

American Gastroenterological Association Medical Position Statement on Constipation

The AGA Institute Medical Position Panel consisted of the lead technical review author (Adil E. Bharucha, MBBS, MD, AGAF), a Clinical Practice and Quality Management Committee representative and content expert (Spencer D. Dorn, MD, MPH), and two gastroenterologists and content experts (Anthony Lembo, MD, and Amanda Pressman, MD).

**Podcast interview: www.gastro.org/gastropodcast.
Also available on iTunes.**

This document presents the official recommendations of the American Gastroenterological Association (AGA) on constipation. It was drafted by the AGA Institute Medical Position Panel, reviewed by the Clinical Practice and Quality Management Committee, and approved by the AGA Institute Governing Board. This medical position statement is published in conjunction with a technical review¹ on the same subject, and interested readers are encouraged to refer to this publication for in-depth considerations of topics covered by these questions. The technical review was begun before the AGA's decision to adopt the GRADE system. However, a GRADE methodologist worked with the authors and panel to rank the quality of the evidence and strength of recommendations.

The medical position statement presents information by addressing clinically related questions and summarizing key points from the technical review. When specific recommendations about medical interventions or management strategies for patients with constipation are stated, the “strength of recommendation” and the “quality of evidence” are provided. The strength of recommendation is either judged as “weak” or “strong” and quality of evidence is ranked as high, moderate, low, or very low in accordance with GRADE criteria. Recommendations are highlighted by appearing within a text box. A strong recommendation implies that, based on available evidence, the benefits outweigh risks and there is less variability in patient's values and preferences. A weak recommendation implies that benefits, risks, and the burden of intervention are more closely balanced, or appreciable uncertainty exists in regards to patient's values and preferences. Applying this approach, high-quality evidence does not always result in strong recommendations and, conversely, strong recommendations may emerge from lower-quality evidence.

Symptoms of constipation are extremely common; the prevalence is approximately 16% in adults overall and 33% in adults older than 60 years. Many people seek medical care for constipation, but fortunately most do not have a life-threatening or disabling disorder and the primary need is for control of symp-

toms, although rare, life-threatening, or treatable conditions must be excluded. If therapeutic trials of laxatives fail, specialized testing should be considered. We suggest the following practice guidelines for the symptom of constipation; our rationale for these guidelines is supported by the accompanying technical review.

Constipation is a symptom that can rarely be associated with life-threatening diseases. Current recommendations will relate to (1) rational and, where possible, more judicious diagnostic approaches and (2) more rational and efficacious therapies that will improve symptoms, both of which should have beneficial fiscal and logistic impacts on the health care system. Although the overall classification of chronic constipation into 3 categories (ie, normal transit, isolated slow transit, and defecatory disorders) and several recommendations in this version are similar to the prior version, there are 3 substantive changes. First, these guidelines recommend assessment of colonic transit at a later stage, that is, only for patients who do not have a defecatory disorder or patients with a defecatory disorder that has not responded to pelvic floor retraining. Second, the evidence supporting these recommendations has been evaluated using the GRADE system, in which the strength of recommendation is rated as strong or weak and the quality of evidence is rated as high, moderate, low, or very low. Third, therapeutic recommendations have been updated to include newer agents and delete certain older agents.

Definitions

Although physicians often regard constipation to be synonymous with infrequent bowel movements, typically fewer than 3 per week, patients have a broader set of symptoms, including hard stools, a feeling of incomplete evacuation, abdominal discomfort, bloating, and distention, as well as other symptoms (eg, excessive straining, a sense of anorectal blockage during defecation, and the need for manual

Abbreviations used in this paper: AGA, American Gastroenterological Association; GRADE, Grading of Recommendations Assessment, Development and Evaluation; NTC, normal transit constipation; STC, slow transit constipation.

© 2013 by the AGA Institute
0016-5085/\$36.00

<http://dx.doi.org/10.1053/j.gastro.2012.10.029>

maneuvers during defecation), which suggest a defecatory disorder. Not infrequently, patients who have daily bowel movements describe constipation. Reduced stool frequency is poorly correlated with delayed colonic transit. Although many people experience occasional constipation (eg, when they travel), this review is geared toward people who have persistent symptoms (ie, chronic constipation).

