Conversations About Constipation
Part 1 Transcript

All right. I am so excited to talk to you guys about constipation. I know this is weird. I know I shouldn't be so excited. But I work all day as a gastroenterologist. This is literally what I do for a living. And I feel like this is what people need the most. People need to understand whether or not they're constipated. How to properly diagnose constipation. What are the different forms of constipation. And how are we going to treat it. And that's what we're here to do tonight, is to dig into all of these things. And I'm gonna tell you guys what I have planned.

Roughly, for about an hour, I'm planning to teach. And this will be interactive. So what I mean by that is, give me a yes. If you're excited to be here tonight in the chat box that lets me know that you are here and you're engaged. See, we got some people already into this, y'all don't waste any time, do you.

I'm going to do as many questions as I can for a little about a half hour. And we had so many questions submitted and this always happens. If you've been on one of my courses, you know, I do my best to try to answer as many questions as possible. And I've never been successful at answering all the questions. I wish I could do that. But it's like literally impossible. So if you submitted a question, and your question is not answered. First of all, I sincerely apologize that I couldn't get to it. I do as many as I can. And the questions that we selected for tonight are ones that we think have the most relevance to the entire group. So that's what we're trying to do.

So anyway, so before we get started, please feel By the way, please, if you haven't, go ahead and grab your ebook. Okay, the conversations about constipation ebook that we've provided. And because I'm going to be basically using that as a guide for our teaching session tonight. And you know, I'm obligated to say this. I think you guys probably already know this, but let me just be upfront and say that, obviously, everything that I'm doing here tonight is for educational purposes only.

I want to empower you with information. That is my goal. I want to empower you as a person who deserves to feel as well as possible to have optimal gut health, to have good, regular glorious bowel movements. And I hope that this happens for every single one of you. I hope that the knowledge that you received during this session gets you there, I hope this is a part of the story for you. And even if you are my own patient, to be totally honest with you, you still need to discuss it with me. So you need to discuss what you learned during this session with your health care provider. So because there's a personal nature to this, we're not all the same.

We are unique individuals with unique needs, and different treatments that are required for every single one of us. And that's the reality of constipation. I wish that it was formulaic. If it were, it would be really simple for all of us, it's not the way it works. So I'm going to try to empower you with the knowledge and with the hope that this really does make a difference in

your life. And but when you start to do these things, my recommendation is that you discuss them with your health care provider to make sure that you are doing what is right for you.

So okay, so let's go ahead and let's jump in the five key points of constipation is really just a primer. That's page three, by the way in your ebook. And that's just the primer to kind of get you started. We're going to be covering everything that's in that primer tonight. So you don't need to worry about that. The first thing that I want to discuss is this question. Are you constipated? And I hope that there are some people here tonight who don't know whether or not they're constipated. Because this is an important question. And I see people routinely in my clinic on a daily basis who look at me like I am an alien.

When I tell them that I think they are constipated. In fact, many times, I have to frame it very apologetically, I will say to my patients, I'll say, "Listen, you're gonna think I'm crazy. And I apologize for even saying this. But just hear me out. And let me walk you through this. I think you're constipated." So I want to walk you through some of the things that I'm thinking about as a gastroenterologist in my clinic, so that you guys understand, like the way that I go about this particular issue. And, and you can apply it to your own life to answer the question whether or not you may be constipated. See, the issue is that we always think of constipation as how often we have a bowel movement.

That's simply not the way it works. There is far more to this than just bowel movement frequency. So, you know, to me, what, what is constipation? How do I define constipation? It has nothing to do with how often you poop?. Like that's literally not in my definition at all. Will I ask “How often you poop?” Yeah, I will. That's part of the equation that I'm thinking about. But at the end of the day, constipation is the manifestation of symptoms, undesirable symptoms, that are the result of inadequate emptying.

And by the way, if you guys want to take notes, you can take notes directly within the ebook, we created some space in there for you. There's space there on page four at the bottom. And there's some additional space if you go a little bit further down, like page seven, for example. So we put spaces in there along the way for you guys to add notes so that you can take notes. While we're doing this, don't feel obligated, you don't have to. By the way, everything that we discussed tonight, this video is going to be made yours, okay, this is going to be available. So don't feel pressure to take it all in here during this time we spend together. Please feel free to kick back, relax and enjoy this conversation. And then you can review this in more detail if you really want to.

