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Constipation

An information guide

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Constipation

Constipation is a common symptom that does not mean you necessarily have a disease.

The word constipated can mean different things to different people. Constipation is generally defined by doctors as a person having one or more of the following features:

- Opening of the bowels fewer than 3 times a week.
- Needing to strain to open the bowels on more than a quarter of occasions.
- Passing of hard or pellet-like stools on more than a quarter of occasions.
- A sensation of incomplete emptying of stool on more than a quarter of occasions.

Two particular groups of people who are most likely to be troubled by constipation are young women and the elderly.

Can constipation cause any complications?

There is no evidence to suggest that constipation causes poisoning of the system due to bugs in the gut, although you may feel sluggish and bloated. Abdominal pain and vomiting are rare complications.

In elderly and immobile patients, it can lead to faecal impaction. This is a condition in which a hard solid ball of stool builds up in the rectum. This can present with diarrhoea and faecal incontinence, as only leaked stool can make its way past the obstructing stool.

Occasionally, you may notice some blood on the tissue after straining. This is usually due to piles; however, this needs to be confirmed by your doctor.

Occasionally, one can get rectal prolapse, which means the rectum or the lining of the rectum comes out of the back passage. This is usually associated with weak pelvic floor muscles.

Very rarely, the hard stool in the large bowel can penetrate through the wall of the bowel and this needs urgent surgical intervention.

What conditions can cause constipation?

Constipation can be due to functional problems (no structural abnormalities in the gut) or anatomical problems. The vast majority is caused by functional problems. These include:

Medication – Constipation is a common side effect of a number of medications, for example painkillers such as codeine, iron tablets, and some of the medications used to treat heartburn, high blood pressure, depression, heart problems and Parkinson's disease.

Pregnancy and after childbirth – The various hormonal changes taking place during pregnancy slow down the gut.

A decrease in thyroxine level in the blood - This is a condition called hypothyroidism which can slow down the gut. Similarly, increased levels of calcium in the blood called hypercalcaemia can also slow down the gut, leading to constipation.

Following any major surgery – This is due to a variety of factors such as painkillers, an inability to push due to severe pain following surgery; decreased food intake and damage to various nerves in the pelvis following some major pelvic operations.

Eating disorders – Patients with eating disorders cannot be expected to have regular bowel action due to lack of roughage. These people may continue to have constipation even after normalisation of their eating behaviour, due to the inability of their gut to recover fully.

Lifestyle – People sometimes feel unable to open their bowels due to various reasons, for example stress, poor toilet access or their busy life schedule. Consequently, they tend to ignore the sensation of needing to go to the toilet to open their bowels and over the years, their gut slows down, resulting in constipation.

Psychological disturbances – Major events in life such as bereavement can result in constipation. Constipation is common in people suffering from depression and anxiety.

Sexual or physical abuse – It is not uncommon to see patients suffering from constipation giving a history of physical or sexual abuse in their childhood. This group of patients are often found to have inco-ordination between the rectum and anal sphincter. During the normal process of bowel evacuation, when the rectum contracts, the anal sphincter relaxes to expel the motion, but in the above group of patients the normal relaxation of the anal sphincter does not happen leading to constipation, which in turn slows down the gut.

Pain in the anal area – For example from a fissure (split in the anal lining) or haemorrhoids – constipation then results from fear of provoking pain on defaecation.

Anatomical problems - Obstruction to the bowels, for example by scarring, inflammation or tumours.

Rectocele – Which means bulging of the rectum, most commonly found in women who have had a baby via vaginal delivery. During defeacation, the rectum bulges forward to the vagina and the stool can get trapped in the rectocele.

Injury to the nerves or nerve disease - For example, people with spinal cord injury, multiple sclerosis or Parkinson's disease.

Mega colon or mega rectum - These are rare conditions in which the gut enlarges.

Hirschprungs disease - This is a very rare condition, usually diagnosed in babies soon after birth. It is due to the lack of nerve supply to the lower part of the bowel.

What investigations are needed for constipation?

A decision to perform various investigations is based on your symptoms, age and family history. It is often unnecessary to carry out tests for constipation but if your doctor is worried, they may organise one or more of the following tests;

Simple blood tests - For example to check your thyroid hormone level, blood calcium level etc.

