Constipation

Constipation is a common symptom of IBS and is characterized by hard or infrequent stools, often with associated symptoms of incomplete emptying, excess straining and/or abnormal toileting behavior. If accompanied by abdominal pain related to bowel habit, it is termed constipation-predominant IBS.

A stepwise approach to management of constipation can be effective, starting with diet and lifestyle, fibre and followed by the addition of medications or consideration of biofeedback if necessary. Providing patients with a management plan in writing may enhance compliance.

Simple Dietary and Lifestyle Modification

- Take advantage of the gastrocolonic response by not skipping meals, avoiding prolonged fasting, and attempting defaecation after a meal. Address simple routine changes such as allowing enough time in the morning for breakfast and going to the toilet afterwards.
- Ensure adequate non-caffeinated, non-alcoholic beverage intake (1.5-2L, or more with exercise).
- Increase dietary fibre, towards the NHMRC recommended 25-30g per day. This is better tolerated if slow increments are made over some time, e.g. 1-2 months.
- Use of foot stool: Encourage patients to keep a foot stool in their bathroom to place their feet on whilst attempting defecation. The recommended position is to have knees higher than the level of the hips and to slightly lean forward. This repositions the pelvis resulting in relaxation of the pelvic floor muscle with less straining required.

Supplemental Fibre

- Often supplemental fibre is useful in combination with an increase in dietary fibre to treat constipation and especially to normalize stool form.
- Options include sterculia, psyllium, ispagula and guar gum (which contains gluten).
- Doses may range from 1 teaspoon daily to several teaspoons daily and it is worthwhile adjusting the dose according to the degree of bloating, the stool form and the dietary fibre intake.

Low Dose Polyethylene Glycol (PEG)

This is the current mainstay of treatment due to safety profile and high quality evidence of efficacy. It works as an osmotic agent, drawing water into the colon and increasing stool frequency and improving stool form. Other osmotic agents that can be used include lactulose (may possibly cause more bloating) or magnesium (such as Epsom salts, may cause more unpredictable, watery stool).

Helpful tips when prescribing PEG:

- It is important to counsel patients that the effect is not the same as with a stimulant laxative, there will not necessarily be a predictable bowel movement at a certain time after taking a dose; it is a more “overall” effect.
- Patients may initially feel some bloating or discomfort until the bowel movements start increasing, but after there has been an increase in bowel emptying the dose is better tolerated and symptoms reduce.

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- The dose should be titrated to stool form. If stools are loose and frequent patients need to reduce the dose, but if stools are still firm or infrequent the dose should be increased.

Stimulant Laxatives

Controversy exists surrounding the use of stimulant laxatives (e.g. senna, bisacodyl, cascara). They cause high amplitude contractions in the colon and predictable bowel movements after taking them. They also cause melanosis coli seen at colonoscopy. They may cause dependency and a dilated atonic colon after many years of use (often over 20 years). For these reasons, they may not be the best choice for young patients but may be very good choices for older patients or for short term use (e.g. after surgery).

Stimulant laxatives come in many different forms including herbal treatments, teas, and over the counter medications. The challenge for doctors (and patients) can be to identify the presence of stimulants, as there is such a variety of formulations with a variety of labelling used.

Prucalopride

This is a 5HT3 antagonist available in Australia for management of chronic constipation in patients who have not had adequate relief from other laxatives. Headache is the most common side effect and sometimes precludes ongoing use. It comes in 1 and 2mg tablets with both doses being moderately efficacious. Expense limits use for some patients and if there is no improvement after a one month trial of therapy it should be ceased

Enemas and Suppositories

Osmotic based enemas (e.g. Microlax and Fleet) and glycerol suppositories can be used readily to treat constipation according to patient preference. In other parts of the world such as Europe, these forms of treatment are much more widely used. They do give predictability and can be a good “quick fix” but can also be given regularly.

Future Medications

- Linaclotide: A guanate cyclase agonist, which is luminally rather than systemically active, has a very favourable side effect profile and is available in tablet form in the USA and Europe. There is high quality evidence showing efficacy for constipation.

- Lubiprostone: A chloride channel activator that increases secretions and softens stool. There is high quality evidence for efficacy in constipation. Not available in Australia as yet.

Biofeedback or Pelvic Floor Physiotherapy

For patients refractory to standard management, or those with dyssynergic symptoms such as incomplete emptying, excess straining, prolonged toileting time or digitation, then anorectal manometry with a view to biofeedback is indicated. During this treatment, patients are given visual feedback about their anorectal and pelvic floor musculature and coached on how to normalise this. It is performed in specialised centers under the supervision of a colorectal surgeon or gastroenterologist. Pelvic floor physiotherapy is a very reasonable alternative.

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Surgery

Total colectomy and ileorectal anastomosis are rarely performed for management of constipation and only in extreme circumstances.

References

https://www.nature.com/articles/ajg2014187/tables/4