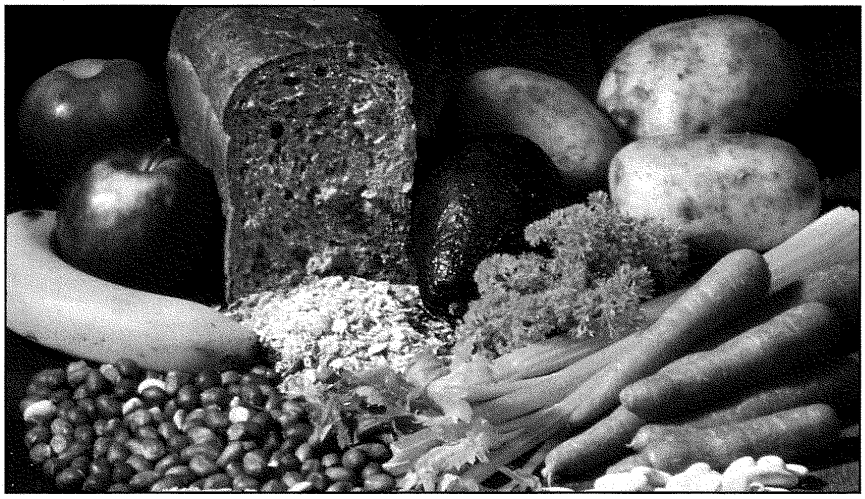

Don't be afraid of laxatives

Peter Whorwell discusses various treatments for constipation: the key is to be flexible with dosing

Constipation is often defined quantitatively as the passage of stools less than three times per week, usually with straining. However, it is often more convenient for clinical purposes to classify the condition in a more practical way. A patient who opens his bowels once or twice a week without any associated problems should be left well alone, whereas an individual struggling several times a day to pass small amounts of hard pellety stools is obviously in need of help.

Assessment

Although there is a tendency for the bowel habit to become more sluggish with age, it is extremely important to bear in mind that in the elderly the problem may be secondary to some co-existent disease or result from the use of one or more of the numerous medications that this group of patients often consume. Thus, all the well-known causes of constipation that appear in major text books such as hypothryoidism and Parkinson's should be ruled out and a careful review of the patient's medication must to be undertaken.

Many drugs of different classes can lead to constipation, but it is crucial not to forget 'over the counter' (OTC) preparations, particularly the large number of codeine-containing analgesics that are now available. From a gastrointestinal point of view, a barium enema may be necessary to rule out neoplasia and this examination is as good for the purpose as colonoscopy.

Further advantages of a barium study are that it can often be ordered without necessarily referring to the outpatient department and it is probably a safer option because the morbidity of colonoscopy is greater in the elderly. Once systemic and structural problems have been ruled out, a functional disorder is most likely and this may be either 'simple' constipation or irritable bowel syndrome (IBS). Some authorities would argue that functional constipation is part of the spectrum of IBS and certainly IBS is no respecter of age, with good evidence to show that it is nearly as common in the elderly as it is in younger age groups. The key features which would support a diagnosis of IBS are the presence of abdominal pain and bloating in addition to the disturbance of bowel habit. The abdominal distension can cause much distress and on some occasions be so prominent that the possibility of ascites or obstruction has to be considered.

It is also well known that patients with constipation and IBS may complain of backache, lethargy, nausea and various urinary symptoms, all of which serve to complicate the clinical picture.

Management

It goes without saying that any underlying cause should be treated appropriately, but if the prob-

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lem is considered to be of a more functional nature, then a direct approach to the problem is indicated, starting with the simplest measures. Many people, including the elderly, do not bother to have breakfast and therefore fail to maximise their morning gastro-colonic response. It is surprising what a positive effect just correcting this omission can sometimes have in terms of an improvement in bowel habit.

Increasing dietary fibre is the next step and this can take the form of cereals, vegetables or fruits, depending on the patient's preferences. Alternatively, proprietary fibre preparations such as those derived from ispaghula can be tried, with the patient being encouraged to titrate the dose according to their individual needs — if a particular dose is specified, the patient is usually afraid to exceed this and thus may not achieve the optimal effect.

It should be borne in mind, however, that if the patient has prominent features of IBS, especially bloating, then fibre — particularly that derived from wheat bran — can lead to an exacerbation of the situation. Furthermore, if the colonic inertia is considerable then the addition of large amounts of fibre to the diet, irrespective of the source, can sometimes make the whole situation worse.

If the simple measures described above do not help, then laxatives have to be considered. Unfortunately, there is considerable resistance to the use of these preparations, both in the minds of the public and the medical profession. This seems to be based on the premise that the bowel will become lazy or damaged in some way, thereby making the situation worse. This concept appears to have followed work done in the 1950s which has now been largely discredited and in fact laxatives at reasonable, therapeutic doses do not appear to have any major detrimental effect on gut function. However, even today many patients feel a strong sense of guilt when using these preparations and keep their use to an absolute minimum.

This attitude needs to be firmly dispelled as it is far better for these preparations to be used on a regular basis than to rely on an intermittent large catharsis. If the latter approach is adopted the patient is forever 'chasing' his bowel habit, whereas with regular use of lower doses of laxatives effective control can often be achieved, although the initial starting dose may have to be somewhat higher. Just as with the use of fibre preparations, the individual response to laxatives can be extremely wide and it is far better if the patient is left to work out the appropriate dosing for themselves.

The choice of preparation often has to be made by a process of trial and error. Lactulose is probably the most commonly used preparation and is extremely safe, but can sometimes lead to bloating. Osmatic laxatives based on either magnesium sulphate, sodium picosulphate or polyethene glycol are also very effective, but sometimes induce cramping with loose stools although this will do no harm as long as fluid balance is not compromised in any way. Sometimes the patient finds that they are most suited to a particular form of OTC preparation and as long as this does not contain something totally unacceptable then this need not be discouraged. The only drug that can occasionally help with constipation is cisapride, although it can cause cramping in some people. However, it may be worth trying if no progress is being made with laxatives.

If the above measures fail, then approaches such as the use of enemas have to be adopted and this is perfectly acceptable as this degree of constipation is never going to sort itself out spontaneously. Again, once this level of intervention has been decided upon, there should be no feelings of guilt on either the side of the doctor or the patient. In the elderly particularly, the use of enemas should be kept under some degree of medical supervision and usually the practice nurses become extremely competent at this approach to treatment. It should not be forgotten that suppositories often suit some people very well and can form a bridge between oral therapy and having to resort to the regular use of enemas.

Conclusions

Constipation is a miserable condition which makes people feel very uncomfortable and will not settle down spontaneously. It is a long-term problem requiring long-term treatment and the frequent feelings of guilt associated with the use of laxatives needs to be firmly dispelled. Once a decision has been made to initiate therapy, treatment is best undertaken on a regular basis, aiming for an optimal effect rather than trying to get away with sub-therapeutic doses.

The key to successful treatment is the use of flexible dosing as the individual response to various preparations can be extremely wide. It is also important to remember that many OTC analgesics today contain codeine which may be the cause of the problem in some instances or at least make it more refractory to treatment in others. ■

> ***"Many people, including the elderly, do not bother to have breakfast and therefore fail to maximise their morning gastro-colonic response"***

Learning points

- Constipation is often iatrogenic
- Many medications contain codeine
- There should be no guilt associated with using laxatives
- Aim for optimal rather than minimal therapy