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Constipation

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Chronic constipation is a common disorder manifested by a variety of symptoms. Assessments of colonic transit and anorectal functions are used to categorize constipated patients into three groups, i.e., normal transit or irritable bowel syndrome, pelvic floor dysfunction (i.e., functional defaecatory disorders) and slow transit constipation. 'Slow transit' constipation is a clinical syndrome attributed to ineffective colonic propulsion and/or increased resistance to propagation of colonic contents. Defaecatory disorders are caused by insufficient relaxation of the pelvic floor muscles or a failure to generate adequate propulsive forces during defaecation. Colonic transit is often delayed in patients with functional defaecatory disorders. Normal and slow transit constipation are generally managed with medications; surgery is necessary for a minority of patients with slow transit constipation. Functional defaecatory disorders are primarily treated with pelvic floor retraining using biofeedback therapy.

Key words: constipation; anorectal; slow transit; pelvic floor; laxatives.

INTRODUCTION

Constipation is prevalent in Western societies and a common symptom in clinical practice. Constipation is often mild, intermittent, and self-treated with over the counter fibre supplements and laxatives. Only a small proportion of all people who perceive they are constipated seek health care.

The definition of constipation varies among physicians and laypersons. The Rome III criteria use symptoms to separate constipation into two syndromes, i.e., functional constipation and constipation-predominant IBS. Recognizing that patients refer to a variety of symptoms when they consider themselves to be constipated, the Rome III criteria

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define functional constipation by the presence of two or more of the following six symptoms, i.e., infrequent bowel habits (i.e., less than 3 stools/week), hard stools, excessive straining, a sense of anorectal blockage, or the use of manual manoeuvres during evacuation, and a sense of incomplete evacuation after defaecation.[1] Though patients with functional constipation may have abdominal discomfort, they do not have criteria for irritable bowel syndrome (IBS), i.e., abdominal discomfort associated with two or more of the following three symptoms, i.e., relief of discomfort passing a bowel movement, an association between discomfort and hard stools, and an association between discomfort and less frequent stools. Depending on the definition used, the prevalence of constipation in the community ranges from 2 to 25% and probably averages approximately 15%.[2]

In clinical practice, assessments of colonic transit and anorectal functions are used to categorize constipated patients into three groups, i.e., normal transit or irritable bowel syndrome, pelvic floor dysfunction and slow transit constipation (Figure 1).[3,4] In a study of more than 1000 patients with chronic constipation, normal transit through the colon was the most prevalent form (occurring in 59% of the patients), followed by defaecatory disorders (25%), slow transit (13%), and a combination of defaecatory disorders and slow transit (3%).[4] Beginning with the earliest report by Preston and Lennard-Jones, an overlap between slow transit constipation and pelvic floor dysfunction has been widely recognized.[5–7] They described a clinical syndrome characterized by intractable constipation poorly responsive to fibre and laxatives, abdominal pain, bloating, malaise, nausea, delayed colonic transit without megacolon and anorectal symptoms suggestive of difficult faecal expulsion.[7] Extragastrointestinal symptoms in this syndrome included painful and/or irregular menses, hesitancy in initiating micturition, and somatic symptoms such as cold hands or blackout. Since anorectal function tests are now more widely available, the term 'slow transit constipation' is reserved for patients who primarily complain of constipation and have delayed colonic transit but no underlying systemic disorder or pelvic floor dysfunction that explains these symptoms. Consistent with the theme of this book, this chapter will focus on 'idiopathic' slow transit constipation. Other causes of slow transit constipation (e.g., medications such as anticholinergic agents or opiates and neurological disorders) will not be discussed in detail.

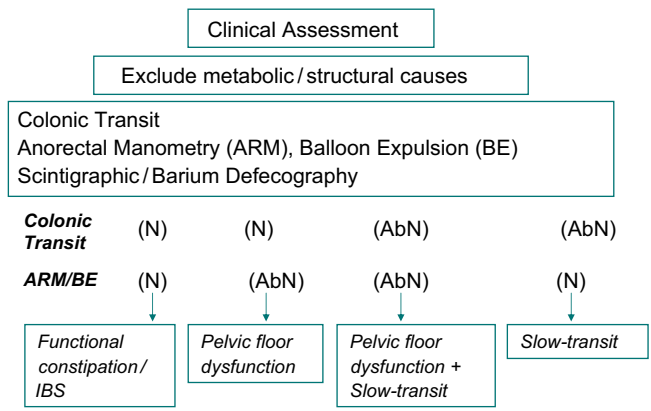

Figure 1. Diagnostic tests in management of constipated patients in clinical practice. Note these simple tests permit categorization of patients and choice of therapy. N, normal; AbN, abnormal. Reprinted with permission from Bharucha AE & Camilleri M. Physiology of the colon and its measurement. In Pemberton JH (ed.) Shackelford's Surgery of the Alimentary Tract. 6th ed. Vol. 4. The Colon. Philadelphia: Elsevier Saunders, 2007, pp 1871–1882.