Complete Summary

GUIDELINE TITLE

ASGE guideline: guideline on the use of endoscopy in the management of constipation.

BIBLIOGRAPHIC SOURCE(S)

Qureshi W, Adler DG, Davila RE, Egan J, Hirota WK, Jacobson BC, Leighton JA, Rajan E, Zuckerman MJ, Fanelli R, Wheeler-Harbaugh J, Baron TH, Faigel DO. ASGE guideline: guideline on the use of endoscopy in the management of constipation. Gastrointest Endosc 2005 Aug;62(2):199-201. [21 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Constipation

GUIDELINE CATEGORY

Management

CLINICAL SPECIALTY

Colon and Rectal Surgery
Family Practice
Gastroenterology
Internal Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To discuss the role of endoscopy in the management of constipation

TARGET POPULATION

Patients with constipation

INTERVENTIONS AND PRACTICES CONSIDERED

1. Colonoscopy
2. Flexible sigmoidoscopy

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

In preparing this guideline, a MEDLINE literature search was performed, and additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not applicable

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the Levels of Evidence (A-C) are provided at the end of the "Major Recommendations" field.

Role of Endoscopy

Colonoscopy is indicated in selected patients to exclude obstruction from cancer, stricture, and extrinsic compression. Patients with constipation should undergo colonoscopy if they have rectal bleeding, heme-positive stool, iron deficiency anemia, weight loss, obstructive symptoms, recent onset of constipation, rectal prolapse, or change in stool caliber. Colonoscopy should also be done before surgery for constipation.

Patients over the age of 50 years who have not had prior colorectal cancer screening should undergo colonoscopy. Chronic constipation was associated with an increased risk of colon cancer in two U.S. population-based, retrospective studies (odds ratio 2.36: 95% confidence intervals [CI] [1.4, 3.93]) (relative risk 4.4 for severe constipation: 95% confidence intervals [2.1, 8.9]) but not in a prospective study of women nurses. A retrospective study from Australia also reported increased cancer risk in patients with constipation, and a retrospective study from Japan found increased risk in frequent laxative users.

In younger patients, a flexible sigmoidoscopy may be sufficient to exclude distal disease. Suspected Hirschsprung's disease requires anorectal manometry and deep biopsy to examine for the absence of myenteric neurons.

The yield of colonoscopy in isolated constipation is low and is comparable with asymptomatic patients who undergo colonoscopy for colon cancer screening. In one study of 563 sigmoidoscopies or colonoscopies done for evaluation of constipation, colorectal cancer was found in 8 (1.4%), adenomas in 82 (14.6%), and advanced lesions (cancer or adenoma with malignancy, high-grade dysplasia, villous features, or size >10 mm) in 24 (4.3%). Associated findings may include solitary rectal ulcer syndrome (indicating prolapse), anal fissure, and melanosis coli (indicating chronic laxative use).

Colonoscopy may be used to provide therapy in some patients. Fibrotic strictures from inflammatory bowel disease, surgery, or ischemia can be dilated at the time of colonoscopy. Colonoscopy has no role in stool disimpaction, although there are reports of removal of sunflower seed bezoars that were causing fecal impaction.

Chronic constipation is an independent risk factor for inadequate bowel preparation for colonoscopy. In these patients, a more aggressive regimen for colon cleansing should be considered.

Some third party payers (e.g., Medicare) may not cover colonoscopy for "constipation" or "weight loss" as the sole indication.

Summary

- Patients with constipation should undergo colonoscopy if they have rectal bleeding, heme-positive stool, iron deficiency anemia, weight loss, obstructive symptoms, recent onset of constipation, rectal prolapse, or change in stool caliber **(C)**.
- Chronic constipation may be a risk factor for colorectal cancer **(B)**. For this reason, patients complaining of constipation who are over the age of 50 years and who have not previously had colon cancer screening should have a colonoscopy **(C)**.
- In younger patients flexible sigmoidoscopy may be adequate **(C)**.

- Colonoscopy allows dilation of benign colonic strictures in some patients **(B)**.

Definitions:

Levels of Evidence

A. Prospective controlled trials
B. Observational studies
C. Expert opinion

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and classified for the recommendations using the following scheme:

A. Prospective controlled trials
B. Observational studies
C. Expert opinion

When little or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts. Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate and effective utilization of gastrointestinal endoscopy in the management of constipation

POTENTIAL HARMS

Not stated

CONTRAINDICATIONS

CONTRAINDICATIONS

Complete or high-grade colonic obstruction or suspected perforation are contraindications to colonoscopy. Other relative contraindications include the following: acute inflammation of the colon, pregnancy in the second or the third

trimester, recent myocardial infarction, pulmonary embolism, large aortic aneurysm, and an uncooperative patient.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Further controlled clinical studies are needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Qureshi W, Adler DG, Davila RE, Egan J, Hirota WK, Jacobson BC, Leighton JA, Rajan E, Zuckerman MJ, Fanelli R, Wheeler-Harbaugh J, Baron TH, Faigel DO. ASGE guideline: guideline on the use of endoscopy in the management of constipation. Gastrointest Endosc 2005 Aug;62(2):199-201. [21 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Aug

GUIDELINE DEVELOPER(S)

American Society for Gastrointestinal Endoscopy - Medical Specialty Society

SOURCE(S) OF FUNDING

American Society for Gastrointestinal Endoscopy

GUIDELINE COMMITTEE

Standards of Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American Society for Gastrointestinal Endoscopy (ASGE) Web site.

Print copies: Available from the American Society for Gastrointestinal Endoscopy, 1520 Kensington Road, Suite 202, Oak Brook, IL 60523

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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