Constipation: Going With the Flow - Frankly Speaking EP 12

Transcript Details

This is a transcript of an episode from the podcast series "Frankly Speaking" accessible at Pri-Med.com. Additional media formats for this podcast are available by visiting http://www.pri-med.com/online-education/Podcast/constipation-going-with-the-flow-frankly-speaking-episode-12.aspx

Dr. Frank Domino:
Turning 50 was easy for me, as for the most part, by that age I had already developed osteoarthritis and hearing loss. So there were not too many new surprises. Yet what I was not prepared for was that I developed constipation. Joining me today is Dr. Robert Baldor, Senior Vice Chair and professor at the University of Massachusetts Medical School. He and I are going to be discussing the diagnosis and management of chronic constipation. Welcome to the show, Bob.

Dr. Robert Baldor:
Thanks, Frank. Pleased to be here, and I'm sorry to hear about that unfortunate development.

Dr. Domino:
So, Bob I'm 56, I'm cruising along through life, I eat a very high fiber, vegetable based diet. I exercise regularly. And all of a sudden, I develop constipation. What's the initial work up for patients who for no apparent reason suddenly develop problems with constipation?

Dr. Baldor:
Well, that's a good question, but let me back you up a little bit, what the heck is constipation, right? So, there is, trying to think about the definition as to what this is, and there is a... The American Gastrologic Association has a definition, which is, "Unsatisfactory defecation with infrequent stools, difficult stool passage or both." So, people look at this saying, "Well, if you're

not going at least three times a week, you're constipated, or you're not going daily." So I think a little bit of this is when you're asking somebody who's coming in saying their constipated, you want to get a little bit of a history as well. You want to find out what do they mean by that, are they not going as frequently as they'd like? Are they having pain or difficulty when they're moving their bowels? And so on. So tease that out. So, if indeed you've got somebody who's

having difficulty moving their bowels, it's important to think about the pathophysiology underlying bowel movements and constipation.

So, there's two components to this; when you have something to eat, it's gonna make it's way through your system, it's got to get through the digestive tract and it's gonna deliver itself into the distal colon and ready to be expelled. So some people can have problems with transit time. So, you've got slow transit time, it's taking too long for the intestinal contents to get down into the rectum to be expelled. Other people, are doing fine. Things flow along okay, but when it gets to that area, if they're having trouble expelling it and that's because they're having problems with sphincter function. So there's two pieces to this component of it. Although, if it turns out most folks have what's called functional constipation. Where if you actually measure their transit time, it's normal and they actually don't have any sphincter dysfunction, if you look at that.

So, what's going on there, and that's a little bit what probably you were having, this, "I'm eating lots of fruits and vegetables, and so on." Well, turns out, you're probably not obeying the urge. So, believe it or not, Frank, we're actually programmed to move our bowels. We have built-in reflexes in our intestinal track, and I won't go through all of this, but you may have remembered it back from when you were in medical school, but when you eat something and it... Your stomach stretches. As you stretch your stomach, about five minutes later a signal goes to your rectum that says, "Okay, whatever's in there, move it along. Let's dump things out." It's built-in to have that have happen.

So, typically, you've had your breakfast, and what's happening? You're not thinking, "I'm gonna go sit on the pot," right? [chuckle] You're thinking, "I've got to get in my car and drive to work." So

you do is you suppress the urge, is the urge to go. Now what happens is, if you have to urinate, you get the urge to urinate, you can suppress that urge. 20 minutes later, maybe you can suppress it again. Within half an hour, you've got to go. There's no way you can continue to suppress that urge to urinate. Well, because it recurs rather frequently. Over in your bowels, that urge recurs every four hours. So, you've suppressed it, because now you're jumping in your car to go work, and now four hours later, what's happened? When the urge comes back? Well, you're at work.

Dr. Domino:
I'm Busy.

Dr. Baldor:
You're busy, but you're not gonna use that public restroom, you're gonna wait 'til you get home. Anyways, this is what happens to people; they suppress the urge over and over again until they become constipated either because they're busy or they don't want to use a public restrooms or they're doing other things as part of that. So, keep all that stuff in mind when you're seeing somebody with constipation. Now, red flags are important. You asked about work up. It turns out, new onset constipation after the age of 50 is a red flag, Frank. So, I don't know if you've got your colonoscopy or not.

Dr. Domino:
I did. I did, Bob. It's all good.

Dr. Baldor:
Alright, 'cause you're concern after that is there's somethings going on and we think about colon cancer really. The other red flags are melena, hematochezia, unintentional weight loss. I don't think that's happened.

Dr. Domino:
Thank you, no.

Dr. Baldor:
Or anemia. So, if you see those red flags, you should pursue the colonoscopy. The other part of this is if someone's having a severe problem, again, you should do... Again, I talked about the history, but a physical exam. You should do an abdominal exam looking for any masses, or so on. A rectal exam, looking for pain or fissures or different things that are going on as well. So, those are all the sort of things you should be thinking about. I tell you, I don't tend to do that a lot, but if there's a severe problem where people aren't responding to my therapy, then I'll be a little bit more aggressive with my physical exam.

Dr. Domino:
How about tests, Bob? What should we order?

