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8

The difficult patient with constipation

Stefan Müller-Lissner* MD

Professor of Medicine

Humboldt University Berlin, Department of Internal Medicine, Park-Klinik Weissensee, Schoenstrasse 80, 13086 Berlin, Germany

Difficult patients with constipation mostly suffer for years, have consulted more than one physician and have had some experience with laxatives. The first step should be sorting out what exactly the patient's problem is. For this purpose technical investigations may be helpful, but the most important measures are a detailed history, symptom analysis and proctological examination. Rarely, an underlying and treatable cause of the constipation can be identified. In disordered defaecation this may be a large rectocele or an intussusception of the rectum amenable to proctosurgery. In most cases, however, some form of laxative treatment will be required. For this purpose, a detailed knowledge of their pharmacology is mandatory. The type of laxative and the schedule of administration often have to be determined on an individual basis over a number of weeks. In some patients, combination treatment with macrogol and a stimulant laxative may be the solution. Psychological features must also be taken into account in difficult patients, in particular if they ask for colectomy. Total colectomy with ileorectal anastomosis is an effective (although not universally successful) treatment of constipation, which is, however, hampered by a high rate of both early and late complications.

Key words: constipation; defaecation; colonic transit; laxatives; dietary fibre.

WHAT IS THE PROBLEM?

A 41-year-old female patient presented with constipation. Her current complaint started after the birth of her third child 6 years previously, but she also used to have hard stools before that. She reported having no bowel movements without using laxatives. Dietary fibre supplements and drinking lots of fluids (2–3 l daily) had not been successful. In addition she complained of abdominal distension after one day without stools. Anthraquinone laxatives were followed by crampy abdominal pain

* Tel.: +49 30 9628 3600; Fax +49 30 9628 3605.
E-mail address: mueli@park-klinik.com.

prior to passage of a stool that was very hard, painful and difficult to pass with occasional bleeding. The patient asked whether her problem could be solved by colectomy.

As a first step, the clinician needs to sort out what exactly this patient's problem is and whether she needs pharmacological treatment with laxatives at all. Her problem may primarily be located in the colon (slow transit) or in the anorectum (disordered defaecation). When a stool bolus enters the rectum from the sigma, the rectal wall is distended, which elicits the rectoanal inhibitory reflex, i.e. the internal sphincter relaxes. The subject may then decide whether the sphincter should be relaxed and defaecation allowed or whether it should be kept contracted to retain stool. Even if both sphincters are relaxed the anal canal does not usually gape, hence some driving force is necessary to propel the stool through it. This may be accomplished by two mechanisms, propulsive colorectal contractions or increasing the abdominal pressure by contracting the abdominal wall musculature. If the lower rectum is too elastic, this pressure may be wasted on ballooning the wall instead of expelling stool. This can occur in rectocele and in severe pelvic floor descent (Table 1). This type of persistently disordered defaecation may well be induced by pregnancy.[1,2] Rectocele may be suspected on proctological examination and can be shown by defaecography.[3] Small rectoceles not retaining contrast may occur in normal people.[4] While there is no proven treatment for pelvic floor descent, a rectocele may be reduced surgically.[5]

Slow transit through the colon may also explain this patient's complaints. It could be due to drugs (Table 2), neurological causes (Parkinson's disease, other degenerative syndromes, spinal cord injury), or – very rarely – may have an endocrine cause (Table 3). In most cases the cause of slow transit remains obscure.[6]

A third possibility is that this patient has neither a problem of colonic motility nor of defaecation. If the colon has been nearly emptied by using a laxative it may take a few days before spontaneous defaecation is resumed. If the patient considers this lag time to be too long she will take the next dose of laxative hence inducing a vicious circle. Furthermore, a sense of abdominal fullness does not correlate with the objective degree of abdominal distension. Hence a lower threshold for distension may induce a sense of fullness. A patient who has been accustomed to an empty colon (e.g. by using laxatives) may experience normal filling of the colon as unpleasant distension.

Finally, the distinction between the conditions described above is not as strict as it may appear because on the one hand anorectal obstruction slows colonic transit,[7] while on the other hand, and clinically probably more importantly, slow transit leads to infrequent small hard stools. Since defaecation is triggered by rectal distension, low stool volumes may not be able to elicit the rectoanal inhibitory reflex and to induce an urge to defaecate.[8] In addition, small pellet-like stools are difficult to evacuate.[9]

Table 1. Mechanisms and causes of functional anorectal outlet obstruction.

Affected structure	Disorder	Physiopathological mechanism
Internal sphincter	Hirschsprung's disease	No relaxation
External sphincter	Pelvic floor dyssynergia ('anismus')	Paradoxical contraction
Rectal wall, circumferential	Intussusception	Luminal obstruction
Rectal wall, mostly anterior	Rectocele	Waste of pressure
Pelvic floor	Pelvic floor descent	Waste of pressure