Flexible sigmoidoscopy or colonoscopy - Which is carried out using a flexible camera to examine the inner lining of the large bowel.

Barium enema – Which is an x-ray examination of the large bowel.

Transit studies – This test gives a measure of whether or not the passage of food through your gut is slow or normal. It is carried out in the x-ray department.

You will be asked to swallow some capsules containing tiny markers that show up on x-ray. You will then have another x-ray a few days later. Looking at the distribution of the markers in your colon, the doctor will be able to tell whether your bowel transit is normal or slow.

Anorectal physiological testing – This test is intended to find out whether the muscles and nerves in the rectum and anus are working properly.

Defecating proctography – This involves the insertion of barium paste into the rectum with x-rays being taken while the barium paste is being passed from the rectum. This test will show whether you can effectively empty the rectal contents and it will also show the presence of rectocele or rectal prolapse.

Dynamic MRI defaecography – This gives the same information as the defecating proctogram but it avoids exposure to xray.

Internal ultrasound - Called endoanal ultrasound is sometimes undertaken to look at the anatomical structure of muscles around the back passage.

What treatments are available?

Lifestyle changes – It is important that you should try to devote time for your bowels every day. Try to go to the toilet at a regular time or times each day. The best time would be following breakfast or after a main meal. The reason for this is that eating triggers gastro-colic reflux (eating sends out signals to the bowel to become active). Try not to rush going to the toilet. You should spend at least 10 minutes in the toilet and preferably, this should be at a time when you are not rushing to do other things.

It is important that you should remain physically active as a sedentary lifestyle can create constipation.

Diet and fluids

It is important that you eat regularly as skipping meals can produce sluggishness of the bowel and thereby constipation. It is important that you should eat a balanced diet. The fibre in the diet is responsible for giving roughage to the stool. Some high fibre containing foodstuffs are All-Bran, Weetabix, Shredded Wheat, porridge and wholemeal bread. A diet containing high fibre is not always the best diet for constipation, as too much fibre can lead to increased bloating and discomfort, especially for people with slow gut transit. If you feel that your diet is short on fibre, then try to use fruit and vegetables, which contain soluble fibre, rather than cereals with bran, which contain insoluble fibre, as they are less likely to cause bloating.

There are certain foodstuffs that can act as natural laxatives, examples of such foods are prunes, figs, liquorice, chocolate,

coffee, spicy food, curry, alcohol (within recommended limits) and molasses.

It is important that you should drink sufficient amounts of fluid daily (at least 8-10 mugs of fluid a day). Too much caffeine in the form of tea, coffee or cola can be dehydrating, as can too much alcohol.

Medications

Medications should only be used if the above measures, namely lifestyle changes and dietary manipulation, do not work. If it is really necessary, you can first try a fibre supplement such as Fybogel, bearing in mind that it can occasionally give rise to an increased bloated feeling and abdominal discomfort.

You can also try suppositories or micro enemas on a short term basis. There are a variety of laxatives you can take orally. Regular use of laxatives is generally best avoided but occasional use is not harmful. There is no convincing evidence that the colon is permanently damaged by long term laxative use. Some laxatives such as senna can produce dark/black discolouration of the inner lining of the bowel which can be seen with the camera examination of the bowel. The problem, however, is that with long term use the bowel becomes progressively less responsive to the increasing doses required. They can also cause pain and diarrhoea. Laxatives can also cause significant loss of minerals from the body which can result in changes in the body's chemistry. There is no evidence that long term laxative use puts you at increased risk of getting colonic cancer.

Suppositories or micro enemas are more predictable than orally taken laxatives and they can be very well tolerated and effective. Suppositories and enemas work by causing contraction of the rectum, softening the stool and by causing the bowel higher up to contract.

Biofeedback therapy

This is a bowel retraining program run by physiotherapists or specialist nurses. Biofeedback therapy is especially useful for the group of patients with constipation secondary to problems with inco-ordination between rectal contraction and anal sphincter relaxation. During biofeedback therapy patients are essentially shown how the muscles and nerves can be retrained to co-ordinate and produce satisfactory emptying of the bowel.

