

# Constipation

Constipation is a common symptom and is a subjective interpretation of a disturbance of bowel function. There is lack of general agreement on the norms for stool frequency, size, or consistency, with considerable uncertainty on how much deviation is required to warrant the label of constipation. Generally, constipation refers to a failure to completely evacuate the lower colon. This is associated with difficulty in defecating, infrequent bowel movements, straining, abdominal pain, and pain on defecating. It can also refer to hardness of stool or a feeling of incomplete evacuation. Obstipation refers to intractable constipation or the regular passage of hard stools at 3- to 5-day intervals.

There are five areas in the defecation process when interference can cause a disturbance in motility and lead to clinical problems: (1) the peristaltic reflex, (2) the spinal arc, (3) relaxation of the anal sphincter, (4) contraction of the voluntary muscle associated with defecation, and (5) the autonomic and cortical control of defecation. Both functional and organic disturbances can cause constipation.

*Acute constipation* refers to a sudden change for that individual. This suggests an organic cause, such as mechanical obstruction, adynamic ileus, or traumatic interruption of the nervous system from medications or following anesthesia. *Persistent constipation* occurs when the condition lasts for weeks or occurs intermittently with increasing frequency or severity. Partial obstruction or local anorectal conditions could be the cause.

Chronic constipation occurs as the result of disruption of the storage, transport, and evacuation mechanisms of the colon. Functional causes are the most common and include poor bowel habits; inadequate intake of dietary fiber, bulk, and fluids; and anal fissure pain. Genetic predisposition to constipation seems to exist.

## Diagnostic reasoning: Focused history

### Is this really constipation?

#### Key Questions

- How many stools do you have per day?
- What is the consistency of the stool?

## Frequency of stool

Stool frequency is the easiest parameter to quantify. In the general adult population, the “normal” frequency of bowel movements ranges from 3 to 12 per week. Having fewer than three bowel movements per week is considered constipation.

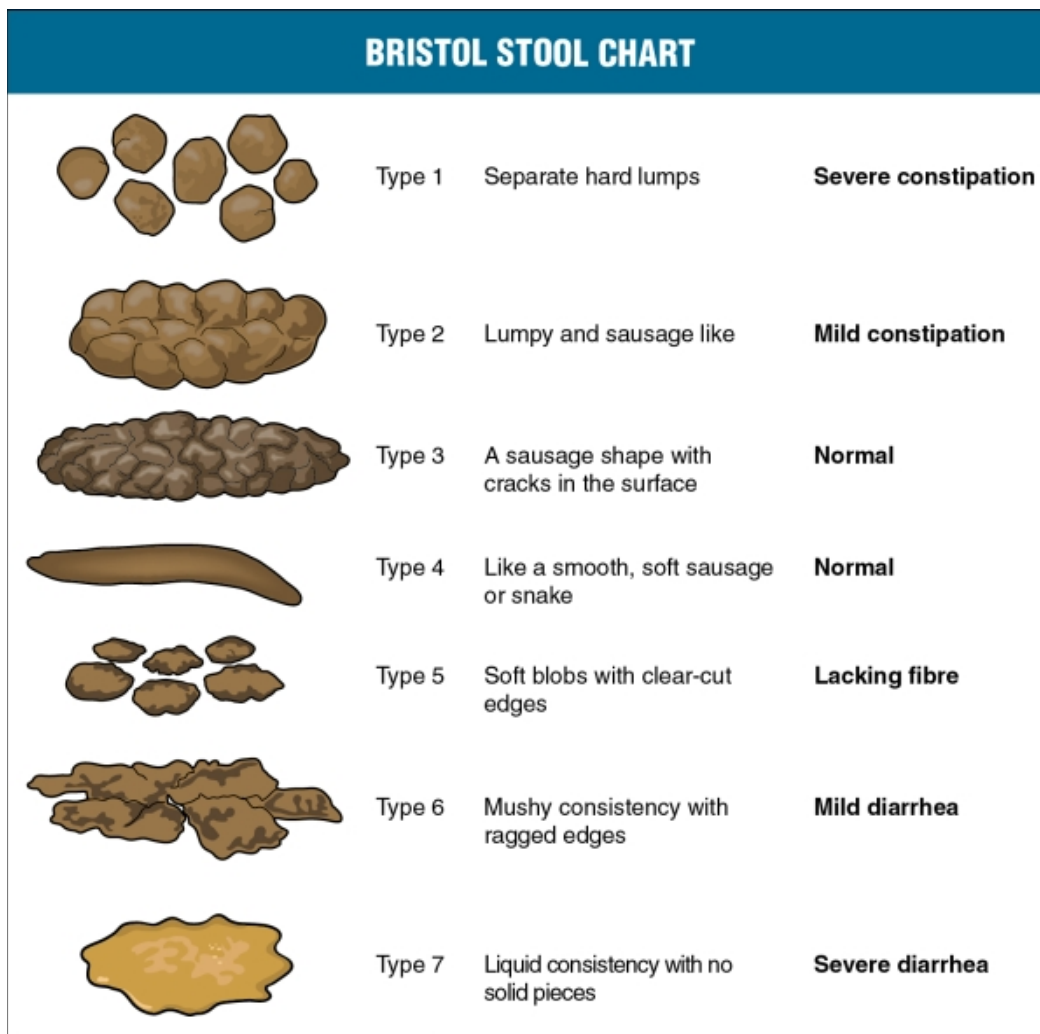
Infants and children have decreasing stool frequency with age, from more than 4 stools per day during the first week of life to 1.2 per day at age 4 years. Infants who have a lower number of stools than average are at greater risk of developing constipation.