So, so just know that but to me, I would define constipation as the manifestation of symptoms that are undesirable as the result of inadequate emptying of the bowels. So that doesn't necessarily have anything to do with how often you go. Clearly, if you don't poop for seven days, you are constipated. That's very clear. And that person, we don't need to get into great detail. It's obvious that they're not pooping. But one of the things that I'll look at, let's flip to page five you guys. And you perhaps saw this on my posts from today. One of the things that I'll look at is the form of the stool. Alright, the form and this is the Bristol stool chart.

So, I wonder who this Bristol character is. I think it's quite amazing. Like I personally would embrace it, but like I wonder how this person Bristol feels about having basically like, the major definition of stool form named after them. And every single time people talk about poop, they talk about Bristol.

So there are seven different types of bowel movements on the Bristol stool chart. And you can see them here, Types 1, 2, 3, 4,5, 6, and 7. All right, so let me stop and start on the opposite end of the spectrum. Type 7. Type 7 is just literally liquid, just literally liquid. And as we're about to learn in just a moment here, even if you have a Type 7, we might look at this and say this is diarrhea.

All right. But even when you're manifesting diarrhea, the question is, what is the root cause of the problem? Why are you having diarrhea? And one of the trickiest things that exists in all of gastroenterology, trips up patients, trips up tons of primary care doctors, trips up plenty of gastroenterologists, is the possibility of overflow diarrhea. We're gonna talk more about that in just a moment here. But you can have a Type 7 movement and still be constipated.

Types 5 and 6. 5 and 6 basically are different forms of diarrhea or looser type stools. Type 4, Type 4 is the goal glorious, this is the smooth criminal smooth, soft sausage. I mean, I've never described the sausage with such endearment, smooth, soft sausage that glorious type four, this is this is the promised land that we're trying to get to here. And type three is really darn close, I wouldn't be too worked up if you have a Type 3, or if you have a Type 5, because you're pretty darn close to a Type 4, which is where we're trying to be. So the type, the type three is a sausage shape, but it's got some cracks, so it's just a little bit hard. Alright, now when you start getting the Type 2. Type 2 has still got a shape to it. But it's really lumpy and bumpy. It almost looks like not to be too graphic, I realized that we're talking about poop here, this is talking about poop all day long.

This is what I do for a living. So I'm, I have to always like stop myself like, I get a little too comfortable with this type of stuff. So but when we talk about a Type 2 bowel movement, it's like if you took a whole bunch of marbles, or bouncy balls, or golf balls, and you just kind of clump them together into a sausage shape, it's still a sausage, but it starts to really look like it's a bunch of nuggets that have been clumped, or pressed together by your body. Which brings us to Type 1, Type 1's are the super hard rock like nuggets. And that is our type one bowel movement, which is a classic appearance for constipation.

So and you know, for what it's worth, I can't think of any cases of diarrhea that presents with a Type 1. So, you know, I may say that constipation could present with type seven. But I'm not really here to say the diarrhea presents with type one, it doesn't really go the other way. So people always like cases, case studies. So let me tell you guys about Mary. Okay, Page Six, we're on now in your ebook.

So Mary is a patient of mine. She's 37. And she came to me. After having several months of abdominal discomfort. It was around her belly button that she was feeling it, tons of gas and bloating. She lost her appetite like she was basically like I don't feel like eating anymore.

She was also having some nausea. It was just like a queasy feeling. She never actually threw up. Alright, and she was having diarrhea. So what did she do? She did what any normal, rational human being would do. She started taking Imodium. Alright, which is loperamide and this is an anti-diarrhea medicine available over the counter in the United States. Alright, so what the problem is that she would take this medication to treat her diarrhea and the diarrhea would come back as soon as the medication wore off. She went to her doctor with all this gas bloating, and she thought that she must have SIBO so her doctor treated her with antibiotics. But she didn't get better. She basically just had persistence of the symptoms and just kind of kept going.

