Legacy Health

Co-Management and Referral Guidelines

Management of Constipation

Legacy Health Pelvic Floor Group

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Introduction

Constipation is a disorder characterized by symptoms of unsatisfactory defecation. Patients may describe symptoms related to infrequent bowel movements, hard stools and difficult evacuation.

This may be chronic, related to IBS or other comorbidities, medications, etc and most patient's symptoms can be managed in the outpatient setting. However, patients with acute change in bowel habits or other "alarm symptoms" including hematochezia, anemia, weight loss, personal or family history of colorectal cancer or IBD require more urgent or emergent evaluation for life-threatening conditions such as GI tract obstruction related to malignancy, incarcerated hernias, adhesive disease or volvulus.

Evaluation and Management

History

Initial evaluation includes a thorough history, particularly identifying the time course of symptom development to differentiate between acute and chronic symptoms. Important symptoms include hematochezia, weight loss, anemia, timing and acuity of change in bowel habits. Patients should be assessed for concomitant conditions such as immobility, medications, history of colorectal cancer or inflammatory bowel disease, IBD, endocrine disorders (DM/hypothyroidism), psychiatric conditions, previous pelvic surgery, obstetric history.

Other pertinent information to consider:

- Patient's defecation pattern: frequency, straining, incomplete evacuation, sensation of obstructed defecation, splinting or digitally disimpacting
- Prior attempted medications/therapies- successes and failures
- History of endoscopy
- Family history of CRC or IBD

Physical exam/lab studies:

- General exam should be performed including abdominal and inguinal node evaluation
- DRE +/- anoscopy should be performed to evaluate for evidence of fecal impaction, stricture, mass. Specialist exam can also be performed to assess for levator tenderness, paradoxical or nonrelaxing puborectalis, rectocele.
- Consider baseline laboratory evaluation — thyroid studies, serum calcium, electrolytes, CBC

Treatment

Patients with acute onset of symptoms or associated pain, bleeding or palpable lesion should be referred for ED evaluation or urgent GI assessment. Evaluation for obstruction can be performed with endoscopic or radiologic assessment.

Initial therapy for patient with chronic constipation and no other concerning symptoms:

- Dietary modification — High fiber diet, goal of 25g of fiber/day, increasing fluid intake to 1.5–2L/day

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- Addition of soluble fiber supplementation (psyllium)
- Addition of stool softeners twice daily, Miralax or milk of magnesia 1–3× daily (avoiding senna and other irritating laxatives)
- Use of techniques to avoid straining and improve relaxation (see PT defecation recommendations)

Diagnostic testing/imaging

If these interventions fail to adequately improve symptoms, referral to the Pelvic Floor team is appropriate. Further workup may include:

- Colonoscopy if no evaluation prior to onset of symptoms/overdue for screening,
- Sitz marker study to evaluate for slow transit
- Anorectal physiology testing/EMG/balloon expulsion to evaluate for dyssynergia/Hirschsprung's disease/hyposensitivity/megarectum
- Cystodefecography to evaluate for structural causes of obstructive defecation.

Specialist treatment of non-urgent conditions is dependent on the diagnosis:

Dyssynergia

- Referral to PT for biofeedback therapy

Obstruction/rectocele

- Re-evaluate and optimize bowel movements — dietary fiber, etc.
- Consideration of rectocele repair

Slow-transit constipation

- Gastroenterologist evaluation of IBS-C, possible tx with lubiprostone, etc.
- If failure to improve, consider surgical treatment with total abdominal colectomy, with or without temporary or permanent ileostomy

When to refer

Emergent/urgent referral — Any patient with acutely worsening or extreme obstructive symptoms including severe abdominal distension, pain, lack of flatus or stool should be considered for ED evaluation and surgical assessment as appropriate. Patients with history of IBD/CRC, weight loss or bleeding should be referred to Gastroenterology for urgent evaluation.

Routine referral — Patients with chronic mild symptoms refractory to initial therapies should be referred to the Pelvic Floor Group

Referral process

Epic referral may be placed to "Pelvic Floor" or call 503-413-5787 for urgent referrals.

For emergent assessment, patients should be referred to the nearest emergency department. Questions regarding appropriate disposition can be directed to Legacy Medical Group–Gastrointestinal Surgery at 503-413-5514.

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Find this and other co-management/referral guidelines online at
www.legacyhealth.org/womenshealth under Resources for Health Care Providers

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Fiber — Soluble vs. insoluble

Presented by Legacy Health Pelvic Floor Group

Soluble fiber helps hydrate and move waste through your intestines at the best rate .

Recommendation:
25 grams or more per day

Good sources of soluble fiber

- Oats and oat bran
- Beans — black, navy, kidney, pinto
- Lentils
- Soybeans
- Tofu
- Barley
- Flaxseed
- Brussels sprouts
- Peas
- Sweet potato
- Avocado
- Berries
- Apples
- Oranges
- Bananas

Beans, fruits and vegetables have both soluble and insoluble fiber.

Soluble fiber supplements

Full effect may take 12–24 hours

Start with 1 teaspoon per day and increase by 1 teaspoon each week. Maximum 3 teaspoons (1 tablespoon).

You also need to also drink lots of water.

- Citrucel (methycellulose) — better tolerated if bloating is an issue
- Konsyl (natural source: psyllium)
- Nature Made Fiber Adult Gummies (inulin)
- Acacia fiber
- Metamucil (natural source: psyllium)
- Benefiber (guar gum)

Good sources of insoluble fiber

- Whole wheat
- Bran
- Bulgur
- Rye
- Brown rice
- Beans — black, navy, kidney, pinto
- Skins of fruits
- Vegetables

Beans, fruits and vegetables have both soluble and insoluble fiber.

November 2017

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Bowel movements made easier

We need both our **belly muscles** and our **pelvic floor muscles** working together to have an easy bowel movement (BM). Sometimes we get into an unhealthy habit of using these muscles wrong, and that means we strain too hard to have a BM. We push too hard and tighten up at the same time, and the BM will not come out easily.

Five easy ways to help yourself

- Keep your feet on the floor or on a footstool/Squatty Potty.®
- Lean forward with your elbows on your knees.
- Relax your pelvic floor.
- Push your belly out.
- Take a deep breath and gently bear down and bulge your pelvic floor out.

Helpful hints

- Keep your jaw slack.
- Push or pull the buttocks apart.
- If a rectocele (a type of pelvic organ prolapse) is present, vaginal splinting* is helpful to initiate the start of defecation.
- After finishing the BM, contract your pelvic floor muscles to bring the anus back into proper position.

** Vaginal splinting is the term used to describe a procedure in which a woman uses her fingers to press on the vagina as a way to help evacuate stool during a bowel movement. Typically this is done in response to constipation and a sense of incomplete evacuation.*

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