

Understanding & Managing Chronic Constipation

A Patient Guide to Chronic Constipation Care

What Is Chronic Constipation?

Chronic constipation means persistent (generally 3+ months) infrequent bowel movements (fewer than 3 per week), hard or lumpy stools, excessive straining, a sense of incomplete emptying, or needing to use manual maneuvers to have a bowel movement. It's extremely common and often has more than one contributing cause, which is part of why identifying the right subtype matters for choosing the most effective treatment rather than just cycling through laxatives by trial and error.

What Causes It?

- **Normal transit constipation** — the most common type. Stool actually moves through the colon at a normal pace, but stools are perceived as infrequent, hard, or difficult to pass. This overlaps significantly with constipation-predominant IBS.
- **Slow transit constipation** — stool moves through the colon more slowly than normal, due to reduced colon muscle contractions and changes in the nerves and pacemaker cells that coordinate them. Less common than the other types, but tends to cause more severe, harder-to-treat symptoms.
- **Dyssynergic defecation** (a pelvic floor coordination problem) — during a bowel movement, the pelvic floor muscles and anal sphincter are supposed to relax to let stool pass. In dyssynergic defecation, they instead tighten or fail to coordinate properly, so stool gets physically stuck even when nothing else is wrong. This distinction matters because this subtype responds specifically to targeted muscle retraining (discussed below) rather than simply needing more or stronger laxatives.
- **Obstructive (structural) constipation** — a physical, anatomical blockage to stool passage, rather than a pure muscle-coordination problem. The most common examples are a **rectocele** (a bulge in the rectal wall, often into the vagina, where stool can pool instead of passing through), **rectal intussusception** (the rectum telescopes into itself during straining), and excessive downward movement of the pelvic floor with straining. These can occur alongside dyssynergic defecation, and often need imaging (discussed below) rather than manometry alone to identify.
- **Medications** — opioids, iron supplements, calcium channel blockers, anticholinergic medications, and some antidepressants are common culprits.
- **Other medical conditions** — an underactive thyroid, diabetes, and neurological conditions affecting gut nerve signaling (Parkinson's disease, multiple sclerosis, spinal cord injury) can all slow the gut down.
- **Diet, activity, and habits** — low fiber or fluid intake, inactivity, and routinely ignoring the urge to go can all contribute, though these are rarely the entire explanation on their own.

How We Evaluate It

Most patients start with a history, exam, and a trial of first-line treatment (below) without needing specialized testing. Testing becomes more useful when symptoms don't respond to initial treatment, to help pinpoint which subtype above is driving things:

- **Anorectal manometry with balloon expulsion testing** — a thin catheter measures pressure and coordination in the rectum and anal sphincter while you simulate a bowel movement, then a small balloon is used to see how easily it's expelled. This is the key test for identifying dyssynergic defecation.
- **Colonic transit study** (swallowing a capsule containing small markers that show up on X-ray, then tracking how long they take to pass over several days, or a wireless motility capsule that transmits the same information electronically) — used to identify slow transit constipation once dyssynergic defecation has been ruled out or addressed.
- **MR defecography** — an MRI scan taken while you simulate a bowel movement (using a small amount of gel placed in the rectum beforehand), giving a detailed, real-time picture of the rectum, pelvic floor, and surrounding structures. This is the best test for identifying the structural causes described above — rectocele, intussusception, and excessive pelvic floor descent — and is typically used when manometry findings are inconclusive, symptoms suggest a structural component, or surgery is being considered.

- **Colonoscopy** — this plays a different role than the tests above: it doesn't help distinguish between the functional subtypes described earlier, but it's the right test to rule out an actual structural or colorectal cause (a mass, stricture, or other lesion). It's reserved for patients with an alarm feature (see “When to Contact Our Office” below) or those simply due for routine colorectal cancer screening — not something we'd recommend for everyone with uncomplicated constipation, since guidelines don't support routine colonoscopy for constipation alone.

How Chronic Constipation Is Treated

Treatment is generally layered from simple, low-risk measures toward more targeted options if those aren't enough, with the specific subtype above guiding which options are likely to help most. A few terms come up below: a study “compared to a dummy pill (placebo)” means some patients got the real treatment and others a fake version, without knowing which, so researchers could isolate the treatment's true effect. A “pooled analysis” (sometimes called a meta-analysis) means researchers combined results from several separate studies for a more reliable answer. And when we say guidelines give something a “strong” versus a more “conditional” recommendation, that's simply reflecting how confident experts are in the evidence — both can still be reasonable options.

