Treatment interventions for bowel dysfunction: constipation

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Bowel dysfunction is a common problem for adults and children, and yet many people do not seek help and when they do it is not up to standard. Unmanaged symptoms impact on the health of the patient, both physically and mentally, and add extra cost to the NHS. This article, by a clinical nurse specialist working with people suffering from bladder and bowel dysfunctions, will help healthcare professionals understand the possible causes of anatomical and functional bowel problems, especially constipation, and the conservative treatment interventions. This first article in a two-part series, explains anatomy and physiology of the lower gastrointestinal tract, what constitutes a normal bowel habit, frequency and variation. The second will focus on the causes of constipation, which are often misunderstood and misdiagnosed, and how they can be assessed and managed, as well as treatment options available.

KEYWORDS: Constipation ■ Anatomy and physiology ■ Clinical features

There remains a stigma attached to our natural daily ablutions, which means that common bowel dysfunctions, such as constipation or lack of control, are kept hidden. People are embarrassed to admit they have problems. They feel ashamed due to a perceived loss of dignity, so they keep quiet and, by doing so, they shield the fact that bowel conditions are incredibly common. In fact, according to a Coloplast report on the cost of constipation (2015), one in seven people experiences a problem with bowel incontinence. Although that means a large number of people require some medical treatment, many delay seeking help for manageable conditions, or they assume that support is not available (NHS Choices, 2012).

‘... bladder and bowel dysfunctions lack the same “status” as more recognised chronic conditions, even though the effect of moderate continence issues on quality of life is similar....’

Unfortunately, bowel dysfunction is often misunderstood by healthcare professionals and when patients do decide to seek medical help, it is not always up to standard. You would expect the NHS to provide reassurance, empathy and high quality clinical care for these people who may be feeling vulnerable and ashamed and whose bowel issues may be affecting their quality of life. However, a report titled ‘Raising Expectations for People with Bladder and Bowel Problems’ (2015) found that patients with these issues were not treated with dignity and respect. Based on insights gathered through a small qualitative workshop and supported by evidence collected through national clinical audits (Royal College of Physicians [RCP], 2010), the report highlighted that patients did not feel listened to or taken seriously when they first sought help from their doctor. They also lacked confidence that clinicians understood their symptoms or knew how to treat them, and they felt that they were not offered adequate information about their condition or treatment options. Additionally, they did not feel involved in decisions made about their treatment and care, or have access to the high-quality interventions that have been recommended by the National Institute for Health and Care Excellence (NICE).

It is sobering reading, as bladder and bowel dysfunctions lack the same ‘status’ as more recognised chronic conditions, even though the effect of moderate continence issues on quality of life is similar to living with diabetes, hypertension or cancer (Robertson et al, 2007). This means that patients often fail to get even the most basic aspects of care correctly. However, given that poor continence care compromises fundamental NHS rights to dignity and respect, it is essential that addressing these shortcomings must now become a priority. Of the 33 cases presented as oral evidence to the Francis Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, 22 included ‘significant concerns’ about continence care, which led to ‘considerable suffering, distress and embarrassment’ to patients (Francis, 2010).

\[\text{Practice point}\]

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Age is a major risk factor for bladder and bowel dysfunction and as the population ages, demand for treatment and care will continue to grow (Department of Health [DH], 2000).

Delayed, inadequate care is costly to the patient healthwise, and it is expensive for the NHS. Unmanaged symptoms can lead to avoidable issues such as urinary tract infection (UTI), pressure ulcers and falls, which result in an increase in service use and prescriptions costs (Health and Social Care Partnership, 2011; Expert Group on Lower Urinary Tract Symptoms, 2012). Urinary incontinence is associated with a number of comorbidities such as arthritis, asthma, chronic anxiety, depression, diabetes, neurological conditions, sleep disorders (Coyne et al, 2009), dementia, heart and kidney diseases (European Association of Urology, 2011), and if outcomes for patients with those issues are to be improved, incontinence cannot be overlooked.

Bladder and bowel issues have to be taken seriously and for that to happen healthcare professionals need to be more open about them. The ‘Raising Expectations for People with Bladder and Bowel Problems’ (2015) report urges the government, NHS leaders, commissioners, providers, healthcare professionals and patients to start talking about common problems of incontinence, and other issues, and to consider what steps they can take to raise expectations for people with these dysfunctions. The purpose of this article is to see what it is like to experience and cope with bowel problems, specifically the common problem of constipation. It also establishes a number of imperatives for the development of NHS practice and policy to improve patient experiences and outcomes through more proactive and cost-effective models of care.