Alternating episodes of constipation and diarrhea are characteristic of irritable bowel syndrome (IBS). Patients describe their constipation stools as hard, round balls.

## Stool consistency

Dry, hard stools suggest a lack of sufficient dietary fluids or fiber. Stools that are marginally frequent but are soft and moist do not indicate constipation. The same number of stools that are hard and dry would indicate constipation. Liquid stool and fecal incontinence, particularly in children and older adults, can represent stool impaction and overflow.

The Bristol Stool Form Scale is useful in characterizing stool consistency (Fig. 10.1)



**FIGURE 10.1** Bristol Stool Form Scale. By Cabot Health, Bristol Stool Chart (<http://cdn.intechopen.com/pdfs-wm/46082.pdf>) [CC BY-SA 3.0 (<https://creativecommons.org/licenses/by-sa/3.0>), via Wikimedia Commons]

### What red flags do I need to consider?

#### Key Questions

- Is there any rectal bleeding or blood in the stool?
- Have you had an unintentional weight loss of more than 5% of your body weight?
- Have you had inflammatory bowel disease?
- Have you or your family members had colorectal cancer?

### Bleeding

Black stools can indicate bleeding from a site in the upper gastrointestinal (GI) tract. Bright red blood indicates bleeding from the lower GI tract and may indicate a mass. Hemorrhoids and anal or rectal fissures can also produce bleeding. Brisk bleeding is uncommon with hemorrhoids and requires immediate investigation.

### Unintentional weight loss

In an adult, an unintended weight loss of more than 5% of usual body weight over a 6- to 12-month period may signal an underlying cancer (see [Chapter 39](#)) or development of frailty syndrome in an older adult.

## History of inflammatory bowel disease or colorectal cancer

Patients with a history of inflammatory bowel disease (IBD; Crohn disease or ulcerative colitis) or with a personal or family history of colorectal cancer are at increased risk for colorectal cancer. A change in bowel habits can signal an intestinal tumor.

### Is the constipation acute or chronic?

#### Key Questions

- When did the constipation start?
- How long have you been constipated?
- Is this an individual episode or is it chronic?
- At what age did the constipation first begin?

## Onset and duration

Recent onset usually reflects changes in lifestyle or physical health such as dietary changes, activity changes, new medications, partially obstructing lesions, or recent illness. Chronic constipation or constipation of long duration (more than 3 weeks) is usually associated either with functional causes, such as lack of dietary fiber and bulk, or with concurrent systemic disorders such as diabetes or hypothyroidism.

## Age of onset

New-onset constipation in adults older than age 40 years is suspicious for colon lesions. Constipation in the newborn is likely to have an anatomical cause. In infants, the cause is likely inadequate fluid and fiber in the diet. In children, the cause is likely to be diet as well as developmental and psychological factors. In adults, the cause is usually related to dietary and bowel habits.

### If the constipation is acute, what conditions should I consider?

#### Key Questions

- Have you been ill recently?
- Have you had a fever?
- Do you have any chronic health problems?

## Recent illness

Dehydration and fever cause hardening of the stools by diminishing intestinal secretions and increasing water absorption from the colon. A transient period of constipation is common during an acute febrile illness. Reflex ileus is sometimes seen with pneumonia.

