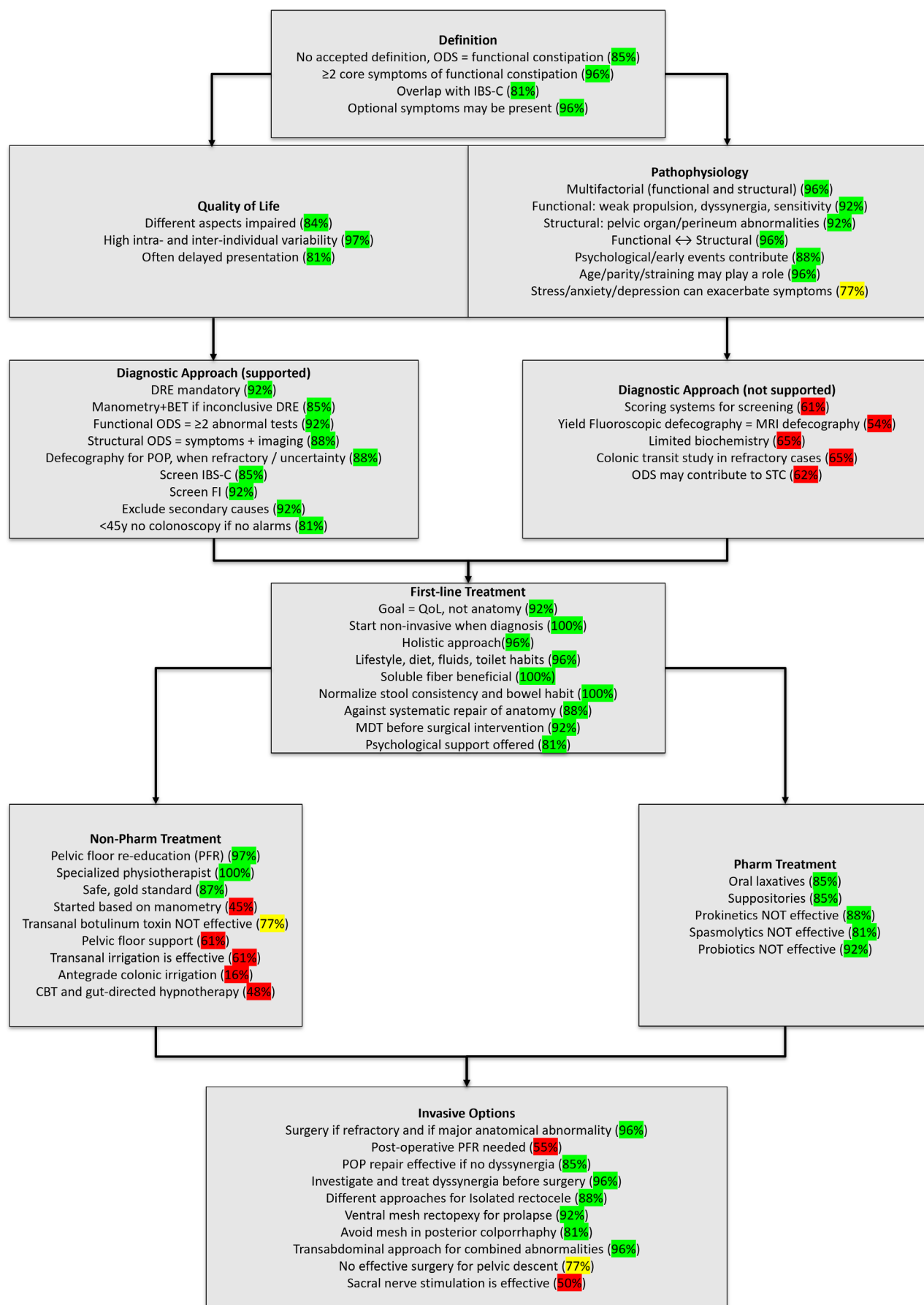


Figure 1. — Schematic representation of the outcome of the consensus on the management of obstructed defecation syndrome (ODS). The percentage of agreement is depicted by colored squares, with green representing > 80% consensus and yellow 70 - 80% agreement.

