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Review Article

Management of constipation in women: the role of milk of magnesia and liquid paraffin combination from a gynecologist's perspective

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ABSTRACT

Constipation is highly prevalent, affecting approximately 15-20% of the general population, with women impacted nearly twice as often as men. It significantly impairs quality of life, psychological well-being, clinical outcomes, and healthcare utilization. From a gynecological perspective, constipation extends far beyond pregnancy-related concerns and remains an under-recognized clinical burden in routine practice. While pregnancy-associated constipation is well acknowledged, non-pregnancy etiologies-including anorectal disorders, PCOS or related hormonal fluctuations and menopause, gynecological postoperative states, endocrine dysfunction, and drug-induced causes (notably opioids and iron therapy)-are frequently overlooked. Milk of magnesia (MoM), particularly in combination with liquid paraffin, offers a distinct dual-action advantage in the management of constipation-combining osmotic stool softening with surface lubrication. Its non-fermentative osmotic mechanism promotes water retention within the intestinal lumen, effectively softening stools without causing gas or bloating, while liquid paraffin enhances ease of passage through lubrication. In women, constipation frequently manifests as hard stools, delayed transit, and painful defecation, especially in scenarios such as menopause, hormonal imbalances, anorectal disorders, and postoperative recovery. In these contexts, therapy must deliver relief that is both effective and gentle. MoM's predictable onset of action, coupled with its favorable tolerability profile, makes it an ideal choice where rapid yet non-irritating relief is required. By addressing both stool consistency and transit comfort, this dual-action approach ensures a more comprehensive and patient-friendly solution to constipation management. Its non-habit-forming profile and low incidence of bloating are advantageous in constipation patients with anorectal disorder, iron-induced gastrointestinal effects, and menopausal symptoms. In postoperative gynecologic patients, MoM supports early bowel recovery without inducing spasmodic activity, thereby minimizing strain on surgical repairs and mitigating opioid-related constipation. Overall, MoM, alone or in combination with liquid paraffin, remains a clinically relevant and practical therapeutic option for managing diverse non-pregnancy-related causes of constipation in women, particularly when rapid symptom relief, tolerability, and adherence are prioritized. This manuscript reviews the role of MoM (magnesium hydroxide), particularly in combination with liquid paraffin, in managing constipation associated with these non-pregnancy-related conditions in women. Clinical evidence and guidelines support the use of magnesium-based osmotic laxatives in chronic constipation, while evidence for MoM-based combinations in specific non pregnant etiologies remains limited and largely extrapolated from pharmacology, clinical experience, and selected studies.

Keywords: Constipation, Non-pregnant etiologies, Gynecological surgery, Anorectal disorders, IDA, Hormonal imbalance, Milk of magnesia, Liquid paraffin

INTRODUCTION

Constipation in women is multifactorial.¹ Prevalence varies across life stages-affecting approximately 8.9% of girls in childhood, increasing during the reproductive years, occurring in up to 32.4% of pregnant women, and remaining common in the postpartum and postmenopausal periods due to pelvic floor injury, hormonal fluctuations, dehydration, and psychosocial stressors.²⁻⁴ Individuals with anorectal disorders are estimated to have a 2.7-fold higher likelihood of experiencing constipation.⁵ While constipation during pregnancy is well recognized, non-pregnancy-related constipation remains comparatively under-addressed in gynecological and primary care practice. Key contributors include anorectal pathology, menopausal hormonal decline, hypothyroidism, opioid use, postoperative immobility following gynecological surgery, include iron deficiency anemia and chronic iron therapy. Beyond gastrointestinal symptoms, constipation adversely affects quality of life, reduces adherence to essential therapies such as oral iron, and contributes to a significant economic burden through increased healthcare utilization and outpatient visits.⁶

