How can community nurses manage chronic constipation?

Sharon Holroyd

Constipation is a widespread problem although its subjective nature can mean that diagnosis and treatment can be difficult as there is often a mismatch between patients’ and clinicians’ view of the condition. Constipation is widely believed to include unsatisfactory defaecation, infrequent stools and/or difficult stool passage. Thorough patient assessment and promotion of continence issues are imperative to improving services for people with constipation. This article highlights how breaking social taboos around bladder and bowel issues, helping people to acknowledge bowel issues, and referring them to the appropriate specialist nurse-led services will all help to provide a more accurate and timely diagnosis of constipation.

KEYWORDS:
Continence ■ Chronic constipation ■ Bowel issues ■ Diagnosis

— 73% of these were emergency admissions rather than elective waiting list episodes and the average length of stay was 5.6 days. The total of 147,000 occupied bed days directly related to constipation equates to a substantial financial burden on the NHS, which, it could be argued, is largely preventable.

WHAT IS CONSTIPATION?

Defining constipation is a challenge as there is no universal agreement on what the term means. It is typically defined as an individual experiencing less than three bowel movements a week, however, patients often describe a wider variety of symptoms (Jamshed et al, 2011). The experience of constipation is subjective and individual perceptions of the condition vary (Woodward, 2012).

However, a broad definition that goes some way to bridging the gap between traditional medical views of the condition and the reality of patient experience would include unsatisfactory defaecation characterised by infrequent stools and/or difficult stool passage (Brandt et al, 2005; Gallegos-Orozco et al, 2012).

It is widely acknowledged that people who experience chronic constipation in any form find that it has a substantial negative effect on the social, economic, functional and personal aspects of their lives. The impact is experienced by both the individual and the healthcare system, with costs associated with hospital admissions and general practitioner visits.

THE SCIENCE — COMMON BOWEL SYMPTOMS

Symptoms of bowel dysfunction are varied, but common problems include:

- Difficulty having bowel movements or less than three bowel movements per week may indicate constipation, as does straining on the toilet or not feeling ‘empty’
- Passing ‘watery’ or very loose stools over three times a day
- Abdominal pain (located in the lower left stomach) and changes in bowel habits, such as constipation or diarrhoea as well as mild fever, nausea and vomiting are symptoms of diverticular disease
- Diarrhoea, weight loss and abdominal pain are symptoms of Crohn’s disease
- Bloody or mucus-filled diarrhoea as well as a constant urge to go to the toilet are symptoms of ulcerative colitis
- Leaking faeces without being aware of it is a sign of faecal incontinence.

Source: Bladder and Bowel Foundation: www.bladderandbowelfoundation.org
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Rectal bleeding can be caused simply by swollen blood vessels or small tears in the tissue of the anus (bright red blood), but can be more serious and should never be ignored. If the blood is darker in colour (melaena — black or plum-coloured blood), it may come from the digestive system and is potentially more serious. Although rectal bleeding can signify early bowel cancer, there are many other symptoms that need to be verified and the patient should always seek medical advice.

Source: [www.nhs.uk/conditions/rectal-bleeding](http://www.nhs.uk/conditions/rectal-bleeding)

CAUSES/TYPES OF CONSTIPATION

Constipation can be acute or chronic. Chronic constipation is generally defined as an episode where the symptoms last for longer than three months (Gray, 2011).

Research organisation the Rome Foundation has issued criteria to assist clinicians in the classification of functional gastrointestinal disorders, the most recent of which is termed Rome III (Rome Foundation, 2006). The classification refers to chronic constipation as exhibiting two or more of the symptoms listed in Table 1 — it also differentiates constipation from irritable bowel syndrome (IBS).

Constipation may also be secondary to an underlying pathology such as Parkinson’s disease, multiple sclerosis (MS) and IBS, or as a side-effect of medication. A well-known example of the latter is constipation as a result of opioid medication used after orthopaedic surgery. A thorough investigation that excludes any underlying pathology will determine a diagnosis of functional constipation (Woodward, 2012).

Normal transit constipation
This refers to the patient’s perception of being constipated despite normal stool movement through the bowel (Jamshed et al, 2011). Individuals often report abdominal pain and bloating, however, these symptoms will generally respond to pharmacological treatment including laxatives and fibre supplementation.