## Chronic illness

Hardened stools are found in patients with renal acidosis and diabetes insipidus. Infants and children with hypotonia of the abdominal and intestinal musculature from neurologic conditions are predisposed to constipation.

Neurologic gut dysfunction, myopathies, endocrine disorders, and electrolyte abnormalities can cause constipation. Constipation in infants can be an early symptom of congenital hypothyroidism.

### If the constipation is chronic or recurrent, what should I consider?

#### Key Questions

- What do you usually eat in a day?
- How many glasses of liquid do you drink each day?
- Do you eat breakfast?
- What are your usual bowel habits?
- How active are you?

- What medications are you taking?
- Do you use laxatives? How often do you take laxatives? How long have you used laxatives?

## Dietary pattern

A 3-day dietary history is more accurate than a 24-hour recall, although a 24-hour recall can provide a reasonable picture of the patient's dietary habits. Diets that lack roughage result in lack of fecal bulk, causing an inadequate stimulus for peristaltic movement. Diets high in protein result in complete digestion of the protein, leaving little residue to stimulate movement. Diets high in calcium content lead to the formation of calcium caseinate in the stools, which does not stimulate peristalsis. Teenagers often drink several quarts of milk per day, causing constipation. Inadequate fluid intake (less than six 8-oz glasses per day) contributes to dry, hard, and infrequent stools.

## Breakfast

Colonic motility is greatest after breakfast. Skipping this meal decreases the postprandial effect associated with food intake.

## Bowel habits

Postponing a bowel movement because of time constraints or other reasons suppresses the normal gastrocolic reflex and can produce constipation.

## Activity level

Constipation is a common problem in individuals with a sedentary lifestyle. The lack of physical activity reduces the peristaltic reflex. Overactivity can also cause constipation as a result of the lack of adequate fluid replacement.

## Medications

Medications that commonly cause or contribute to constipation include narcotics, imipramine, diuretics, calcium channel blockers, anticholinergics, psychotropic agents, antacids, decongestants, anticonvulsants, iron, bismuth, and lead. Opioid-induced constipation (OIC) occurs in almost half the patients on long-term opioids.

## Use of enemas, laxatives, and suppositories

Use of stimulants to empty the colon removes the peristalsis stimulus for 2 to 3 days. Diarrhea is usually followed by infrequent stools for several days. Chronic use of stimulants can produce chronic atonic constipation.

### How can I further narrow the causes?

#### Key Questions

- Is the stool size large or small?
- What is the general shape of the stool (e.g., small, round, ribbon-like)?
- Is the stool formed or liquid?
- Have you had any involuntary loss of stool?
- Does the constipation alternate with periods of diarrhea?

## Size or caliber of stool

Infrequent passage of small, hard stools can indicate congenital aganglionic megacolon. Very large stools can indicate functional constipation, with the size of the stools a function of the size of the colon. Ribbon-like stools suggest a motility disorder, such as IBS. They can also be caused by narrowing of the distal or sigmoid colon from an organic lesion. A progressive decrease in the caliber of stool suggests an organic lesion. Stools with a toothpaste-like caliber suggest fecal impaction.

## Consistency of stool and fecal incontinence

Dry, hard stools suggest a lack of sufficient dietary fluids or fiber. Liquid stool and fecal incontinence, particularly in older adults, can represent stool impaction and overflow. Overflow incontinence in children can indicate constipation from a fecal impaction.

## Alternating constipation and diarrhea

Alternating episodes are characteristic of IBS. Patients often describe the stool during the constipation episodes as hard and pellet-like.

### What else do I need to consider?

#### Key Questions

- Do you have the urge to defecate?
- Do you have any urinary tract symptoms?
- Do you have any nausea or vomiting?
- Is there any pain with defecation?
- Is there any bleeding with defecation? How much?
- What color are your stools? Are the stools very dark colored or black?

## Urge to defecate

Children with Hirschsprung disease (aganglionic megacolon) do not have an urge to defecate because the stool accumulates proximal to the lower portion of the rectum where the proprioceptors for defecation are located. Evidence of stiffening, squeezing, and crying indicates stool is being propelled to the rectum. Adults who overuse laxatives or other stimulants also may not experience the urge to defecate.

## Associated urinary tract problems

Voiding problems can indicate an abdominal mass. Day and night enuresis is seen in some children with encopresis (fecal soiling). Typically, a neurologic lesion that produces fecal incontinence also disturbs bladder control.

