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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Understanding and Treating Chronic Constipation

DIFFERENTIATING OCCASIONAL AND CHRONIC CONSTIPATION FROM IBS-C

You are listening to ReachMD XM160, The Channel for Medical Professionals. Welcome to GI Insights where we cover the latest clinical issues, trends, and technologies in gastroenterological practice. GI Insights is brought to you by AGA Institute and sponsored by Takeda Pharmaceuticals North America. Your host for GI Insights is Professor of Medicine and Director of the Digestive Disease Center at The Medical University of South Carolina, Dr. Mark DeLegge.

Constipation is a common symptom can have various underlying causes. How can we determine the best methods for treating occasional and chronic constipation. Joining us to discuss chronic constipation is Dr. David Peura, Professor of Medicine at the University of Virginia School of Medicine and past president of The American Gastroenterological Association.

DR. MARK DELEGGE:

Welcome Dr. Peura.

DR. DAVID PEURA:

Well Mark thank you very much.

DR. MARK DELEGGE:

David I am bombarded with commercials and print ads about having a normal or comfortable bowel movement or changing my bowel movements to be less constipated. Just how common is this diagnosis of constipation?

DR. DAVID PEURA:

Well Mark that really depends, I guess, on you know where you are seeing the patients, what sort of practice. It is estimated some where over may be between 10% and 15% of the adult population is going to have a diagnosis of constipation. Many of those people don’t actually see their physicians or health care providers. About 10% to 15%, much more common in women, about 2 to 3 to 1 woman to men and it also increases with age. So if you are seeing a large number of chronologically gifted patients, let's say, in your practice, you

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are going to be seeing more patients with constipation. It is estimated that almost a third of individuals say over the age of 60 are going to have constipation and it's almost as high as 50% if you look at institutionalized patients. So its really a common problem. No wonder you are inundated.

DR. MARK DELEGGE:

You are absolutely right. Well my other question then is, I have heard about this irritable bowel syndrome, constipation predominant and then separately patients who are chronically constipated. Is that the same group or are they different?

DR. DAVID PEURA:

Yeah Mark, they are very different people and I think that a lot of confusion arises from chronic constipation versus irritable bowel, the constipation predominant type. You really have to talk to people and try to get an idea of what their major symptoms are and chronic constipation means different things. We will probably talk a little bit about that what it means to patients is we go on, but chronic constipation usually is a painless condition. Pain is not a major component. People are just unsatisfied with their defecation. Whereas individuals that have IBS, the hallmark is really going to be abdominal pain. So if somebody comes to you and they are complaining of abdominal pain and they are unhappy with their bowel movements, likely they have IBS. If they come to you just complaining of being unsatisfied with their bowel movements, likely they have chronic constipation. It is going to be important to make that distinction because the treatment is going to be a little bit different.

DR. MARK DELEGGE:

From that perspective, what causes constipation? When I was growing up, my mom always told me, you know you are just stressed, that's what the problem is, is that what it is?

DR. DAVID PEURA:

Yes, stress could play a little role in it, but you know I think that some of our lifestyle probably has something to do with it. We traditionally divide constipation into primary and secondary causes. Primary causes are you know just things like colonic inertia. The colon doesn’t work very well, and that's not a very common diagnosis. That's what people think is their colon isn't working, but when we do tests on these people that only makes up probably less than 5% of our chronically constipated individuals. There are some people thought that have disordered defecation. Maybe about 15% to 20%, maybe even higher if we really tested them. Those are people that just have difficulty relaxing their sphincter. You know when people strain, they have a bowel movement. Their sphincter is supposed to relax, but there are people with disordered defecation that harder they strain, the more the sphincter actually contracts. So its like having a bowel movement through a shut door and that's a unique population that requires a different treatment, but the majority, probably over 65% to 75% of folks actually have what we call normal transit, the stool gets through the intestine in a reasonable time. It is just the patients are having difficulty passing the bowel movement. We always have to think though about secondary causes, that's the challenge for us as healthcare providers, especially in our older folks who are taking multiple medications. Remember many of the meds that our patients are taking have potential side effects that can result in constipation. We need to think about structural problems, we always worry about colon cancer, that's why we image people. Endocrine diseases and diabetes. People think about diarrhea being a common sequela of diabetes, but actually the most common GI sequela of diabetes is going to be constipation. Remember things like hypothyroidism, hypercalcemia, you know, muscle problems as people get older, they just get weaker. They don’t have the muscle strength that they used to when they were younger, so they end up doing a lot of straining. So primary and secondary causes really are things that we need to consider when we are evaluating our folks.

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DR. MARK DELEGGE:

David I know there has been a lot of talk about how to approach a patient with constipation, meaning some of us in the office and they start to talk about their bowel movements and lets just say you suspect constipation as a diagnosis, is there an algorithm or some way that a practicing gastroenterologist should approach these patients?