Lifestyle & Dietary Measures

Goal: address the basics first — low-risk and reasonable for nearly everyone regardless of subtype.

- **Soluble fiber**, particularly psyllium (Metamucil and similar products), rather than insoluble/wheat bran fiber.

Evidence: Psyllium has the most consistent trial evidence among fiber types for improving stool frequency and consistency. Insoluble fiber (like wheat bran) has weaker, less consistent evidence and can actually worsen bloating in some patients, so it's not a reliable substitute if psyllium isn't working.

- **Kiwifruit** — 2 green kiwis daily.

Evidence: A randomized trial that had the same patients try both found kiwifruit worked better than psyllium, increasing bowel movements to 6.3 per week versus 4.5 with psyllium (and 3.3 before starting either one). A pooled analysis of several studies confirmed a similar, consistent improvement, making kiwifruit a reasonable, low-risk whole-food option or alternative to fiber supplements.

- **Prunes (dried plums)** — about 100 g daily (roughly 8–12 prunes), split into two servings.

Evidence: A randomized trial that had the same patients try both found prunes worked better than psyllium, improving both how often (3.5 versus 2.8 bowel movements per week) and how easily stool passed. Prunes contain sorbitol, a natural sugar alcohol that draws extra water into the stool, along with fiber; the study's authors concluded prunes should be considered a first-line option for mild-to-moderate constipation.

- **Partially hydrolyzed guar gum (PHGG, sold as Sunfiber)** — a soluble fiber supplement, usually 5–6 g daily.

Evidence: A randomized trial in patients with constipation linked to IBS found significantly more people improved on PHGG than on a dummy pill (34.2% versus 17.7%, reaching at least 3 bowel movements per week and keeping that improvement over time). Because it's broken down more slowly and gently in the gut than other fibers, it tends to cause less gas and bloating, making it a reasonable option for patients who don't tolerate psyllium or other fiber supplements well.

- **Adequate fluid intake** alongside fiber.

Evidence: Fiber without enough fluid can worsen constipation rather than help it, since soluble fiber works partly by absorbing water to soften stool.

- **Regular physical activity.**

Evidence: Associated with improved bowel regularity in observational studies; a reasonable, broadly beneficial recommendation even though dedicated trial evidence specifically for constipation is modest.

- **Toileting posture** — using a footstool to raise the knees above hip level while sitting on the toilet, approximating a squatting position.

Evidence: This position straightens the angle stool has to pass through, letting the surrounding muscle relax more fully. Studies comparing sitting and squatting-assisted positions found less straining, shorter bowel movements, and a more complete sense of emptying with the squatting-assisted position.

- **Responding to the urge promptly**, ideally trying after meals when the gut's natural post-meal contractions (the gastrocolic reflex) are strongest.

Evidence: Consistent with normal gut physiology; low-risk and often overlooked amid a focus on medications.

Over-the-Counter Laxatives

Goal: directly increase stool water content or stimulate movement when lifestyle measures aren't enough.

- **Polyethylene glycol (PEG/Miralax)** — an osmotic laxative that draws water into the colon; generally considered first-line.

Evidence: Well-supported by placebo-controlled trials for both short- and long-term use, with sustained improvement in bowel function over a year of continued use in controlled studies. It doesn't act on gut nerves or muscles, so it doesn't cause dependence or damage with regular use.

- **Lactulose** — another osmotic laxative, an alternative to PEG.

Evidence: Comparably effective to PEG in head-to-head studies, though it tends to cause more gas and bloating as a side effect, which is why PEG is generally preferred first when available.

- **Magnesium-based laxatives** — magnesium oxide (as a daily supplement/tablet) or magnesium citrate (typically for faster, more complete relief rather than daily routine use).

Evidence: Magnesium oxide has the better trial evidence of the two: a study combining results across several trials found it significantly outperformed a dummy pill (68% versus 19% response). Magnesium citrate is reasonable and commonly used, especially for quicker relief, but doesn't have the same depth of dedicated trial data. The main caution with any magnesium laxative is the kidneys: magnesium is cleared by the kidneys, and people with reduced kidney function (or who are elderly, since kidney function often declines with age) can build up dangerously high magnesium levels even at typical doses — this is why we'd want to know your kidney function before recommending regular use, and wouldn't recommend it at all for anyone with significant kidney disease.

