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Managing Misconceptions Surrounding Chronic Constipation

Dr. Buch:
There are many misconceptions surrounding constipation. What do we need to know about these misconceptions in order to better diagnose and treat chronic idiopathic constipation, or CIC? This is *GI Insights*, on ReachMD. I'm your host, Dr. Peter Buch, and joining me today is Dr. Kyle Staller, who is an assistant professor of medicine at the Harvard Medical School, and the Director of the Gastrointestinal Motility Laboratory at Mass General. Dr. Staller is the coauthor of an article that was recently published in the American Journal of Gastroenterology, titled, "Myths and Misconceptions about Constipation: A New View for the 2020s." Dr. Staller, thanks for joining us today.

Dr. Staller:
Thank you so much for having me. Really an honor to be here and an honor to talk about one of my favorite topics.

Dr. Buch:
Perfect. Let's get into it. When interviewing patients, some of our colleagues accept the word constipation without asking more information. Why is this a misconception?

Dr. Staller:
Well, I think constipation by its very nature really is a sensory phenomenon in the sense that people are bothered by it for certain reasons, right? And what are those reasons? Is it the infrequency of bowel movements? Is it the consistency? Is it the symptoms that they have when they're having bowel movements? Or is it bloating because they have not had a bowel movement? And so, I think really meeting the patient where they are, figure out what do they conceive to be constipation, is very important because what they conceive to be constipation and what you, as the provider, do may be very different and sometimes treatment is just really bridging that gap.

Dr. Buch:
Thank you. Why is it a misconception to distinguish chronic, idiopathic constipation from irritable bowel syndrome with constipation?

Dr. Staller:
You know, this has been something that's been a topic of debate and some controversy, and really evolving definitions over time. In reality, the key for providers to realize is that irritable bowel syndrome fundamentally involves abdominal pain, and with the latest iteration of the Rome IV criteria, abdominal pain really takes predominance, in fact is the only symptom, whereas it used to be abdominal pain or discomfort, and discomfort was really open to interpretation. And so, when patients are primarily complaining of pain, then we're really thinking more on the IBS, irritable bowel syndrome spectrum. But in reality, patients really can vary from day to day, from week to week, from month to month. And so, I think, really asking the patient what bothers them the most really is what's going to be driving what your treatment approach may be, and in reality, a lot of the treatments that we have – although dosing may be different for some of the medications – we often are using a very similar armamentarium when we approach these patients.

Dr. Buch:
So basically, you're saying that the spectrum can change from one to the other, from idiopathic constipation to irritable bowel syndrome.

Dr. Staller:
That's right. And I think we also have to, again, sort of see the patients where they're at, both chronic idiopathic constipation or functional constipation, and IBS with constipation can involve abnormal physiology in the way that the colon works. So, both of those complaints can have slow transit from one end of the colon to the other. Both of those complaints can have pelvic floor dysfunction or erectile evacuation disorder, and both of those complaints, in my opinion, can have elements of visceral hypersensitivity.

Dr. Buch:
Thank you. Many of our colleagues are concerned about the development of colon cancer in young individuals. This has been further reinforced by the untimely death of Chadwick Boseman. When should young individuals with constipation get a colonoscopy?

Dr. Staller:
In general, constipation really shouldn't be a driver for a patient to get a colonoscopy, and that includes older patients as well. The data would suggest that despite the fact that we often think about changes in bowel habits as being an indicator for a colonoscopy, but really colonoscopy does not add to our ability to detect cancer when constipation is the reason that we're getting it. And so, in reality we should be using the normal alarm symptoms that we send anyone for a constipation – things like rectal bleeding. But I think even in younger patients, in the 20s and 30s, who are now presenting with newer onset constipation, the likelihood that colon cancer is driving this is really minimal.

Dr. Buch:
I wanna circle back, for those listeners who are not familiar with alarm symptoms. Could you just elaborate what alarm symptoms are, please?

Dr. Staller:
I think, you know, the things we think about – bright red blood per rectum, weight loss – these types of things, particularly when it comes to colon cancer. A family history always sort of adds, and makes any alarm symptom more relevant. But these are the kind of things where, you know, when we hear the anecdotal stories of young patients with colon cancer, who may have been, sort of, blown off or may have had their diagnosis delayed, these are often patients who really had ongoing bright red blood per rectum, or bleeding that really wasn't paid attention to, and was attributed to hemorrhoids or things like that, because they had constipation. And so, that's – I think certainly constipation can lead to bleeding, because of fissures, because of hemorrhoids, etc. But I think ongoing bleeding does merit investigation.

Dr. Buch:
Thank you. For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today I'm speaking with Dr. Kyle Staller about misconceptions surrounding constipation. So, Dr. Staller, what are your recommendations for lifestyle changes and fiber use in constipation?