Slow transit constipation
As the name suggests, this refers to the delayed movement of bowel contents through the intestine. The efficiency of bowel motility is reduced and often accompanied by increased resistance of bowel contents in transit (Bharucha, 2007). People with slow transit constipation have difficulty with the physical act of defaecation.

Generally, this type of constipation has no obvious or identifiable anatomical or physiological cause and the sufferers are often otherwise healthy (Marples, 2011). It is more common in women, but crosses all ages and genders (Kyle, 2011; Marples, 2011).

Slow transit constipation may go undiagnosed for a long time, in part due to individuals managing the symptoms themselves with over-the-counter medications (Burke, 2010). People often complain of nausea, bloating, cramps and faecal straining or incontinence. They are often too embarrassed to ask for help and their symptoms can cause them to take time off work, having a significant impact on social and economic status (Tod et al, 2007; Neri et al, 2014; Sanchez and Bercik, 2011).

DEFAECATION DISORDERS

Also known as outlet constipation or pelvic floor dysfunction, these disorders are characterised by an inability to coordinate the muscles of the pelvic floor during defaecation. In such cases, the stool reaches the rectum but cannot be expelled. Patients describe excessive or prolonged straining, soft stools that are difficult to pass and rectal

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Table 1: Summary of the Rome III classification

<table>
<thead>
<tr>
<th>Criteria must be fulfilled for at least the last three months with symptom onset at least six months before diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of two or more of the following symptoms:</td>
</tr>
<tr>
<td>‣ Lumpy/hard stools in at least a quarter of all bowel movements</td>
</tr>
<tr>
<td>‣ Straining during at least a quarter of all defaecations</td>
</tr>
<tr>
<td>‣ Sensation of incomplete emptying in at least a quarter of all defaecations</td>
</tr>
<tr>
<td>‣ Sensation of anorectal obstruction/blockage in at least a quarter of all defaecations</td>
</tr>
<tr>
<td>‣ Manual manoeuvres to facilitate at least a quarter of all defaecations (digital stimulation, evacuation, pelvic floor support).</td>
</tr>
<tr>
<td>Loose stools rarely present without use of laxatives</td>
</tr>
<tr>
<td>Insufficient criteria for irritable bowel syndrome (IBS)</td>
</tr>
</tbody>
</table>
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MOVICOL® Plain, MOVICOL® Chocolate, MOVICOL® Half, MOVICOL® Paediatric Plain and MOVICOL® Paediatric Chocolate.

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REPERTO FULL SUMMARY OF PRODUCT CHARACTERISTICS (SMPC) BEFORE PRESCRIBING.

Presentation: MOVICOL Sachet of white powder which dissolves in about 125ml water to make a chocolate flavoured drink. Each sachet contains: 13.125g macrogol 3350, 178.5mg sodium hydrogen carbonate, 355.7mg sodium chloride and 46.6mg potassium chloride. MOVICOL Plain Sachet of white powder which dissolves in about 125ml water. Each sachet contains: 13.125g macrogol 3350, 178.5mg sodium hydrogen carbonate, 355.7mg sodium chloride and 31.7mg potassium chloride. MOVICOL Liquid: A clear concentrated liquid, which is diluted in water to make an orange flavoured drink. Each 25ml of MOVICOL Liquid is diluted in 100ml of water before use and consists of the following active ingredients: 13.125g macrogol (polyethylene glycol) 3350, 178.5mg sodium hydrogen carbonate, 350.7mg sodium chloride and 46.6mg potassium chloride. MOVICOL Half Sachet of white powder which dissolves in about 62.5ml of water to make a lemon and lime flavoured drink. Each sachet contains: 6.563g macrogol 3350, 86.3mg sodium hydrogen carbonate, 175.4mg sodium chloride and 23.3mg potassium chloride. MOVICOL Paediatric: Presentation: Sachet of white to light brown powder, which dissolves in about 62.5ml of water to make a chocolate flavoured drink. Each sachet contains: 6.656g macrogol 3350, 86.3mg sodium hydrogen carbonate, 175.4mg sodium chloride and 23.3mg potassium chloride. Does not contain flavourings or sweeteners. MOVICOL Plain Sachet of white powder which dissolves in about 125ml water to make a chocolate flavoured drink. Each sachet contains: 13.125g macrogol 3350, 178.5mg sodium hydrogen carbonate, 350.7mg sodium chloride and 46.6mg potassium chloride. MOVICOL Plain Sachet of white to light brown powder which dissolves in about 125ml water to make a chocolate flavoured drink. Each sachet contains: 6.656g macrogol 3350, 86.3mg sodium hydrogen carbonate, 175.4mg sodium chloride and 23.3mg potassium chloride.