Despite availability of multiple therapeutic options, structured assessment and proactive management of constipation in women remain suboptimal, resulting in persistent symptoms and avoidable complications. MoM particularly when combined with liquid paraffin, aligns well with current management strategies that favor gentle, locally acting agents with minimal systemic absorption. As non-fermentable osmotic laxative, magnesium hydroxide promotes predictable and rapid stool softening without inducing excessive bowel contractions, thereby minimizing cramping and risk of dependency associated with stimulant laxatives.⁷ In contrast to fermentable agents

such as lactulose-which are metabolized by colonic bacteria and produce gas (hydrogen and methane) leading to bloating-magnesium hydroxide associated with minimal gas formation and lower incidence of abdominal distension.^{8,9} Addition of liquid paraffin complements this action by providing lubrication, facilitating smoother stool passage, reducing intraluminal pressure, and minimizing discomfort during defecation.⁹ This dual-action approach (softening + lubrication) is particularly valuable in women with anorectal disorders and in those recovering from pelvic/abdominal gynecological surgery, where avoidance of straining is essential for pain control and prevention of complications.

THE INTERSECTION OF GENDER, STIGMA, AND UNDERDIAGNOSIS: CONSTIPATION CARE IN INDIAN WOMEN

Constipation among Indian women remains underdiagnosed due to entrenched gender norms, cultural stigma, and limited awareness. Care-seeking is often hindered by embarrassment and silence around bowel health. Sociocultural factors, such as inadequate sanitation and restricted fluid intake, further increase risk. Hormonal transitions across the life course, particularly fluctuations in progesterone and estrogen during menstruation, pregnancy, and menopause, slow gastrointestinal transit, alter neuromuscular function, and predispose to constipation (Figure 1). Despite its burden, chronic constipation is underreported, highlighting the need for proactive screening, improved clinician-patient dialogue, and culturally sensitive, gender-responsive care.

Multifactorial causes of constipation in women: anemia, anorectal disorders, gynecologic factors, and menopause shown in Figure 1

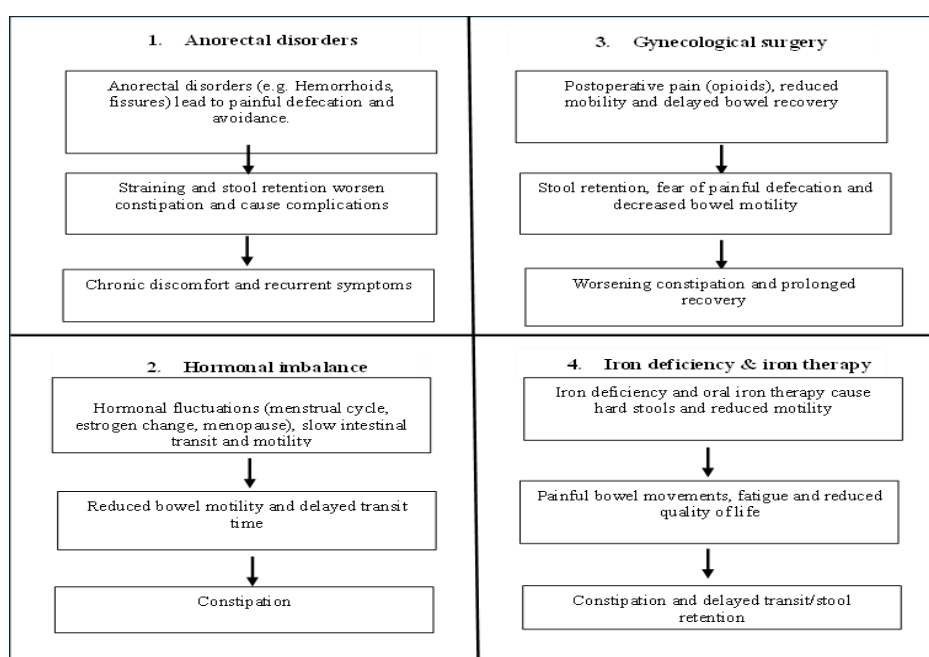


Figure 1: Key non-pregnancy drivers of constipation in women: a gynecological perspective.¹⁰⁻²¹