- **Stimulant laxatives** (senna, bisacodyl) — work by directly stimulating colon contractions.

Evidence: Effective, and safe for regular long-term use in the doses typically recommended — the old concern that stimulant laxatives cause “dependency” or damage the colon with ongoing use isn't well supported by current evidence. A reasonable option, whether used regularly or as needed.

- **Docusate (a stool softener)** — widely available and commonly recommended.

Evidence: Despite how often it's used, the trial evidence for docusate is weak: most controlled trials, including a placebo-controlled trial in hospice patients, found no meaningful difference from a dummy pill in stool frequency or consistency. We don't recommend relying on it as a primary treatment.

Prescription Secretagogues & Prokinetics

Goal: increase fluid secretion into the gut or stimulate colon movement directly, for constipation that doesn't respond to the steps above.

- **Linaclotide (Linzess)** and **plecanatide (Trulance)** — taken once daily, these work by pulling more fluid into the intestine to soften stool and help it move along.

Evidence: Guidelines confidently recommend both, based on multiple placebo-controlled trials showing people had bowel movements more often and reported a better quality of life. Diarrhea is the main side effect, though it's uncommon enough to require stopping the medication.

- **Lubiprostone (Amitiza)** — works through a different pathway in the gut wall to increase fluid pulled into the stool.

Evidence: Improves stool frequency, consistency, and bloating in placebo-controlled trials, though guidelines recommend it a bit more cautiously than linaclotide or plecanatide, since the supporting evidence for it is somewhat less extensive.

- **Prucalopride (Motegrity)** — directly stimulates colon muscle contractions rather than pulling in more fluid.

Evidence: Five placebo-controlled trials found a consistent increase in bowel movements per week, giving it a confident guideline recommendation specifically for chronic constipation.

Medications for Opioid-Induced Constipation

Goal: specifically counteract constipation caused by opioid pain medications, without reducing their pain-relieving effect.

• **PAMORAs** — medications specifically designed to block the effect of opioids on the gut, without affecting pain relief. Options include naldemedine (Symproic), naloxegol (Movantik), and methylnaltrexone (Relistor, given by injection).

Evidence: These block opioid receptors specifically in the gut without crossing into the brain, so they relieve constipation without undoing pain control or triggering withdrawal. Naldemedine and naloxegol have the strongest trial evidence and are generally tried first. Methylnaltrexone is recommended a bit more cautiously, but worked notably fast in its key clinical trial — about half of patients had a bowel movement within 4 hours of a dose, versus 15% on a dummy injection — making it a reasonable option specifically when other laxatives haven't worked.

Treating Dyssynergic Defecation

Goal: retrain the pelvic floor and anal sphincter muscles to coordinate properly during a bowel movement — the most effective treatment specifically for this subtype, identified through the testing described above.

• **Biofeedback therapy** — sensors provide real-time visual feedback on muscle activity while a therapist guides you through relaxation and coordination exercises simulating a bowel movement; typically several sessions.

Evidence: A randomized trial found biofeedback corrected the abnormal muscle pattern in 79% of patients, compared with 4% receiving a fake version of the feedback (used for comparison) and 8% receiving standard therapy (diet, exercise, laxatives) — a large, well-controlled difference, with benefits sustained at long-term follow-up. For this specific subtype, biofeedback outperforms simply adding more laxatives, which is why correctly identifying dyssynergic defecation through testing matters so much.

When to Contact Our Office

- Blood in the stool, unintentional weight loss, or symptoms of anemia (unusual fatigue, lightheadedness)
- New constipation starting after age 50, or a family history of colon cancer
- Severe abdominal pain, distension, or vomiting — possible signs of a bowel blockage, requiring urgent evaluation
- A sudden, significant change in your usual bowel pattern
- Before starting, stopping, or combining any medication or supplement in this guide

This guide supports your personalized plan and isn't a substitute for individualized medical advice. Check with your provider before starting, stopping, or combining anything mentioned here.

Innovative GI • Cameron Sikavi, MD • 8631 W 3rd St, Suite 1015-E, Los Angeles, CA 90048 • (310) 652-4472 • innovativegi.com