## Vomiting

Bilious vomiting can indicate intestinal obstruction in the newborn. Vomiting associated with pain in adults can indicate obstruction.

## Pain

Chronic recurrent abdominal pain is commonly present in constipation. Pain is intermittent and can be localized to the periumbilical region. Crampy lower abdominal pain is usually caused by bowel distention, which can result from IBS, intermittent obstruction, or adhesions. Noncrampy dull pain in the left abdomen is associated with diverticulosis. Pain on defecation can indicate an anal or a rectal lesion such as hemorrhoids or anal fissures.

## Bleeding

Bright red blood in the stool indicates hemorrhoid, fissure, or possible rectal mass. Black stools can indicate bleeding from a site in the upper GI tract because blood mixed with gastric acid makes the stools appear black. Brisk bleeding is uncommon with hemorrhoids and requires immediate thorough investigation.

## Color

Red stools can be the result of using laxatives of vegetable origin or ingestion of foods such as red beets. A black or very dark brown color can be caused by drugs such as iron and bismuth, both of which contribute to constipation.

### **If this is a child, is there anything else I need to consider?**

#### Key Questions

- Is there crying with defecation?
- Is there fecal soiling of underpants?
- If an infant: Is there a history of delayed passage of meconium stool?
- Has the child begun to drink milk?
- Has the child recently started toilet training?
- Does the child have urinary frequency?

## Crying with defecation

Small children with constipation will cry with movement when a fissure is present. With large hard stools, the child will not want to defecate because of the pain and will do stool-holding mannerisms such as sitting and standing still.

## Fecal soiling of underpants

Repeated fecal soiling, from involuntary passage of small amounts of feces into the underpants of children older than age 4 years, is consistent with encopresis. This is generally caused by functional megacolon secondary to chronic constipation. This constipation is usually secondary to painful defecation, with a resultant anal fissure. Coercive bowel training, fear of the toilet, or reactive voluntary withholding of bowel movements can also cause this condition.

## History of delayed passage of meconium stool

Such a history can indicate congenital aganglionic megacolon (Hirschsprung disease).

## Change in diet

Cow's milk is a common cause of constipation in young children who have been on breast milk or formula.

## Toilet training

Some children develop stool withholding when toilet training is initiated.

## History of urinary frequency

Urinary frequency, enuresis, incontinence (especially in frail older adults), and urinary tract infections (UTIs) can be the result of constipation. Fecal soiling can cause UTI by the introduction of the fecal flora. Furthermore, an enlarged dilated rectum can push on the bladder, causing a frequent need to urinate.

### Is there a family history or genetic predisposition?

#### Key Questions

- Is there a family history of constipation or IBS?

Genetic predisposition to constipation seems to exist. It is common for more than one family member to have a history of chronic constipation or IBS.

## Diagnostic reasoning: Focused physical examination

### Plot growth curve in children

Slow growth can indicate congenital aganglionic megacolon. Incorrect formula mixing, underfeeding, starvation, and anorexia nervosa can first be recognized by a report of constipation.

### Perform an abdominal examination

Observe abdominal contour, looking for distention. Abdominal distention is frequently not marked in patients with functional constipation but can be present with other causes. Auscultate for bowel sounds. Silent or abnormal bowel sounds can indicate an organic cause such as obstruction. On palpation, stool can be felt as mobile, nontender masses in the left lower quadrant (LLQ). Firm, rubbery masses of stool palpable in the right lower quadrant (RLQ) in newborns can indicate meconium ileus. Palpable abdominal masses or organomegaly points to an organic cause. Note tenderness, which can indicate an organic cause, although a tender bowel can be palpable in IBS. Inspect the sacral region of the back. The presence of dimpling could indicate a spinal deformity contributing to the constipation.

Look for hernias. Large abdominal wall hernias can interfere with the ability to generate the intra-abdominal pressure that is required to initiate defecation.

### Perform digital rectal examination

On perianal inspection, look for skin excoriation, skin tags, fissures, strictures, tears, or hemorrhoids, any of which can cause painful defecation. Early fissures have the appearance of superficial erosions. More advanced lesions are linear or elliptical breaks in the skin. Long-standing fissures are deep and indurated. Internal fissures are seen when the anal sphincter relaxes as the examining finger is withdrawn. To examine for a fissure in a child, place the infant or child in the knee–chest position and spread the buttocks to reveal the mucocutaneous junction of the anus.

