ACUTE AND CHRONIC CONSTIPATION

DEFINED BY THE ROME CRITERIA IN THE FOLLOWING TERMS:

Table 77-1 Rome Criteria for Diagnosis of Constipation
Two or more of the following must be present to make a diagnosis of constipation:
Straining at defecation at least 25% of the time
Hard stools at least 25% of the time
Incomplete evacuation at least 25% of the time
Less than three bowel movements per week
Chronic constipation includes symptoms for at least 12 wk (consecutive or nonconsecutive) in the preceding 12 mo

PATHOPHYSIOLOGY:

- Constipation is complicated and often has multiple/overlapping causes

Table 77-2 Differential Diagnosis of Constipation
Acute causes:
GI: quickly growing tumors, strictures, hernias, adhesions, inflammatory conditions, and volvulus
Medicinal: narcotic analgesic, antipsychotic, anticholinergic, antacid, antihistamine
Exercise and nutrition: decrease in level of exercise, fiber intake, fluid intake
Painful anal pathology: anal fissure, hemorrhoids, anorectal abscesses, proctitis
Chronic causes:
GI: slowly growing tumor, colonic dysmotility, chronic anal pathology
Medicinal: chronic laxative abuse, narcotic analgesic, antipsychotic, anticholinergic, antacid, antihistamine
Neurologic: neuropathies, Parkinson disease, cerebral palsy, paraplegia
Endocrine: hypothyroidism, hyperparathyroidism, diabetes
Electrolyte abnormalities: hypomagnesia, hypercalcemia, hypokalemia
Rheumatologic: amyloidosis, scleroderma
Toxicologic: lead, iron

- Gut motility is affected by diet, activity level, anatomic lesions, neurologic conditions, medications, toxins, microflora, hormone levels and psychiatric complaints
- ACUTE CONSTIPATION IS INTESTINAL OBSTRUCTION UNTIL PROVEN OTHERWISE! → common causes shown above
- Chronic constipation can be caused by the same conditions that cause acute constipation

CLINICAL FEATURES:

- HISTORY:
    - Several historical elements point towards a more ominous cause of symptoms of acute constipation (although most are non-sinister):
        - Rapid onset nausea or vomiting
        - Inability to pass flatus

        - Severe abdominal pain or distension
        - Unexplained weight loss
        - Rectal bleeding
        - Un-explained iron deficiency anaemia
        - Family history of colon cancer
    - DIARRHOEA ALONE DOES NOT RULE OUT CONSTIPATION OR OBSTRUCTION AS LIQUID STOOL CAN BE PASSING PAST AN OBSTRUCTIVE SOURCE
- PHYSICAL EXAMINATION:
    - Focussed abdominal and pelvic exam PLUS RECTAL EXAMINATION
    - Look for herniae and abdominal or pelvic masses
    - External recetal exam → anal fissures, haemorrhoids,, absecesses or protruding masses
    - Digital rectal exam → faecal impaction or obstructing rectal mass
- LABORATORY EVALUATION/IMAGING:
    - In patient with concerning history for obstruction → upright chest film, and erect/supine AXR → air-fluid levels or dilated bowel → if high suspicion for intestinal obstruction despite normal X-ray → CT IS NECESSARY TO MAKE DIAGNOSIS

SELECT ENTITIES:

- FUNCTIONAL CONSTIPATION:
    - No quick fix → multi-disciplinary approach
    - Stress lifestyle and diet modification → without adequate fluid, exercise and fibre, medicinal methods fail
    - Medical options shown below

Table 77-3 Medical Adjuncts for the Treatment of Constipation

Type	Generic Name	Trade Name	PRN Doses	Side Effects	Mechanism
Fiber	Bran	NA	1 cup daily	Bloating, flatulence	Increases stool bulk or transit time, increases gut motility
	Psyllium	Metamucil	1 teaspoon three times a day	Bloating, flatulence	
Emollient	Docusate sodium	Colace	100 milligrams daily/twice a day	Cramping	Facilitates mixture of stool fat and water
Stimulants	Bisacodyl	Dulcolax	10 milligrams PR three times a day	Incontinence, rectal burning	Stimulates the myenteric plexus, thereby increasing intestinal motility
	Anthraquinones	Peri-Colace	One to two tablets PO daily/twice a day	Melanosis coli, degeneration of myenteric plexus	
	Senna	Senokot, Ex-lax	Two tablets PO daily/twice a day or 15–30 mL daily/twice a day	Laxative abuse, nausea, melanosis coli, cramping	
Saline laxative	Magnesium	Milk of magnesia	15–30 mL daily/twice a day	Magnesium toxicity, especially in renal insufficiency	Decreased colonic transit time
		Magnesium citrate	100–240 mL daily/twice a day	Cramping, flatulence, hypermagnesemia	
Suppository	Glycerin suppository	NA	1 PR daily	Rectal irritation	Local rectal stimulation
Hyperosmolar agents	Lactulose	NA	15–30 mL daily/twice a day	Cramps, flatulence, belching, nausea	Osmotically active nonabsorbable sugars pull fluid into the gut
	Sorbitol	NA	15–30 mL daily/twice a day	Cramps, flatulence	
	Polyethylene glycol	GoLYTELY	1 gallon/4 h	Nausea, cramping, anal irritation	
		MiraLAX	17 grams		
Enemas	Mineral oil	NA	100–250 mL PR	Local trauma	Colonic distention encourages evacuation
	Tap water	NA	500 mL PR	Local trauma	
	Soap suds	NA	1500 mL PR	Local trauma	
	Monophosphate	Fleets	1 unit PR	Local trauma, hyperphosphatemia (especially in patients with renal failure)	

- In its extreme form, functional constipation can result in a variety of potentially life-threatening complications, especially faecal impaction and intestinal pseudo-obstruction (OGILVIE SYNDROME)

- FAECAL IMPACTION:
    - Requires manual disimpaction as enemas provide little or no relief
- INTESTINAL PSEUDO-OBSTRUCTION:
    - Ogilvie syndrome or acute colonic pseudo-obstruction is a clinical disorder with signs/symptoms and radiographic appearance of an acute large bowel obstruction with no evidence of distal colonic obstruction
    - Colon can become massively dilated (>10cm), if not decompressed, the patient risks perforation, peritonitis and death
    - Predisposing factors include recent surgery, underlying neurological disorders and critical illness

PRIOR TO DISCHARGE:

- Need to address potential organic cause of obstruction:

Table 77-4 Symptoms Suggestive of Organic Constipation
Acute onset
Weight loss
Rectal bleeding/melena
Nausea/vomiting
Fever
Rectal pain
Change in stool caliber

- Also need to address:
    - Possible obstructing lesion
    - Systemic illness
    - Electrolyte imbalance
    - Potential for intestinal perforation from self-administered enema