CONSTIPATION IN WOMEN-DUE TO ANORECTAL DISORDERS

Constipation in women is not a homogeneous condition; it manifests in distinct clinical contexts where pathophysiological mechanisms, symptom burden, and therapeutic priorities differ markedly. Constipation significantly worsens benign anorectal disorders in women, including hemorrhoids, anal fissures, and pelvic floor dysfunction, by promoting hard stools and excessive straining, which increase intra-abdominal pressure and stress on the anal sphincter. Untreated constipation in this subgroup worsens anorectal outcomes, impairs quality of life, and increases the risk of chronic fissure, mucosal tearing, and prolapse.¹⁰ Consensus statements and position papers strongly emphasize stool softening and reducing straining as therapeutic priorities.¹¹

Constipation significantly exacerbates anorectal conditions, including hemorrhoids, anal fissures, and pelvic floor dysfunction in women, by elevating stool hardness, straining, and anorectal pressure. Clinical guidelines generally highlight stool softness and minimizing straining as primary treatment objectives for these patients. In this context, MoM (magnesium hydroxide) enhances stool hydration and bowel regularity via osmotic action. In contrast, liquid paraffin offers a lubricant that diminishes friction and promotes effortless stool passage. This combination facilitates softer evacuation, reduces anorectal damage, and may enhance patient comfort and quality of life in women with constipation-related anorectal diseases.^{7,22}

CONSTIPATION IN WOMEN-DUE TO HORMONAL IMBALANCE

Various hormones and hormonal fluctuations play a central role in gastrointestinal motility among women (Table 1). Variations in estrogen and progesterone influence colonic transit, contributing to constipation during reproductive

years, particularly in the late luteal phase. Estrogen receptors exist in the gastrointestinal tract, and variations in estrogen levels can influence motility and the transit of colon contents. Progesterone and estrogen, primarily examined in relation to pregnancy and menstrual cycle stages, also influence digestive muscle contractions and the neural regulation of bowel motions.^{12,23} Hormonal fluctuations across the female lifespan play a significant role in development of constipation by influencing gastrointestinal motility and colonic transit. Variations in estrogen and progesterone levels during menstrual cycle, perimenopause, and menopause are associated with delayed bowel transit, harder stools, and reduced bowel frequency. Estrogen receptors present within gastrointestinal tract further support role of hormonal modulation in bowel function. In such patients, MoM helps improve stool hydration and bowel regularity through osmotic action, while liquid paraffin facilitates smoother stool passage by providing lubrication. Combination offers gentle, predictable relief with good tolerability and minimal bloating, making it suitable for women with hormonally associated bowel dysfunction.⁹

Among elderly populations, constipation prevalence is markedly higher in women than in men, reaching up to 34% in women over 80 years. Constipation is significantly more prevalent in women during perimenopause (42%) and post-menopause (26%), with hormonal changes playing a complex role in gastrointestinal function. Stress physiology also increasingly contributes to constipation in perimenopausal and postmenopausal women.^{13,24} Elevated cortisol levels and heightened psychological stress correlate strongly with slowed bowel motility, straining, and hard stool consistency. Many women also experience reduced activity levels, pelvic floor weakening, comorbid medical illnesses, and polypharmacy, all of which amplify constipation risk.²⁴ In such women, therapeutic goals extend beyond symptom relief to maintaining bowel regularity, preventing anorectal complications, and enhancing postmenopausal quality of life.

Table 1: Constipation due to hormonal imbalance.

