Chapter 6.2
Managing Slow-Transit Constipation

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History

In 1908, Sir Arbuthnot Lane published the first series of abdominal procedures for the treatment of chronic intractable constipation (1). He postulated that “auto-intoxication” (caused by chronic constipation) was responsible for a large number of diseases in the population of London, such as, “dilatation of the stomach, peptic ulceration, mobility of the kidney and degenerative changes of the breasts.” His advocacy of colectomy for constipation is still a controversial issue among specialist surgeons dealing with this problem. Over recent decades, there have been a variety of physiological tests designed in part to improve our understanding of the pathophysiology of constipation, where it was realized that there is indeed a small group of patients with this chronic complaint who can benefit from surgery. The aim of this chapter is to summarize the indications for and results of surgery in adult patients presenting with severe and intractable slow-transit constipation.

Introduction

Constipation is one of the most frequent gastrointestinal symptoms and one of the most common reasons for medical consultation. Broadly, constipation can be related to intestinal motility disorders, pelvic floor disturbances, or a combination of both, although the exact origin of these disorders (and the interplay of factors responsible for their chronicity) is not yet fully understood.

The definition of constipation is sometimes difficult, as physicians and patients have different opinions about what constitutes constipation. Patients often include such subjective feelings as incomplete evacuation, abdominal or rectal pain, firm stool consistency, and the repeated need for straining. Probably the best definition for constipation was proposed by Whitehead and colleagues (2), where two or more of the following com-
plaints must be present when the patient is not taking laxatives and where symptoms must have persisted for at least 12 months; namely:

1. Straining on ≥25% of bowel movements
2. Feeling of incomplete evacuation after ≥25% of bowel movements
3. Scyballous stools on ≥25% of bowel movements
4. Stools less frequent than two per week with or without other symptoms of constipation.

Objective scoring recently has been introduced to standardize the clinical presentation and severity of chronic constipation, and although these systems have been validated in specialized clinical practice, they have not yet been widely adopted or utilized as discriminants in the decision for surgery (3,4).

Initial Assessment

History
A detailed history addressing the specifics of bowel activities, as well as the medication profile, must be obtained from constipated patients. Extracolonic causes for constipation must be excluded systematically before applying terms such as “functional disorder” or “idiopathic constipation.” Table 6.2-1 shows a veritable legion of extracolonic causes that may play a role in the patient’s presentation with this symptom. The scoring systems (alluded to above) provide a much more detailed and objective assessment, as they include more variables than just stool frequency and stool consistency; however, it must be remembered that constipation is a symptom and not a disorder. Several authors report higher rates of constipation in patients after hysterectomy (5).

Physical Examination
The first step is inspection of the anus and the perianal area, as well as a digital examination. During rectal digitations, the patient should be asked to squeeze, push down, and to relax. With this simple test, it often is easy to diagnose pelvic outlet obstruction caused by non-relaxation of the pelvic floor muscles. The next step is a proctoscopy without any preliminary bowel preparation. As patients with slow-transit constipation typically complain of diffuse abdominal pain and bloating, the abdomen should be inspected and palpated. Examination also will reveal a rectocele by turning the examining digit through 180 degrees and inspecting the posterior vaginal wall (6), and bimanual examination in the standing position during a Valsalva maneuver will be suggestive of an attendant enterocele (7).