Dr. Baldor:
Well, I think it's appropriate to think about underlying metabolic disorders that can cause this, and so I certainly would grab a CBC. Again, you're looking more for anemia with that and do

glucose, 'cause we certainly know that diabetics have decreased transit time and constipation is a problem for them. Thyroid testing, creatinine, looking for any renal dysfunction and calcium, but those are the only tests you really need to be doing on a routine basis for folks coming in.

Dr. Domino:
Oh, great. Any indications for imaging?

Dr. Baldor:
Well again, I think if... So I talked about the red flags. So assuming that, the only time to really think further about imaging is, if people aren't responding to your treatment, and to what's happening. It's more of a resistant case. And so, you may wanna then think about whether you're gonna do a barium enema looking for megacolon. There are some special tests you can order. You can have people swallow these what's called radiopaque sitzmarkers. And then you do a

KUB, and you follow them through the intestine to see how long it takes for them to get through the intestine. Really, by five days, things should be out of your system. And if five days later, you do that KUB, and the sitzmarkers are sitting throughout the intestine, that's slow transit time. If they're all sitting in the rectum, that's a problem with with sphincter dysfunction.

Dr. Domino:
Great. We've talked about initial diagnosis and workup. What are the best treatments for constipation?

Dr. Baldor:
So, it's really interesting. I think for years, we talked about stool softeners and docusate as the best treatment and we come to find out that's probably not the best treatment with some recent studies that have looked at that. But there are classes that will use medications, but different things that we can do. And so, just to quickly tick through these. There are bulking agents. You already tried that fiber as a piece of this. And so, we can get fiber at the grocery store, but you can also get it at the pharmacy too, over the counter, using such things as C-Lium C and different things, but the problem with fiber, fiber can make things worse if it's not coupled with adequate fluid. So, first of all, you eat 25 grams of fiber a day. So, an apple has 2 grams of fiber. So you eat 12 apples a day to keep the doctor away. So you really... It's hard to get enough fiber with that. And for every... When you're having the fiber, you have to couple that with adequate fluid, which is probably a half a gallon of fluid that needs to go along with that. Most people don't take in enough fiber, they may think they do. And secondly, they're not taking in enough fluids. So that's

the general sense of it.

So we can prescribe things, right? There's stimulant laxatives. There are lubricant laxatives. There's osmotic agents. And if you look at the data out there, the osmotic agents have the best data for efficacy. And we talk about polyethylene glycol. That's probably the most efficacious sets out there. What that does is, it's a non-absorbable, not metabolized compound that sits in the bowel and it pulls fluid into the stool, keeping the stool soft so that it moves along. For years, we

talked about things like lactulose. Lactulose is a very similar compound to the polyethylene glycol, but the lactulose itself though gets metabolized by the bowel floor, and you have a lot of gas and cramping with it. And the polyethylene glycol, you don't see that.

So those are the general laxative agents we've talked about. What's truly interesting in the last few years has been medications we can prescribe. So this was probably... The first one was lubiprostone/ Amitizia, which is a selective chloride calcium channel activator. And what this does, this is a pill you take by mouth and it increases the secretion of chloride into the small bowel. So as chloride goes, what goes with chloride, sodium chloride. So, sodium follows the chloride, you pull a lot of fluid into the bowel, and that helps you to have a softer bulkier stool to move things around.

And then, actually, just last month, there was this... FDA approved a new medication for chronic idiopathic constipation, and this is a newer class of drug. There was another compound approved here a year ago and these are guanylate cyclase-C agonists. So this is the latest class of agents. The medication that was just approved is called plecanatide and the one that was approved just before this was linaclotide. I can't say those names really well, but what they do, what these class of agents does? Is it works on the intestinal lining. It's a little bit kind of like what the chloride channels that are out there, but it triggers the conductance regulator ion, the CFTR ion channels.

And what channel does is it opens up chloride. Chloride then flows into the intestinal lumen, pulling sodium with it, and increasing fluid as you go along with it. And so, really, this is the first time we've had something that's been approved just for chronic idiopathic constipation as opposed to being for opioid induced or somebody who is dealing with hospice care, those types of conditions or related to irritable bowel syndrome, constipation dominant irritable bowel syndrome. This is really for... So, it's really... I have not used this agent, just approved last month. And so, again, when people aren't responding to my basic advice, I then prescribe these

medications.

Dr. Domino:
Alright, so, to summarize, it sounds like you need to try to first decide whether this is transit time, sphincter problem, or idiopathic. Do tests if you need to, but if you don't suspect, if there's no red flags, go ahead and treat aggressively with bulking up with fiber and certainly increasing the water and then when if things can...

Dr. Baldor:
And exercise. So, we always go with that first, is exercise, fiber, and fluids. Of those three, probably the most important is the fluid.

Dr. Domino:
Then I loved your thought about obeying the urge. I think this is something that patients are very busy, and we as clinicians don't always know that we should be giving that advice. I really appreciate that insight.

Dr. Baldor:
Yeah, it's real important to have. Even when they're on agents, if they're not obeying the urge, you're still gonna have problems and that's the thing, it's like you know, not a great time but five or ten minutes after you've eaten, go and sit on the pot and see if you can move your bowels. So for a lot of people, they've ignored this urge for many, many years. It will take awhile for it to come back, it's not something that's just gonna happen overnight, but for them to try to move their bowels at that time, that'll be a big help as probably... Just as important as the medications that we're using.

Dr. Domino:
Thank you Bob. This has been very helpful and sheds new light on both my and many of my patients' problems.