Dr. Staller:
I think this is a great question, because I think when patients approach you as a physician or as a provider, with a complaint of constipation, they're coming in with a preconceived set of ideas about perhaps something that they are doing that's making them constipated. And I think, very important, early on when I meet patients, it's sort of figuring out what type of constipation patient am I dealing with today? Is this sort of a green light kind of constipation patient — someone who has very mild, intermittent constipation? Probably less likely to be referred to a subspecialty center, maybe presenting to their primary care provider. Or is this sort of a yellow or a red light — someone who's really having chronic symptoms, really affecting their quality of life is really starting to affect the way that they approach life, perhaps even associated with some degree of disability? So, when I see the green light people, you know, these lifestyle changes, I think probably can be helpful. I think drinking more water probably physiologically is not going to make a huge difference unless the patient is dehydrated. That's a common misconception, that water is going to be the key to solving all constipation. And similarly, fiber – I think for your average patient, intermittent constipation fiber supplementation can make a difference. But when we're looking at the chronic patient, right? The patient who has been constipated for at least six months. This is probably some manifestation of a neuromuscular dysfunction in the colon that we have yet to fully understand. These patients, it's really a drop in the bucket to be giving them fiber, and in some cases, fiber may make symptoms worse.

Dr. Buch:
Are there any insights you would like to share regarding constipation in older adults?

Dr. Staller:
We do know, from the epidemiologic data, right – if we look at large populations of patients – that as people get older, they are more likely to become constipated. And the reasons for this could be variable. I mean, certainly we know that the colon likely slows down, in terms of its transit from one end of the colon to the other, as people age. The colon tends to be somewhat less resilient, for example, than the small bowel, in sort of resisting, sort of, the onslaught of aging. We know that people may develop some degree of pelvic floor dysfunction, meaning that the stool gets to the end of the colon, and then it's not able to be effectively pushed out. And then lastly, we think about medication. I think, you know, probably pharmacy is certainly a big issue in the United States and many other countries, but there may be many medications that may exacerbate constipation and the patients, or the prescribers of those medications may not be thinking about constipation as a potential side effect.

Dr. Buch:
Next question is how do you decide which patients with chronic, idiopathic constipation need surgery?

Dr. Staller:
I think the short answer – the knee-jerk answer should be none. I think as we look through the history and the case reports of patients who have had constipation-related surgery, and specifically, we're talking about the removal of the colon, right? Because that's really what we're doing. In most cases, we're doing a total colectomy and maybe an ileorectal anastomosis — we're connecting the end of the small intestine to the rectum. Many patients are coming back with symptoms that are ongoing. And so, one thing that we've developed at our institution is a very, very clear guidance as to which patients should go for constipation-related surgery to remove their colon. And what that guidance does is really almost treat constipation like a transplant. As I said, the outcomes are not very good. We really have this very strict protocol at Mass General on patients who are potentially considering surgery for constipation, and we make sure that they really undergo a thorough physiologic evaluation first. We need to make sure that they actually have slow transit constipation, right? Constipation is multi-factorial. And then we wanna make sure that in those patients who really are predominantly complaining of pain or bloating, that those patients may not necessarily be the most appropriate candidates for surgery. And then, you know, one maxim that I keep in mind when I'm treating patients with any motility disorder anywhere in the GI tract is that, you know, nerve dysfunction, which is primarily what drives constipation, it doesn't respect anatomic boundaries, which means it may be very likely that someone with very severe constipation also may have abnormalities in the motility of their stomach or their small bowel as well. And you can imagine removing the colon – you're leaving those problematic areas behind. And then finally, we do a formal psychological evaluation, and the reason is we think of a colectomy almost like a transplant, right? It needs the right patient, who's going to be able to understand what does surgery entail, what will it and what will it not solve, and really do they have the coping mechanisms and the support systems in place to be able to deal with some complications that may happen after surgery, and also have realistic expectations about what surgery can and cannot do.

Dr. Buch:
I think that was excellent, and it goes back to the old maxim, "Primum non nocere." Above all, do no harm. So, last question – what additional message do you wanna share with our audience today?

Dr. Staller:
I think the most important things that I think are often missed is really taking the time to ask your patient, "What bothers you the most?" And I always say, "If I had a magic wand, and I could get rid of one of the symptoms, what would you say?" And if patients tell me infrequent bowel movements — well, that's a patient who will maybe do really well with laxatives. And ultimately, if it were really severe, they might do well with surgery. But inevitably, when I see a patient at the tertiary level, and I ask them, "What bothers you the most about constipation?" Often, they're telling me it's bloating, it's abdominal distention. And the other thing to keep in mind is many of these patients, you know, it's called chronic constipation, yet there is this really long-held belief that probably because constipation is something that we all may experience at one time or another, that people with chronic constipation need to do something better in their lifestyle. But in really chronic patients, the first thing I do is really disconnect that there's something that they're doing wrong. And many patients, once they take a regular laxative agent – and it may not necessarily be a prescription agent, it may be something over-the-counter – many of them can actually do quite well.

Dr. Buch:
Well, that's all the time we have for today, but I want to thank Dr. Kyle Staller for joining me to discuss misconceptions and treatment recommendations for patients with chronic, idiopathic constipation. Dr. Staller, it was great speaking with you today.

Dr. Staller:
Thank you so much for having me. It's been an honor.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this episode and others from *GI Insights,* visit reachmd.com/giinsights, where you can Be Part of the Knowledge. Thanks for listening!