NewWave

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BRITISH SOCIETY OF GASTROENTEROLOGY

AGIP

Contents

If you have any relevant articles or papers that you would like to be included in future issues, please contact Gemma Willis

AGIP Council Members 2026

Role	Council Member
President	Dr Rami Sweis
Upper GI Representative	Dr Jamal Hayat
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Communications Officer	Andres Vales
Accreditation Officer	Tanya Miller
Publication Secretary	Gemma Willis
Lower GI Representative	Mark Scott
Symposium Secretary	John Hayman
IQIPS Representative / Interim Minutes Secretary	Gianni Raise
Paediatric Representative	Lucy Griffin
National Standards Officer	Samantha Morris
Trainee Representative	Samuel Ndaa

From the Editor

Welcome to the **April 2026** issue of *NewWave*.

This edition brings together a wide range of updates, developments and opportunities from across GI Physiology, reflecting the AGIP Council's current national priorities.

We begin with an overview of recent AGIP activity, keeping members informed of the ongoing work taking place behind the scenes to support standards, education and the future direction of GI Physiology.

You'll also find an update on AGIP bursaries, including the announcement of this year's Graeme Duthie International Award recipient! . We hope this continues to highlight the value of these opportunities and encourages members to consider applying in future rounds. .

This issue draws attention to the upcoming AGIP Spring elections, and provides details regarding the voting process. We would encourage all members to cast a vote, and to have your say in shaping the future of AGIP.

The AGIP Council is also pleased to introduce the development of the AGIP Honorary Fellow Award, recognising individuals who have made a significant and lasting contribution to GI Physiology, see Page 7 for more details.

In addition, we feature a brilliant example of outreach work during Healthcare Science Week, showcasing how colleagues are helping to raise awareness of GI Physiology and inspire the next generation of healthcare scientists.

Finally, Council has continued to work on developing a series of standardisation documents to support consistency and quality across GI Physiology services. These resources have been created in response to increasing variation in practice, reporting and service delivery between departments, with the aim of providing clear, practical guidance that can be followed with ease. We would strongly encourage departments to review and utilise these documents within their own services, to promote high quality, standardised investigations.

We hope you enjoy this issue.

Happy reading!

Gemma

If you have any relevant articles or papers that you would like to be included in future editions, please contact Gemma Willis

Upcoming Events

May 2026	Digestive Diseases Week 2nd—5th May 2026 Chicago, Illinois HRM Oesophageal Patient Case Interpretation 12th May 2026 2-3pm Webinar Reflux and Motility Course 13th May 2026 Milan (available in hybrid format) Guy's and St Thomas' Pelvic Floor Disorders Course 20th May 2026 London
June 2026	Endo-Anal, Endo-Rectal & Pelvic Floor Ultrasound Course 8th June 2026 Online Advanced HR-ARM Study Day 9th June 2026 Birmingham THD Pelvic Floor Diagnostics Course 17th & 18th June 2026 Solihull BSG Live'26 22nd—25th June 2026 Liverpool ESPGHAN Annual Conference—Motility Learning Zone 25th—26th June 2026 Lille, France
September 2026	Advanced HRM & Impedance pH Study Day 16th September 2026 Leeds HRM Oesophageal Patient Case Interpretation 29th September 2026 2-3pm Webinar
October 2026	United European Gastroenterology (UEG) Week 17th—20th October 2026 Barcelona UEG
November 2026	The Pelvic Floor Society 2026 Annual Meeting 4th—6th November 2026 Guildford European Foregut Society Annual Congress 11th—13th November 2026 Zurich
December 2026	HRM Oesophageal Patient Case Interpretation 8th December 2026 2-3pm Webinar

AGIP Council Meeting 9th March 2026

The AGIP Council met in March to review ongoing projects and discuss future priorities and initiatives. A wide range of work continues behind the scenes to support GI Physiology services across the country.

Mentorship Scheme Development
Council reviewed plans for a new mentorship scheme designed to support AGIP members at different career stages. The proposed platform would directly match mentors and mentees, allowing users to manage goals and meetings independently. Further discussion will continue regarding promotion of the scheme and appropriate checks for mentor applications. More information will follow as the programme develops.

Membership & Funding Updates
Several governance updates were confirmed, including simplified membership criteria and alignment of membership fees with wider British Society of Gastroenterology policy. Responsibility for AGIP finances will now sit within the BSG structure. Council was reassured that long-standing bursaries, awards and member initiatives will continue to receive financial support going forwards.

Accreditation & Professional Routes
Council progressed work on alternative accreditation pathways to recognise equivalent expertise within specific areas of GI Physiology practice. This is intended to create robust and transparent routes for suitably experienced applicants who already hold Clinical Scientist registration.
Further discussions also took place regarding support for international applicants and future advisory processes linked to Consultant Clinical Scientist appointments.

National Representation & Workforce Planning
AGIP continues to engage with wider NHS workforce and transformation discussions to ensure GI Physiology is appropriately represented in future service planning, particularly around community diagnostics and emerging models of care.

Work also continues on national banding and career pathway guidance to better support departments and staff development. Further discussions took place regarding the continued expansion of Consultant Clinical Scientist roles, including clearer definition of responsibilities and senior leadership contribution within services. Consultation with NHS England regarding appropriate Agenda for Change banding of posts is also planned.

Standards & Guidance Documents
Significant progress continues across AGIP's standardisation workstream:

- Oesophageal manometry guidance is now available
- Anorectal manometry standard operating procedures and essential reporting standards were in development at the time of the meeting and can now be accessed from Page 11.
- Paediatric guidance was in development at the time of the meeting and can now be accessed on Page19.
- pH testing guidance was in development at the time of the meeting and can now be accessed on Page23.

Council also discussed the endoscopic placement of oesophageal manometry catheters for patients unable to tolerate standard placement, with a future statement planned once further supporting evidence (currently pending publication) becomes available.

Education & Training
Current educational focus includes the development of online learning resources and ongoing success of practice educator schemes. Discussions are also taking place, relating to future podcast-style educational content and digital teaching resources. Additional video content covering oesophageal manometry and pH testing is now available through AGIP social platforms—please do give us a follow.

