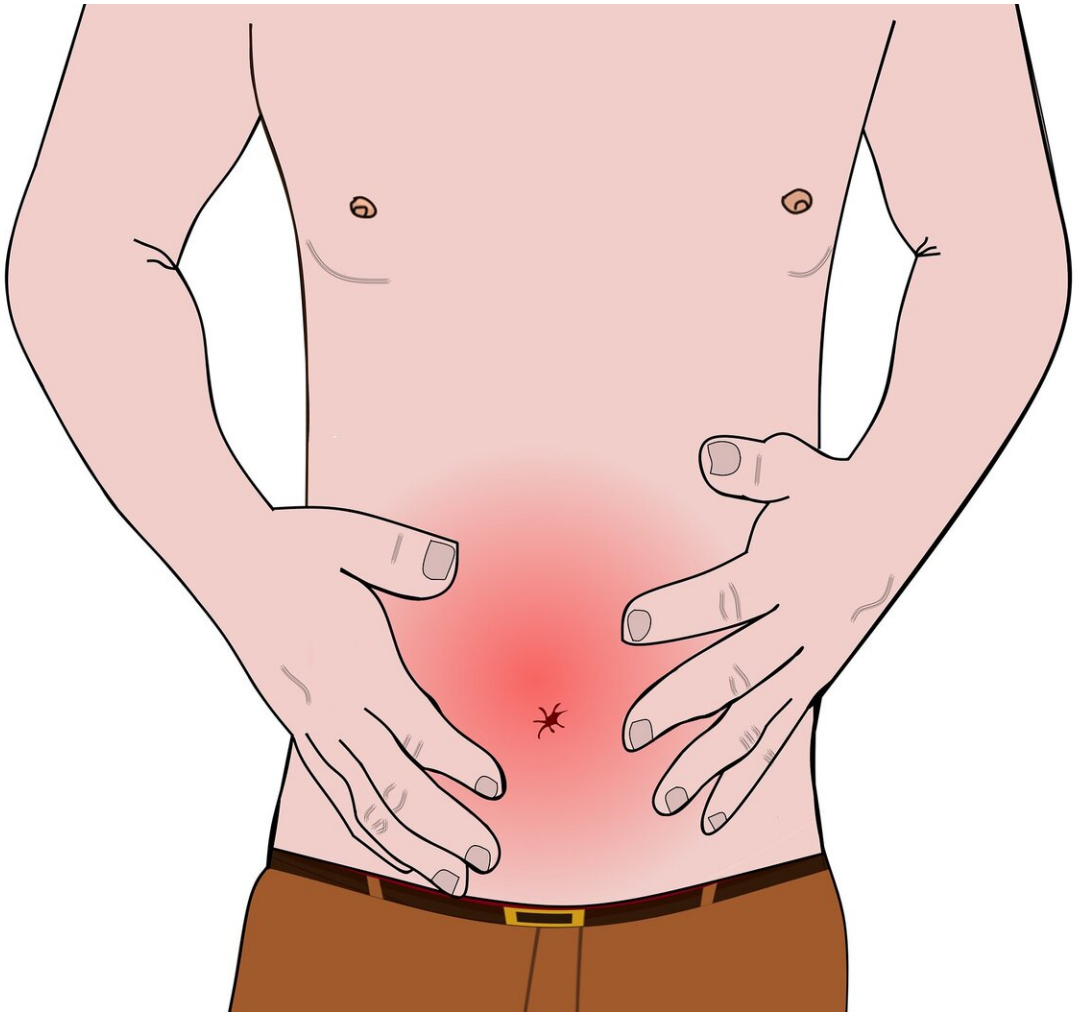
Updated guidelines published for evaluating and managing chronic constipation

September 10 2024



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The American Society of Colon and Rectal Surgeons (ASCRS) has issued updated guidelines on how to evaluate and manage chronic constipation. The research is published in the journal *Diseases of the Colon & Rectum*.

"The complex etiology and variable severity of constipation symptoms mandate an individualized approach to evaluation and treatment," write senior author Ian M. Paquette, MD, of the University of Cincinnati, and colleagues on the ASCRS Clinical Practice Guidelines Committee. After reviewing 134 English-language studies of adults published between January 1, 2014 and February 1, 2024, they developed 13 recommendations.

Strong recommendations

Each recommendation in the new guidelines is labeled "strong" or "conditional" using the GRADE system for evaluating the certainty of evidence in medical literature. The six strong recommendations are:

- A directed history and physical examination should be performed.
- The initial management of patients with symptomatic constipation involves dietary modifications and ensuring adequate fluid intake and fiber supplementation.
- Osmotic laxatives are an appropriate first-line medical therapy to manage chronic constipation. Stimulant laxatives, such as bisacodyl, can be considered for rescue therapy or as a second-line therapy, if needed.
- Colonic motility and transit should be measured before surgical intervention is considered.

- Biofeedback therapy is considered a first-line treatment for patients with symptomatic pelvic floor dyssynergia.

- Stapled trans-anal rectal resection (STARR) is not recommended for the repair of rectocele or internal rectal intussusception due to the high complication rates associated with this procedure.

Conditional recommendations

The guidelines also include seven conditional recommendations:

- Objective measures assessing the nature and severity can be useful when evaluating patients with constipation.

- Patients who fail to improve with dietary changes, fiber therapy, and osmotic laxatives should be evaluated for outlet dysfunction. Anorectal physiology testing or dynamic imaging by fluoroscopic defecography, MRI defecography, or dynamic ultrasound may help identify functional or structural etiologies related to an evacuation disorder.

- Injecting botulinum toxin into the puborectalis and external sphincter muscle may be considered in patients with outlet dysfunction constipation related to nonrelaxing puborectalis muscle.

- Patients with significant outlet dysfunction from a rectocele may be considered for surgical repair after addressing any concomitant functional etiologies such as nonrelaxing puborectalis muscle.

- Repair of rectal intussusception may be considered in patients with severe obstructed defecation in whom nonoperative

treatments were unsuccessful.

- Patients with isolated refractory colonic slow-transit constipation may benefit from total abdominal colectomy with ileorectal anastomosis.

- Fecal diversion may be considered in patients with intractable constipation refractory to other treatment options.

"Given the range of specialties that manage constipation, a collaborative approach is often warranted to achieve optimal patient outcomes," the guidelines committee emphasizes.

More information: Karim Alavi et al, The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for the Evaluation and Management of Chronic Constipation, *Diseases of the Colon & Rectum* (2024). DOI: 10.1097/DCR.0000000000003430

Provided by Wolters Kluwer Health