Management of Constipation in Irritable Bowel Syndrome

Most constipation is constitutional and is not associated with structural abnormalities of the colon or other diseases (exceptions being hypothyroidism and hypercalcaemia)
A change in bowel habit to fewer or more solid stools seldom indicates serious colonic pathology
Contributing factors include low levels of physical activity, low levels of dietary fibre , poor intake of fluids and use of constipating medicines such as opiate analgesics, calcium supplements or verapamil

Approach to Treatment

Give general lifestyle advice e.g. Lifestyle and foods in IBS Patient Information Leaflet
Review medication

Discuss dietary changes

- Give "Lifestyle and foods in IBS" Patient Information Leaflet
- Assess fibre intake and cautiously increase over 1-2 weeks if tolerated
- Note that an increase in insoluble fibre may improve constipation but cause more wind, bloating and abdominal pains
- Increasing water soluble fibre such as oats or linseeds may be better tolerated
- Advise regular porridge or trying up to a tablespoon of linseeds scattered on foods
- Linseeds are readily available in the "nuts and seeds" sections of all large supermarkets
- If this fails to help refer to the NICE/British Dietetic Association IBS advice leaflet
- Consider a trial of a probiotic drink or yoghurt (containing at least 1x106 organisms) for at least 4 weeks. Stick with the same brand but the choice of brand is up to the patient

Pharmacologic

- Ispaghula husk (1-2 sachets/day)
- Laxido (1-2 sachets/day initially)
- Linaclotide (when 2 or more laxatives have failed. 4-8 week trial of 290µg daily or alternate days, SPECIALIST ADVICE ONLY)
- Consider SSRI* (sertraline 50mg od or fluoxetine 20mg od)
- SSRIs should be discontinued after 3 months if there has been no evidence of benefit at the doses stated
- Where there is clear clinical improvement, treatment can be continued for 6-12 months before a trial of discontinuation

* This is an unlicensed indication

Other symptoms

Some people may complain of **difficulty evacuating** rather than passing fewer of firmer stools (**NOT** tenesmus)
They may complain of straining or the need to self-digitate to facilitate defaecation

This may indicate a degree of pelvic nerve dysfunction (often a history of pelvic surgery or radiotherapy or hitherto unnoticed obstetric trauma)
How they sit on the toilet may be part of the problem.
A combination of pelvic floor exercises and raising their feet 15cm or so off the floor so that the knees are above the hips (by using a low plastic stool to mimic the act of squatting) can be very useful