Clinical Subgroups

Symptoms of constipation may be secondary to diseases of the colon (stricture, cancer, anal fissure, proctitis), metabolic disturbances (hypercalcemia, hypothyroidism, diabetes mellitus), and neurologic disorders (parkinsonism, spinal cord lesions). Some of these will be amenable to specific therapies, but when they are not, the challenge remains one of symptomatic treatment of constipation. More frequently, constipation is due to disordered colonic and/or pelvic floor/anorectal function. Assessments of colonic transit and anorectal function allow patients to be categorized into 3 subgroups (ie, defecatory disorders, normal transit constipation [NTC], and slow transit constipation [STC]), which facilitates management in refractory patients.

Defecatory Disorders

These disorders are primarily characterized by impaired rectal evacuation from inadequate rectal propulsive forces and/or increased resistance to evacuation; the latter may result from high anal resting pressure (“anismus”) and/or incomplete relaxation or paradoxical contraction of the pelvic floor and external anal sphincters (“dyssynergia”) during defecation. Structural disturbances (eg, rectocele, intussusception) and reduced rectal sensation may coexist. Other terms for these conditions include outlet obstruction, obstructed defecation, dyschezia, anismus, and pelvic floor dyssynergia. Patients with defecatory disorders may have slow colonic transit that may improve once the defecatory disorder is treated.

NTC and STC

In addition to normal anorectal function, patients with NTC and STC have normal or slow colonic transit, respectively. Some patients with STC have colonic motor disturbances (ie, reduced colonic propulsive activity or increased uncoordinated motor activity in the distal colon) that may impede colonic transit. However, others do not. Indeed, a similar proportion of patients with NTC, STC, and even defecatory disorders have colonic motor disturbances as measured by intraluminal techniques (ie, manometry and a barostat). Hence, the relationship between colonic motor disturbances and transit needs further study. Abnormal (ie, reduced or increased) colonic sensation has also been described in chronic constipation, and increased sensation may explain symptoms (ie, abdominal pain and bloating) in some patients. Resected colonic specimens from patients with STC who undergo colectomy reveal

a marked reduction in colonic intrinsic nerves and interstitial cells of Cajal.

Combination Disorders

Some patients may have combination or overlap disorders (eg, STC with defecatory disorders), perhaps even associated with features of irritable bowel syndrome.

Clinical Evaluation

Historical features are key, and the questioning of the patient must be specific. What feature does the patient rate as most distressing? Is it infrequency per se, straining, hard stools, unsatisfied defecation, or symptoms unrelated to bowel habits or defecation per se (eg, bloating, pain, malaise)? The presence of these last characteristics suggests underlying irritable bowel syndrome.

Defecatory disorders should be suspected strongly on the basis of a careful history and digital rectal examination. Prolonged and excessive straining before elimination are suggestive; when evacuatory defects are pronounced, soft stools and even enema fluid may be difficult to pass. The need for perineal or vaginal pressure to allow stools to be passed or direct digital evacuation of stools is an even stronger clue. It is important to raise these questions early, because evacuatory disorders do not respond well to standard laxative programs and failure to recognize this component is a frequent reason for therapeutic failure.

The current regimen and bowel pattern should be recorded. How often is a “call to stool” noted? Is the call always answered? What laxatives are being used, how often, and at what dosage? Are suppositories or enemas used in addition? How often are the bowels moved, and what is the consistency of the stools? Physicians and patients need to be aware that after a complete purge it will take several days for residue to accumulate such that a normal fecal mass will be formed. Importantly, many commonly used medications have constipation as a notable side effect (eg, opiates, anticholinergics, calcium channel blockers). A full record of prescription and over-the-counter medications must be obtained.

The physical examination and screening tests, if deemed appropriate, should also eliminate diseases to which constipation is secondary (see technical review). The key components of the rectal examination include the following:

- In the left lateral position, with the buttocks separated, observe the descent of the perineum during simulated evacuation and the elevation during a squeeze aimed at retention. The perianal skin can be observed for evidence of fecal soiling and the anal reflex tested by a light pinprick or scratch.
- During simulated defecation, the anal verge should be observed for any patulous opening (suspect neurogenic constipation with or without incontinence) or prolapse of anorectal mucosa.
- The digital examination should evaluate resting tone of the sphincter segment and its augmentation by a squeezing effort. Above the internal sphincter is the

Download English Version:

<https://daneshyari.com/en/article/3293684>

Download Persian Version:

<https://daneshyari.com/article/3293684>

[Daneshyari.com](https://daneshyari.com)