Causes	Mechanism	Evidence highlights
Hormonal imbalance in PCOS or PMOS ^{25,26}	Autonomic dysfunction, insulin resistance, and androgen excess may impair gut motility.	Evidence is limited to ~three to five mechanistic or the observational studies (~200-500 women) showing autonomic dysfunction and metabolic disturbance, with the indirect association (no direct causality established).
Menopause ^{27,28}	Hormonal decline (estrogen/progesterone) and stress-related hormonal changes may influence gut motility and bowel habits.	Evidence from ≥5 observational studies (~2000+ women) shows higher prevalence of constipation in postmenopausal women, though causality is multifactorial (hormonal + aging).
Hormonal imbalance in metabolic disorders (e.g., obesity) ^{26,29}	Low-grade inflammation, altered gut motility, reduced activity, and dietary factors slow colonic transit.	Evidence from large epidemiologic studies and reviews (>20 studies; >50,000 participants) shows consistent association between obesity and the chronic constipation, supporting the moderate causal inference.

Continued.

Causes	Mechanism	Evidence highlights
Menstrual cycle fluctuations ^{28,30}	In the premenstrual phase, estrogen and progesterone decelerate gut motility, which can lead to constipation.	Evidence from ≥10 physiological and observational studies involving ~500-1500 women shows consistent slowing of GI transit and increased constipation symptoms in luteal phase, supporting a moderate causal relationship.
Hypothyroidism ^{31,32}	Reduced thyroid hormone slows intestinal motility and prolongs transit time.	Strong evidence from ≥10 clinical and physiologic studies (~500+ patients) shows delayed GI transit and constipation, supporting well-established causality
Diabetes (autonomic neuropathy) ^{33,34}	Autonomic neuropathy impairs enteric nervous system → slowed intestinal transit.	Evidence from ≥10 cohort and mechanistic studies (>3000 patients) shows significant prevalence of constipation and GI dysmotility in diabetes, establishing strong causality.
Primary hyperparathyroidism/ hypercalcemia ³⁵⁻³⁸	Elevated calcium impairs smooth muscle contractility and reduces GI motility.	Evidence from clinical observational studies and case series (~100-300 patients) demonstrates reversible constipation with hypercalcemia, supporting a clear mechanistic causal link.
Oral contraceptives/ progestin-only contraception ³⁹⁻⁴²	Progesterone-related effects reduce GI motility.	Evidence limited to physiologic and indirect observational data (~3-6 studies; <500 women); plausible mechanism but weak direct clinical causality.

CONSTIPATION IN WOMEN-ASSOCIATED WITH GYNECOLOGICAL SURGERIES

Constipation is a common and multifactorial complication following gynecological surgeries, including elective laparoscopies, pelvic reconstructive procedures, and hysterectomies. It can significantly affect patient comfort, recovery, and quality of life in the early postoperative period. Although rates and severity vary by procedure and patient factors, evidence consistently shows that postoperative constipation requires proactive attention in perioperative care.¹⁴

In a prospective analysis of women receiving elective laparoscopic surgery for benign gynecological conditions, over 70% experienced postoperative constipation, with the initial bowel movement occurring, on average, 3 days after surgery.¹⁵ Another study indicated that pelvic surgeries, including presacral neurectomy and hysterectomy, correlate with elevated rates of postoperative constipation (25-32%) in contrast to women who did not undergo gynecologic surgery (about 10%). Studies also revealed that up to one-third of women experience constipation following minimally invasive gynecologic procedures, with nearly 32% experiencing delayed bowel movement

beyond three days post-surgery.^{16,17} The passing of soft stool is highlighted as a crucial postoperative recovery goal, especially in pelvic reconstructive surgeries, where straining may jeopardize sutures and anatomical integrity.¹⁸ Table 2 describes constipation related to various gynecological surgeries.