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References:

Date of preparation: July 2015.

Code: UK/MOV/0715/0092.
discomfort. Haemorrhoids and anal fissure can occur due to the prolonged straining and constant increased tone of the pelvic floor.

This type of constipation does not react well to laxative use and suffers often resort to manual evacuation techniques to empty their bowel (Andrews and Storr, 2011).

Prolonged deliberate avoidance of defaecation can also lead to a chronic defaecation disorder. This may be to avoid pain caused by fissures, behaviourally poor toileting habits, obstetric injury or spinal injuries.

Dyssynergia (disturbance of smooth muscular coordination) occurs when an individual is unable to coordinate the pelvic floor, rectoanal and abdominal muscles to propel stool from the rectum. This lack of coordination leads to excessive straining and an inability or reduced ability to empty the rectum, as well as a loss of desire to defaecate (a natural urge known as the ‘call to stool’) (Kyle, 2011).

As with many medications, those given to treat the menopausal symptoms may also lead to constipation. However, it could also be argued that women seek medical advice more than men, and thus the reporting of bowel issues is more obvious in the female population (Kyle, 2011).

Age is widely recognised as a significant indicator in the prevalence of constipation (Gallegos-Orozco et al, 2012; Woodward, 2012), however, not every older person will suffer with constipation.

There are some studies that suggest a higher prevalence of constipation in different races and socio-economic groups (Peppas et al, 2008; Sun et al, 2011), but little consensus. It is perhaps a more accurate statement to say that age, race and socio-economic status are recognised risk factors but not absolute indicators of constipation prevalence (Belsey et al, 2010).

**ASSESSMENT AND DIAGNOSIS**

Nurses are in an ideal position to initiate the first assessment of a person’s bowel habit as they come into contact with patients in all settings, both acute and community. The National Institute for Health and Care Excellence (NICE, 2007) has produced evidence-based guidelines suggesting the benefits of a structured approach to assessing any form of bowel dysfunction using appropriate tools such as the Bristol Stool Chart, diaries that record the type, consistency and frequency of stool, as well as any evidence of straining, and Rome III classification.

A comprehensive history and physical examination should be the first steps to diagnosing and managing constipation (Storr, 2011). The history should include the following elements:

- Bowel habit
- Diary of food, fluid intake and frequency/consistency of stool
- Medication (including any over-the-counter products)
- Other medical conditions
- Lifestyle and activity (e.g. does the individual exercise; go to work; regularly walk to the shops, etc).

It is important to identify any red flags that may be indicators of cancer (Table 2). A comprehensive history and examination will help the community nurse to establish a diagnosis and an individualised plan for treatment (Ness, 2009; 2013).

Physical examination must include abdominal palpation and rectal examination (NICE 2007; Gray, 2011). However, there is still a reluctance among nurses to perform a digital rectal examination. Ness (2013) suggested that this could be attributed to a fear of legal action or accusations of abuse due to the intimate nature of the examination, therefore a chaperone should be offered not only for the safety and comfort of the patient, but also for that of the nurse.

Many patients also fear this element of the examination and many healthcare professionals believe...
this is a real factor in high ‘do not attend’ (DNA) rates at specialist bladder and bowel clinics.

The Royal College of Nursing (RCN, 2012) has published many guidelines on digital rectal and manual evacuation to help clarify the procedure, the training required and the required competencies. These guidelines are designed to be used in all areas of health care, whether in the independent, NHS or social care sector and should help to ensure that best practice is adopted (Ness, 2013).