Table 1. — **6-point Likert scale of agreement / disagreement.**

Point	Description
A+	Agree strongly
A	Agree with minor reservation
A-	Agree with major reservation
D-	Disagree with minor reservation
D	Disagree with major reservation
D+	Strongly disagree

Table 2. — **Grading of recommendations assessment, development and evaluation system (GRADE) (6).**

Code	Quality of evidence	Definition
A	High	Further research is very unlikely to change our confidence in the estimate of effect - Several high-quality studies with consistent results - In special cases: one large, high-quality multicenter trial
B	Moderate	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate - One high-quality study - Several studies with some limitations
C	Low	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate One or more studies with severe limitations
D	Very low	Any estimate of effect is very uncertain - Expert opinion - No direct research evidence - One or more studies with very severe limitations

Table 3. — **Overview of statements on definitions and associated symptoms with endorsement and grading of evidence.**

Statements on definitions and differential diagnosis	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
There is to date no accepted definition for obstructed defecation syndrome (ODS), but ODS meets the criteria of functional constipation (FC).	85%, Yes	D	A+ 31%, A 54%, A- 4%, D- 0%, D 12%, D+ 0%	(1, 7)
ODS is characterized by the presence of two or more symptoms during at least 25% of defecations: straining, lumpy or hard stools (Bristol I-II), sensation of incomplete evacuation, sensation of anorectal obstruction/blockage, and need for manual maneuvers to facilitate defecation (e.g., digital evacuation, support of the pelvic floor).	96%, Yes	A	A+ 69%, A 27%, A- 4%, D- 0%, D 0%, D+ 0%	(1, 7)
ODS frequently overlaps with Irritable Bowel Syndrome (IBS), with predominant constipation (IBS-C).	81%, Yes	B	A+ 35%, A 46%, A- 12%, D- 8%, D 0%, D+ 0%	(8-11)
Bloating, constipation, fecal incontinence, fragmented defecation, tenesmus, need for vaginal splinting and abdominal pain may be part of the spectrum of ODS, but do not need to be present.	96%, Yes	B	A+ 58%, A 38%, A- 0%, D- 4%, D 0%, D+ 0%	(12-15)

Table 4. — Definition of Functional Constipation (FC) and Obstructed Defecation Syndrome (ODS).

Diagnosis	Definition	References
Functional Constipation	- Presence of two or more symptoms during at least 25% of defecations: ▪ Straining ▪ Lumpy or hard stools (Bristol stool scale type I-II) ▪ Sensation of incomplete evacuation ▪ Sensation of anorectal obstruction/blockage ▪ Need for manual maneuvers to facilitate defecation (e.g., digital evacuation, support of the pelvic floor, vaginal splinting) - Symptoms should be present for at least six months, with the criteria being met for at least three months	(7)
Obstructed Defecation syndrome	- Meeting the criteria of Functional constipation and/or IBS-C - Failed attempts to defecate, as defined by 2/3 positive functional tests for impaired evacuation: ▪ Anorectal manometry ▪ Balloon Expulsion Test ▪ Defecography	(7)

Table 5. — Overview of statements on Impact on Quality of Life (QoL) with endorsement and grading of evidence.

Statements on Impact on Quality of Life (QoL)*	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Different aspects of QoL are impaired in ODS.	84%, Yes	C	A+ 48%, A 35%, A- 13%, D- 3%, D 0%, D+ 0%	(29)
There is a high intra- and inter-individual variation in ODS severity and its impact on QoL.	97%, Yes	C	A+ 58%, A 39%, A- 3%, D- 0%, D 0%, D+ 0%	(29)
Presentation is often delayed due to personal reasons, including embarrassment.	81%, Yes	B	A+ 39%, A 42%, A- 16%, D- 3%, D 0%, D+ 0%	(30)

Table 6. — Overview of statements on etiology and pathophysiology with endorsement and grading of evidence.

