Constipation—a simple approach to treatment

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SUMMARY. A simple method of treating patients with constipation is outlined and has been used successfully in 40 patients with severe primary constipation or constipation associated with diverticular disease.

Introduction

REMEDIES for constipation are prominent in both the lay and professional literature. Treatment of constipation often appears to be synonymous with purgation. Few patients are questioned in detail about their dietary habits in relation to bowel action. Our experience in the treatment of diverticular disease by dietary advice and the liberal administration of bran has led to a simple approach to the treatment of constipation—with few failures.

The problem

The variation in normal bowel habit is so great that constipation can be difficult to define. An enormous interest in bowel function and diet has resulted from the work of Burkitt and Trowell (1975), so much so that diverticular disease is now less prominent in some communities, and surgery for this condition is now a rare operation. Nevertheless, the rectal clinic still has many patients with symptoms of colonic dysfunction, or the complications of constipation such as fissure, abscess, or even piles. Treatment of the acute condition usually necessitates correction of the underlying cause—usually constipation.

Constipation is recognized by patients as a departure from a regular evacuation which is simple, comfortable, and even satisfying, to an ordeal that is time-consuming and requires effort or straining which on occasions may be temporarily exhausting.

The consistency of faeces is related to bulk and viscosity. The bulk is largely determined by dietary fibre, which varies widely in the community (Southgate, 1978), and viscosity, which also varies widely (Exton-Smith *et al.*, 1975), and is usually inversely related to bulk. The third factor in normal bowel function is motility which is principally stimulated by bulk. Good bowel function therefore demands a diet with sufficient residue to provide adequate bulk to stimulate colonic motility and sufficient fluid to allow a stool consistency to enable it to be passed without discomfort.

Method

During the last three years we have examined a number of patients with severe long-standing constipation referred either to the rectal clinic with acute ano-rectal problems or to the general clinic with abdominal pain. After treating any local disease, or excluding more serious disorders by investigations such as barium enema or colonoscopy, we have used a simple approach to treating the constipation.

First, we obtain a dietary history. For minor degrees of constipation an immediate verbal history of one day's typical diet is sufficient, but for long-standing complaints a prospective detailed seven-day history is obtained, when other useful information such as abdominal pain and frequency of bowel movement can also be recorded. Advice is then given on the basis of the information obtained (Paul and Southgate, 1978).

Secondly, the use of ispaghula husk (Fybogel) as a bulking agent given one to three times a day, depending on circumstances, is most effective in obtaining quick results where the patient's attitude to diet or his occupation prevents the more correct dietary approach.

Thirdly, in patients where a further stimulus is required, the prescription of magnesium hydroxide tablets 300 mg is used as a stool softener. Although they are not available in the *British National Formulary, Drug Tariff* or *MIMS*, they are readily obtainable from pharmacists as tablets, 'Milk of Magnesia' or 'Cream of Magnesia'. The normal dose is one tablet with each meal, increasing or decreasing depending on the response.