ANATOMY AND PHYSIOLOGY

For healthcare professionals to understand, care and treat people with bowel dysfunction, they need in-depth knowledge and understanding of the anatomy and physiology of lower gastrointestinal tract in both men and women. The normal bowel has five main functions: storage, absorption, secretion, synthesis and elimination (Norton, 2001). The colon stores unabsorbed food residue and within 72 hours 70% of this is excreted, while the remaining 30% stays in the colon for up to a week (Norton and Chelvanayagam, 2004). Sodium, water, chloride, some vitamins and drugs, including steroids and aspirins, are also absorbed from the colon. Mucus is secreted and used to lubricate the faeces to make it easier to pass. A small amount of vitamin K (which aids blood clotting) is synthesised. Peristaltic movement, or contractions, move the faecal matter into the rectum and sensory nerve endings tell us we are full and that we need to go. This is known as the ‘call-to-stool’ (Norton, 2001).

Sitting or squatting is the best position to be in for defecation to occur. In doing so, the diaphragm and abdominal muscles contract and the rectum’s puborectalis muscle relaxes, as do the external anal sphincter muscles, which results in the stool being expelled (Norton, 2001; Bladder and Bowel Community, 2017).

The body’s physical actions are ruled largely by the nerves, which is why our brain tells us where and when we can go and this is why, in normal, healthy situations, we can control our bowel movements. The rectum and internal anal sphincter receive extrinsic autonomic innervations from lumbar (sympathetic) and sacral (parasympathetic) nerve roots (Norton and Chelvanayagam, 2004). This innervation transfers information between the lower bowel and the brain. In addition, the dense network of neurones within the gut transfers messages from the brain to the rectum and anus. The motor nerve supply to the striated (voluntary) muscle of the external anal sphincter is from the second to fourth sacral spinal cord segments, via the pudendal nerves. Thus, the neurological control of the bowel is the result of an intricate balance between the intestinal smooth muscle cells (Norton and Chelvanayagam, 2004).

The body also plays a role in controlling bodily functions. Pelvic floor muscles — the exercise of which are frequently relied on to retain urinary incontinence, especially for women following childbirth — consist of two layers of muscles: a superficial and deep layer referred to as levator ani (literally meaning ‘lift the anuses’). The puborectalis muscle component of the levator ani contributes to maintenance of the ano-rectal angle, which is important in maintaining continence (Norton and Chelvanayagam, 2004). The internal anal sphincter is a smooth muscle which is able to maintain tonic (sustained) contraction for long periods of time. The sphincter contributes about 85% of the resting anal sphincter zone and thus, weakness of the internal anal sphincter may result in passive faecal incontinence. This is when people experience no sensation before soiling themselves. The external anal sphincter is a striated muscle which contributes only 15% towards resting anal tone. Weakness of the external anal sphincter muscle may result in urge faecal incontinence. This is when people feel a sudden need to go to the toilet but are unable to get there on time (Royal College of Nursing [RCN], 2008).

In healthy situations, the reflexes in and around the anus operate on an involuntary basis. When the ‘call-to-stool’ can be sensed and the rectum fills and distends, the recto-anal inhibitory reflex relaxes and allows some rectal contents to drop into the anal canal. The anal reflex is the contraction of the anal sphincter muscles, which occur when the skin around the back passage is touched, stroked or irritated. The ‘closing reflex’ is when the anal sphincter snaps shut at the end of rectal evacuation. Patients can enhance this by squeezing their sphincter muscle at the end of their motion.

NORMAL BOWEL HABIT

It is normal to produce around 200g of faeces a day (Norton and Chelvanayagam, 2004) and production is influenced by gender, diet and health. The frequency and consistency of the stool can vary. There is no generally accepted normal range and it can differ according to race, personality,
emotional state and gender (see the Bristol Stool Chart). A third of men (but not women) go to the toilet every day like clockwork after breakfast (Rex, 2013). Nevertheless, bowel function is regarded as normal if you go between three times a day and three times a week and need to strain for less than a quarter of the time (Emmanuel 2004; The Cost of Constipation Report, 2015).

Because people do not tend to talk about bowel habits, it is difficult to know what is ‘normal’ (Rex, 2013). However, it is producing a stool that is not too hard and not too soft, with a motion that is easy to start, easy to do and easy to finish. There should be no pain, bleeding, straining, forcing or need to push and there should be a feeling of emptiness upon completion. It should take only one minute to complete and result in a feeling of happiness and satisfaction (Rex, 2013). For this to be achieved, Rex (2013) cites the requirements of the four fs: a diet rich in fibre; plenty of fluids, fitness (if you don’t move, it won’t move), and feet, which relates to the best sitting position to help achieve bowel evacuation successfully.