Statements on etiology and pathophysiology	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
The origin of symptoms in ODS is multifactorial, and both functional and structural causes can contribute to its origin.	96%, Yes	B	A+ 73%, A 23%, A- 4%, D- 0%, D 0%, D+ 0%	(31)
Functional ODS is caused by inadequate propulsive forces, inappropriate contraction of the pelvic floor, rectal hypo- or hypersensitivity, or a combination of these factors.	92%, Yes	B	A+ 46%, A 46%, A- 8%, D- 0%, D 0%, D+ 0%	(32, 33)
Structural ODS is caused by the abnormal position or mobility of one or more pelvic organs or the perineum.	92%, Yes	B	A+ 69%, A 23%, A- 4%, D- 4%, D 0%, D+ 0%	(34-36)
Structural ODS can be caused by anatomical abnormalities, but it can also develop as a result of structural changes triggered by functional ODS.	96%, Yes	C	A+ 65%, A 31%, A- 4%, D- 0%, D 0%, D+ 0%	(37)
A history of psychological adverse events or early life adverse events can contribute to functional ODS.	88%, Yes	D	A+ 62%, A 27%, A- 12%, D- 0%, D 0%, D+ 0%	(10)
Physiological factors, such as parity, age, and straining during defecation may result into structural changes, which can exacerbate symptoms, and influence ODS severity.	96%, Yes	C	A+ 62%, A 35%, A- 4%, D- 0%, D 0%, D+ 0%	(38-44)
Psychological factors such as stress, anxiety and depressive mood represent important risk factors in ODS, which can exacerbate symptoms, and influence ODS severity.	77%, No	C	A+ 38%, A 38%, A- 19%, D- 4%, D 0%, D+ 0%	(7, 45)

Table 7. — Overview of clinical and radiological definitions of anatomical abnormalities in ODS.

Anatomical abnormality	Clinical definition	Radiological definition
Rectocele	Herniation of the rectal wall through a defect in the posterior rectovaginal septum into the back of the vagina (68). Defined on vaginal exam with the patient performing Valsalva (Baden-Walker or Pelvic Organ Prolapse Quantification, POP-Q): Grade 0 - normal position Grade 1 - Descent halfway to the hymen Grade 2 - Descent to the hymen Grade 3 - Descent halfway past the hymen Grade 4 - Descent is as far as possible past the hymen	Displacement of the anterior rectal wall. Rectoceles should be quantified in centimeters by measuring this displacement, from its position at rest to the maximally displaced position during evacuation (69): Small < 2cm Medium 2-4cm Large > 4cm
Internal rectal prolapse/ Intussusception/ External rectal prolapse	Telescoping of the rectal wall into itself or through the anal canal. Oxford grading: I-II: recto-rectal III-IV: recto-anal V: external rectal prolapse High (proximal rectum) vs low (distal rectum) take-off, depending on the position where the fold or intussuscept starts during straining.	Rectal intussusception is classified as intra-rectal, intra-anal, or complete external (extra-anal) based on the extent of prolapse of the rectal wall relative to the anal canal (69). Further defined as: - Partial, only a portion of the rectal circumference folds inward - Circumferential, entire circumference of the rectal wall prolapses - Mucosal, the muscular wall remains in place - Full thickness, all layers of the rectal wall prolapse
Perineocele	Isolated central defect and herniation of the posterior perineum in patients without diffuse vaginal prolapse (70).	Bulge in the perineum associated with herniation of the anterior wall of the rectum (71).
Enterocoele, sigmoidocoele, elytrocele	Cul-de-sac hernias (enterocoele, sigmoidocoele, elytrocele) occur when peritoneal contents herniate into the rectovaginal space: - Enterocoele: small intestine - Sigmoidocoele: sigmoid colon - Elytrocele: peritoneal sac without bowel (often fluid-filled) They are clinically relevant when they descend far enough to enter the rectovaginal space, causing a posterior vaginal bulge.	Defined by the content of cul de sac hernia (small bowel, sigmoid, peritoneal fat) (69). Extent is quantified below the Pubococcygeal Line (PCL) (in centimeters).
Descending perineum	Bulging of perineum below the bony outlet of the pelvis during straining.	Bulging of perineum below the bony outlet of the pelvis, measured by drawing a perpendicular line to the PCL and measuring the distance (in centimeters) of the location of the anorectal junction in relationship to the PCL at rest and during maximum defecation (69).
Solitary rectal ulcer (SRU)	Single or multiple ulcerations of the rectal mucosa, with the passage of blood and mucus, associated with straining or abnormal defecation (72). Despite its association with defecatory symptoms, SRU is not considered a direct cause of ODS, but is seen as a consequence of chronic straining or internal rectal prolapse rather than a primary etiology.	Not applicable.

