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CONSTIPATION*

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The Trades Exhibition is an essential part of a successful Medical Congress and the members of the Medical Association have reason to be grateful to our friends the Trade Exhibitors who make our Congresses so interesting and instructive. This morning one of the exhibitors handed me a beautifully illustrated and well printed brochure entitled 'Constipation—Its Types and Therapy'. This little book contains some very useful information about a subject which has been very much neglected by our teachers of medicine. The coloured illustrations suggest that *Homo sapiens* may have a very attractive interior, particularly if regular use is made of a very elegant and well advertized American preparation which is the treatment of choice in all cases.

Homo sapiens is indeed a queer creature, distinguished from other mammals not only by its peculiar posture. There are other characteristics. The human animal differs from most other creatures in that it, and it alone, is interested in its excreta. The newborn baby may be microcephalic or hydrocephalic, but this may not be noticed by the mother, who seems more concerned over the infant's stools. The colour, the frequency and even the odour of the newborn's excreta are, I am informed, some of the less noxious subjects discussed at fashionable mothers' tea parties. The infant shares its mother's pride when the stool is yellow and well formed and shares parental anxiety when symptoms resulting from paternal rejection or maternal engulfment are attributed to constipation. The child is thus, from its earliest days, conditioned to become a bowel-conscious adult.

It becomes part of its credo that bowels should act every day, but there is so much else to do that the urge to defaecate is suppressed; it also happens that urge and opportunity do not always coincide. Houses and families may be large, but lavatories few, and frequently occupied. School lavatories are also not very inviting and not free when required. The child, which is conscious of its negligence, resents the circumstances which make its bowel negligence inevitable. Even in the infant frustration and resentment are the main causes of psychosomatic disturbances, and the gastro-intestinal system is most frequently disturbed. Bowel motility is altered, and the bowel-conscious child grows into the colospastic or dyschezic adult.

Constipation can be defined as the condition in which there is delay in the evacuation of faeces, resulting in the passage of hard, dry stools. This may be due to or associated with gross organic disease, which must in every case be excluded. In the majority of cases no organic cause can be detected.

It is essential to know that the pattern of bowel evacuation varies with the individual. Once a day is normal for most, twice a day for others and twice a week for some.

The superstition that bowel contents are toxic and that health is promoted by keeping the bowel empty is nonsense. Excessive purgation interferes with bowel function and with health. The right half of the colon should always contain food residue. Cellulose is partially digested by bacterial activity and rendered non-irritating, and excess fluid is absorbed. Excessive motility of caecum and colon is responsible for excessive gas formation. A colon without residue is a colon full of gas. The normal function of the distal colon is storage and expulsion and there should be no interference with normal function.

Dyschesia

Normal defaecation is a conditioned reflex and failure to develop and maintain regular habits may lead to a breakdown of the reflex mechanism, as a result of which rectum and pelvic colon can become tightly packed and distended with a hard faecal mass. This condition is known as dyschezia and is very much commoner than is generally believed. Purgatives do not dislodge this mass, but will force a canal through the mass of faeces through which liquid bowel-contents can escape. The symptoms are abdominal pain and discomfort, headache, backache, lassitude and nausea; these are not caused by toxaemia as used to be believed,

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and can also be produced by packing the rectum with cotton wool. It is not unusual to find a rapidly emptying stomach and a spastic colon associated with an over-distended pelvic colon and rectum. Unfortunately the diagnosis is often missed because the patient is not properly examined. Rectal examination is essential both in young and old. It cannot be repeated too often that 'if you do not put your finger into it, you put your foot into it'. The following case illustrates a very advanced form of this condition, but a clinical history of this type is not unusual.

Mrs. X, aged 38, was referred to me by a colleague, who had diagnosed an ovarian cyst. The patient was very anxious to have surgical treatment. She was an obese married woman with 2 children, aged 6 and 8. The confinements had been normal and there was nothing abnormal in the menstrual history. She had been constipated since her schooldays and always complained of cramp-like abdominal pains. She had been swallowing laxative pills, liquid extract of cascara and, on special occasions, castor oil, for as long as she could remember.

The appendix had been removed when she was 18 years old, and the gall-bladder when she was 28. She informed me with great pride that it had been a most abnormal gall-bladder and that the surgeon had had great difficulty in disentangling adherent stomach, bowel and liver. Two years later she had an operation for adhesions. (It should be more generally known that adhesions which do not cause obstruction usually cause no symptoms. Those who suffer from excessive surgical libido should remember that what the Lord has joined together, no man shall put asunder.) The year after her first confinement a ventral suspension was done and a cyst removed from the right ovary. (It is only very seldom that a ventral suspension is indicated and it seems most unlikely that this was such a case.)

