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Solutions for Defeating the Negative Impacts of Refractory Constipation

Dr. Buch:
This is ReachMD, *GI Insights*. I'm your host, Dr. Peter Buch, and today I'll be discussing best practices for evaluating and treating refractory constipation with Dr. Joy Liu. Dr. Liu is an Instructor of Gastroenterology and Hepatology at the Feinberg School of Medicine at Northwestern. Her special interests include constipation, motility, and irritable bowel syndrome.

Welcome to the program, Dr. Liu.

Dr. Liu:
Thank you for having me, Dr. Buch.

Dr. Buch:
It's truly a pleasure. To get us started, Dr. Liu, how would you define refractory constipation?

Dr. Liu:
So I like to start out by asking my patients very specific questions about constipation. I think it helps to ask them what they mean in terms of number of bowel movements, the kind of stool that they're seeing, what other associated features there are of the constipation, such as straining, feeling like there's blockage, or just feeling like they can't have a good bowel movement. It takes a few extra minutes to ask these questions, but I think it's important because we get a sense of what their expectations are of what is normal versus abnormal. And we may also be able to identify issues that make this refractory constipation versus constipation that maybe just hasn't been adequately treated yet.

I think one good definition of refractory constipation that I've seen in the literature has been that individuals who don't have a response in their symptoms to lifestyle changes, which includes increasing fiber intake and using at least one over-the-counter osmotic and stimulant laxative. However, when there are people who come into clinic saying that they have constipation and they've tried things from the drugstore and it didn't work, when we start to get into the details, they may reveal that they tried MiraLAX or PEG, and they tried it just a couple of times, didn't get a result, and so they feel like they've not had success, and now they're looking for something else. I sometimes will do counseling with people about how it's normal to not have one perfect bowel movement every single day but that there is that spectrum of normal, which I think can be reassuring to people, and also that a lot of medications that we use for constipation are not always on-demand and may take a few days to work. So that's my definition, and also my approach to figuring out what is truly refractory.

Dr. Buch:
Thank you for that. So now let's go into a little bit more depth of this. What are the potential etiologies of refractory constipation?

Dr. Liu:
So a lot of my patients think that constipation only comes from a slow colon, and so they are surprised when we talk about other potential etiologies, including pelvic floor dysfunction, which I think is probably the other major point on the differential. So in terms of diagnosing slow-transit constipation and pelvic floor issues, such as dyssynergia, we use different kinds of studies to figure that out. I do think that if there has not been a colonoscopy recently, in the last few years, or if somebody is due for screening purposes, it's still worth considering whether that test should be performed to rule out a mechanical obstruction even in people who have had constipation for a long time.

I do have some patients who present with features of overflow incontinence, and so their perception is that they're having leakage and diarrhea when in fact the etiology may be refractory constipation, and for those people it can be helpful to get a quick x-ray to see if

there is a significant stool burden to help convince them that we actually need to treat constipation and not use Imodium on a regular basis.

For diagnosing pelvic floor disorders, I typically reserve anorectal manometry for individuals who have not had response to at least one prescription medication for constipation. I'd like to think that there are certain symptoms that may be more associated with pelvic floor issues, also called defecatory disorders or outlet evacuation disorders. Some of these symptoms are things like feeling like there's always incomplete evacuation and having the sensation of blockage in the anorectum. However, in studies that have been done looking at this, there hasn't been a great correlation identified between specific symptoms and different etiologies of constipation. I suspect that part of this may be because outlet disorders can affect colon transit time, and so there may be some difficulty in separating those two completely, but in general, I think the diagnostic workup depends more on the severity of constipation and lack of response to traditional agents.

Dr. Buch:
Thank you for that clarification. And you were just alluding to some of the testing. Can you talk a little bit more about the testing to clarify the diagnosis?

Dr. Liu:
Yeah. So I think that anorectal manometry is a real game-changer when it comes to diagnosing and treating refractory constipation. Anorectal manometry is used to diagnose conditions including defecatory dyssynergia, puborectalis spasm. It can be useful as well for looking at sensation issues, whether somebody has primary or secondary rectal hyposensitivity that may be contributing to the symptoms associated with constipation. I also think that there is a limited role for colon transit studies, such as the sitz marker study. As I had previously mentioned, we think that the colon transit studies can be abnormal if the anorectal manometry results are abnormal, and so it is not always helpful to get just that test. I like to start with the anorectal manometry and work on any abnormalities that are found, and then consider a colon transit study if there are persistent issues.

Dr. Buch:
For those just tuning in, you're listening to *GI insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Liu about refractory constipation.

Now that we have a better understanding of diagnosing patients with refractory constipation, Dr. Liu, what treatment options are available?