Look for rectal prolapse and feel for a rectocele, which might interfere with defecation. A normal anal sphincter with an empty rectal ampulla can indicate Hirschsprung disease. In functional constipation, expect to find a large dilated rectum full of stool. Assess sphincter tone, both at resting and with a squeezing effort. Sphincter tone is increased in functional problems and strictures but is decreased in neurologic diseases. The presence of a mass in the rectum indicates an impaction or obstructive lesion. A pilonidal dimple is seen with spinal bifida occulta.

### Perform a focused neurologic examination

Test relevant deep tendon and superficial reflexes. Interruption of the T12 to S3 nerves causes loss of voluntary control of defecation (Table 10.1).

**Table 10.1****Superficial and Deep Tendon Reflexes and Spinal Level Tested**

REFLEX	SPINAL LEVEL TESTED
<b>SUPERFICIAL</b>	
Upper abdominal	T7, T8, T9
Lower abdominal	T10, T11
Cremasteric	T12, L1, L2
<b>DEEP</b>	
Biceps	C5, C6
Brachioradial	C5, C6
Triceps	C6, C7, C8
Patellar	L2, L3, L4
Achilles	S1, S2

## Laboratory and diagnostic studies

### Fecal occult blood test

A positive guaiac-based fecal occult blood test (gFOBT) indicates blood in the stool, which can be the result of ulcerative or malignant lesions. The sensitivity of this test in detecting colorectal cancers and adenomas ranges from 50% to 90%. It is an inexpensive and noninvasive method to screen for bleeding lesions. Three days of serial testing can be done using stool cards at home, that are returned by mail for analysis. Annual gFOBT, beginning at age 50 years, is one of the recommended screening tests for colon cancer. The [Evidence-Based Practice](#) box describes the current recommendations.





### Screening for Colon Cancer

The American Cancer Society, US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology jointly developed consensus guidelines for colorectal cancer screening in asymptomatic adults 50 years of age and older who are at average risk. The screening tests were grouped into those that primarily detect cancer and those that can detect both cancer and adenomatous polyps, which provides the opportunity for cancer prevention through polypectomy. The panel supports screening primarily for cancer prevention. Specific recommendations may be found at <http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations>.

The US Preventive Services Task Force (USPSTF) concludes that there is convincing evidence that colorectal cancer screening substantially reduces deaths from colorectal cancer and does not emphasize specific screening tests.

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References: Levin et al, 2008; USPSTF, 2016.

### Fecal immunochemical test

Fecal immunochemical test (FIT), also called immunochemical FOBT (iFOBT), can be used as an alternative to FOBT. FIT uses antibodies to human globin to detect a specific portion of a human blood protein and does not react with nonhuman hemoglobin or peroxidase, so food restrictions before the test are not necessary. Immunochemical FOBTs are also more specific for lower GI tract bleeding because they target the globin portion of hemoglobin, which does not survive passage through the upper GI tract. This test is done essentially the same way as conventional FOBT but is more specific and reduces the number of false-positive results. Vitamins or foods do not affect the FIT and some forms require only one or two stool specimens.

### Fecal or stool DNA

Cells from precancerous polyps and cancerous tumors are shed in the stool and contain recognizable DNA markers. A stool DNA test can identify several of these markers, indicating the presence of precancerous polyps or colon cancer.

### Complete blood count

Obtain a complete blood count when you suspect bleeding. Hematocrit and hemoglobin levels will be below the expected reference range with a bleeding lesion.

### Serum electrolytes

Severely ill patients can develop hypokalemia and hypercalcemia, which are causes of constipation. Patients on thiazide diuretics can develop hypokalemia and subsequent constipation.

### Serum thyroid-stimulating hormone

An elevated thyroid-stimulating hormone (TSH) level may be suggestive of hypothyroidism, which can be a cause of constipation. Screen for elevated TSH levels in people with other symptoms suggestive of hypothyroidism such as sparse, coarse, dry hair; hirsutism; dry skin; or hoarse speech.

### Urinalysis

A urinalysis and culture should be done if a child has an associated rectosigmoid impaction because of encopresis.