She had the sense that she wasn't really emptying her bowel. And one of the things is that she would have pain when she would go to the bathroom. It felt like shards of glass or razor blades passing through. And once in a while she would go to wipe and the stool itself would be fine. No blood there. But when she used the toilet paper she would see blood on the toilet paper. And so basically she came to me, you know, months of the symptoms: ongoing diarrhea, gas, bloating, nausea, lack of appetite, abdominal pain around the belly button, blood in the stool, pain with bowel movements. She says, "Doc, what's going on with me here?"

There are layers to her constipation. It's not so simple as you're just constipated. There are different things, different signals that I'm catching here. A person comes to me, says I'm having gas, bloating, lack of appetite and some nausea. Instantly, I'm thinking about constipation. Mary comes to me with these symptoms, regardless of whether she says I'm pooping once every seven days, or seven times a day. If she says I'm having gas, bloating, lack of appetite and some nausea. I'm thinking about constipation. I'm not necessarily ready to make it the number one diagnosis, but it is on my list. And it is staying on my list until proven otherwise.

And there are some other factors that are weighing in here. Mary sees blood on the tissue paper. This is a bright red, bright red blood. Again, only on the tissue paper, this is not a large volume of blood that she's seeing. And when I think about this blood on the tissue paper, I narrow it down to one or two things. I'm thinking about internal hemorrhoids, hemorrhoids that are inside the rectum that you won't see you won't necessarily feel, but they bleed. I'm also thinking about an anal fissure. Anal fissure is a tear of the paper, like a paper cut or a tear of the anal canal. Alright. And when people have an anal fissure, you can almost diagnose them by history. The story that Mary tells us is classic, the feeling of shards of glass going through her bottom, or razor blades passing through her bottom.

This is classic for an anal fissure. Now the thing that you guys need to know about this, you know, anal fissure, and we'll talk a little bit more about this during the course of the hour, is that, not to be too graphic, okay, but I use my hands to illustrate concepts that I think are important. And if this is the bottom, okay, when a person has an anal fissure, it's kind of like you see this crease in my finger right here. Imagine that that crease is a deep paper cut. Alright, that's what

an anal fissure is. Now, here's the problem. Every time you go to poop, this area gets stretched by the bowel movement, especially if that poop is hard. So it gets stretched and basically this crease gets opened up. All right, it gets opened up in split open. And we have now re-traumatized the anal fissure.

A person can suffer with an anal fissure, I'm not exaggerating, for decades. I have patients in their 50s and 60s who tell me I've been having this issue since I was in my 20s and I'm like, you have an anal fissure. And it comes and goes literally for decades. Alright, so the problem is that when you go to poop, this gets stretched and it opens up and re-traumatizes that fissure. So what does the body do? Clamps down. Alright, it clamps down and it white knuckles it and by clamping down, you can protect itself from the pain, it can protect itself from the fissure, it doesn't actually heal the fissure, it clamps down so hard that you can't get adequate blood flow to heal the fissure.

And the other thing that happens is you can't poop. You're so clamped down, your bottom will not relax to allow you to defecate. So anyway, part of what we have to do with Mary, in order to get her feeling better and to get her poop, is we have to address the anal fissure. And that is something where we use actual medication or cream inside the bottom. You put medication inside the bottom, and that will actually relax the bottom so that you can poop and also allow you to get the blood flow that you need in order to heal up the anal fissure.

Alright, so with Mary, what's interesting is that as I worked through her issues, it became clear to me that the problem was not diarrhea. The problem was constipation with overflow. And when that's the case, paradoxically, the solution is to make a person poop. You got to make them poop even more than what they're currently doing. Which makes no sense when we're talking about diarrhea. But the problem is when you have diarrhea and the problem, the root of the problem is constipation. Then you take medications for constipation and it backs you up more and your problem gets worse. Alright, so the solution for Mary is multiple fold. We need to get her pooping, but we also need to get her bottom to relax and so we have to treat the anal fissure.

So let's talk about the symptoms of constipation. So I've alluded to a few of these symptoms already. But I'm going to jump straight to page nine. Okay, which looks like a bingo card, please feel free to put your bingo chips on the symptoms that you personally have.