**CONSTIPATION**

Constipation is a common bowel dysfunction with one in seven adults and one in three children thought to be affected at any one time (Coloplast, 2015). Studies show that women are twice as likely to suffer from constipation than men and it is common during pregnancy (Coloplast, 2015). Older adults are also five times as more likely to have constipation than younger people.

Constipation is a digestive problem and a symptom, not a disease, reflecting either slow colonic transit and/or impaired rectal emptying (Frattini and Nogueras, 2008). It can be mild, causing no disruption to life, moderate, or severe, which can affect the patient socially and personally. Only a few people with constipation see their GPs and of these, a small number are referred to a hospital. Usually, these patients have severe quality of life impairment and have not had success with dietary fibre supplementary trials (Emmanuel, 2004).

Constipation can mean different things to different people. For some it feels that the stool is too hard, for others it is too difficult to pass, and for others, it is simply that the bowels are not working as regularly as they should. However, what unites all these people is that anyone experiencing constipation will tend to experience poor quality of life, compared with the general population (Norton, 2006).

**TYPES OF CONSTIPATION**

Constipation comes in two forms: slow colonic transit or difficulties with evacuation, and it is possible for patients to have both. Those suffering from slow colonic transit tend to complain that they rarely feel the urge to go to the toilet and some cannot go at all unless they take laxatives. According to the Coloplast (2015) report on the cost of constipation, sufferers can be divided into two groups: ‘functional’ and ‘neurogenic’. The majority of people fall into the ‘functional’ category.

Functional constipation is diagnosed when a person is experiencing symptoms, but there are no underlying known bowel problems and all of the organs in the body are working (RCN, 2015). Most of these people would not consider visiting their GP due to embarrassment or fear that it may be the result of a more serious underlying condition. Although this is rarely the case, it is best to rule these worries out by speaking to a GP or healthcare provider.

Neurogenic constipation is common in people who already have an underlying condition, such as spina bifida, multiple sclerosis (MS), Parkinson’s disease, spinal cord injury or the patient has suffered a stroke. (Bladder and Bowel Community, 2017). Neurogenic bowel is a condition that affects the body’s process to store and eliminate solid wastes from food. Because nerve endings in the rectum alert us of the need to pass a stool, a lack of nervous control prevents the bowel

### Figure 1.
Bristol stool chart.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces Entirely liquid</td>
</tr>
</tbody>
</table>
from functioning properly. In people with spina bifida, MS or spinal cord injury, this message from the nerve to the brain may become lost or incomplete. Control of the external anal sphincter may also be disrupted, which increases the risk of faecal incontinence. Approximately 68% of people with MS will develop bowel problems such as chronic constipation and faecal incontinence (Coloplast, 2015).

Constipation is either primary (idiopathic) or secondary (RCN, 2008). Primary constipation is when it is not associated with any other complaint and has no pathological cause. Instead, it is linked with slow colonic transit, pelvic floor abnormalities, poor diet and mobility. Secondary constipation is secondary to another disorder, whether this is metabolic, psychological or neurological. This means that there is an identifiable cause for the constipation (RCN, 2008).

Patients who suffer from functional constipation experience two or more of the following symptoms at least 25% of the time for three to six months. These are straining during elimination, lumpy or hard stools, a sensation that evacuation is incomplete, a rectal blockage, a need to use manual manoeuvres (such as fingers) to aid defecation, fewer than three eliminations a week or rarely achieving a loose motion without the use of laxatives (Longstreth et al, 2006).

Obstructive defecation syndrome, or rectal outlet delay, is defined as a sensation of anorectal blockage on more than one in four occasions, prolonged elimination taking more than 10 minutes to complete evacuation, or the need to use fingers on any occasion (Harari, 2004). Faecal impaction, or loading, is when the rectum and often the lower colon is full of hard or soft stool and the patient is unable to evacuate the bowel unaided (Norton, 2006). This can lead to impaction with overfull ‘spurious diarrhea’, which is common in the frail elderly population (Harari, 2004) and may be misdiagnosed as diarrhoea and therefore treated incorrectly (Norton, 2006).

Constipation, especially when chronic, can have damaging effects on the colon. The colon is constantly extracting water from its contents to transform liquid wastes into solids. If elimination is not regular and complete, the wastes will dry and become cemented to the walls of the colon. Constipation has been shown to increase the risk of colon cancer (American College of Gastroenterology 2012), and has been implicated in diverticulitis and appendicitis. It is essential that it is treated as a serious condition.

