gihealth.com.au reception@gihealth.com.au 03 9709 2777

Endoscopy Gastrointestinal Medicine Nutrition

# The Centre for GI Health

# CONSTIPATION

Constipation can be an embarrassing topic to discuss with your doctor, however it is relatively common, up to 17% of adult Australians admit to using laxatives on a regular basis.

We usually define constipation as the passage of less than three stools per week, however the passage of hard pellet-like stools more frequently than this may also be considered as constipation.

Often there is a no obvious cause to explain the development of constipation, the bowel is said to be "hypotonic" or "lazy". The time it takes for food residues to travel the length of the bowel is increased, predominantly due to diminished propulsive muscular activity (prolonged transit time).

Other causes of constipation include: dysfunction of the rectal sphincter and pelvic floor muscles (this may be seen in patients that have had either pelvic surgery or who have had several children), neurological damage (spinal injuries), diminished thyroid activity (hypothyroidism), disturbed calcium and potassium metabolism, a variety of drug therapies e.g. anti-depressants, anti-parkinsonian drugs, iron medications and some hypertension treatments (calcium channel blockers), as well as opiate based "Painkillers".

Colonoscopy and barium enema are two investigations often used to diagnose the cause of constipation. Other investigations may include nuclear medicine transit studies, defecating proctogram and anorectal physiology studies.

## TREATMENT

How we treat constipation depends on what the underlying cause is. In general, when the bowel is transiting slowly or "lazy" the following treatments may be helpful.

### 01 INCREASE YOUR DAILY FIBRE INTAKE

Ensure that you are eating regular cereals and leafy vegetables and consider supplementing your fibre intake with psyllium, ispaghula or guar based products (e.g Metamucil / Fybogel / Benefiber): 2-6 teaspoons in divided doses daily. In some cases it may be necessary to commence other laxatives (see below) to establish bowel activity before introducing a high fibre diet.

### 02 INCREASE FLUID INTAKE

It is important to maintain a high fluid intake - between 1.5 - 2 litres a day of fluid may be required. This should include a variety of juices and water. (Coffee contains a natural diuretic agent and is therefore not optimal).

### 03 TOILET TRAINING

Try to enhance natural physiological reflexes by training your bowel to work at specific times. The bowel is normally activated maximally following meals, take advantage of this by trying to toilet at a regular time after either breakfast, lunch or dinner. Do not resist or inhibit the normal "call to nature".

### 04 LAXATIVES

In many cases, laxatives will be required. Osmotic type laxatives such as Duphalac (Actilax), Sorbitol and Movicol, draw fluid into the colon "lubricating" contents and are considered first line laxatives. Ultimately stimulating laxatives may be required. Judicious use of products such as Nulax. Coloxyl & Senna, Blackmores "Peritone", Blackmores "Colon Care" or Dulcolax could be considered. Colon purgatives such as Colonlytely or Picolax may be used in a cautious fashion to manage the obstinate bowel as may enemas (microlax, Glycerin).

### 05 LIFESTYLE CHANGES

Regular exercise may improve bowel function.

### 06 PELVIC FLOOR PHYSIOTHERAPIST

Referral to a specialised Physiotherapist is mandatory in patients requiring pelvic floor rehabilitation.

### 07 SURGERY

Rarely surgery is required for chronic constipation that does not respond to medical treatments. An operation referred to as subtotal colectomy with ileorectal anastomosis (removal of the non-functioning colon) is the most common operation performed in this situation.