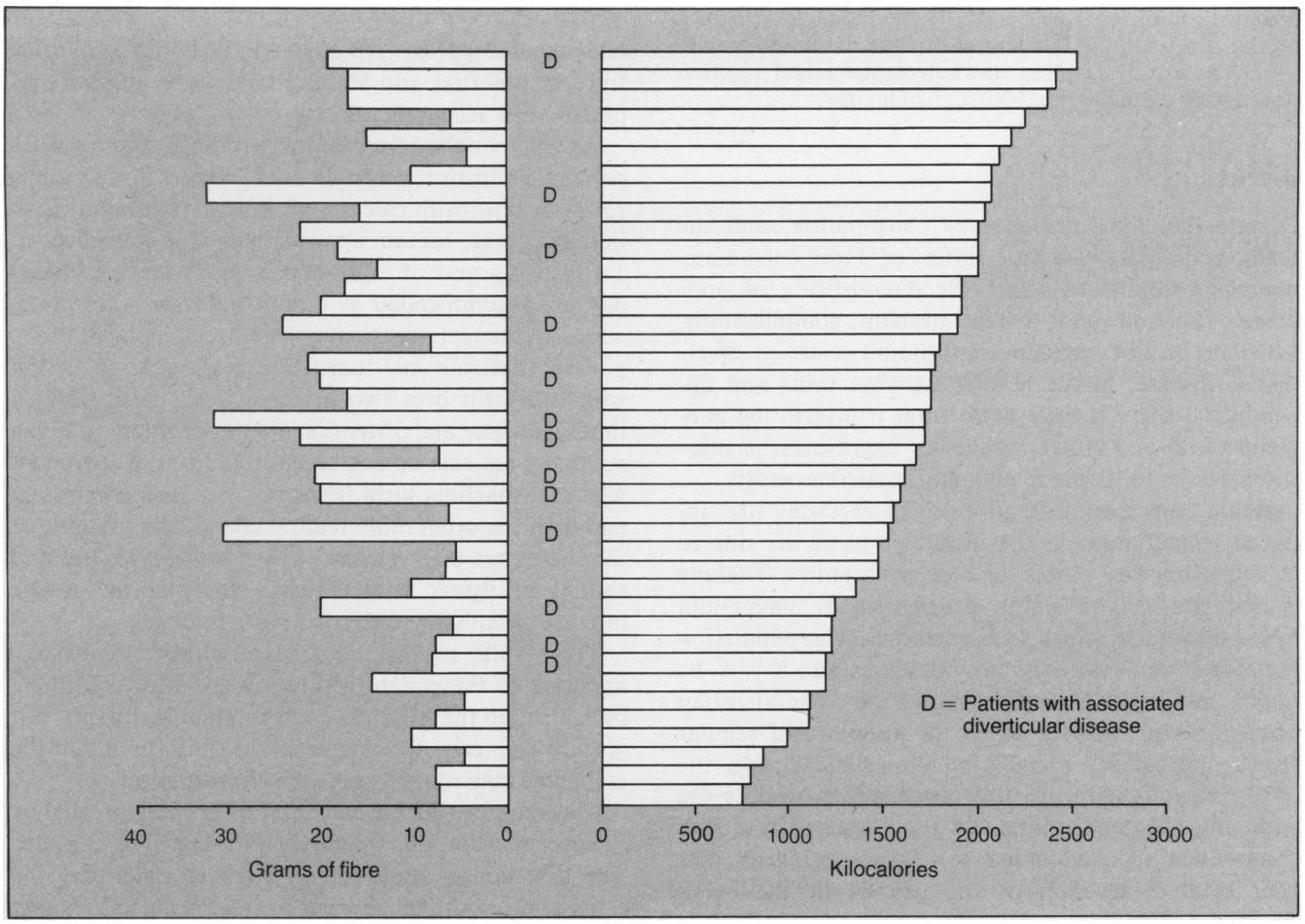

Figure 1. *Dietary fibre and calorie intake in 40 patients with severe constipation.*

Results

The recommendations are based on the treatment of 40 patients with severe troublesome constipation. Their ages ranged from 23 to 79 years (mean age 54.3) and only 10 were men. All were taking some form of treatment, the favourites of the older patients being 'Veracolate' and senna (Senokot), with young patients favouring sterculia (Normacol) and sometimes bisacodyl (Dulcolax) suppositories. Several had used a variety of preparations before persisting with one and eight were using antispasmodics for colic. All the patients were in good general health although 14 of the patients, all over 60 years of age, had diverticular disease. All were referred because of symptoms due to constipation.

Figure 1 illustrates the dietary intake in respect of calories and dietary fibre. Some of the lowest fibre diets occur in patients with poor calorie intake and this generally reflects a weight-conscious patient. Several of the patients with diverticular disease have satisfactory fibre in the diet and require the addition of magnesium hydroxide to provide more water in the colon.

Case histories

1. Two secretaries, aged 23 and 29, had bowel actions once every two to three weeks. Both were weight conscious. One was overweight at 67 kg (10 st 7 lb), her height being 5 ft 5 in, with 2,128 calories but only four grams of fibre. A weight-reducing diet with an increase to 20 g of fibre daily and ispaghula husk (Fybogel) for two months led to a daily bowel movement and weight reduction. The other had had persistent constipation since childhood. Though only 51 kg (8 st) at height 5 ft 4 in, she felt overweight and her dietary intake was only 890 calories. She ate relatively large amounts of fruit and vegetables but her fibre intake was only 8 g. After six months' treatment, she still requires ispaghula husk (Fybogel) twice daily and magnesium hydroxide tablets but her bowels move daily. Both patients probably responded because of regular consultations and appropriate alterations in treatment.