Table 8. — Overview of statements on diagnostic approach with endorsement and grading of evidence.

Statements on diagnostic approach	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Scoring systems improve screening in suspected ODS.	61%, No	C	A+ 19%, A 42%, A- 23%, D- 15%, D 0%, D+ 0%	(73, 74)
Digital rectal examination (DRE) is mandatory in ODS.	92%, Yes	B	A+ 69%, A 23%, A- 0%, D- 8%, D 0%, D+ 0%	(75, 76)
In patients presenting with symptoms suggestive of ODS, anorectal manometry combined with a BET is the preferred first technical investigation to consider beyond clinical evaluation, if DRE is inconclusive.	85%, Yes	C	A+ 42%, A 42%, A- 4%, D- 12%, D 0%, D+ 0%	(7, 8, 11)
To confirm functional ODS, objective evidence of impaired evacuation in two of the following tests is mandatory: abnormal balloon expulsion test (BET), abnormal anorectal evacuation pattern on anorectal manometry, impaired rectal evacuation by imaging.	92%, Yes	B	A+ 46%, A 46%, A- 0%, D- 4%, D 0%, D+ 4%	(77)
To diagnose structural ODS, typical symptoms for ODS and structural abnormalities by imaging are mandatory.	88%, Yes	D	A+ 42%, A 46%, A- 8%, D- 0%, D 4%, D+ 0%	(27)
Fluoroscopic defecography or MRI defecography should be offered to patients with suspected posterior organ prolapse (POP), not responding to first line treatment for ODS or when there is uncertainty around the diagnosis.	88%, Yes	B	A+ 50%, A 38%, A- 8%, D- 4%, D 0%, D+ 0%	(27)
Fluoroscopic defecography (cystocolpodefecography, CCD) and MRI defecography have an equivalent diagnostic yield.	54%, No	A	A+ 12%, A 42%, A- 31%, D- 8%, D 8%, D+ 0%	(78)
Dynamic ultrasound, performed transperineally, endoanally, or endovaginally, is a valuable screening tool for patients with ODS.	62%, No	B	A+ 15%, A 46%, A- 35%, D- 0%, D 0%, D+ 4%	(79)
Screening for co-existing IBS-C should be done in all patients presenting with ODS.	85%, Yes	B	A+ 46%, A 38%, A- 12%, D- 4%, D 0%, D+ 0%	(8-11)
ODS can increase the risk of developing fecal incontinence (FI) and screening for co-existing FI should be done in all patients presenting with ODS.	92%, Yes	B	A+ 62%, A 31%, A- 4%, D- 4%, D 0%, D+ 0%	(21-23)
A secondary cause for ODS needs to be excluded in patients with new onset ODS, in the presence of alarm symptoms.	92%, Yes	B	A+ 69%, A 23%, A- 8%, D- 0%, D 0%, D+ 0%	(16, 17, 26, 80, 81)
In the absence of alarm symptoms, in patients with an age ≤ 45 years old, a colonoscopy can initially be omitted in the work-up of ODS.	81%, Yes	C	A+ 42%, A 38%, A- 12%, D- 8%, D 0%, D+ 0%	(81, 82)
In refractory patients with ODS, after correction of the functional component, a colon transit study to rule out concomitant primary slow transit constipation, can be considered.	65%, No	C	A+ 27%, A 38%, A- 27%, D- 8%, D 0%, D+ 0%	(83)
ODS can contribute to slow transit constipation upon testing.	62%, No	B	A+ 19%, A 42%, A- 35%, D- 4%, D 0%, D+ 0%	(84, 85)
Limited biochemical work-up can be considered to rule out causes for constipation.	65%, No	C	A+ 27%, A 38%, A- 27%, D- 8%, D 0%, D+ 0%	(86)

Table 9. — Overview of statements on when and whom to treat with endorsement and grading of evidence.

