Exhaust Medical Management First for Constipation

BY SHARON WORCESTER
Southeast Bureau

FORT LAUDERDALE, FLA. — Constipation is a common complaint, and the causes for this condition are varied, Dana R. Sands, M.D., said at a symposium on pelvic floor disorders sponsored by the Cleveland Clinic Florida.

In a survey of more than 10,000 people, nearly 14% reported difficulty with evacuation, including infrequent defecation, incomplete defecation, and blockage of bowel movement.

"A surprising 12% said they need to use digital maneuvers in order to defecate—that's a high number," said Dr. Sands of the Cleveland Clinic Florida, Weston.

Among the causes of constipation are paradoxical puborectalis contraction, rectocele, and pelvic floor failure, including rectal prolapse and rectoanal intussusception, but sometimes the cause is simple.

Those who haven't tried fiber supplements and increased water intake will often find their constipation is "miraculously" cured simply by trying these two things, she noted.

But a thorough history and physical examination are important in all patients, and every complaint of bleeding and obstruction should be investigated, she said.

"It's our job to make sure rectal bleeding really is from hemorrhoids, and that constipation really is constipation," and that obstructing cancer is not the cause in either case, she said, noting that she performs colonoscopy on all patients reporting changes in bowel habits.

Defecography, surface EMG, anal manometry, and colonic transit studies also may be useful. She said she also orders a cursory panel of blood work including measurement of thyroid-stimulating hormone, to look for obvious and easily correctable metabolic processes that could be causing constipation.

Most patients will be diagnosed on the basis of TSH, defecography, and/or surface EMG findings, she said.

Regardless of whether constipation is caused by dietary or metabolic conditions or by a benign condition that could be treated surgically, medical management options should be exhausted first.

For significant outlet obstruction caused by paradoxical contraction, for example, biofeedback and/or botulinum toxin (Botox) injections may be helpful. Biofeedback has had varying success, with studies showing success rates from 8% to 100%.

In a Cleveland Clinic study of 194 patients who used biofeedback, 68 (35%) had complete resolution of symptoms, 27 (14%) had partial resolution, and 99 (51%) had no improvement. However, when patients were analyzed separately according to whether they completed all 10 biofeedback sessions, those who did complete all sessions had a success rate of 63%, compared with 25% in those who did not. Motivated patients are going to have better success, Dr. Sands said.

As for use of botulinum toxin, a small series involving four patients injected with 30 U of Botox showed good results. One patient required reinjection, but none experienced incontinence. In another series involving 17 Cleveland Clinic patients injected with an average of 50 U of Botox, 11 (64%) had improvements in symptoms, and only 1 had transient fecal incontinence.

For patients with a rectocele, it is best to base therapy on the functional, rather than the anatomical, problem, Dr. Sands said. Try medical management, but consider surgery in patients with rectoceles greater than 4 cm who fail to respond and in those who must use rectal or vaginal digitation or perineal support maneuvers to defecate.

Rectoanal intussusception is more difficult to treat. Start with dietary modification and fiber supplementation. Then try biofeedback, but don't expect too much, she said, noting that outcomes were somewhat disappointing in a recent study of 36 patients treated with dietary therapy, biofeedback, or surgery.

Of 13 patients receiving dietary therapy, 5 improved, 6 had no change, and 2 worsened. Of 13 in the biofeedback group, 11 improved or had no change, and 2 worsened. Of 10 who underwent surgery, 6 improved, 1 had no change, and 3 worsened.

For rectal prolapse, it's important to evaluate for associated anterior compartment prolapse and to consider combined surgical correction when warranted.

In the most severe cases of constipation, colostomy may be necessary, although it should be a last resort. If you do perform a colostomy in these patients, consider it permanent, Dr. Sands said. ■

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