### Anoscopy

Anoscopy is indicated if digital rectal examination detects hemorrhoids, fissures, strictures, or masses in the anus or rectum. It enables a view of the immediate internal anal canal that is not possible on manual digital rectal

examination. A handheld anoscope is warmed, lubricated, and slowly eased into the anus while the patient bears down to relax the external sphincter muscle. A light source is necessary; a head lamp is preferable. Anoscopy may not be possible initially with a fissure or abscess because of the pain. However, it should be performed on a follow-up visit to detect IBD or rectal cancer.

## Flexible sigmoidoscopy and colonoscopy

These tests are indicated for patients in whom conservative treatment fails, for people older than age 50 years or with new-onset constipation, and for those with anemia or fecal occult blood. Colonoscopy is indicated for the patient with rectal bleeding.

## Barium enema

This contrast technique can be used to detect diverticula, polyps, and masses. It is also used to determine the extent of dilated bowel in megacolon. The barium enema in children is reserved to rule out Hirschsprung disease. A barium enema is contraindicated if enterocolitis is suspected.

## Colon transit studies

Colon transit studies are useful for patients with severe chronic constipation that responds poorly to treatment.

## Anorectal manometry

This test measures the pressure of the anal sphincter muscles, the sensation in the rectum, and the neural reflexes that are needed for normal bowel movements. The manometry probe, a thin tube of soft plastic or rigid metal, is inserted into the rectum about 4 inches and then slowly withdrawn halfway. As the probe is withdrawn, the transducer continuously records the pressure at different points. Alternatively, the pressure can be measured with a balloon manometry system, a hollow metal cylinder to which three balloons are attached to measure pressure during anal contraction. A balloon at the tip of the probe is inflated to determine whether the patient feels a sensation of rectal fullness and an urge to defecate.

## Differential diagnosis

Despite the high prevalence of constipation, only a small number of adults or children with constipation have a significant abnormality. In otherwise healthy individuals, first consider functional causes, particularly dietary, fluid, bowel, and laxative habits. In adults, depression can be associated with constipation.

## Simple constipation

Typically, individuals with simple constipation report a diet low in fiber and bulk or inadequate fluid intake. A sedentary lifestyle is common. They also often report pain before and with bowel movements because of the hard, dry nature of the stools. Patients can also report loss of appetite. The results of the physical examination of the abdomen and rectum are normal. It may be possible to feel fecal masses in the colon and rectum. No diagnostic workup is needed unless the patient does not respond to therapy.

## Functional constipation

Functional causes of constipation include poor bowel habits; inadequate intake of dietary fiber, bulk, and fluids; and chronic use of laxatives. Patients may report straining during defecation, hard or lumpy stools, and sensations of incomplete evacuation or anorectal obstruction. The abdomen may or may not be distended. The external sphincter is intact.

Functional constipation is seen in children who have large, hard stools that become difficult or painful to pass. The resulting fecal retention sets up a cycle in which the sensitivity of the defecation reflex and the effectiveness of peristalsis lessen. Watery stool from the proximal colon soils the underwear. On physical examination, stool is present in the LLQ, and the rectum is dilated and filled with packed stool. The external sphincter is intact.

## Irritable bowel syndrome

Irritable bowel syndrome is common in adults, with onset usually in young adulthood. The presenting symptoms can be either predominantly diarrhea (IBS-D), constipation (IBS-C), or mixed (IBS-M), using the Bristol Stool Form

to classify abnormal stool consistency—IBS-C is defined as having hard stools more than 25% of the time and loose stools less than 25% of the time. IBS-M is defined as having both hard and soft stools more than 25% of the time. Abdominal pain related to defecation often occurs, usually in the LLQ, and the bowel may be tender to palpation (see [Chapter 12](#)).

## **Fecal impaction**

Fecal impaction is common in older adults and in those who are confined to bed. The passage of hard stools at 3- to 5-day intervals can occur. Some people with impaction have continuous diarrhea-like passage of stools and can experience incontinence. Stools can be of small caliber, sometimes described as toothpaste-like. On rectal examination, large quantities of hard feces are palpable in the rectal ampulla. On abdominal examination, feces-filled bowel may be palpable.

## **Idiopathic slow transit**

This condition is most common in older people, especially those who are less active and have inadequate dietary fiber and fluid intake. These patients experience decreased stool frequency; stools are typically dry and hard.

## **Hirschsprung disease (congenital aganglionic megacolon)**

Hirschsprung disease is present from birth and is usually detected in young children. Delayed passage of meconium stool can indicate Hirschsprung disease in infants. Children with Hirschsprung disease do not have an urge to defecate because the stools accumulate proximal to the lower portion of the rectum where the proprioceptors for defecation are located. Evidence of stiffening, squeezing, and crying indicates stool is being propelled to the rectum. On examination, the rectal ampulla is empty.