And it is basically the top cue for me, clue for me to move towards a diagnosis of constipation. So when a person comes from having a lot of gas and bloating, it's an automatic question in my mind, until proven otherwise, is this person constipated? It's not the only cause of gas and bloating, but it is probably the most common cause. The person who wakes up in the morning, flat tummy, has food, and then gets wildly distended. That person many times is constipated, and they're having trouble mobilizing and emptying their bowels.

Constipation causes gas. Gas causes constipation. They have these fascinating studies. I know this is disturbing to hear. Gas causes constipation. They have these interesting studies where

basically they infuse methane gas and show that it slows bowel motility. So it's a vicious cycle. Gas, bloating and constipation go hand in hand and they feed off of one another. More constipation means more gas and bloating. More gas and bloating means more constipation.

Do you feel like you can't fully empty your bowels? If you're not completely releasing the bowel movement, then you are by definition potentially backing up. Nausea, queasiness, loss of appetite getting full too quickly. The concept here for all three of these is the same. If you're not emptying your colon, then your colon, the large intestine, will send a signal upstream to the rest of the body to say there's no room down here. So the stomach stops emptying. So instead of sending things down, it wants to send them back up.

Nausea queasiness, loss of appetite, you get full super quickly because your stomach is not moving. And then you get heartburn or acid reflux. Another classic symptom. Tell me you guys, if you've experienced this, have you ever been dismissed by your doctor for fatigue that you have? Give me a yes, if that's the case. Some emphatic yeses. Fatigue is a tough symptom for doctors. I hate that it's the case and it makes patients feel like they're being dismissed. And that's super frustrating because you don't deserve that. Constipation is a common cause of fatigue. If you have fatigue, gas, bloating, and some of these symptoms that we're describing, you need to think about whether it's constipation, the fatigue will lift when you get your bowels moving.

Diarrhea. We talked about brain fog, kind of goes along with the fatigue. Alright, abdominal pain, many different potential locations. Left lower quadrant is the classical occasion for constipation to manifest. So left lower quadrant, oh gosh, see, I'm backwards. I probably shouldn't use my hands for this part. Left lower quadrant is the classical, but you can also get it in the left upper quadrant radiating to your back. Okay, there's not much in your left upper quadrant there. Not much else. I see a ton of people who come in with left upper quadrant pain radiating to their back and to me, I'm like, okay, this, this patient's probably constipated.

We need to do the right testing to prove it. You can have it in the upper abdomen in the middle and think that it's your stomach or your pancreas. But it can be your colon. Your colon runs right across the middle across the top. You can have in the right upper quadrant radiating to your back. I had a classic patient when I was at the University of North Carolina, who came in tons of pain worse with meals, nausea, the pain would radiate. It was the right upper quadrant radio to his back. All the gallbladder tests were normal. His wife literally said to me, his wife said, if you don't fix my husband, I'm going to divorce him. I honestly couldn't tell if she was serious or not. Thankfully, we ultimately figured out that his problem was constipation. How did I figure it out? I went to go do a colonoscopy and he had tons of stool in his colon still, even after prepping for a colonoscopy.

So I treated him for constipation. His pain went away entirely. And his family came in and gave me a family T-shirt. I got a family T-shirt from them, this was like eight years ago.

So let's talk about a couple scenarios here. You know, obviously, if you don't go for a whole week, then that would make it pretty clear to me that you're constipated. But let's talk about some other scenarios. How about if you have a daily bowel movement? Is it possible to be constipated? Absolutely. You have a daily bowel movement, but are you completely empty? Because if you're not completely emptying, you are by definition backing up. And it's like compound interest. So you could empty 80%. But if you trap 20%, that 20% is going to compound over days, until you feel completely full backed up and constipated. And that's frustrating, because you are pooping. You're pooping every day. And it's a pretty good movement. But you're not completely emptying.

Alright, how about if you have several small bowel movements per day, I hear I had these people who say to me, like "Doc, I poop in the morning. And then I poop again, like 45 minutes later. And the second poop is looser than the first one.What's going on there?" They're not completely empty. Because if they completely emptied, they wouldn't be pooping again. 45 minutes later. So when you have small nuggets when you have these little, you know, little balls of stool, turds. That's what some people call them. I think that's the technical term. That is, that is constipation. You are incompletely emptying, similar to the person above.