Peer Review & CPD
Council supported the development of a regional peer review scheme, allowing departments to participate in supportive service review activity that may also contribute towards CPD evidence and quality improvement.

Symposium & Upcoming Meetings
Planning for AGIP activity at BSG Live 26 continues. The AGIP session will take place on **Tuesday 23rd June at 2.30pm.**

AGIP Council Spring Elections 2026

The AGIP Committee elections are now underway, with a number of nominations received for both Committee Member and Trainee Representative roles.

Voting will open soon, and all eligible members will receive a voting email directly from **Civica**, the BSG's election partner. This email will contain your individual voting link and access code, which will allow you to vote across all contested BSG roles. Please look out for communications from Civica Election Services and remember to check your junk folder if you do not receive an email.

Who Can Vote?

Voting is open to all BSG members who have selected AGIP as one of their section interests.

Have your Say!

AGIP elections are an important opportunity to help shape the future direction of the specialty. By voting, you are supporting the colleagues who will represent GI Physiology at a national level and contribute to ongoing work across standards, education and professional development.

If you do not receive your voting email, or have any queries regarding the process, please contact **Lucy Cope**

Introducing the AGIP Honorary Fellow Award

AGIP is pleased to introduce the development of a new **Honorary Fellow Award**, designed to recognise individuals who have made an outstanding and sustained contribution to GI Physiology services.

This award aims to celebrate those individuals who have gone above and beyond in advancing the specialty—whether through clinical excellence, leadership, education, research, service development or wider professional influence. It is intended to acknowledge the individuals who have helped shape GI Physiology as we know it today and who continue to inspire others within the profession.

Who Can Be Nominated?

Nominations are welcomed for individuals who have demonstrated exceptional contribution to GI Physiology. This may include colleagues who are:

- Currently in post and actively contributing to the GI Physiology
- Retired, but whose legacy and impact continue to be recognised
- Individuals who have significantly influenced practice, standards or education within GI Physiology

Nominees do not need to hold a specific role or title, but should clearly demonstrate a meaningful and lasting contribution to the profession.

How to Nominate

AGIP members are invited to submit nominations to the AGIP Council for review. Nominations should outline:

- The nominee's contribution to GI Physiology
- The impact of their work on the specialty or wider profession
- Any leadership, innovation, education or service development achievements

Selection Process

All nominations will be reviewed by the AGIP Council, who will consider each submission carefully against the principles of the award. Selection will be based on merit, impact and contribution to the advancement of the specialty.

Recognising Excellence

The introduction of the Honorary Fellow Award reflects AGIP's ongoing commitment to recognising excellence within the profession and celebrating those who have made a lasting difference to GI Physiology.

Further details regarding the format and presentation of the award will be announced in due course.

AGIP Bursaries

The AGIP Council is delighted to continue offering a range of conference bursaries to support members with continuing professional development through attendance at national and international meetings.

These awards are designed to help members showcase their work, develop professionally, build networks and bring valuable learning back to their departments.

Congratulations to Catherine Sykes, recipient of the 2026 Graeme Duthie International Award!

Catherine has secured an accepted abstract and has also been invited to speak at a satellite symposium on motility in eosinophilic oesophagitis at Digestive Disease Week 2026 in Chicago.

The Graeme Duthie International Award will provide up to £1,500 towards travel expenses, to support this exciting opportunity and help to showcase UK GI Physiology on a global stage.

We look forward to hearing about Catherine's experience in a future issue of NewWave.

2026 National Bursaries Awarded

The eight Margaret Marples Bursaries supporting attendance at BSG LIVE 26! have also now been awarded. Thank you to all members who applied.

Why Apply?

AGIP Bursaries provide an excellent opportunity to:

- present your work nationally or internationally
- gain CPD and new knowledge
- network with leaders in the field
- Bring new ideas back to your service
- raise the profile of GI Physiology

Details of the next application rounds will be shared through AGIP communications and future editions of NewWave.

IQIPS: A Call for Assessors

IQIPS has identified a need for additional GI Physiology assessors to support accreditation activity. If you have senior experience within GI Physiology and an interest in quality improvement, this could be an excellent professional development opportunity.

IQIPS is the UK's nationally recognised accreditation scheme for physiological science services and is delivered by United Kingdom Accreditation Service (UKAS). The scheme aims to improve the quality, safety and patient experience of physiological services across the UK.

As GI Physiology services continue to grow, there is an increasing need for experienced professionals to support the assessment process, and support units in their accreditation journey.

What Does an Assessor Do?

IQIPS assessments are carried out by trained assessment teams who review whether services meet the required standards for quality and competence. This may include review of governance systems, staffing competence, patient pathways, equipment management, safety processes and overall service delivery.

Why Become an Assessor?

- Support Standards in GI Physiology—Help to ensure services are reviewed by professionals who understand the realities of specialist GI Physiology investigations.
- Valuable CPD Opportunity—Assessment work can support governance knowledge and wider professional development.
- Learn From Other Services—Gain insight into how departments across the UK structure pathways, staffing and quality systems.
- Raise the Profile of GI Physiology —Greater GI Physiology representation strengthens our voice within national accreditation activity.

Who Might Be Suitable?

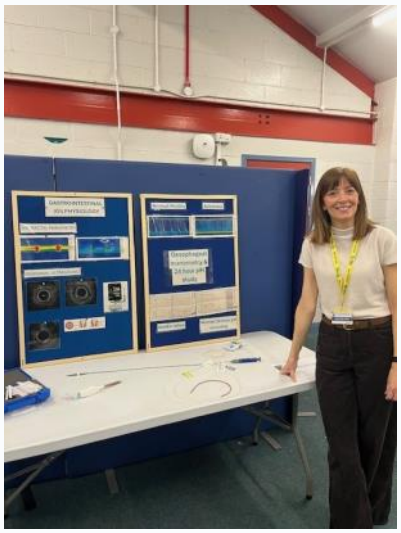
This opportunity may suit experienced colleagues working in GI Physiology such as:

- Consultant Clinical Scientists
- Senior Clinical Scientists
- Service Leads

Interested?

If you would like to explore becoming an IQIPS assessor, please contact **Gianni Raise** (IQIPS Representative of the AGIP Council) or visit the **UKAS website** for further information.

