

GUIDANCE

High-Resolution Anorectal Manometry – Essential Elements of a Report

Target Audience	All registered and unregistered healthcare professionals who are certified in the performance of High-Resolution Anorectal Manometry
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A well-structured **High-Resolution Anorectal Manometry (HR-ARM)** report should include the following essential elements:

Patient Information

- Full name, date of birth, hospital number and the hospital and department details (e.g. location, contact details) where the study was conducted.
- Date of investigation and who referred the patient for HRAM
- Indication for the study (e.g., faecal incontinence, constipation / evacuatory dysfunction, coexistent faecal incontinence & constipation / evacuatory dysfunction fistula, postnatal assessment etc.)
- Symptom history – duration of symptoms; bowel frequency and stool type; defaecation effectiveness (is defaecation protracted, difficult, felt to be obstructed, perceived as complete / incomplete, need for digitation / vaginal splinting / any other manoeuvres); incontinence (specifying type), symptoms of prolapse; other, etc.

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- Medical and surgical history – to include any prior pelvic or abdominal surgery/injuries; spinal issues; MS; diabetes, etc.
- Obstetric history – vaginal/caesarean delivery, instrumental/assisted (e.g. episiotomy, forceps, Ventouse), tear (extent if known)
- Relevant medications – laxatives, prokinetics, opiates etc.

Technical Information

- Catheter type and manufacturer (e.g. Unisensor 12 channel solid-state or Mui 16 channel water-perfused)
- Manometry software platform (e.g. Laborie Solar system, or Medtronic HRM system)

Study Quality

These details only need mentioning if study quality is not optimal

- Any technical limitations (e.g., catheter dislodgement, sensor issues, artifact etc.)
- Comment on patient's tolerance (e.g. good, poor, pain etc.)

Patient safety

- Confirmation of previous rigid/flexible sigmoidoscopy or colonoscopy
- If no prior luminal assessment, confirmation that red flags were suitably assessed as per “Contraindications to HR-ARM” document.

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Digital Rectal Examination Findings

If suitably trained, a digital rectal examination should be performed prior to the investigation.

- Report findings from inspection of the perineum
 - Excoriation
 - Erythema
 - Skin lesions
 - Scars from previous surgery / perineal trauma
 - Fistulae / fissures
 - External haemorrhoids or anal skin tags
 - Present of mucosal or rectal prolapse either at rest or on straining
- Report findings from digital rectal examination
 - Palpable anorectal lesions
 - Anal sphincter tone at rest
 - Anal sphincter and puborectalis response on request to squeeze
 - Anal sphincter and puborectalis response on request to strain
 - Presence of stool within the anorectum
 - Presence of a rectocoele

Resting Pressure Assessment

- Mean anal canal resting pressure (value and quantitative comment e.g. anal normotension)
- Anal canal length

Anal Squeeze Assessment

- Anal canal pressure on 5 second squeeze – this can either be total or incremental (compared to resting) as long as specified and correct normal values used. State both value measured and quantitative comment (e.g. voluntary anal hypocontractility). Use the best of 3 squeezes.
- Endurance squeeze – length of time in seconds squeeze maintained for.

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Cough Assessment

- Comment on anal and rectal pressure ratio (e.g. anal pressure > rectal pressure, or rectal pressure > anal pressure).

Push Assessment

- Maximum rectal pressure increase above rectal resting pressure on “push”
- Anal canal pressure on “push” - both a quantitative comment (numerical change in pressure compared to resting) and qualitative comment (e.g. relaxation or contraction).
- Overall summary based on London Classification (see below)

RAIR Assessment

- Comment on whether or not recto-anal inhibitory reflex was elicited
- Volume of balloon inflation where RAIR occurred.

Sensation Assessment

- First constant sensation volume
- Defaecatory desire volume
- Maximum tolerated volume
- Quantitative comment based on these results e.g. rectal hyposensitivity

Balloon Expulsion Assessment

- Was this performed? Yes or No
- Successful expulsion – time taken for balloon to be expelled
- Unsuccessful expulsion – include length of time attempted e.g. 180 seconds

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Images

- Images are not essential, but can be included if relevant to overall diagnosis

Classification According to the latest London Classification (currently v 1.0).

- Disorders of anorectal reflexes – “Rectoanal areflexia” or “No disorder of the rectoanal inhibitory reflex”
- Disorders of anal tone and contractility - “Anal hypertension”, “Combined anal hypotension and hypocontractility”, “Anal hypotension with normal contractility”, “Anal normotension with hypocontractility” or “No disorder of anal tone and contractility”
- Disorders of rectoanal co-ordination - “Abnormal expulsion with normal manometric pattern of rectoanal co-ordination”, “Abnormal expulsion with dyssynergia”, “Abnormal expulsion with poor propulsion”, “Abnormal expulsion with poor propulsion and dyssynergia”, “Normal expulsion with abnormal manometric pattern of rectoanal co-ordination”
- Disorders of rectal sensation - “Rectal hyposensitivity”, “Borderline rectal hyposensitivity”, “Rectal hypersensitivity”, “No disorder of rectal sensation to distension”

Anorectal Manometry Summary

- Final diagnosis (using the latest London Classification)
- Recommendations, if appropriate (e.g., further testing, management options)

Reporting Investigator Professional [AGIP approved] Details:

- Name and position/role
- Date of report

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