Dr. Liu:
There's a lot of great treatment options. So thinking about the people who are coming in with refractory constipation, these are probably individuals who have already tried increasing the amount of fiber in their diet, staying hydrated, trying over-the-counter laxatives, and so typically, we are talking about classes of medications like the secretagogues, like linaclotide, plecanatide, and lubiprostone, as well as prokinetics like prucalopride.

For specific situations, such as in opioid-induced constipation, the PAMORAs can be a helpful class of medications. We like to distinguish between constipation that is new with the onset of opioid use versus pre-existing constipation that is exacerbated by opioid use, and we find that the PAMORAs are especially helpful in people who have new-onset constipation, whereas people who previously had constipation and are having worsening on opioids may still benefit from agents like the secretagogues.

In addition to these medications, there is a vibrating capsule now that can be used to treat constipation. That is FDA approved as of last year. Any patient who has tried at least one over-the-counter laxative, I think potentially, qualifies to try this vibrating capsule, which in the clinical studies was associated with inducing a bowel movement in 50 percent of individuals within three hours of activating the capsule, so that's been a very interesting option for some of our patients.

When it comes to other etiologies of constipation, like pelvic floor disorder, pelvic floor physical therapy is a critical treatment, and we like to ask our patients specifically about what kind of interventions are being performed during physical therapy. Are they getting abdominal massage and learning breathing exercises? Are they having any kind of internal rectal work that's being done such as balloon expulsion? Are they doing biofeedback? And if they're doing biofeedback, is it with external sensors, or is it digital rectal biofeedback? Knowing the details of what kind of treatments they're undergoing can mean the difference between having a successful treatment regimen versus a patient who comes to you and says, "I tried PT, but it didn't work." It could be because they didn't get bowel-specific pelvic floor PT.

One class of constipation that I hadn't mentioned before is when individuals have refractory constipation from neurogenic bowel, and one option that has emerged there is using a device for transanal irrigation because a lot of these patients respond more to rectal therapies, so that would be like the Peristeen. We're trialing that in some of our clinic patients.

Dr. Buch:
And a couple of follow-up questions, Dr. Liu. What's your favorite secretagogue? And why?

Dr. Liu:
So I would have to say the answer is probably going to be different for everybody just based on their personal experience, and so my personal experience has been to use linaclotide just because we have the most amount of data available for that agent and that is the one that has a strong recommendation with a good evidence base from both the AGA and the ACG.

Anecdotally, I think of plecanatide as a gentler secretagogue, and so it may be better tolerated especially in some of my older patients. And then I think that a prokinetic, like prucalopride has a lot of interest for whether it's effective for people who also have slowed stomach emptying or gastroparesis because of data in the trials showing that there was decreased gastric transit time. So I will sometimes use this medication for constipation and make sure the insurance companies know that I'm using it for constipation but specifically in my patients where there are also upper GI symptoms and gastroparesis.

Dr. Buch:
Very useful information. So now a real key question is when should surgery be considered for refractory constipation? And when can we get into trouble in considering surgery?

Dr. Liu:
Surgery is always, I think, a tricky topic, and I think really should be considered a last resort for people who have refractory constipation or pelvic floor disorders. There are several different situations that may warrant consideration of different surgical approaches. This is when we need to really do our homework and make sure that our patients have adequate motility testing before sending them to see the surgeon. So in the event that a person has delayed colonic motility but has normal pelvic floor function as seen on anorectal manometry, that's a situation where I think consideration of a total abdominal colectomy could be considered if the patient really has not responded to any medical therapy. If the patient has normal colonic motility but they have severe refractory pelvic floor issues surgical approaches, like a sigmoid colostomy or potentially a temporary trial of a loop ileostomy could be considered. For people who have both severe constipation by a delayed colonic transit and refractory pelvic floor disorder loop ileostomy could be considered as well.

Dr. Buch:
As we come to the end of our discussion, is there anything else you would like to add?

Dr. Liu:
For refractory constipation, one thing that I like to evaluate for is the psychological impact of these symptoms on our patients. I have had patients come to clinic who are afraid to leave their house because they're not sure if they're going to need to evacuate. They're unable to perform normal work duties because they're in the bathroom for three or four hours a day and all of that can be extremely draining on a person. Some patients may benefit from seeking general therapy to discuss their health issues, and other people may actually benefit from specific GI psychology to address issues of psychological factors that may be contributing, especially to pelvic floor disorders or to learn coping mechanisms or relaxation techniques for the severe symptoms of constipation. At Northwestern, we're very lucky to have five GI psychologists, so I am very lucky to be able to refer people who are in distress to my colleagues. However, there are some apps that can be used for IBS with constipation that are widely available, so I would encourage people to check those out.

Dr. Buch:
I want to thank my guest, Dr. Joy Liu, for educating us about this very important topic. Dr. Liu, I really enjoyed our conversation today.

Dr. Liu:
As did I. Thank you so much.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.