Healthcare Science Week Involvement 2026



Gemma Pickering (Clinical Scientist)

As part of Sheffield Healthcare Science Week, following the success of last year we were invited again to represent GI Physiology at Thomas Rotherham College. Along with Biomedical Science, Clinical Engineering, Spinal IOM, Neurophysiology, Embryology, Medical Photography, Cardiology/Respiratory and Assistive Technology we held workshops, introducing students to potential careers in clinical science.

Throughout the day myself and Eve Self (Trainee GI Clinical Scientist) chatted to at least 80 students in small groups of 3-4, 10 minutes per group. It felt almost like speed dating! It was challenging at first to fit a round up of GI Physiology into 10 minutes and to pitch it at their level of understanding, but we soon got into the swing of things.

The reaction from students ranged from intrigue, amusement and sometimes boredom, but you can't win them all! I'd like to think that we inspired at least some of the students to look beyond a role in radiology and opened their eyes to the range of careers out there in Clinical Science.

Eve Self (Trainee Clinical Scientist)

Inspiring the Next Generation of Healthcare Scientists

Outreach events such as this, hosted by Gemma and Eve, play an important role in raising awareness of the wide range of careers available within Healthcare Science. While many students may already be familiar with professions such as medicine, nursing or radiography, fewer are aware of the many specialist scientific careers working directly with patients behind the scenes across the NHS.

By speaking directly with students, we are able to showcase the important work carried out within GI Physiology, the specialist investigations we perform and the career opportunities available within our specialty. It also gives students the chance to ask questions and discover career paths they may not have considered before.

We are always proud to see GI Physiology represented at these events and thank colleagues who continue to champion the specialty through education and outreach.

AGIP Standardisation Document:
Performance of High-Resolution Anorectal Manometry in Adults

Target Audience	Professionals certified in the performance of High-Resolution Anorectal Manometry
Document Reference:	AGIP.HRARM.2
Version:	2.0
Approved by AGIP Committee Date:	March 2026
Review Date:	March 2029
Frequency of Review:	3 yearly

The member of staff performing the procedure must be either fully trained and accredited by AGIP in this procedure or supervised by a fully trained and accredited practitioner.

HR-ARM is a dynamic evaluation of anorectal function, making it essential that practitioners understand the nuances of all metrics informing a London Classification outcome.

Patient Selection and Preparation in Advance of Procedure:

- Patients should be assessed by gastroenterologist or colorectal surgeon prior to referral for HR-ARM. Ideally, patients should undergo endoscopy +/- biopsies to exclude carcinoma or inflammatory conditions as the cause of symptoms, and to assess for structural abnormalities such as intussusception or stricture
- HR-ARM can be performed without previous endoscopy, if red flags have been assessed, and the patient is deemed suitable to proceed. At appointment, the practitioner performing the HR-ARM investigation should be aware of any red flags (according to local guidance; see also list below). If any current sinister pathology is suspected, this needs to be documented, the referring clinician informed without delay, and the procedure postponed until the issue is resolved. Red flags:
    - Known anal or rectal stenosis or stricture
    - Known acute inflammation of rectum (proctitis) or colon (IBD, diverticulitis etc.)
    - Recent rectal surgery with anastomosis (avoid balloon distension for 6 months post-surgery) or any question of ongoing anastomotic leak
    - Previous radiation therapy to the anorectum (within past 6 months)
    - Pre-operative assessment of anal or rectal cancer OR strong suspicion of new rectal cancer diagnosis that has not been investigated (e.g. bleeding with diarrhoea)
    - Any anorectal surgery within the last 3 months (excluding minimally invasive procedures, e.g. seton insertion, haemorrhoidal banding)
    - Polypectomy within the last 4 weeks
    - Faecal impaction
    - <20 weeks gestation or prior to gross abnormality scan (balloon distention not performed in all cases)
- An information leaflet should be given to patients prior to attendance outlining preparation required, what to expect during the procedure, risks and post-procedure advice
- Patients should be informed of the date of their test well in advance
- Patients should be informed that they may continue to take their usual laxatives, enemas or suppositories (if necessary) prior to attendance
- If required, an advocate should be in attendance during the procedure

Patient Preparation on Attendance:

- The patient's details should be checked prior to starting the procedure
- The patient may be invited to open their bowels prior to starting the procedure. Enema administration to facilitate rectal emptying is not routinely recommended, although this can be considered in the context of faecal impaction
- A full and focused clinical history should be taken from the patient documenting relevant symptoms, associated past medical, surgical and obstetric history, and current medications
- The procedure should be explained in detail to allow informed consent and for full co-operation during the test.
- The patient must be given the opportunity to allow any questions or concerns be answered to their satisfaction before the procedure begins.
- Informed patient consent (in accordance with local policy) must be obtained prior to the start of the procedure.
- The patient should be informed that they can withdraw consent at any time during the procedure.

Equipment Suggestions:

- Either a solid-state (reusable) or water-perfused (usually disposable) high-resolution anorectal manometry (HR-ARM) catheter should be used
- A maximum of 10 mm inter-sensor spacing is recommended to allow pressures between sensors to be appropriately interpolated (estimation of a value between two known values) for display / analysis
- A minimum recording length of 8 cm is recommended to allow for assessment of both distal rectal and anal events
- For water-perfused catheters, perfusion rate should be kept to a minimum to limit the volume of water flowing within the anorectum during the procedure, but of sufficient rate to retain fidelity / accuracy of recording
- A standard (approximately 6 cm length x 4 cm width; maximum volume >360 ml) non-latex balloon should be mounted onto the catheter tip for assessment of rectal sensation and the rectoanal inhibitory reflex (RAIR)
- If possible, balloon inflation should be performed with an automated pump, to allow standardisation of inflation speed (for sensation, recommended at 2 ml / sec)

Equipment Preparation:

- As per the "BSG Guidelines for Decontamination of Equipment for Gastrointestinal Endoscopy" (June 2020), before the start of each procedure the anorectal catheter (if reusable) should undergo a full cleaning cycle, unless last used and decontaminated within the preceding 3 hours. This should be undertaken by trained, competent staff. Relevant tracking details should be entered into an appropriate (catheter) cleaning log
- In the case of reusable catheters, it is important to ensure that the chosen disinfectant has been approved for decontamination by the catheter manufacturer
- Catheter calibration should be checked as per manufacturers' guidelines
- If required, the non-latex balloon should be adequately secured to the catheter, and inflation performed *ex vivo* to check for air leaks; if a leak is evident, the balloon should be re-secured to the catheter, and then re-tested
- The catheter should be zeroed at the start of every procedure

Performance of the Procedure:

- The member of staff performing the procedure must either be fully trained and accredited in this procedure, or supervised by a fully trained and accredited practitioner
- Staff should wear appropriate personal protective equipment in line with local SOP
- Ideally, a chaperone should be present during the procedure
- Each step of the procedure should be explained to the patient to ensure compliance
- The patient should be asked to lie down in the left lateral position with a sheet covering any exposed areas to ensure dignity
- If required, and performed by an appropriately trained and experienced practitioner, a digital rectal examination should be undertaken prior to HR-ARM, and documented with particular reference to:
    - Inspection of the perineum
    - Excoriation
    - Erythema
    - Skin lesions
    - Scars from previous surgery / perineal trauma
    - Fistulae / external haemorrhoids
    - Present of mucosal prolapse / rectal prolapse on request to strain

- Digital rectal examination
    - Palpable anal / rectal 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 rectum
    - Presence of a rectocele

- Any untoward sinister pathology noted incidentally during the procedure should be documented and the referring clinician informed without delay
- During digital rectal examination, a brief trial / tutorial of “squeeze” and “push” can be performed to ensure patient understanding prior to onset of the procedure
- Lubrication gel should be applied to the catheter prior to commencement of the HR-ARM procedure to allow for comfortable insertion
- The HR-ARM catheter tip should be gently advanced through the anus into the rectum. If resistance is felt during insertion, pull back the catheter before readvancing. If catheter placement is problematic then do not continue to advance the catheter if discomfort is caused or if placement is overly difficult
- The catheter should be placed with the last 2 manometric sensors visible from the anal verge (to facilitate *post hoc* analysis), and preferably taped into position to prevent inadvertent movement during the testing protocol.

Test Protocol:

The following protocol should be performed, incorporating several manoeuvres:

1) **Stabilisation** – a minimum of 3 minutes stabilisation period should be allowed. The patient should be asked to lie still, relaxed, without talking if possible. During this time it is useful to make define the upper and lower borders of the anal canal using the manometry software for future reference

2) **Resting period** – a 1 minute period of measurement at rest should be taken, again with the patient relaxed and without talking. Any sudden movement (e.g. talking, coughing etc.) should be noted on the trace to prevent confusion during *post hoc* analysis.

3) **Squeeze manoeuvre** – three squeezes, each of 5 seconds duration and separated by 30 second rest periods, should be performed in response to the (suggested) following command “please squeeze in tight with the muscles around your bottom and hold until I say stop”. A 30 second rest period should also be allowed following the third manoeuvre.

4) **Endurance squeeze manoeuvre** – a single 30 second endurance squeeze should be performed in response to the (suggested) following command “please squeeze in tight with the muscles around your bottom. This time I would like you to hold for 30 seconds, or as long as you can”. The patient should be encouraged to continue squeezing during the 30 second period to aid compliance. A 60 second rest period should be allowed following this manoeuvre.

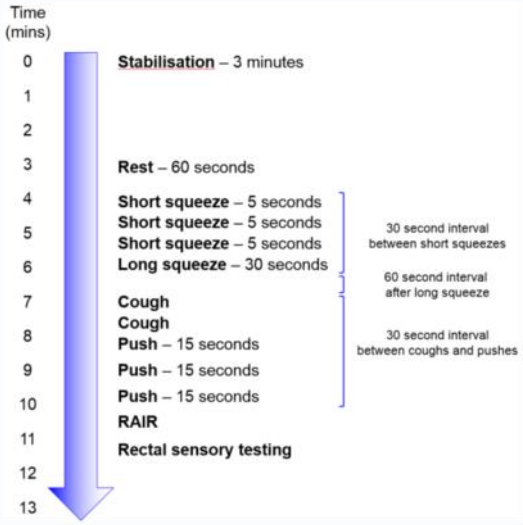
5) **"Push" manoeuvre** - three 15 second pushes (simulated defaecation), each separated by a 30 second rest period, should be performed in response to the (suggested) following command "please push / bear down as if you were going to the toilet to open your bowels". A 30 second rest period should be allowed following the third manoeuvre.

6) **Cough manoeuvre** - two *single* coughs, separated by a 30 second rest period, should be performed, with the patient encouraged to cough as forcefully as possible. The patient should be instructed to refrain from coughing multiple times, as this impairs data interpretation. A 30 second rest period should be allowed following the second manoeuvre

7) **Rectoanal inhibitory reflex (RAIR)** - if this test is to be performed, the balloon should be inflated (ideally with an automated pump) at a rate of 30 ml/second to a volume of 60 ml. If the reflex is absent at this volume, increase the inflation volume in 60 ml increments (to a maximum of 300 ml, or at a level intolerable to the patient) until the reflex is observed and sustained

8) **Rectal sensory testing** - rectal sensory testing should ideally be performed with an automated pump attached to the anorectal catheter. Using a ramp (continuous) inflation paradigm, the balloon should be inflated at a rate of 2 ml/second and the patient asked to report: (1) volume for first constant sensation, (2) desire to defaecate volume, and (3) maximum tolerated volume. It is important to explain all 3 sensations to the patient prior to proceeding with the rectal sensory testing, so they understand the sensations they should expect. Then remind the patient of each subsequent sensation as the test progresses

At the end of the procedure, the catheter should be removed. Follow manufacturers guidance for extubating - some systems require recording a short period of atmospheric pressure with the catheter *ex vivo* to ensure there has been no pressure "drift" during the recording period. However, this is not required with all systems.
The catheter should then be disconnected for decontamination purposes, and the recording saved for *post hoc* analysis.



