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Summary

Clinical scenario 1: What's the problem? Give a laxative and it's sorted

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Neurogastroenterology & Motility | Surgery | Primary Care | Small Intestine & Nutrition

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The speaker presented a diagnostic framework for chronic constipation using a case-based approach, emphasizing that proper diagnosis requires detailed history, physical examination including digital rectal exam, and systematic exclusion of alarm features and secondary causes before classifying as primary constipation or IBS-C.

KEY POINTS

- The case patient was a 48-year-old woman with 10-year history of constipation (bowel movements once or twice weekly only with bisacodyl, hard stools, bloating, mild abdominal pain), normal colonoscopy, and borderline normal digital rectal exam showing only hemorrhoidal skin tags.
- Initial evaluation of all constipated patients should include detailed medical history assessing stool patterns, duration, onset, and defecation characteristics, physical examination with digital rectal exam, and limited blood tests (full blood count, C-reactive protein, coeliac serology, and in selected patients metabolic and thyroid function).
- Patients with alarm features (anemia, rectal bleeding, unexplained weight loss with diarrhea, onset over age 50, family history of IBD/coeliac/colon cancer) require further investigation, typically colonoscopy.
- The speaker emphasized assessing for constipating drugs, particularly opioids, which the Rome Commission included as a main bowel disorder due to increasing prevalence of opioid-induced constipation.
- After excluding secondary causes, patients with abdominal pain/discomfort should be evaluated for IBS-C criteria, while those meeting Rome 5 chronic constipation criteria without pain are diagnosed as chronic constipation; the speaker noted these disorders exist on a spectrum and patients require periodic reassessment as they can switch between categories.

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