Manometry Offers Useful Diagnostic Information

BY SHARON WORCESTER
Tallahassee Bureau

FORT LAUDERDALE, FLA. — Anal manometry is a useful tool for the evaluation of patients with abnormal anorectal physiology, including those presenting with constipation, fecal incontinence, proctalgia, or rectal prolapse, according to Dana R. Sands, M.D.

Manometry provides information about the functional status of the anal sphincter and distal rectum, and often is used with other tests such as anal ultrasound, anal sphincter EMG, pudendal nerve terminal motor latency assessment, and defecography, said Dr. Sands of the Cleveland Clinic Florida, Weston.

In patients with fecal incontinence, for example, anal ultrasound is the cornerstone of treatment, but anal manometry, EMG, and pudendal nerve assessment "round out the evaluation," she said at a symposium on pelvic floor disorders sponsored by the Cleveland Clinic Florida.

Anal manometry, however, is not well standardized, Dr. Sands said, noting that different facilities have different protocols and normal values.

Some manometry devices include a microtransducer, some use air-filled balloon systems, and still others use continuously perfused probes. The Cleveland Clinic uses a balloon-tip catheter system that is perfused with water. The device measures rectal sensation, resting and squeezing pressures at different levels in the anal canal, and rectal compliance, all of which can play a role in fecal incontinence.

Although some surgeons say their index finger is the best device for identifying anal sphincter pathology, manometry provides a higher level of information than that achieved via digital rectal exam, she said.

In one study of 64 patients, digital rectal exam performed by an experienced colorectal surgeon yielded 63% sensitivity and 57% specificity for internal anal sphincter pathology, and 84% sensitivity and 57% specificity for external anal sphincter pathology.

"I think we can be a little more sophisticated than that with the manometry machine," she said, adding that manometry also provides insight into the etiology of conditions such as fecal incontinence and can aid in discussions with patients about expected outcomes and prognosis. ■

Patients Need Not Stop Clopidogrel Before Surgery

WASHINGTON — Patients on long-term clopidogrel treatment don't need to stop the drug before surgery, Richard E. Kuntz, M.D., said at a meeting that was sponsored by the Cardiovascular Research Institute at Washington Hospital Center.

"There is growing experience that it's safe to perform surgery on a patient taking clopidogrel. At our institution, surgeons will operate on these patients. There is no significant difference in morbidity and mortality" during surgery, said Dr. Kuntz, who is a cardiologist at Brigham and Women's Hospital in Boston.

"Surgeons make more of a big deal about clopidogrel than they need to," he added.

This approach to dealing with patients on long-term treatment with the antiplatelet drug clopidogrel (Plavix) was endorsed also by Ron Waksman, M.D., of the division of cardiology at the Washington Hospital Center.

"If we push our surgeons, they'll do surgery without waiting to stop clopidogrel," said Dr. Waksman, who chaired the meeting.

The issue of when to stop clopidogrel recently became critical for patients who take the drug after they have received drug-eluting coronary stents. A report last year detailed four anecdotal cases of patients who developed clinically significant coronary thrombosis within a drug-eluting stent after their clopidogrel and aspirin regimens were stopped (Lancet 2004;364:1519-21).

In three of these cases, patients had stopped their antiplatelet medications before surgery.

These reports have made experts wary about stopping aspirin and clopidogrel in their patients.

—Mitchel L. Zoler