Despite all the guidelines, however, in truth there still appears to be a wide gap in practice, with some practitioners having a real fear of undertaking this valuable clinical skill (Royal College of Physicians, 2010). Physical visual inspection of the perineum, observation of leakage of stool on straining, testing pelvic floor dysfunction and testing anal contractions using the ‘anal wink reflex’ test (a reflexive contraction of the external anal sphincter when the skin around the anus is touched) will complete elements of assessment.

In some cases it may be useful to request blood tests, radiology and endoscopy, although in the absence of red flag symptoms these are not first-line investigations when considering chronic constipation (Jamshed et al, 2011).

Alternatively, insoluble fibres add bulk to the stool allowing a smoother and faster passage through the gut, thus helping to reduce constipation. However, an excess of insoluble fibres can lead to loose watery stools, in turn leading to dehydration. A balance of the different types of fibre is essential to maintaining a healthy functioning bowel.

Nurses are less likely than doctors to use pharmacological options to treat chronic constipation (Milhaylov et al, 2008), preferring lifestyle modifications, exercise and increased fluid intake to relieve symptoms, although the data relating to the benefits of increasing exercise and fluids can be conflicting (Tennent et al, 2007; Wong and Lubowski, 2007; Marples, 2011).

The clinical evidence is inconclusive on the optimum fluid intake, although 1.5–2 litres a day is widely accepted as a healthy average. Similarly, evidence on the most beneficial amount of exercise is conflicting, inconclusive and often anecdotal. The author would advise that some exercise is better than none at all.

**Medication**

Pharmacological preparations are widely available both over the counter and on prescription. However, it is easy to confuse the different types available and the effect they may have on symptoms (Table 4). Patients often take a variety of laxatives over time with little reported relief (Emmanuel, 2004; Storr, 2011). This can lead to a poor patient experience and lack of confidence in the treatment (Mihaylov et al, 2008; Basotti and Blandizzi, 2014).

Laxatives vary in their effect, with some exerting a ‘softening’ influence on bowel function, while others act as a purge (see Table 4 for specific details of different products/actions). It is important to understand how a laxative is designed to work and to offer the correct choice dependent on the symptoms, i.e. does the bowel need to slow down or speed up? Laxatives are most effective when taken according to

<table>
<thead>
<tr>
<th>Table 3: Soluble versus insoluble fibre</th>
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<tbody>
<tr>
<td>Soluble fibre</td>
</tr>
<tr>
<td>Passion fruit</td>
</tr>
<tr>
<td>Brussel sprouts</td>
</tr>
<tr>
<td>Figs</td>
</tr>
<tr>
<td>Oranges</td>
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<tr>
<td>Sweet potato</td>
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<tr>
<td>Asparagus</td>
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<tr>
<td>Broccoli</td>
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<td>Pear</td>
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<td>Peach</td>
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<tr>
<td>Apricot</td>
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<tr>
<td>Nectarine</td>
</tr>
<tr>
<td>Aubergine</td>
</tr>
<tr>
<td>Mango</td>
</tr>
<tr>
<td>Carrot</td>
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<tr>
<td>Ground golden linseed</td>
</tr>
</tbody>
</table>

**Table 4**

**Management**

**Conservative management**

Conservative management such as lifestyle modifications, exercise and increased fluid intake are preferred initially and can be very effective in treating chronic constipation (Gallegos-Orozco et al, 2012; Portalatin and Winstead 2012; Woodward, 2012).

A review of fluid intake and dietary habits can lead to some subtle changes that relieve symptoms, whereas halting medication used for constipation will also optimise conservative treatments (Emmanuel, 2011), as it will allow alternative treatments time and scope to work effectively.

An understanding of how the gut works and the effect of soluble and insoluble fibre on bowel transit will help to inform patients about prevention and enable achievable goals and cost-effective treatment (Emmanuel, 2011). Soluble fibre dissolves in water to form a gel that can bind to other substances and soaks up water to maintain a soft but ‘formed’ stool. In simple terms, soluble fibre slows the bowel transit time but can lead to constipation if too much is ingested, as the faecal matter remains in the bowel for too long and becomes dehydrated as the bowel reabsorbs water.
the patient’s presenting symptoms, without conflicting agents and as per manufacturer’s instructions.

