Content from /en/blog/dgbi-anorektal/

The final stage of digestion: anorectal DGBIs



Author: Dr. Bahir Hadi, Consultant Surgeon, PhD · **Date:** June 2026

Abstract

Of all the categories in Rome V, **anorectal DGBIs** are often the hardest for patients to discuss. The stigma surrounding bowel coordination issues keeps many people suffering in silence. Yet these conditions are **common, highly treatable and arise from the very same gut-brain miscommunications** as acid issues or stomach bloating [1, 2].

The art of defecation

Having a normal bowel movement requires a complex, highly coordinated dance between brain, pelvic floor and anal sphincters: abdominal muscles must push while the pelvic floor relaxes [2]. When the brain sends uncoordinated signals, these muscles pull

against each other - producing functional constipation, pain or incontinence [1].

The major anorectal DGBIs

- **Functional defecation disorders (pelvic floor dyssynergia):** the patient tries to pass stool, but pelvic floor muscles **paradoxically tighten** instead of relaxing, effectively blocking the exit. It feels like pushing against a brick wall, regardless of how soft the stool is [2].
- **Functional anorectal pain:** includes levator ani syndrome (dull, constant rectal ache from chronic muscle spasm) and proctalgia fugax (sudden, fleeting, stabbing pains lasting seconds to minutes) [2].
- **Faecal incontinence:** involuntary leakage of gas or stool due to a breakdown in sensory awareness or sphincter coordination - without an underlying structural tear or nerve injury [2].

Retraining the system

Because these conditions are mechanical and neural, standard laxatives often fail to solve the core issue [2]. Instead, **pelvic floor biofeedback** - where visual sensors help patients relearn how to coordinate and relax these muscles - has very high success rates by restoring proper gut-brain physical mechanics [1, 2].

Differential diagnoses

Anorectal symptoms can also be caused by **structural disease** - for example hemorrhoids, anal fissure, rectal prolapse or pudendal neuralgia. These should be excluded by clinical anal examination before a DGBI diagnosis [1].

Work-up at Kirurgen.dk

We offer discreet clinical anal examination, sigmoidoscopy and referral to pelvic floor physiotherapy. Continue the DGBI series: Bowel DGBIs, Centrally mediated pain, Rome V new diagnoses.

References

1. **Rome Foundation. Rome V Diagnostic Criteria for Disorders of Gut-Brain Interaction.** Drossman DA, Tack J, Chang L et al. (eds.), 2026 update.
2. **Rao SSC, Bharucha AE, Chiarioni G et al.** *Anorectal Disorders.* Rome IV/V chapter on functional defecation disorder, functional anorectal pain and faecal incontinence. Gastroenterology - consensus article.