
The epidemiology and health-related quality of life associated with functional gastrointestinal disorders are reviewed, with particular emphasis on irritable bowel syndrome and functional dyspepsia. The literature supports the significant worldwide prevalence of functional gastrointestinal disorders, including irritable bowel syndrome (IBS), functional dyspepsia, and chronic constipation. An increased female prevalence has been demonstrated in most studies in patients with IBS and chronic constipation, but not functional dyspepsia. The female-to-male ratio appears to be greater in the healthcare-seeking population than in community populations. However, some differences in the reported general prevalence and gender-related prevalence of functional gastrointestinal disorders may be due to cultural factors and study methodology. A significant healthcare burden is associated with IBS, with increased outpatient services, abdominal and pelvic surgeries, and gastrointestinal- and non–gastrointestinal-related physician visits and healthcare costs. Health-related quality of life is impacted significantly in patients with functional gastrointestinal disorders, such as functional dyspepsia and IBS, compared with the general healthy population, as well as patients with other chronic medical conditions, such as gastroesophageal reflux disease and asthma. Impaired health-related quality of life has been demonstrated, in particular, in patients with moderate to severe disease seen in referral settings. The health-related quality of life appears to improve in treatment responders, or correlates with symptom improvement, with at least some treatment modalities studied in functional gastrointestinal disorders, but further studies are needed. Predictors of health-related quality of life in patients with functional gastrointestinal disorders include psychosocial factors, such as early adverse life events, and symptoms related to visceral perception, eg, pain and chronic stress. The presence of extraintestinal symptoms appears to have a major if not greater impact on healthcare visits, excess healthcare costs, and health-related quality of life in patients with functional gastrointestinal disorders.


OBJECTIVES: Constipation is common, and its treatment is unsatisfactory. Although many agents have been tried, there are limited data to support their use. Our aim was to undertake a systematic review of the efficacy and safety of traditional medical therapies for chronic constipation and to make evidence-based recommendations.

METHODS: We searched the English literature for drug trials evaluating treatment of constipation by using MEDLINE and PUBMED databases from 1966 to 2003. Only studies that were randomized, conducted on adult subjects, and published as full manuscripts were included. Studies were assigned a quality score based on published methodology. Standard forms were used to abstract data regarding study design, duration, outcome measures, and adverse events. By using the cumulative evidence of published data for each agent, recommendations were made regarding their use following the US Preventive Services Task Force guidelines.

RESULTS: Good evidence (Grade A) was found to support the use of polyethylene glycol (PEG) and tegaserod. Moderate evidence (Grade B) was found to support the use of psyllium and lactulose. There was a paucity of quality data regarding many commonly used agents including milk of magnesia, senna, bisacodyl, and stool softeners.

CONCLUSIONS: There is good evidence to support the use of PEG, tegaserod, lactulose, and psyllium. Surprisingly, there is a paucity of trials for many commonly used agents. These aspects should be considered when designing trials comparing new agents with traditional therapies because their use may not be well validated.
SELECTED CLINICAL ABSTRACTS


No abstract available.


INTRODUCTION: Functional abdominal symptoms are very common and account for nearly 2 million primary care consultations in Britain every year and produce significant morbidity. The aims of this study were to evaluate the impact of 2 self-help interventions on consultation rates and symptom severity in patients with a primary care diagnosis of irritable bowel syndrome.

METHODS: 420 patients from 54 primary care centers were randomized either to receive self-help information in the form of a guidebook or the guidebook plus a “self-help” group meeting or to be in a control group receiving neither intervention. Data were collected using questionnaires and primary care records.

RESULTS: At 1 year, patients in the guidebook group had a 60% reduction in primary care consultations (P < .001) and a reduction in perceived symptom severity (P < .001) compared with controls. Allocation to the self-help group conferred no additional benefit. Actual symptom scores did not change significantly in any group. Costs per patient were reduced by £73 (C.I. £43, £103) or 40% per year.

CONCLUSION: Introduction of a self-help guidebook results in a reduction in primary care consultations, a perceived reduction in symptoms, and significant health service savings. This suggests that patients attending their primary care physician with functional abdominal symptoms should be offered self-help information as part of their management.


