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EDITORIAL

Chronic constipation, more needs to be done

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In 2017, we published a paper surveying patients with various functional gastrointestinal disorders (FGIDs) presenting to secondary care gastrointestinal (GI) clinics across 11 Asian cities. We found that chronic constipation symptoms and defecation disorders received the highest dissatisfaction ratings. According to patients' reported most bothersome symptom, straining at defecation topped the list at 61%, while according to Rome III criteria, defecation disorders (69%) and functional constipation (FC, 63.4%) had the highest dissatisfaction [1]. What might be the reasons for patient dissatisfaction? When we reviewed the treatments received by patients with FC, 53.4% and 24.8%, respectively had received laxatives and fiber supplements; 31% had received traditional medicine, while 49% prokinetics and 46% proton pump inhibitors (PPI). One possibility is that patients in Asia were reluctant to use laxatives. A multinational study of self-perceived constipation found that compared against people in Latin America, US, and Europe, self-management with laxatives was lowest in South Korea, with the majority favoring lifestyle changes [2].

Another possibility is that constipation symptoms could have been missed by doctors treating these patients. In a follow up study to identify symptom clusters among Asian FGID patients, we found a particularly strong factor comprising upper abdominal pain in association with constipation symptoms [3]. In the hectic clinical environment that physicians and patients find themselves in Asia, patients who present with dyspepsia could have their constipation overlooked.

In our earlier paper, we found that among patients with FC, 46% had received PPI, while 53% and 25%, respectively received laxatives and fiber [1].

Given these discomforting findings, it is timely that in this issue of the *Indian Journal of Gastroenterology*, the Indian consensus on chronic constipation in adults is presented [4].

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To fully appreciate the value of this paper, we should ask why is a consensus necessary, and why an Indian consensus? Medical consensus statements seek to represent current knowledge in a field of medical inquiry based on available evidence. Typically, a panel of experts sets out to identify key questions that they seek to provide an answer to.

One of the key aims of this Indian document was to draw attention to important differences between India and the West. Unlike the West, the profile of an Indian patient with chronic constipation is as likely to be a male as a female. The frequency and consistency of stools in the Indian general population are different from the West. The people in India generally have faster colonic transit times; thus, Ghoshal et al. made a case for having a different standard for defining what is delayed colonic transit in India [4]. The first and rate-limiting step in management is to make the diagnosis. Thus, it is important that physicians in India are able to recognize constipation based on Indian experience, rather than parameters set by the West.

Consensus truly comes to the fore when there are insufficient data to make a firm conclusion. In this situation, the panelists have to look at all the available, albeit limited, evidence and then take an opinion based on their clinical experience and even the prevailing socio-cultural factors. By analyzing the voting pattern, we may gain some interesting insights into the perceptions, and prejudices, of not just the panelists, but also the wider medical community whom they represent. In this context, it is the reservations that are interesting rather than the complete acceptance.

Take for example the simplest statement that "Chronic constipation is common in India", to which 20% of panelists expressed some reservations. At the other end of the spectrum, was the statement proposing a top-down approach to management to which close to 90% expressed either reservations or even rejected outright.

As alluded in their discussion, some may presume that in a society with a highly prevalent practice of vegetarianism, and its associated high dietary fiber intake, constipation should not be a common experience. The authors themselves reinforce this belief in their discussion on lifestyle factors; they report several epidemiological studies identifying non-vegetarianism

as a factor in constipation. However, epidemiological studies involve non-patients, and such studies are not able to verify cause and effect. Conversely, there are controlled studies with measurement of dietary fiber intake which have found no differences between constipated and non-constipated subjects [5, 6]. Furthermore, careful analysis of the available treatment studies show that the data are weak, and that overall increasing dietary fiber does not produce a convincing improvement in patients with chronic constipation [7–9]. The point is that we should not simply blame the patient for having a bad diet. We should try to understand whether the dietary fiber could be making the patient feel worse. We should also not expect too much from fiber treatment. Recently, we performed a systematic review of all relevant literature to determine whether there is a consistent definition of refractory constipation [10]. Amazingly, a number of surgical series considered failed fiber treatment as a basis to justify ablative surgery [10].

These are important points to emphasize. Diet plays a minor role. There are real physiological disturbances. More needs to be done. This brings us back to statement 25. The reasons for the rejection of the top-down approach, even with the caveat for tertiary centers, were not made healthcare costs, and patient-acceptance may be considered. However, one wonders if a more critical analysis of the data could allow us to be more empathetic to the patient. Perhaps if we can overcome old prejudices about constipation, we may be more inclined to move quickly up the treatment ladder.

The hope is that one day, our patients with this age-old condition with the age old ideas of diet will be better cared for.

Compliance with ethical standards

Conflict of interest K-AG declare that they have no conflict of interest.

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References

1. Xiong L, Gong X, Siah KT, et al. Rome foundation Asian working team report: real world treatment experience of Asian patients with functional bowel disorders. J Gastroenterol Hepatol. 2017;32:1450–6.
2. Wald A, Scarpignato C, Mueller-Lissner S, et al. A multinational survey of prevalence and patterns of laxative use among adults with self-defined constipation. Aliment Pharmacol Ther. 2008;28:917–30.
3. Siah KTH, Gong X, Yang XJ, et al. Rome Foundation-Asian working team report: Asian functional gastrointestinal disorder symptom clusters. Gut. 2018;67:1071–7.
4. Ghoshal UC, Sachdeva S, Pratap N, et al. Indian consensus on chronic constipation in adults: a joint position statement of the Indian Motility and Functional Diseases Association and the Indian Society of Gastroenterology. Indian J Gastroenterol. 2018;37: https://doi.org/10.1007/s12664-018-0894-1.
5. Müller-Lissner SA, Kamm MA, Scarpignato C, Wald A. Myths and misconceptions about chronic constipation. Am J Gastroenterol. 2005;100:232–42.
6. Markland AD, Palsson O, Goode PS, Burgio KL, Busby-Whitehead J, Whitehead WE. Association of low dietary intake of fiber and liquids with constipation: evidence from the National Health and Nutrition Examination Survey. Am J Gastroenterol. 2013;108:796–803.
7. Suares NC, Ford AC. Systematic review: the effects of fiber in the management of chronic idiopathic constipation. Aliment Pharmacol Ther. 2011;33:895–901.
8. Yang J, Wang HP, Zhou L, Xu CF. Effect of dietary fiber on constipation: a meta analysis. World J Gastroenterol. 2012;18:7378–83.
9. Rao SS, Yu S, Fedewa A. Systematic review: dietary fiber and FODMA prestricted diet in the management of constipation and irritable bowel syndrome. Aliment Pharmacol Ther. 2015;41:1256–70.
10. Soh AYS, Kang JY, Siah KTH, Scarpignato C, Gwee KA. Searching for a definition for pharmacologically refractory constipation: a systematic review. J Gastroenterol Hepatol. 2018;33:564–75.