Statements on when of whom to treat	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
The treatment should target the improvement of quality of life and should not be focused on correcting anatomical or proctographic abnormalities.	92%, Yes	C	A+ 77%, A 15%, A- 4%, D- 4%, D 0%, D+ 0%	(54, 110)
First-line, non-invasive treatment should be started upon suspicion of ODS.	100%, Yes	D	A+ 73%, A 27%, A- 0%, D- 0%, D 0%, D+ 0%	(111)

Table 10. — Overview of statements on first-line treatment, general measures, with endorsement and grading of evidence.

Statements on first-line treatment, general measures	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Initial treatment should address functional, physiological and behavioral aspects, before addressing any anatomical derangement.	100%, Yes	B	A+ 54%, A 46%, A- 0%, D- 0%, D 0%, D+ 0%	(15, 16, 47, 49, 66, 79, 110, 114-118)
Initial management should address lifestyle factors, including diet, exercise, fluid intake, and toilet habits (sitting position, distractions such as phone or reading...).	96%, Yes	C	A+ 62%, A 35%, A- 4%, D- 0%, D 0%, D+ 0%	(119)
Dietary modifications through soluble fiber supplementation are beneficial in the management of ODS.	100%, Yes	A	A+ 42%, A 58%, A- 0%, D- 0%, D 0%, D+ 0%	(120-123)
Normalization of bowel habit and stool consistency may improve ODS-like symptoms.	100%, Yes	A	A+ 50%, A 50%, A- 0%, D- 0%, D 0%, D+ 0%	(120-123)
We recommend against systematic repair of anatomical anomalies identified by imaging.	88%, Yes	C	A+ 69%, A 19%, A- 8%, D- 4%, D 0%, D+ 0%	(16, 47, 49, 54, 66, 79, 110, 114-116)
Before any surgical intervention, a multidisciplinary team is mandatory for decision-making, taking into account the three anatomical compartments.	92%, Yes	D	A+ 54%, A 38%, A- 8%, D- 0%, D 0%, D+ 0%	(42)
Psychological support should be offered to all patients with ODS and coexisting psychological problems and/or a history of psychological adverse events or early life adverse events.	81%, Yes	B	A+ 50%, A 31%, A- 19%, D- 0%, D 0%, D+ 0%	(66, 124)

Table 11. — Overview of statements on first-line treatment, pharmacological measures, with endorsement and grading of evidence.

Statements on first-line treatment, pharmacological measures	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Oral laxatives can improve ODS symptoms.	85%, Yes	D	A+ 38%, A 46%, A- 15%, D- 0%, D 0%, D+ 0%	(15, 132)
Suppositories containing rectal laxatives can improve ODS symptoms.	85%, Yes	D	A+ 27%, A 58%, A- 15%, D- 0%, D 0%, D+ 0%	(15, 132)
Prokinetics are not effective in the management of ODS, in the absence of slow transit constipation.	88%, Yes	C	A+ 38%, A 50%, A- 8%, D- 4%, D 0%, D+ 0%	(133)
Spasmolytics are not effective in the management of ODS.	81%, Yes	D	A+ 38%, A 42%, A- 15%, D- 4%, D 0%, D+ 0%	(134)
Probiotics are not effective in the management of ODS.	92%, Yes	D	A+ 46%, A 46%, A- 8%, D- 0%, D 0%, D+ 0%	(135)

Table 12. — Overview of statements on first-line treatment, non-pharmacological measures with endorsement and grading of evidence.