Constipation is a common postoperative complication after gynecological surgeries, including hysterectomy, laparoscopic procedures, pelvic floor repair, and oncologic pelvic surgery. Contributing factors include anesthesia, opioid administration, altered pelvic anatomy, autonomic nerve damage, and decreased mobility, all of which lead to delayed bowel motility and challenging defecation. Clinical therapy for these patients emphasizes facilitation of soft stool passage and reduction of straining to safeguard surgical integrity and enhance postop recovery. In this context, MoM enhances bowel hydration and physiological evacuation via osmotic action. In contrast, liquid paraffin offers a lubricant that eases stool passage and diminishes mechanical strain during defecation. This combination provides a mild and well-accepted method for postoperative bowel management, facilitating earlier, pleasant bowel movements and enhancing recovery in women after gynecological surgery.¹⁹

Table 2: Constipation in gynecological surgeries.

Causes	Mechanism	Evidence highlights
Women who have undergone vaginal or laparoscopic hysterectomies ^{43,44}	Obstructive defecation due to altered pelvic anatomy, nerve injury, and adhesions affecting rectal emptying.	Evidence from ≥2 prospective cohort studies (~533 patients) shows no consistent increase in de novo constipation, though some patients report postoperative bowel changes and obstructed defecation symptoms.

Continued.

Causes	Mechanism	Evidence highlights
Women with abdominal or pelvic surgeries ¹⁶	Postoperative adhesions, pelvic floor dysfunction, or altered bowel mechanics depending on surgery type.	Evidence from observational and clinical studies suggests a multifactorial association, with postoperative constipation reported in up to one-third of patients after gynecologic surgery, influenced by anesthesia, immobility, and bowel handling.
Postoperative constipation from use of analgesics (opioids) ^{45,46}	Opioids bind to μ -receptors in the gut \rightarrow reduced peristalsis, increased fluid absorption, increased sphincter tone.	Strong evidence from multiple reviews/meta-analyses (thousands of patients) shows high prevalence (22-81%), establishing a clear causal relationship for opioid-induced constipation.
Extensive pelvic floor repair or prolapse surgery ⁴⁷	Altered pelvic floor coordination, rectocele correction effects, or postoperative dyssynergia causing obstructed defecation.	Evidence including large cohort data (n \approx 3515) shows significant association between prolapse severity/repair and obstructed defecation symptoms, though causality remains complex.
Endometriosis surgery (especially bowel/rectal involvement) ^{48,49}	Adhesions, nerve injury, or bowel resection-related dysfunction leading to constipation or altered bowel habits.	Evidence from a systematic review (14 studies) and large cohort (n \approx 1497) shows postoperative bowel dysfunction including constipation, especially after segmental resection.
Radical hysterectomy or oncologic pelvic surgery ⁵⁰	Pelvic autonomic nerve injury \rightarrow impaired colonic motility, defecatory dysfunction, incomplete evacuation.	Cohort evidence (\sim 200+ patients) shows increased straining and incomplete evacuation, supporting causal role of autonomic nerve disruption.

CONSTIPATION IN WOMEN-ASSOCIATED WITH IRON DEFICIENCY ANEMIA

Iron deficiency anemia (IDA) remains highly prevalent among women of reproductive age in India, affecting approximately 57% of women aged 15-49 years, largely due to menstrual blood loss, inadequate dietary iron intake, and limited bioavailability of dietary iron.²⁰ Constipation occurring in the setting of IDA should be regarded as an alarm feature that warrants careful clinical assessment. This association is clinically relevant for several reasons. Patients with IDA may report a greater constipation symptom burden with associated impairment in quality of life. In addition, IDA with constipation may signal underlying gastrointestinal pathology (e.g., gastrointestinal malignancy, coeliac disease, or gastritis), particularly when accompanied by other concerning features such as unintentional weight loss or rectal bleeding, which may necessitate urgent specialist referral. Where features suggestive of organic disease are absent, psychological/psychiatric contributors should also be considered as part of a structured evaluation before extensive gastrointestinal investigations. Iron (and calcium) supplementation is recognized as an exogenous factor that can alter bowel motility and contribute to the development/worsening of chronic constipation. Gastrointestinal adverse effects frequently limit oral iron supplementation; constipation and bloating are reported in up to \sim 60% of users and may contribute to poor adherence, thereby delaying/preventing effective correction of IDA.²¹