The therapy involves four or five one-to-one sessions between the patient and the therapist.

Abdominal or diaphragmatic breathing exercises for constipation

The purpose of this breathing exercise is to improve co-ordination between the abdominal muscles, the anal muscles, and your breathing pattern.

Who would benefit?

This exercise will help those who have constipation associated with obstructive defecation. Additionally, it may help patients who experience a feeling of incomplete bowel movement and those who have to strain excessively to open their bowels.

Your breathing pattern:

Usually, we breathe using one of two techniques – the chest type or the abdominal type. In order to understand your breathing pattern, place one hand on your upper chest and the other hand on your abdomen and take a deep breath. Inhale slowly. Observe the movements of your hands. If you see a greater movement of the hand placed on your chest, your breathing pattern is commonly referred to as the "chest type". On the other hand, if you observe a greater movement of the hand placed on your abdomen, your pattern is referred to as the "abdominal type". **The goal of this exercise is to achieve an abdominal type of breathing.**

Technique:

1. Choose a quite place where you can concentrate undisturbed for 20 minutes

2. Sit comfortably on a chair or a toilet seat with your feet at shoulder width

3. Rest your feet on a small stool at least 6 inches high

4. Place one hand on your chest and the other on your abdomen

5. **Inhale slowly and steadily** by taking a deep breath for 6-8 seconds as if sucking through a straw

6. When breathing in, you must observe and expect the hand placed on the abdomen to move outwards, as if you are trying to fill the abdomen

7. When breathing in, the upper chest and rib cage should not expand. Therefore, there must by very little or no movement of the hand placed on your chest

8. Next, you must **hold your breath** and count for 20 seconds

9. Then, **breathe out (exhale) gradually** over 6-8 seconds

10. You may pause briefly for 10-15 seconds before repeating the manoeuvre

11. Practice this breathing technique for 15-20 minutes at least 3 times per day. At first, this pattern of breathing may feel awkward. However, with patience and practice, this breathing pattern will become easy and natural. Remember, "practice makes you perfect".

Process of defaecation

1. A desire or urge sensation is felt. Be aware – do not ignore! Go to the toilet immediately. It is helpful to raise your feet about 6 inches using a foot stool. Feet should be shoulder width apart.

2. Take a deep diaphragmatic breath by inhaling slowly through your mouth as if sucking through a straw. Your shoulders should remain still and the abdomen should expand like blowing up a balloon.

3. Lean forward and bear down gently as you lean forward, remembering to gently increase your effort to a medium strong push, pushing evenly throughout your effort while relaxing the anal sphincter. Remember to push the same muscle groups in the abdomen and the rectum as you learned from the monitor.

Remember to do this technique every time you go to the toilet so that habit can be formed and maintained. **Do not strain.**

Do not spend more than 5-10 minutes in the toilet. If the bowels do not open do not panic. Try again at the same time next day. It may not be normal for you to pass stool every day. Remember the effect of the above exercise regime may not be evident immediately and it will take time and practice.

Surgery

The vast majority of patients can be treated medically. However, a small proportion of patients may end up having surgery. The most common operation is removal of all or part of the colon to improve the bowel function. However, the decision to undertake the above operation has to be made after careful consideration, as the results can be quite poor if patients are not properly selected. About a tenth of patients quickly return to their previous levels of constipation and about a third have incapacitating diarrhoea, some with a degree of incontinence. Some patients who have had part of their colon removed will eventually end up with a stoma (bowel

brought out to the abdominal wall with the bowel contents going into a bag), as a result of the failure of previous surgery.

When should you see your doctor?

If constipation is not responding to simple treatment and is causing symptoms such as abdominal pain and bloating etc, seek advice from your doctor. Sudden or gradual changes in bowel habits occurring for no obvious reason in people aged 40 years or more should be reported to the doctor, especially if there is rectal bleeding.

If English is not your first language and you need help, please contact the Interpretation and Translation Service

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The NCA brings together Salford Royal NHS Foundation Trust and the hospitals and community services of The Royal Oldham Hospital, Fairfield General Hospital in Bury, and Rochdale Infirmary (currently part of The Pennine Acute Hospitals NHS Trust).

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