Constipation

Understanding Mechanisms and Management

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KEYWORDS

• Chronic constipation • Constipation testing • Anorectal manometry
• Dyssynergic defecation • Pelvic floor dysfunction • Outlet dysfunction
• Slow transit constipation

KEY POINTS

- Patients usually have a broader definition of constipation than physicians that encompasses myriad symptoms, including hard stools, feeling of incomplete evacuation, abdominal discomfort, bloating and distension, and excessive straining.
- There are 3 primary types of constipation: functional, slow transit, and outlet dysfunction, and many secondary causes.
- Diagnostic testing is not routinely recommended in the initial evaluation of constipation in the absence of alarm signs and should be targeted at symptoms or signs elicited in the history or physical that suggest an organic process.
- Because sedentary lifestyle and low-fiber diets are associated with constipation, self-management strategies of lifestyle changes that include increased exercise, high-fiber diets, and toilet training are often effective first-line management.
- Fiber and fiber supplements can worsen symptoms in some types of constipation.
- A variety of over-the-counter and prescription medications with unique mechanisms of action are available to remedy constipation.

INTRODUCTION

Constipation is one of the most common gastrointestinal disorders seen by gastroenterologists and primary care physicians. Symptoms of constipation occur frequently, with the greatest prevalence in the elderly. The prevalence in adults older than 60 years is 33%, whereas the overall prevalence among adults of all ages is about 16%.[1] Constipation is found more frequently in women[2] and in lower socioeconomic populations.

No funding.
No conflict of interest.
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Clin Geriatr Med 30 (2014) 107–115
http://dx.doi.org/10.1016/j.cger.2013.10.001
geriatric.theclinics.com
0749-0690/14/$ – see front matter Published by Elsevier Inc.

Constipation reduces quality of life and poses a large economic burden, with more than $820 million spent on laxatives each year.[3] Complications of constipation include hemorrhoids, fecal impaction, stercoral ulcers, fecal incontinence, rectal prolapse, volvulus, and excessive perineal or inadequate perineal descent. These complications often lead to emergency department visits and hospitalizations. The mechanisms and management of chronic constipation in the elderly are the focus of this article.

Chronic Constipation: Definitions

Physicians and patients often have different definitions of constipation. Physicians typically define chronic constipation as infrequent bowel movements, usually less than 3 per week, for at least 3 of the prior 12 months. Patients usually have a broader definition that encompasses myriad symptoms including hard stools, feeling of incomplete evacuation, abdominal discomfort, bloating and distension, excessive straining, sense of anorectal blockage during defecation, and the need for manual maneuvers.[1]

Primary Constipation

Chronic constipation can be divided into 2 main categories: primary and secondary. Primary constipation is further divided into 3 main types: functional, outlet dysfunction, and slow transit constipation. There can be overlap of primary types of constipation.

- Functional constipation is diagnosed using the Rome III criteria (**Box 1**). Functional idiopathic constipation is distinct from constipation-predominant irritable bowel syndrome (C-IBS) (**Box 2**), based on the severity of abdominal pain. C-IBS is characterized by abdominal pain or discomfort that improves with defecation.[4]
- Outlet dysfunction (also called *defecation disorders* and *pelvic floor dysfunction*) encompasses several defecation disorders in which the patient experiences difficult or unsatisfactory expulsion of stool from the rectum. Several causes exist, including presence of an anal fissure or stricture, hemorrhoids, rectocele, enterocele, impaired descent (excessive or inadequate), and dyssynergic defecation.[5] Dyssynergic defecation is the impaired relaxation and coordination of abdominal and pelvic floor muscles during evacuation.

Box 1
Functional constipation: Rome III criteria

1. Must include 2 or more of the following:
   a. Straining during at least 25% of defecations
   b. Lumpy or hard stools in at least 25% of defecations
   c. Sensation of incomplete evacuation for at least 25% of defecations
   d. Sensation of anorectal obstruction/blockage for at least 25% of defecations
   e. Manuel maneuvers to facilitate at least 25% of defecations (eg, digital evacuation, support of the pelvic floor)
   f. Fewer than 3 defecations per week
2. Loose stools are rarely present without the use of laxatives
3. Insufficient stools are rarely present without the use of laxatives
4. Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.[4]

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