Post Procedure:

- If a reusable catheter has been used, then a trained, competent member of staff needs to immediately clean the catheter as per the manufacturers' recommendations
- The cleaning details should then be entered into an appropriate catheter cleaning log
- If a single-use, water-perfused catheter has been used, it should be placed straight into an appropriate clinical waste bag for disposal
- The patient may either go home, or progress to other studies of anorectal / colorectal function within the same clinical appointment (e.g. endoanal ultrasound, pudendal nerve terminal motor latencies, anal sensitivity testing, evacuation proctography, and gastrointestinal / colonic transit studies, as required)

Reporting:

Analysis of the HR-ARM recording and subsequent reporting should be made by an appropriately trained and accredited practitioner, or under the supervision of a fully trained and accredited practitioner

Reports should follow the standards outlines in the "AGIP essential elements of a report document".

Any complications noted during the study should be fully documented and appropriate follow-up provided if required

References:

Laborie Solid State normal values: Carrington 2014
Carrington EV, Brokjaer A, Craven H, Zarate N, Horrocks EJ, Palit S, Jackson W, Duthie GS, Knowles CH, Lunniss PJ, Scott SM. Traditional measures of normal anal sphincter function using high-resolution anorectal manometry (HRAM) in 115 healthy volunteers. Neurogastroenterol Motil. 2014 May;26(5):625-35. doi: 10.1111/nmo.12307. Epub 2014 Mar 13. PMID: 24628873.
Laborie water-perfused normal values: Gosling 2019
Gosling J, Plumb A, Taylor SA, Cohen R, Emmanuel AV. High-resolution anal manometry: Repeatability, validation, and comparison with conventional manometry. Neurogastroenterol Motil. 2019 Jun;31(6):e13591. doi: 10.1111/nmo.13591. PMID: 31094054.
Medtronic solid state normal values: Oblizajek 2019
Oblizajek NR, Gandhi S, Sharma M, Chakraborty S, Muthyala A, Prichard D, Feuerhak K, Bharucha AE. Anorectal pressures measured with high-resolution manometry in healthy people-Normal values and asymptomatic pelvic floor dysfunction. Neurogastroenterol Motil. 2019 Jul;31(7):e13597. doi: 10.1111/nmo.13597. Epub 2019 Apr 8. PMID: 30957382; PMCID: PMC6559859.

AGIP Standardisation Document:
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
Document Reference:	AGIP.HRARM.1
Version:	1.0
Approved by AGIP Committee Date:	March 2026
Review Date:	March 2029
Frequency of Review:	3 yearly

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.
- 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.

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 rectocele

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.

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

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

AGIP Standardisation Document:
Guidance for Paediatric GI Investigations in Adult GI Physiology Units

Guidance for Paediatric GI Investigations in Adult GI Physiology Units

Wherever possible, paediatric GI investigations should be performed in specialist paediatric GI physiology services by appropriately trained paediatric teams. If this is not feasible due to clinical urgency, investigations may be performed in adult GI physiology units, provided

Target Audience	GI Physiology Professionals
Document Reference:	AGIP.PAEDS.1
Version:	1.0
Author:	Lucy Griffin
Approved by:	Carly Bingham, Rachael McGhee, Liam Mackay
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Frequency of Review:	1 yearly

the additional safeguards below are followed alongside current AGIP procedure-specific guidelines. Adult GI physiology units undertaking paediatric investigations must have local approval and defined pathways agreed with paediatric services.

This guidance aims to ensure safe, effective, and child-centred delivery of GI Physiology Investigations performed in adult GI physiology units.

This guidance applies to older children and adolescents (aged 9-18 years), with the strong recommendation that investigations in younger children are performed in paediatric centres.
The clinician performing the procedure must be either fully trained and accredited by AGIP in this procedure or supervised by a fully trained and accredited practitioner.

Referral and Indications

- Referral must be made by a Consultant Paediatric Gastroenterologist or Consultant Paediatric Surgeon.
- The referral should clearly state:
  - the clinical indication.
  - recent relevant investigations
- Note: in paediatric practice, endoscopy is performed under general anaesthesia; therefore, manometry may be requested prior to performing endoscopy.
- Prior imaging, if performed, (e.g. barium swallow, OGD, colon transit study) should ideally be within the previous 12 months.
- The indication should be clinically urgent (e.g. weight loss, suspected achalasia, severe dysphagia, or failure to thrive with possible motility disorder).

Patient Preparation

- Preparation is key to reducing anxiety and improving coordination.
- Ideally the clinician performing the investigation should contact the family in advance to explain the procedure.
- Identify and document: additional needs (e.g. learning disability, autism, anxiety, previous procedural trauma etc).
- any previous healthcare trauma/previous attempts at this procedure
- parental/carer anxiety associated with the procedure.
- Advise parents/carer to inform the child what they will be attending hospital for
- Clearly explain to parents/carers that the procedure is not painful and that they are likely to remain present throughout. Ensuring they are well informed helps minimise anxiety, distress, or adverse reactions (e.g., syncope) and supports a calm environment for the child.
- Discuss risks associated with intubation (that will be consented for on the day) so that this discussion does not need to happen in depth on the day in front of the child.
- Encourage families to bring along distraction tools (e.g. tablet for music/games etc, fidget toys) and/or comfort items (soft toy etc).
- Inform that a packed lunch, with a variety of foods and including trigger foods, should be brought in by the family for oesophageal manometry investigations (consider alternative drinks if the child is likely to refuse water).
- Confirm who will accompany the child and ensure that the accompanying adult has parental responsibility, as this determines their legal right to provide consent for the procedure.
- Inform the family which clinical staff will be present (including trainees and healthcare assistants).
- A paediatric-trained nurse must always be present and act as chaperone.
- Book an extended appointment slot to allow adequate time for the procedure.

Adjustments

Supportive tools

- A hospital/health passport can be very helpful for children with learning disabilities, autism or complex needs; this is a document completed by parents/carers or the child themselves to communicate information about their health, preferences and requirements. It is important to acquire this prior to arranging the appointment.
- Photos or visual information about the department and procedure can aid familiarisation.
- Communication cards can be very helpful, when available. These are laminated cards displaying single words such as “yes,” “no,” and “pause,” and can support children who are unable to communicate verbally, or who have difficulty doing so, during the procedure.