In the author’s experience, single doses rarely solve the problem and dosage needs to be considered along with lifestyle/dietary changes. Anecdotally, many patients try a medication expecting a quick result and often struggle to regulate their bowel habit, misinterpreting diarrhoea, overflow and constipation.

Biofeedback
Biofeedback is a technique of neuromuscular re-education. An anorectal probe is inserted to measure bowel function and identify abnormal responses. This is a painless procedure that when used correctly and in conjunction with other lifestyle/behavioural changes can help to modify or change bowel habit.

Biofeedback is usually offered by specialist nurses or physiotherapists and aims to improve bowel function by combining behaviour and exercise, correcting unsynchronised contractions of the pelvic floor and external anal sphincter during defaecation (Wald et al, 2007; Marples, 2011).

Transanal irrigation
Transanal irrigation has emerged as a useful and effective treatment for constipation in some patients. There are a variety of commercial systems available (Peristeen®, Coloplast; Qufora®, MacGregor Healthcare; Aquaflush®, Oakmed; IryPump®, B. Braun) — these comprise a single-use cone or catheter which is inserted rectally and has a pump system to irrigate the lower bowel and rectum, from every day to several times a week.

The aim of irrigation is to empty the rectum, sigmoid and descending colon of faecal matter, allowing the patient to exercise more control and be able to predict bowel movements. The clinical evidence suggests that emptying as high as the sigmoid colon can prevent impaction and constipation in the long term (Christensen and Krogh, 2010).

Transanal irrigation is considered to be minimally invasive and has a proven benefit in people with neurogenic bowel disorders related to spinal cord injury and multiple sclerosis (Emmanuel, 2010; 2011). These systems all require training and ongoing support from a specialist continence nurse, however (Woodward, 2012; Christensen and Krogh 2010), and can be expensive initially depending on the delivery system. Future prescriptions are less

<table>
<thead>
<tr>
<th>Type</th>
<th>Action</th>
<th>Active ingredient (products)</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulk-forming laxative</td>
<td>Increase the amount of fibre and water absorption in gut, increase transit time</td>
<td>Bran, Polycarbophil, Methylcellulose (Celevac®, Amdipharm UK), Carboxymethylcellulose, Ispaghual husk (Fybogel®, Reckitt Benckiser Healthcare; Regular®, Procter &amp; Gamble), Sterculia (Normacol®, Norgine)</td>
<td>Bloating, flatulence</td>
</tr>
<tr>
<td>Stimulant laxatives</td>
<td>Increase motility and secretions of gut, Increase frequency, Improve stool consistency</td>
<td>Anthraquinone, Senna (Senokot®, Reckitt Benckiser Healthcare), Bisacodyl (Dulcolax®, Boehringer Ingelheim; Correctol®, Bayer Group), Sodium picosulphate (Dulcolax® Pico Liquid; Boehringer Ingelheim), Castor oil, Glycerine suppositories, Sodium docusate (Diocol®; UCB Pharma; Norgalax®, Norgine)</td>
<td>Electrolyte disturbance, abdominal cramps</td>
</tr>
<tr>
<td>Osmotic laxatives</td>
<td>Attract water into stool using osmosis, Require adequate fluid intake</td>
<td>Macrogols or polyethylene glycol (Movicol®, Norgine), Lactulose, Magnesium salts, Rectal phosphates, Sodium citrate (Micralax®, UCB Pharma), Magnesium salts, Phosphate enema</td>
<td>Can be poorly tolerated, bloating, flatulence</td>
</tr>
<tr>
<td>Faecal softeners</td>
<td>Allow water into stool mass, Lubricate and emulsify faeces</td>
<td>Sodium docusate, Aachis oil, Liquid paraffin</td>
<td>Irritation, impact on dignity</td>
</tr>
<tr>
<td>Prokinetic (promotility) agents</td>
<td>Increases colonic contractions thereby increasing transit</td>
<td>Prucalopride (Resolor®, Shire Pharmaceuticals), Linacotide (Constella®, Almirall)</td>
<td>Nausea, vomiting, abdominal pain,</td>
</tr>
<tr>
<td>Chloride channel activator</td>
<td>Increases fluid secretion in intestine, Decreases transit time</td>
<td>Lubiprostone (Sucampo®, Pharma Europe)</td>
<td>Nausea, headache, diarrhoea</td>
</tr>
</tbody>
</table>
costly as only the consumables need to be frequently replaced. Compared to the cost of someone taking long-term medication — which might involve repeated tests, consultations and hospital admissions — transanal irrigation can be far better value for money (Christensen et al, 2009).