## **Secondary constipation from anorectal lesion**

Because defecation is painful with an anorectal lesion, the patient suppresses it. With the eventual passage of hard stools, the patient can report blood on the surface of the stool, on the toilet paper, or in the toilet. On digital rectal examination, look for hemorrhoids (rare in children), fissures, tears, or abrasions.

## **Drug-induced constipation**

Drug-induced constipation is consistent with a history of chronic laxative use or taking medications that can produce constipation. It occurs most often in older adults. Abdominal and rectal examinations are usually normal. OIC is defined as a change from baseline bowel habits upon initiation of opioids that is characterized by any of the following symptoms: reduced bowel movement frequency, development or worsening of straining to pass stool, a sense of incomplete rectal evacuation, and harder stool consistency.

## **Tumors**

Tumors are uncommon in children, but the frequency increases in the population over the age of 40 years. Colicky abdominal pain and distention can occur in people with bowel tumors. People with rectosigmoid tumors may report rectal discomfort, stool leakage, urgency, and tenesmus. The patient may report rectal bleeding or blood in the stool. Stool may test positive for occult blood. An abdominal mass may be palpable. Older adult patients who present with constipation, anemia, anorexia, and weight loss are at high suspicion for colorectal cancer. Constipation occurs in less than one-third of people with colon cancer; diarrhea is more common. The onset is recent, and there can be progressive narrowing of stool caliber.



## DIFFERENTIAL DIAGNOSIS OF *Common Causes of Constipation*

CONDITION	HISTORY	PHYSICAL FINDINGS	DIAGNOSTIC STUDIES
Simple constipation	Low dietary fiber and bulk; inadequate fluid intake; physical inactivity; pain before and with bowel movements; anorexia	Normal abdominal and rectal examination; can feel fecal masses in colon and rectum	None if resolved; consider colonoscopy or sigmoidoscopy, anorectal manometry, colon transit studies if not resolved
Functional constipation	Adults: bowel habits; chronic use of laxatives; straining during defecation, hard or lumpy stools, a sensation of incomplete evacuation or anorectal obstruction Preschool and school-age children: history of abdominal pain and stool soiling	Abdomen may or may not be distended. The external sphincter is intact. Palpable stool in LLQ; large dilated rectum with packed stool; external sphincter intact	Abdominal radiography, unprepped barium radiography
Irritable bowel syndrome (IBS)	Onset in young adulthood IBS-C: hard stools >25% of the time and loose stools <25% of the time IBS-M: both hard and soft stools >25% of the time	Can have tender, palpable colon	Colonoscopy or sigmoidoscopy if indicated
Obstipation or impaction	Passage of hard stool at 3- to 5-day intervals; diarrhea, small caliber stools; common in those confined to bed	Hard feces in rectal ampulla; may have palpable feces-filled bowel	Colonoscopy or sigmoidoscopy if indicated
Slow transit	Common in older adults; physical inactivity; decreased stool frequency; stool dry and hard	Normal abdominal and rectal examination	Colonoscopy, FOBT, or FIT to rule out tumors; consider anorectal manometry, colon transit studies
Hirschsprung disease	Delayed passage of meconium at birth; no urge to defecate	Empty rectal ampulla on examination	Colonoscopy
Anoctal lesions	Rectal pain on defecation; history of hemorrhoids; blood on stool, on toilet tissue, or in toilet	On rectal examination: hemorrhoids, fissures, tears, abrasions; increased sphincter tone	Anoscopy
Drug-induced constipation	History of chronic laxative use; history of taking medications that produce constipation	Normal rectal and abdominal examinations	None if resolved; consider colonoscopy or sigmoidoscopy, barium enema if not resolved
Colorectal cancer	Recent onset: pain and abdominal distention, stool		CBC, FOBT, FIT, fecal or stool DNA; colonoscopy

CONDITION	HISTORY	PHYSICAL FINDINGS	DIAGNOSTIC STUDIES
	leakage, urgency; late onset: weight loss, anorexia; rectal bleeding; increased incidence after age 40 yr; uncommon in children	Can have palpable abdominal mass or organomegaly	

*CBC*, Complete blood count; *FIT*, fecal immunochemical test; *FOBT*, fecal occult blood test; *LLQ*, left lower quadrant.