She now complained of severe backache, dysuria, dysparunia and pain in the region of the left iliac fossa.

Examination revealed a much-scarred abdomen, normal chest and cardio-vascular system, and normal urine. A mass the size of a small melon could be felt in the left iliac fossa and could be moved from side to side. On vaginal examination this mass had the characteristics of an ovarian cyst. The rectum was tightly packed with faeces, but I did not consider this of major importance at the time.

On opening the abdomen I found an enormously distended pelvic colon. The abdomen was closed, the patient put into lithotomy position and a flushing curette introduced into the rectum. It took almost an hour of flushing and digital manipulation of the faecal mass to clear the bowel. A sanitation specialist might perhaps have done the work more expeditiously.

The patient was extremely satisfied with the result and I was given great credit for my diagnostic skill and surgical ability.

Laporotomy, of course, is not as a rule the treatment of choice and I have not again found it a necessary diagnostic procedure, but I have frequently done the operation of digital removal of faeces under general anaesthesia. The mass should first be softened and lubricated with an enema of warm oil. Once the bowel is emptied it is essential to re-educate the bowel, which can be a slow and difficult process. Giving enemas of glycerine and water, which must gradually be reduced in strength, quantity and frequency is very useful. Purgatives must be avoided.

Spastic Constipation

Spastic constipation results from emotional disturbances, is aggravated by menopausal or other endocrine dysfunction, and is made worse by purgatives, enemas and excessive exercise. An enema cannot remove frustration and a purgative is no cure for marital maladjustment. A diet containing too much roughage is also harmful. Successful treatment requires low-residue diet with sufficient protein and vitamins, an adequate fluid intake, explanation and reassurance. Sedatives and antispasmodics are helpful, but should play a minor part in treatment. The following case illustrates the condition.

An unmarried teacher aged 40 (female) gave the following history: She had suffered from abdominal discomfort and occasional severe colicky abdominal pain for the past 15 years. She did not marry, because she was the youngest daughter of a large family and had to stay at home and look after her invalid mother (now deceased). She had always been constipated and always suffered from 'indigestion'. She felt very unhappy unless she swallowed milk of magnesia, the action of which was occasionally augmented with cascara or Beecham's pills. Her appendix had been removed 10 years previously and a ventral suspension had been done at the same time. Haemorrhoids had been injected 2 years later but they were still troublesome. Menstruation had lately become more frequent and there was very considerable dysmenorrhoea. She was referred to me by a colleague, who suggested I should investigate her condition with a view to advising another surgical procedure.

Examination revealed an undernourished, anxious-looking, obviously frustrated female. Her teeth had long been replaced by ill-fitting dentures. There was a slight tremor of the tongue. She had tachycardia but there was no evidence of hyperthyroidism or organic cardiac disease. There was tenderness on palpating the caecum and sigmoid colon. Rectal examination showed no significant abnormality and urine was normal. X-ray examination revealed a rapidly-emptying ptosed stomach, a rapidly-emptying small intestine, and a very spastic caecum and colon. Barium enema showed a few small diverticulae, but no other abnormality.

This lady was given a low-residue, high-protein diet, a vitamin supplement and pill Bellergal (belladonna, phenobarb and ergotamine) *t.d.s.* Her condition has improved very considerably, though she still enjoys bad health.

Treatment

The drug addict and the chronic alcoholic are difficult to treat; it is even more difficult to treat the pill-and-purgative addict. These cases frequently require hospitalization and prolonged supervision.

In the old and debilitated, constipation is usually associated with an atonic bowel. Re-education is no longer possible. The 'enjoyment of bad health' may be the only pleasure left to the patient, and the bowel habits of a lifetime should not be lightly disturbed. When pills and purgatives have been used for many decades they have done all the harm they can do and no useful purpose will be served by depriving the old of something which they consider essential. When dealing with the old, the doctor must not attempt to change the habits of a lifetime; he will not change the patient, but the patient may change the doctor. It is, however, necessary to stop a liquid-paraffin habit. This apparently innocuous and chemically inert oil prevents absorption of vitamins and interferes with the absorption of nourishment. The habitual use of this mineral oil can be harmful both in old and young. Constipation, and the symptoms attributed to constipation, in the old are often relieved by treating a minor degree of hypothyroidism, and by correctly treating a previously unsuspected congestive cardiac failure.

The young must be taught the importance of regular habits, and must learn that punctuality is important in all things. The adult must use laxatives only occasionally. The innocent well-advertized pill may be habit forming.