A careful clinical evaluation, exclusion of secondary causes (eg, colonic obstruction, metabolic conditions, and drug-induced constipation), and assessments of colonic transit and rectal evacuation are necessary to ascertain whether constipation is attributable to normal colonic transit, delayed colonic transit (ie, slow-transit constipation), or a rectal evacuation disorder (with or without delayed colonic transit). Idiopathic slow-transit constipation is a clinical syndrome predominantly affecting women and is characterized by intractable constipation and delayed colonic transit. This syndrome is attributed to disordered colonic motor function and spans a spectrum of variable severity ranging from patients who have relatively mild delays in transit, but are otherwise indistinguishable from irritable bowel syndrome, at one extreme to patients with colonic inertia or chronic megacolon at the other extreme. Most patients are treated with one or more pharmacological agent. A subtotal colectomy is effective and occasionally indicated for patients with medically refractory severe slow-transit constipation, provided that pelvic floor dysfunction has been excluded or treated. Pelvic floor dysfunction can be diagnosed by the clinical features and anorectal testing. Most patients with pelvic floor dysfunction will respond to pelvic floor retraining by biofeedback therapy.


Constipation, however it is defined, is a common problem in the community. The exact prevalence of constipation depends on the definition used; prevalence estimates range from 2% to 28%. The prevalence of constipation has been stable because the onset and disappearance rates over time are similar, but accurate data on the incidence of constipation are lacking. Approximately one third of those individuals with constipation seek healthcare; this is an expensive fraction due to investigational and medication costs. The evidence that lifestyle factors are causally linked to constipation is weak, although non-steroidal anti-inflammatory drug use and the use of other constipation-inducing medications are important risk factors. Constipation is not of clinical importance until it causes physical risks or impairs quality of life. There is accumulating evidence that self-reported constipation and functional constipation as defined by the Rome criteria lead to significant impairment of quality of life, with the implication that this is a serious
condition in the majority of people afflicted. Constipation may have other serious consequences; an increased risk of colon cancer has been reported but could be explained by confounding. Although hemorrhoids have been attributed to constipation, this association has been questioned. The costs of testing in patients presenting with constipation has been conservatively estimated to be $6.9 billion annually in the United States; treatment costs add substantially to the healthcare burden.


Using health statistics from the United States and England and Wales, we review the epidemiology of constipation and possible etiologies of this disorder as suggested by its epidemiologic distribution. The analysis revealed that constipation is one of the most common chronic digestive disorders in the United States, affecting 1 of every 50 people. The occurrence of constipation increased with advancing age, showing an exponential increase in prevalence after the age of 65. The age distribution of constipation was similar in both sexes, but overall constipation was 3 times more common in women than in men. Constipation more frequently affected nonwhites than whites, and people from families with low income or less formal education. The characteristic epidemiologic pattern of constipation suggests the influence of environmental factors. Insufficient dietary fiber is widely believed to be a major cause of constipation, yet it is difficult to devise a mechanism by which dietary fiber alone could produce the marked differences observed between gender, race, and socioeconomic status. Recent evidence suggests that disruption of neural regulation of colonic motility plays an important role in the development of chronic constipation. This loss of neural regulation may result from mechanical damage to the pelvic nerves due to childbirth or pelvic surgery, exposure to environmental toxins (e.g., organochlorine insecticides or heavy metals), or possibly exposure to an infectious agent. Other environmental factors that may play a role in the pathogenesis of chronic constipation have not yet been elucidated. Consequently, studies examining the epidemiology of chronic constipation are important for providing insight into potential environmental risk factors relevant to the etiology of this disorder.

**Prather CM. Subtypes of constipation: sorting out the confusion. Rev Gastroenterol Disord. 2004;4(suppl 2):S11-16.**

In patients with chronic constipation, identifying subtypes based on underlying physiology guides subsequent therapeutic choices. Chronic constipation subtypes include slow-transit constipation, pelvic floor dyssynergia, functional constipation, and irritable bowel syndrome with constipation. Chronic constipation subtypes are defined by the result of colonic transit, pelvic floor function, and the presence or absence of significant abdominal pain. Although a variety of tests are available, the most straightforward approach uses the 5-day colonic marker test of transit and anorectal manometry with balloon expulsion testing to evaluate for pelvic floor dysfunction. Patients with normal physiologic tests have either irritable bowel syndrome with constipation or normal-transit constipation. Significant overlap exists between subtypes and a clear distinction is not always possible, with up to a 50% overlap between patients with slow-transit constipation and irritable bowel syndrome, approximately 10% of patients evaluated exhibiting both slow transit and pelvic floor dyssynergia, and 50% of patients with pelvic floor dyssynergia also found to have slow transit. Symptom severity assessment provides the rationale for pursuing further testing and directing the aggressiveness of treatment as patients with greater symptom severity have reduced quality of life and poor physical functioning scores. Few constipation-specific validated measures exist for measuring symptom severity in chronic constipation. In clinical practice severity may be defined as mild symptoms having minimal impact upon daily activities or moderate to severe symptoms that increasingly interfere with daily life.