Environment

- Consider reasonable adjustments for sensory needs (e.g. softer lighting, reduced noise)
- Offer a separate waiting area away from adult patients where possible.
- Where possible, schedule the child first on the list to minimise waiting and anxiety.

Equipment

- Paediatric resuscitation equipment must always be available and appropriate to the size of the patient. This may be brought to the appointment by the paediatric chaperone if not available in the department (check local protocol).
- Adult impedance catheters (A01/A02) are suitable for height >150cm (BSPGHAN position statement).
- Paediatric impedance catheters (P01/P02) are suitable for height >75cm - <150cm (BSPGHAN position statement).
- Manometry can be used to measure distance to LOS for positioning of pH sensor. The placement of the distal pH sensor should be estimated at 1.5 cm (infants), 3 cm (<10 years old) or 5cm (>10 years old) above the LOS. However, fluoroscopic or X-ray confirmation of position is helpful in confirming the advised position of two vertebral bodies above the diaphragm (ESPGHAN consensus).
- Laborie 24-channel water-perfused (AHC HR2412MAL) or 8 French solid-state HRM catheters are generally suitable for children aged ≥9 years (contact agip@bsg.org.uk in advance of the procedure date for any queries).
- Laborie 24-channel (S7-R24-1009) or 10-channel (AHC 710MAL) adult anorectal water -perfused catheters are used for children aged 9 years and above in paediatric centres.
- For other equipment manufacturers, refer to manufacturer guidelines for lower age limit and sensor spacing – contact agip@bsg.org.uk in advance of the procedure date for any queries.
- For younger or smaller children, liaise with paediatric services to source appropriate-sized catheters.
- Assess whether the couch/bed is appropriate for a child's size and consider if there is sufficient space for a parent or carer to sit alongside if needed.
- All equipment must be checked in advance to confirm suitability.

Procedure

- Height and weight should be measured on the day unless already recently documented.
- Greet the child soon after arrival to introduce yourself, check in and identify any current or arising concerns.
- Prepare the room as fully as possible before the child arrives, ensuring all required items (e.g., vomit bowl, tissues, Inco pads) are immediately accessible. Carrying out visible preparation in front of the child can increase anxiety, so this should be avoided where possible.
- Take time to build rapport.
- Be friendly, open and honest about the procedure. Using clear, concrete, age-appropriate language can help reduce anxiety and build trust.
- Where appropriate, consider covering equipment such as transducers and catheters, which may appear intimidating to the child. Assess whether it would be beneficial for the child to see the equipment beforehand and allow them to explore it if helpful (for example, by feeling the catheter or lubricating gel) prior to the procedure.
- Consider explaining any risks in a way that is appropriate to the child's age and level of understanding.
- Do not assume the procedure has been explained fully at home; explain it clearly to the child using age-appropriate language. Consider asking the child what they are expecting to happen.
- Be aware of body language and terminology used when discussing the procedure. Some terms can be taken literally e.g. 'jump up on the couch'. Be mindful when referring equipment, for example the 'rectal balloon' may be visualised by a child as a large party balloon - it can be helpful to clarify that it is a very small, soft medical balloon that gently inflates and is specifically designed for the test. Using simple and reassuring language can prevent unnecessary anxiety or misunderstanding.

Consent

Obtain informed consent from the parent or carer, ensuring you are familiar with current guidance on consent for children and young people, and confirming who holds legal parental responsibility and is therefore authorised to provide consent on the child's behalf:

- **Consent to treatment - Children and young people - NHS**

- **Parental rights and responsibilities: Who has parental responsibility**

- Be mindful of Gillick competence in children.
- Seek assent from the child where appropriate.
- Ensure arrangements are in place for any communication needs so consent is fully informed.
- Ensure the parent or carer (and child, where appropriate) understands the purpose of the investigation, what it involves, the potential risks and discomforts, benefits, and any alternative options, including the option to defer.
- Explain clearly what the child may experience during and after the procedure (e.g. sensations, duration, possible after-effects), avoiding misleading reassurance.
- Confirm that consent is voluntary and that questions from both parent/carer and child are encouraged.
- Document the consent discussion clearly, including who provided consent and their relationship to the child.

Protocols

- Follow established adult protocols (e.g. Chicago Classification v4.0, London Classification).
- Empower the child to take ownership of their test, e.g. agree a clear 'hand-up to pause' signal so they understand they can request a break at any time.
- Listen to the child throughout the procedure, validating concerns while remaining mindful of potential avoidance or delaying behaviours.
- Be prepared to adapt the protocol depending on the child's tolerance, comprehension and cooperation.

Common adaptations include:

Manoeuvres performed in a different order to standard protocols.
Taking resting pressure at the end of the study.
Practice/repeat manoeuvres to allow for understanding of instructions.
Where possible, have suitable alternative solids or fluids available in case the initial items are declined, to ensure adequate swallow measurements can be obtained during oesophageal manometry.

Completion of the procedure (whether tolerated or not)

- Praise the patient on aspects they did well such as listening to instructions / asking relevant questions.
- Say thank you to the child for attempting the procedure, even if the procedure was not tolerated.
- Emphasise what the child has achieved — even if it is simply attending the appointment and being willing to try. Reinforcing a positive outcome, regardless of whether the procedure is completed, helps build constructive healthcare experiences and improves the likelihood of success at future attempts.
- Reward stickers and/or certificates can greatly contribute to a positive experience and help reinforce the child's sense of achievement.

AGIP Standardisation Document:
Gastroesophageal Reflux Monitoring

Target Audience	Professionals certified in the performance of oesophageal reflux monitoring
Document Reference:	AGIP.PH.1
Version:	1.0
Approved by AGIP Committee Date:	April 2026
Review Date:	April 2029
Frequency of Review:	3 yearly

Catheter-Based reflux monitoring

Preferred Method

For ambulatory catheter-based reflux monitoring, the AGIP committee strongly recommends **ambulatory 24-hour pH impedance catheters** over single- or dual-channel pH only catheters. AGIP strongly recommends that Impedance-pH study is **only performed by skilled, accredited operators** who are able to accurately conduct a detailed, manual analysis of the data.