All right, how about this pattern? Let me know you guys. If you've seen this, or you've ever experienced this fluctuation between diarrhea and constipation, you will have one day where you have diarrhea, loose stool throughout the day, the first bowel movement is formed every bowel movement over that after that gets looser and looser and looser. And by the afternoon, you're having tons of diarrhea, and you're miserable. Right? So you go to your doctor, you go to your doctor and you say, "Doc, I'm having diarrhea."

All right. And the problem is that this happens after not pooping for three or four days. So the patient interprets this as basically that they are, that they are having diarrhea, and then emptying to the point that they won't poop. When in fact, what's actually happening is they are backing up until they explode.

So the colon is like a slingshot. Alright, if you take a slingshot and you don't pull it back, it's got no energy, that rock is not going anywhere. But you take that slingshot you back, back, back, back, back, back, it will explode. That's what happens when you go three, four days without a bomb movement, back up, back up, back up, explode. Back up, back up, back up, explode. You say to the doctor, the problem is diarrhea. And I don't blame you, I totally get it because the diarrhea is the part that troubles you, because it messes up your day. And you actually feel pretty good on your constipated days. But this problem here is constipation. And the solution is to get into a rhythm and start pooping. This is by the way, the first time that I've done this movement, and you're gonna be seeing this. Alright, get into a rhythm and start pooping.

So, when push comes to shove, if you're trying to figure out whether or not you're constipated, if you're trying to figure this out, you can lean on imaging. That's what I will do. When I have patients who are skeptical, and they say, Doc, there's no way I'm constipated. This literally

happened today. They say, "No way I'm constipated." And I suspect that they're constipated. Fine. Let's do objective testing. Answer the question.

If we do an X-ray or a CAT scan, and it shows constipation, there's just no debate anymore. And if it doesn't, then so be it and we will move on to other testing. So now the key here is that radiologists don't really comment on poop very much, which is frustrating, because I've seen literally a bazillion cases where the CAT scan is read as being normal, normal, no acute reason for abdominal pain. That's what it says.

And you pull up the pictures, and you look and the patient says, "Doc, I'm having pain in my right upper quadrant." And you look at the pictures and you see in that exact location, they are severely backed up in that location. Alright, so how do we get around this? You ask your GI doctor to review the imaging, they could review it with you. Show me the pictures. The other thing is when you order the test, whether it's with your GI doctor, your primary care doctor, or an emergency room doctor, when they order the test, ask them to order it to rule out constipation. If you put it on the radiologist and say, "rule out constipation, rule it out." Then they're going to comment on constipation.

Is that an MRI or a sonogram? A sonogram will not help you with constipation. MRIs are not great for constipation. They're great for other stuff, not for constipation. All right. Cool. What questions do y'all have? I'm going to do one or two quick questions here. And we're gonna move into part two, what questions do you all have about the content that I just taught you?

"So what do we order?" It's an abdominal X-ray or a CT that is the classic.

"Can constipation cause ulcerative colitis?" No ulcerative colitis can cause constipation. Alright, so also, of course, you can be so inflamed in your rectum, because ulcerative colitis, by definition, always involves inflammation of the rectum. You can be so inflamed in your rectum, that you have a lot of edema, swelling, and because of that swelling, you can't empty your bottom. By the way, speaking of that, swelling, hemorrhoids are another potential cause of constipation.

"How does SIBO play into this?" Great question. So SIBO is a complex topic and I can literally teach an entire course on. The thing that you need to know is that many people who believe that they have SIBO actually are just constipated. If you have constipation, and you have gas and bloating, and you do a SIBO test, it will probably be positive. But the problem is not SIBO. The problem is constipation. If you take an antibiotic for SIBO, you probably will not be better. If you treat your constipation, and you get yourself into a rhythm and you poop, you will be better. I'm very confident of that. So if you are constipated, you have to get yourself into a rhythm and start pooping.

Alright, cool. Let's move into part two you guys. Great questions. Of course, you know, I would love to do more. But I want to keep things moving.