Surgery
Surgery is considered a last resort for sufferers of chronic constipation and only when all other treatment options have been tried. Surgical options include:
- Prolapse repair
- Sphincter replacement
- Sacro-neuromodulation: electrical stimulation therapy typically involving the implantation of a subcutaneous programmable stimulator
- Antegrade continent enema formation: surgical procedure used to create a continent pathway proximal to the anus that facilitates faecal evacuation using enemas
- Colectomy and raising of a colostomy (in severe intractable cases).

QUALITY OF LIFE

Continence is a skill learnt in childhood through toilet training (Holroyd, 2015), with defaecation in particular being regarded as a private part of life (Woodward, 2012). The Department of Health (DH, 2010) has identified the importance of privacy and dignity in relation to bowel and bladder care.

Constipation is a subject that is often laughed about, however, many people are embarrassed to use public facilities, with hospitals in particular lacking privacy and easy access to toilet facilities, thus contributing to the incidence of constipation (Tariq, 2007).

Any deviation from so-called ‘normal’ toilet patterns can have a significant and distressing effect on people’s physical, psychological and social wellbeing (Belsey et al, 2010; Lukacz et al, 2011). It is common for people with incontinence to report feelings of isolation, anxiety, depression and embarrassment (Wan and Wang, 2014).

ECONOMICS OF CONSTIPATION

The actual cost of constipation is difficult to define as many sufferers do not seek professional help and manage their symptoms with over-the-counter remedies, such as such as Dulcolax® (Boehringer Ingelheim) and Senokot® (Reckitt Benckiser Healthcare).

Similarly, many cost-comparative studies have focused on the prescribing costs of laxatives and do not include other considerations such as loss of work/school days and reduced productivity (Lacy et al, 2012; Neri et al, 2014; Sanchez and Bercik, 2011).

One Europe-wide study (Müller-Lissner et al, 2012) reported that almost one-third of people with constipation were unhappy with their laxative treatment and the majority would have liked to look at alternative treatment options, suggesting that millions is being wasted on inappropriate or unsatisfactory treatments.

With the life expectancy continuing to rise as people’s general health improves, it is safe to assume — if current management approaches continue unchallenged — that the burden on the health economy of chronic constipation will increase.

In the author’s opinion, a reasonable strategy would be an emphasis on early identification with potential referral to specialist continence services where nurses could offer effective lifestyle and dietary advice rather than simply reaching for medication. However, this would rely on a certain amount of self-confidence and patients being confident enough to identify and report the issue rather than attempting self-diagnosis and management.

Education on normal bowel health and function aimed at the general public would also help to break the taboo of discussing bowel issues and might encourage other healthcare professionals to view bowel function as an essential rather than a basic requirement. This could only improve the long-term experience of patients experiencing chronic constipation.

CONCLUSION

Constipation is a common problem worldwide. The treatment is challenging as diagnosis and definition varies between clinicians and sufferers. As discussed in this article, many over-the-counter and prescribed laxatives have proven ineffective or unsatisfactory for many patients, often resulting in long-term use of several medications and a detrimental effect on the person’s social and emotional wellbeing.

Thorough patient assessment and promotion of continence issues are vital if services are to improve, with an emphasis on all clinicians recognising continence issues as essential to any patient’s overall health (Holroyd, 2015).

Breaking the social taboo that surrounds bladder and bowel issues and referring to appropriate specialist nurse-led services will lead to more accurate and timely diagnosis of constipation (Orrell et al, 2013). Similarly, empowering patients with appropriate information about treatment options will improve their quality of life and reduce the financial burden of constipation for health economies.

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