Both the AGIP Committee and the Lyon 2.0 Consensus advise against the use of single- or dual-channel pH only catheters. pH (without impedance) studies only detect acidic pH drops below pH 4, irrespective of if these are due to swallowing or true reflux. If these catheters are used, significant restrictions on patient behaviour during the testing period **must** be followed in order to have any meaningful data and to increase confidence in the obtained results (see below). However, there is still a significant risk of inaccurate, false positive results.

Multichannel Intraluminal Impedance-pH monitoring allows for assessment of direction of fluid-flow as well as content (liquid/gas), and careful analysis of this provides greater confidence in the validity of acid exposure time calculations. It also allows for assessment of other conditions (e.g. supragastric belching, aerophagia, rumination and others), whilst providing additional metrics that allow for a more accurate assessment of reflux (e.g. Mean Nocturnal Baseline Impedance; number of reflux episodes overall irrespective of acidity, reflux proximal extent). Further, it permits for reflux-symptom association measurements of both acid and non-acid reflux events separately. However, accuracy of Impedance pH monitoring relies on manual review. The AGIP Committee strongly advises that centres should **NOT** be using automated analysis alone. The automated measurements tend to over-estimate reflux related events. An inappropriately analysed study could result in patient harm and unnecessary surgery. Thus, adequate time in a quiet space, away from distractions and interruptions, needs to be provided to the professional to allow for detailed, manual review of the automated analysis.

Meals / Drinks

1. pH Only Studies - (Wired or Wireless)

If a pH study is performed without impedance (wired or wireless), it is essential that the patient follows a restricted diet during the study period.

For pH only studies, patients should follow these instructions when eating and drinking:

- Eat as normal, but minimise snacking and grazing as much as possible.
- Only drink plain water (not flavoured or carbonated), or non-acidic drinks (e.g. milk, or tea). Do not continuously sip drinks throughout the day.
- Avoid alcoholic drinks. If consumed, accurate documentation of start and finishing times with type of alcohol consumed is essential.
- Minimise sweets and avoid chewing chew gum in order to avoid unnecessary artefact of continuous swallowing. Document whatever is placed in the mouth so that it can be taken into consideration when reporting.

Rationale:

- Frequent sipping, snacking and grazing prolong ingestion periods, reducing the time available for accurate reflux assessment. It also increases artefact, making it technically difficult to be confident in measurements obtained. Mealtimes need to be manually blocked from analysis and excessive grazing reduces analysis periods.
- Acidic drinks may linger in the oesophagus, especially with poor motility. This leads to reduced measurement certainty and contributes to false positives, where the acidic contents pool around the pH sensor, long after the drinking period finished.
- The inability to measure direction of flow of swallowed fluids may be misinterpreted as an acid reflux if the fluid swallowed has a low pH (e.g. coke) and is not recorded beforehand.
- Carbonated drinks can lead to increased belching and gas transfer.
- Patients complete their paper diary sheets and press symptom buttons, but these approaches are not 100% reliable and discordance is not uncommon; meals and drinks are often missed or mis-recorded. These cannot be manually added in when reviewing the trace without impedance, and thus it is essential that steps are taken to minimise the likelihood of artefact by restricting diet and minimising acidic readings from meals/drinks.
- Excessive swallowing when chewing gum or sucking sweets can be associated with artefact of excessive clearance and/or belching so passive reflux cannot be reliably assessed.

Conclusion: For pH-only studies (if performed at all), strict limitations on meals and drinks are essential.

2. Multichannel Intraluminal Impedance-pH monitoring

AGIP strongly recommends that Impedance-pH study is only performed by skilled, accredited operators who are able to accurately conduct a detailed, manual analysis of the data. Automated analysis should not be used alone. With these provisions, the above strict limitations on meals and drinks are not essential if the aim is to reproduce normal behaviour. However, if there is any doubt about the analytical skills of the operator, the above pH sensor dietary restrictions are recommended to increase confidence in obtained results.

If the patient does follow their normal diet with no restrictions, it is crucial that:

- accurate diary recording is **critical.** The patient should be made aware of this, so they understand the need to accurately record their meals and drinks. If this may be unreliable, then the strict dietary recommendations described above should be followed.
- the operator must correlate the recording with the diary entry carefully and annotate the trace as required to correlate with the diary before analysis. Missed or inaccurately recorded meals, drinks and position change should be inserted and/or edited where required before analysis can begin.
- careful manual analysis of the recording must then follow automated analysis; there is an increased risk of overinterpretation with automated analysis leading to false positives outcomes, particularly with symptom association.

Other Patient Instructions

The following apply for all methods of assessment (Multichannel Intraluminal Impedance-pH monitoring, single- or dual-channel pH only catheters, Wireless pH monitoring):

1. Sleeping

The patient should try to lay flat when in bed, using just one pillow and avoid propping themselves up. This ensures that the sleep period is a true supine assessment of reflux. Further, supine periods do not necessarily have to be at night when the patient is asleep. All supine periods should be recorded.

2. Activity

The patient should be encouraged to have as normal a day as possible, maintaining their normal activity levels. Resting all day is not recommended (unless this is reflective of their normal behaviour), but any strenuous physical activity should be recorded.

The patient should avoid getting the recorder wet (no showers/baths/swimming). With wireless pH monitoring, the recorder can be placed nearby but not under the shower.

Upon removal of the equipment, it is useful to ascertain if normal behaviour and activity was maintained, how well the patient tolerated the investigation, and if symptoms during the study period were typical for the patient. Having a 'good day' should be noted as should intolerance leading to reduced activity. It is possible to extend the study for more than one day if it is deemed appropriate and the patient is willing to continue.

3. Medication

Any medications discontinued in advance of this investigation (e.g. PPIs, H2 Receptor Antagonists or antacids) **must not be taken during the study period**. They may be restarted once the test is complete.

If a Multichannel Intraluminal Impedance-pH study is being performed **on therapy**, the patient should continue taking their medications as usual, but this should have been agreed in advance. If the patient takes such medicines during the study, it should be clearly documented.

If a patient is on weight loss medication (GLP-1 agonists e.g. Mounjaro, Wygovy and similar), this needs to be well documented as it could be contributing to their symptoms. Although we do not require these medications to be stopped for pH testing, they are known to lead to delayed gastric emptying and reflux.