Statements on first-line treatment, non-pharmacological measures*	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Pelvic floor re-education should include biofeedback training, balloon training, pelvic floor muscle training, and explication of anatomy, physiology and coordination.	97%, Yes	C	A+ 71%, A 26%, A- 0%, D- 3%, D 0%, D+ 0%	(139)
Pelvic floor re-education should be provided by a physiotherapist with special training in pelvic floor abnormalities.	100%, Yes	D	A+ 90%, A 10%, A- 0%, D- 0%, D 0%, D+ 0%	(140)
Pelvic floor re-education is safe, and the golden standard for treating ODS.	87%, Yes	A	A+ 65%, A 23%, A- 10%, D- 3%, D 0%, D+ 0%	(10, 141, 142)
Pelvic floor re-education should be started based on anorectal manometry results.	45%, No	B	A+ 23%, A 23%, A- 35%, D- 16%, D 3%, D+ 0%	(143)
Transanal botulinum toxin type A (BTXA) injection into the pelvic floor should not be offered as an add-on treatment to enhance the effectiveness of biofeedback.	77%, No	B	A+ 45%, A 32%, A- 16%, D- 6%, D 0%, D+ 0%	(144-148)
Pelvic floor support, internally or externally, during defecation is effective in ODS.	61%, No	B	A+ 16%, A 45%, A- 23%, D- 13%, D 3%, D+ 0%	(34, 149)
Transanal irrigation is effective in treating ODS.	61%, No	B	A+ 13%, A 48%, A- 32%, D- 6%, D 0%, D+ 0%	(150, 151)
Antegrade colonic irrigation is effective in treating ODS.	16%, No	C	A+ 6%, A 10%, A- 32%, D- 19%, D 29%, D+ 3%	(152, 153)
Cognitive-behavioral therapy (CBT) and gut-directed hypnotherapy can improve ODS symptoms as an add-on treatment.	48%, No	B	A+ 10%, A 39%, A- 42%, D- 10%, D 0%, D+ 0%	(154)

Table 13. — Overview of statements on invasive management, general measures, with endorsement and grading of evidence.

Statements on invasive options: general measures	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Surgery should be considered in patients with major anatomic abnormalities and evident symptoms, with the aim of restoring normal anatomy and function, when conservative first-line treatments have failed or proven insufficient.	96%, Yes	B	A+ 65%, A 31%, A- 0%, D- 4%, D 0%, D+ 0%	(36, 111)
Postoperative pelvic floor re-education is mandatory in all patients following surgical correction.*	55%, No	D	A+ 23%, A 32%, A- 29%, D- 10%, D 3%, D+ 3%	(15, 163)

Table 14. — Overview of statements invasive management, surgery, with endorsement and grading of evidence.

Statements on invasive options: surgery	Overall agreement, Endorsement	Grade of evidence	Voting distribution	References
Repair of posterior pelvic organ prolapse (POP) is effective in ODS in the absence of anorectal dyssynergia.	85%, Yes	A	A+ 27%, A 58%, A- 4%, D- 8%, D 4%, D+ 0%	(170)
Anorectal dyssynergia should be investigated and treated before surgery.	96%, Yes	C	A+ 69%, A 27%, A- 4%, D- 0%, D 0%, D+ 0%	(168, 171)
Isolated rectocele can be treated by abdominal, perineal, transvaginal or transanal approach.	88%, Yes	A	A+ 42%, A 46%, A- 12%, D- 0%, D 0%, D+ 0%	(117, 170, 172-190)
We recommend a ventral mesh rectopexy (or abdominal approach) in case of full thickness rectal prolapse.	92%, Yes	A	A+ 58%, A 35%, A- 8%, D- 0%, D 0%, D+ 0%	(188, 191-194)
We recommend against Mesh placement in posterior colporrhaphy.	81%, Yes	A	A+ 46%, A 35%, A- 15%, D- 4%, D 0%, D+ 0%	(195, 196)
We recommend a transabdominal approach in case of combined anatomical abnormalities (e.g. enterocele, sigmoidocele, internal prolapse...).	96%, Yes	D	A+ 58%, A 38%, A- 4%, D- 0%, D 0%, D+ 0%	(174)
There is no effective surgical treatment for pelvic descent.	77%, No	D	A+ 46%, A 31%, A- 19%, D- 4%, D 0%, D+ 0%	(197-200)
Sacral nerve stimulation is effective in selected patients with functional ODS.	50%, No	D	A+ 12%, A 38%, A- 31%, D- 12%, D 8%, D+ 0%	(219-221)

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