DR. DAVID PEURA:

Remember Mark most of these patients really are coming to the primary care physician, so by the time they see us as gastroenterologists, often times they have been evaluated and treated, but I think the biggest challenge that folks face is communication. You know just talking about trying to get an idea of what bothers the patient, I mean, you and I, I am sure, were taught when we were in medical school and early on in our training that constipation was quantity based. People weren't having enough bowel movement. Really most people aren't as much concerned about quantity as they are about quality. They are more concerned about straining or hard or lumpy stools or sensation of incomplete evacuation. So I think the first thing in the algorithm is really to get on the same wavelength as the patient. Ask the patient to really describe what their major concerns are. Because your approach is going to be very different if they are just having hard stools, about a hard stool once a day versus having a stool every 5 or 6 days, so unless you can really get a definition of what is bothering the patient, you are not going to be able to proceed in effective management.

DR. MARK DELEGGE:

If you are just tuning in, you are listening to GI Insights on ReachMD, The Channel for Medical Professionals. I am your host, Dr. Mark DeLegge and joining me to discuss chronic constipation is Dr. David Peura, Professor of Medicine at The University of Virginia School of Medicine and past president of The American Gastroenterological Association.

David how about lifestyle changes, does that work at all for patients who are constipated, is it really effective?

DR. DAVID PEURA:

Well you know Mark, something we always do, I mean it makes sense to tell our patients to drink a lot of liquid and we tell our patients to bulk up their stools with fiber and we tell them to exercise, but you know if you really look at the data. You are an evidenced-based physician, you probably wouldn't recommend those things, but I am going to continue to recommend them because patients expect some sort of lifestyle advice. They know that probably part of what they are doing is contributing to their problem, but a couple of things that you know I find are very helpful. #1, I always tell my constipated patients to make sort of a dedicated bathroom time. You know Mark we live in a society, where we are sometimes to busy to stop and have a bowel movement. If we neglect that or if we ignore that urge to have a bowel movement frequently enough, we are going to lose that urge. So I tell patients to you know in the morning usually because right after breakfast or the cup of coffee because that is when the gastrocolic reflex seems to be on its height. I ask them to sit on the toilet and to strain. They say well doc how hard should I strain? Well I say that you know if 10 is straining so you blow an aneurysm, you know some where around a 5 or a 6. So they do that and see if they can have a bowel movement. The other thing I got in the habit of doing recently is using probiotics. You know there is not a lot of evidence to support them, but there are some data to suggest that you can improve bowel function with certain of the probiotics and some of the supplemented yoghurts for example have been shown to improve bowel function. You know there are a 100 trillion cells in our body, only 10 trillion or around 90 trillion are bacteria. So they have got to be doing something and I think that we are going to find it, sort of altering or modulating our gut flora probably it is going to play a role in managing lots of things, not only just constipation.

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DR. MARK DELEGGE:

How about from the perspective of someone that comes in and says I am having constipation, but it ends up being every couple of weeks versus the person, who is chronically constipated. Is there a difference in how you would approach the treatment in them?

DR. DAVID PEURA:

Yeah I think there is Mark, I think the first scenario you described is sort of an occasional phenomena. Those patients generally do real well with you know some over-the-counter health and some of the over-the-counter laxatives, osmotics, PEG for instance polyethylene glycol is now available over-the-counter and its approved for you know 7 days of use for occasional constipation and those are also the patients that probably are going to benefit most from lifestyle, but the patients I am sure they challenge you and me are the ones that have constipation all the time. It is not an occasional thing, I mean occasionally they may have a normal bowel movement, the rest of the time, they are constipated. Now those patients you know do benefit maybe a little bit from lifestyle modifications, I still as I mentioned do recommend that. We use off-label medications, over-the-counter meds like PEG, it is only approved for episodic or occasional constipation, but I am sure you like me will give polyethylene glycol to patients long term, lactulose is something that is out there. It is a prescription medicine, it is a nonabsorbable sugar that sort of works as an osmotic laxative and helps some people. The problem with lactulose in at least my practice is patients get a lot of gas and bloating. Because remember giving lactulose to somebody is like giving somebody with lactase deficiency a couple of glasses of milk to drink. So you know they are going to be unhappy and then there are some new things. There is a new medication lubiprostone, which has a unique mechanism of action. It actually opens up chloride channels in the intestine. How we move fluids and electrolytes from one space to another is through chloride channels. So what it does is, it opens a type 2 chloride channel and fluid and electrolytes can come into the small intestine and stimulate peristalsis, but it has been recently approved for IBS-C also. That's why it's so important that you make a distinction between chronic constipation and irritable bowel because the dose is different. In chronic constipation, the higher dose, it is 24 mcg twice daily and in the IBS-C patients, it’s a third of that. It’s an 8 mcg dose twice daily. So you really have to make that distinction. So you give a high enough dose for the chronic constipation patients and not too high a dose for the irritable bowel patients.

DR. MARK DELEGGE:

Dr. Peura thank you very much for being our guest this week on GI Insights.

DR. DAVID PEURA:

My pleasure.

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