There are many causes of constipation as illustrated in Table 1.

### Table 1: Causes of constipation (Emmanuel, 2004)

<table>
<thead>
<tr>
<th>Category</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiopathic</td>
<td>No obvious cause</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Hyperthyroidism, Hyperparathyroidism, Glucagonoma (a hormone-secreting tumour of the pancreas), Diabetes mellitus</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Hypercalcaemia, Uraemia, Hypocalcaemia, Periphya, Amyloidosis, Lead poisoning</td>
</tr>
<tr>
<td>Neurological</td>
<td>Cortical lesions (tumour, infarction), Spinal cord lesions (injury, infarction), Peripheral lesions (autonomic neuropathy, eg diabetes mellitus)</td>
</tr>
<tr>
<td>Neuromuscular disorders</td>
<td>Systemic sclerosis, Dermatomyositis, Dystrophia myotonica</td>
</tr>
<tr>
<td>Psychological</td>
<td>Anorexia nervosa, Bulimia nervosa, Affective disorder (eg depression), Demencia or learning difficulty (inappropriate response to gut signals)</td>
</tr>
<tr>
<td>Physiological</td>
<td>Pregnancy, Old age</td>
</tr>
<tr>
<td>Colonic</td>
<td>Neuromuscular disorder (Hirschsprung’s, megabowel, chronic intestinal pseudo-obstruction), Stricture (tumour, ischaemia, diverticulitis)</td>
</tr>
<tr>
<td>Anal</td>
<td>Fissure, Polyp, tumour</td>
</tr>
<tr>
<td>Functional bowel disorders</td>
<td>Irritable bowel syndrome (IBS)</td>
</tr>
</tbody>
</table>

### CLINICAL FEATURES

According to Emmanuel (2004), symptoms of constipation develop gradually, which means there is a ‘lag period’ of many years between initial symptoms and the first consultation. During this period, other physical complaints may arise. By the time they do present to hospital, patients often have abdominal pain, distension and nausea in addition to infrequent and incomplete bowel emptying. Emanuel (2004) claims that there is often a history of heavy laxative consumption, general feeling of discomfort and lack of energy and enthusiasm. He adds that, in addition, headaches, mood swings and poor concentration are also often reported. Some patients can describe a clear cause to their symptoms, for example abdominal or pelvic surgery, childbirth or emotional trauma, and this should not change the management of constipation.

Left unmanaged, bowel problems can lead to issues including urinary tract infections, pressure ulcers and falls.
CONCLUSION

Ill health can have a massive impact on quality life. Feeling run down and under the weather can prevent people from taking part in normal daily activities such as going to work, socialising with friends, maintaining relationships, enjoying leisure time or caring for their loved ones and themselves. Bowel problems, including constipation, affect many people in the UK, but with simple changes to diet or lifestyle, medical advice and treatments, it can be dealt with or managed. However, patients are often too embarrassed to visit their GP and if they do, they can feel the condition is not taken seriously or it is misunderstood.

Bowel dysfunction should not be dismissed as a minor issue. Chronic constipation can cause a person debilitating psychological and physical distress and render them incapable of enjoying life. It can also lead to serious health issues, including UTIs in women and long-term pain for both genders. If not treated early, constipation can result in haemorrhoids, anal fissures or rectal prolapses (Bladder and Bowel Community, 2017). For those with an existing condition, constipation is a secondary health impact, adding to health complications. It also adds considerable cost to the NHS.

Constipation is restrictive: making it hard for people to socialise or travel without knowing they have constant access to toilets. People suffering from constipation can spend a great deal of time on the toilet, either trying to open their bowels or worrying about it. These factors can all have a knock-on effect on mental wellbeing, damaging confidence and self-esteem.

REFERENCES

American College of Gastroenterology (2012) Chronic constipation linked to increased risk of colorectal cancer. ScienceDaily, 22 October. Available online: www.sciencedaily.com/releases/2012/10/1210220801228.htm

resources/toilet-positions/


Health and Social Care Partnership South East (2011) Prevention and early intervention continence services, July


Raising Expectations for People with Bladder and Bowel Problems (2012) Additionally by the Bladder and Bowel Foundation (B&BF), Cystitis and Urethral Ectopic Bladder Foundation (CUBF), Association for Continence Advice and expert group on lower urinary tract symptoms (LUTS). London: Astellas Pharma Ltd


Revalidation

Alert

Having read this article, reflect on:

- The four ‘Fs’ that aid healthy bowel function
- How often bowels should be emptied for it to be considered ‘normal’
- Your knowledge of the symptoms of constipation.

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