2. A housewife aged 40 was referred for haemorrhoidectomy, and appeared in outpatients petrified and almost in a state of shock. Her bowel moved about once in 10 days and she was on a low fibre weight-reducing diet. When it was suggested that improving the state of her bowel function might relieve her anal discomfort she was enthusiastic to try. A detailed dietary history was taken and her diet altered to increase the fibre content while maintaining a relatively low caloric intake; she improved immediately. With further advice she obtained a daily bowel action and has had no further trouble with haemorrhoids.

3. An elderly male hemiplegic spent two hours each day in the lavatory often without success. Enemas were administered weekly, and a variety of drugs had been tried without success. His diet was good with adequate fibre. Ispaghula husk (Fybogel) twice daily led to only a little improvement and eventually increasing doses of magnesium hydroxide were

prescribed until, on 3,600 mg daily, he began to achieve a regular evacuation. After several months the dose of magnesium hydroxide required was halved and bowel function ceased to be the major preoccupation of his day.

Discussion

Despite the high incidence of constipation, and the ready availability of a wide variety of treatments, many patients continue to suffer the discomfiture of poor bowel function and a few develop complications. Whether or not chronic constipation leads to diverticular disease, hiatus hernia, varicose veins and appendicitis, there is little doubt that it injures the anorectal canal and either induces or aggravates haemorrhoids, leads to fissure in ano, and sometimes sepsis.

Acute constipation is an event in everyday life, induced by variation in the normal way of life due to travel, temporary illness, or dietary variation. Therapy is best confined to simple drugs such as magnesium hydroxide and a return to normal diet. The population is becoming increasingly diet conscious and it is to be hoped that British bowels function better. The Victorian obsession with bowels led to the adoption of regular weekly purgation, a habit which extended into the 1950s. Fastidious but ill-informed parents, so obsessed with this approach, sometimes used apparently simple compounds such as senna with such regularity that near total destruction of the ganglia of the colon resulted in a few.

Chronic constipation in the majority of patients is literally a bad habit. It results from a variety of circumstances, the fundamental basis being poor training and inadequate diet. Poor training is often due to preoccupation with other matters, work, travel or anxiety. Poor diet has many causes, principally ignorance and, in females, over-consciousness of the problem of obesity. Probably no other single factor has such an influence on bowel function in the female population as its attitude to body weight. Some of our most difficult problems have been in patients where weight reduction was a major component of the patient's demands.

The basic needs of a good diet are well known, as are the benefits of dietary fibre. There are currently three best-selling books on diet and health (Pritkin and McGrady, 1979; *Slimming Magazine,* 1979; Tarnower and Baker, 1980), as well as innumerable publications on health, nutrition, and weight reduction. Perhaps this plethora of information is the cause of some confusion since some dietary régimes incline towards weight gain and many slimming régimes lead to constipation.

In addition, we have to contend with the ever increasing number of drugs prescribed for a wide variety of conditions, and many drugs have an effect on colonic motility. The use of antispasmodics for gastro-intestinal disorders must be carefully controlled, and for the colic of constipation they are contraindicated. Unless the colon is inert, as can occur with chronic senna poisoning, the effect of other types of medication can usually be compensated for. An adequate diet with additional fibre is the first consideration, and the majority of patients can accept this advice.

A few patients find bran revolting, and in such patients a substitute must be used. 'Proctofibe' in tablet form, or bran with calcium phosphate (Fybranta), also in tablet form, contain approximately the equivalent of 1.5 to two grams of bran, and as many as 12 tablets a day are recommended as a substitute for wheat bran added to the diet. These may be more acceptable to the patient. Patients may need encouragement to persist with treatment over two or three weeks during which time flatulence and distention are not uncommon. Even so, many patients do not accept this form of treatment whereas ispaghula husk (Fybogel), one sachet morning and night, is often more readily taken. The contents of the sachet are effervescent when mixed with water and should be drunk immediately, otherwise an orange mixture resembling wall paper paste results.

The results of this kind of treatment are usually apparent to the patient within a week. More obstinate patients need the addition of magnesium hydroxide, but given with meals. This increases the fluid content of the colon and consequently the ease of evacuation.

Chronic constipation can never be properly treated by a single consultation, and rarely by a single prescription. The first consultation is important to determine the cause and to outline the basis of treatment. Subsequent consultations need not be long, for it is often only a simple matter of altering one or other of the three variables outlined. For some patients a good deal of encouragement is needed and many have relied for years on some particular drug that they are unwilling to change. Nevertheless, the simple approach that we have used has proved most valuable in our patients, and we recommend it to others.

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