Post-Study

For ambulatory catheter-based assessment, it is useful to ask the patient how they perceived the 24-hour testing period. This can help to determine if repeat testing, or a prolonged wireless study, would be beneficial. The information can be obtained verbally or through a formal questionnaire, to determine:

- patient tolerance.
- patient activity/behaviour - to assess if it was a "normal" day for the patient.
- symptoms - to determine if representative of the patient's normal experience

Patient Safety

- A paediatric-trained nurse must be present throughout the investigation.
- Paediatric resuscitation equipment must be immediately available.
- Ensure a clear and appropriate plan is in place to address any specific medical management needs (e.g. a seizure management plan for individuals with epilepsy, where relevant).
- Ensure reduced fasting times are considered and appropriately managed for children with diabetes or metabolic conditions, in line with relevant clinical guidance.
- Document and escalate any safeguarding concerns.

Interpretation and Reporting

- Document any:
  - tolerance difficulties with the procedure
  - adaptations made to improve tolerance
  -safeguarding concerns

Analysis

- Analysis of results is advised directly following completion of the test as patient compliance may make interpretation difficult.
- While there are currently limited established normal paediatric reference values; be aware of recognised metric variations associated with a shorter oesophagus length: Shorter latency
- Smaller peristaltic breaks

Reporting

- Discuss with paediatric colleagues if there is uncertainty in interpretation. Email AGIP for support from paediatric GI Clinical Scientists.
- The full report should be sent directly to the referring paediatric consultant.
- It is advised that the results are discussed with the referrer in a multidisciplinary team setting for clarity and shared decision-making.

Training and Governance Requirements

- All staff involved in the care of paediatric patients must have:
  - An enhanced DBS check for working with children.
  - Up to date paediatric Basic Life Support training
  - Up to date paediatric safeguarding training
  - A strong understanding of consent to treatment in children
  - Familiarity with age-appropriate communication techniques

Example High-Resolution Anorectal Manometry Report

Hi-Res Anorectal manometry (London Classification)

Patient name:	AGIP 2026, TEST	Investigation date:	01/01/2026
Gender:	FEMALE	Hospital:	NHS Trust
Date of birth:	xx/xx/xxxx	Investigator:	Name Name
Patient number:	12345	Referred by:	Dr Surgeon

London Classification

Disorders of anal tone and contractility:	No disorders of anal tone and contractility
Disorders of recto-anal co-ordination:	No disorder of recto-anal co-ordination
Disorders of rectal sensation:	No disorder of rectal sensation
Disorders of the recto-anal inhibitory reflex:	No disorder of the recto-anal inhibitory reflex

Disclaimer:
As recommended in "Standardized testing protocol and the London classification for disorders of anorectal function", publishe d in NGM 2020

Investigation memo

Indication for testing / Symptoms

Main Symptom: 5-year history of incomplete rectal emptying on defaecation.
She opens her bowels 3 times per day passing soft stool. Defaecation is difficult, where she strains, with a sensation of incomplete rectal emptying. She uses glycerine suppositories and performs vaginal splinting to aid emptying. She takes Laxido. She struggles with post-defaecatory soiling but no other faecal incontinence.

Medical History
Asthma, Hypertension, Back pain

Surgical History
Total abdominal hysterectomy and bilateral salpingo-oophorectomy

Obstetric History
2 vaginal deliveries
1st - forceps assisted
2nd - non-instrumental

Medication
Bisoprolol, Laxido, Salbutamol, Tramadol

Patient Safety
Recent flexible sigmoidoscopy performed - safe to proceed *[include date of endoscopic assessment]*

Digital Rectal Examination
Visual inspection of the perineum revealed an external haemorrhoid at 6 o'clock, with scarring evident to the perineum.
Digital rectal examination revealed a good resting tone. There was good anal contraction on squeeze. On "push", there was good relaxation of the puborectalis. Stool was present within the anorectum. A rectocele was palpated.

Technical Information
Catheter type: [INSERT CATHETER INFO HERE - e.g. "Laborie Unitip High Resolution Solid State catheter (12 pressure sensor)" or " ManoScan high resolution anorectal 3D catheter" or other]
Manometry software platform: [INSERT SOFTWARE INFO HERE - e.g. "Laborie Solar GI High-Resolution Anorectal Manometry system" or "ManoScan AR High Resolution Manometry System" or other]

Investigation conclusion

Anorectal Manometry Results

		Normal Values
Resting Pressure Assessment:		
• Mean anal canal resting pressure	45 mmHg	33 - 101 mmHg
• Anal canal length	3.6 cm	2.3 - 4.9 cm
Squeeze Assessment:		
• Incremental Anal Squeeze Pressure	118 mmHg	45 - 315 mmHg
• Endurance Squeeze Length	Maintained for 30 seconds	
Cough Assessment	Anal pressure 54 mmHg > Rectal pressure 38 mmHg	Anal > rectal
Push Assessment:		
• Maximum rectal pressure	41 mmHg	>18 mmHg
• Anal pressure decrease	22 mmHg	>0 mmHg
RAIR Assessment:		
• RAIR present?	Yes	
• Balloon volume at RAIR	50ml	
Sensation Assessment:		
• First constant sensation volume	24 ml	20 - 100 ml
• Defaecatory desire volume	43 ml	40 - 200 ml
• Maximum tolerated volume	108 ml	75 - 280 ml
• Overall result	Normal	
Balloon Expulsion Assessment:		
• Was investigation performed?	Yes	
• Result	Successful - expelled in 65 seconds	<180 seconds

Normal values according to Carrington et al, NGM 2014
[note - different normal values may apply for different manometric systems, change where required]

Summary

- No disorder of anal tone and contractility - anal normotension with normal contractility. Able to maintain squeeze for the full 30 seconds.
- Normal cough reflex response
- No disorder of recto-anal co-ordination. Successful balloon expulsion result. Good defaecatory dynamics demonstrated on "push" with appropriate increase in rectal pressure with anal relaxation.
- RAIR evident at 50 ml balloon inflation.
- No disorder of rectal sensation to distension.

Conclusion

Normal result.

Further investigations (e.g. endoanal ultrasound and/or defaecation proctography) recommended for further assessment of symptoms.