INTRODUCTION AND EPIDEMIOLOGY

Constipation is a common symptom affecting 2% to 27% of the population and resulting in about 2.5 million physician visits in the United States annually. The prevalence of constipation is higher in women than in men and increases with age. Low socioeconomic status, physical inactivity, a history of sexual abuse, and depression have all been reported to be risk factors for constipation.

DEFINITION

Chronic constipation has been defined by the Rome III diagnostic criteria. Chronic constipation symptoms include excessive straining, discomfort at defecation, or passage of hard or pellet-like stools, even though the frequency of defecation may be normal.

THE ROLE OF ENDOSCOPY

Patients with constipation should undergo colonoscopy if they have rectal bleeding, heme-positive stool, iron deficiency anemia, weight loss, or obstructive symptoms. In addition, colonoscopy should be considered in selected patients to exclude obstruction from cancer, stricture, and extrinsic compression. Colonoscopy also should be done prior to surgery for constipation. In younger patients, a flexible sigmoidoscopy may be sufficient to exclude distal disease. Suspected Hirschsprung’s disease requires anorectal manometry and deep biopsy to examine for the absence of myenteric neurons.

Patients aged >50 years who have not had prior colorectal cancer screening should undergo colonoscopy. Studies evaluating the association of chronic constipation and colorectal cancer have produced inconsistent findings. Chronic constipation was associated with an increased risk of colon cancer in two U.S. population–based retrospective studies but not in a prospective study of female nurses. A retrospective study from Australia also reported increased cancer risk in patients with constipation, and a retrospective study from Japan found increased risk in those who used laxatives frequently. However, a meta-analysis of 28 studies (8 cross-sectional surveys, 3 cohort studies, 17 case-control studies) demonstrated no increase in colorectal cancer in patients with chronic constipation.

The yield of colonoscopy in isolated constipation is low and comparable to that of asymptomatic patients undergoing colonoscopy for colorectal cancer screening. In one study of 563 sigmoidoscopies or colonoscopies done for the evaluation of constipation, colorectal cancer was found in 8 (1.4%), adenomas in 82 (14.6%), and advanced...
lesions (cancer or adenoma with malignancy, high-grade dysplasia, villous features, or size >10 mm) in 24 (4.3%).

Another study that evaluated the yield of colonoscopy performed for the sole indication of constipation found that the prevalence of colorectal neoplasia was lower in patients with constipation than in those undergoing colonoscopy for routine colorectal cancer screening.

A retrospective review of 41,775 index colonoscopies performed for colorectal cancer screening, constipation alone, or constipation with another indication found that patients with constipation alone had a lower risk of significant findings than patients undergoing colonoscopy for average-risk screening. Associated findings may include solitary rectal ulcer syndrome (indicating rectal prolapse), anal fissure, and melanosis coli (indicating chronic laxative use).

Colonoscopy may be used to provide therapy in some patients. Fibrotic strictures from inflammatory bowel disease, surgery, or ischemia can be dilated at the time of colonoscopy. Percutaneous endoscopic cecostomy or colostomy has been used with favorable results in children with severe refractory constipation caused by conditions such as neurogenic bowel. In adults with acute colonic pseudo-obstruction and neurogenic bowel, percutaneous endoscopic cecostomy may be effective when conservative treatment fails. It is important to understand that colonoscopy has no role in stool disimpaction, although there are reports of colonoscopic removal of bezoar-induced fecal impaction.

Chronic constipation is an independent risk factor for inadequate bowel preparation for colonoscopy. In these patients, a more aggressive regimen for colon cleansing should be considered.

SUMMARY

1. We recommend that GI endoscopy should not be performed in the initial evaluation of patients presenting with symptoms of chronic constipation in the absence of alarm features or suspicion of organic GI disease.

2. We recommend that patients with constipation undergo colonoscopy to exclude organic disease if they have rectal bleeding, heme-positive stool, iron deficiency anemia, or weight loss prior to surgical therapy for chronic constipation.

3. We recommend that patients aged >50 years presenting with constipation who have not previously had colon cancer screening should have a colonoscopy.

4. We recommend colonoscopy to allow dilation of benign colon strictures and creation of percutaneous cecostomy when clinically appropriate and feasible.

DISCLOSURES

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REFERENCES