Iron deficiency anemia is widespread among Indian women, and oral iron supplementation frequently leads to constipation, bloating, and stiff stools, which can hinder treatment adherence and diminish quality of life. In this

context, MoM (magnesium hydroxide) enhances stool hydration and bowel regularity via osmotic action. In contrast, liquid paraffin promotes smoother stool passage through lubrication, hence alleviating straining and discomfort during defecation.^{7,22} The combination may help manage iron-associated hard stools and thereby support continuation of therapy, especially in women suffering from iron-induced gastrointestinal dysfunction.

ROLE AND CLINICAL SCOPE OF MoM AND LIQUID PARAFFIN COMBINATION IN THE MANAGEMENT OF CONSTIPATION IN WOMEN

MoM acts as a hyperosmotic laxative, drawing water into the intestinal lumen through osmotic gradients. This increases stool water content, softens fecal matter, and stimulates colonic peristalsis, thereby facilitating bowel movement with reduced straining. Liquid paraffin functions as an emollient (lubricant) laxative, coating the stool and intestinal mucosa to reduce friction and resistance during defecation. The combination of magnesia and liquid paraffin produces a complementary and synergistic laxative effect by targeting distinct mechanisms underlying constipation.⁵¹

MoM and liquid paraffin are widely used non-stimulant laxatives for constipation management. MoM has been used as a saline osmotic laxative for decades, with clinical evidence supporting its safety and effectiveness at approved doses.⁹ In cases of anorectal problems and postoperative conditions, liquid paraffin has been used as a lubricant laxative to ease stool movement. Both medications exhibit a high degree of tolerability and demonstrate minimal significant adverse effects in appropriately selected patients. Magnesium hydroxide

exhibits a lower degree of intestinal fermentation compared to fermentable osmotic agents such as lactulose, thereby minimizing the production of bloating and gas.¹⁰ The application of liquid paraffin to decrease stool friction has the potential to enhance patient comfort and compliance, particularly in cases of painful defecation. Given their extensive clinical history and established tolerability, these medications continue to be utilized for mild bowel evacuation in the treatment of constipation.⁵²

The combination of MoM and liquid paraffin provides an effective and well-tolerated option for the management of

constipation. By combining osmotic stool hydration with lubrication, this regimen facilitates smoother and less painful bowel evacuation without inducing intestinal spasms, making it particularly suitable for short-term relief in patients with conditions such as hemorrhoids or anal fissures.⁵³ Unlike stimulant laxatives that cause intense, often painful contraction of the bowel, this combination is gentle on the gastrointestinal mucosa and supports comfortable defecation. Moreover, because it does not rely on stimulating bowel nerves, it is not associated with the dependency issues often found with stimulant laxatives (like Senna).⁵⁴

Table 3: Comparison between osmotic laxatives.

Parameters	MoM ⁵⁵	Polyethylene glycol (PEG) ⁵⁶	Lactulose ^{57,58}
Primary mechanism	Saline osmotic laxative; increases intraluminal water and softens stool.	Non-absorbable polymer; retains water in stool and softens stool.	Synthetic non-absorbable disaccharide; increases colonic water content after metabolism in the colon.
Typical onset of action	Usually produces a bowel movement within 0.5-6 hours.	Usually produces a bowel movement within 1-3 days.	24-48 hours may be required to produce a bowel movement.
Gas and bloating	Bloating or flatulence is rarely reported.	Bloating or abdominal discomfort may occur.	Flatulence, gaseous distention, and bloating may occur, particularly at initiation.
Tolerability across age groups and comorbidity	Use caution/ask doctor in kidney disease or magnesium-restricted diet.	Ask doctor before use in kidney disease, abdominal pain, nausea/vomiting, sudden bowel habit changes or irritable bowel syndrome	Fermentable and commonly associated with gas/bloating; use caution in diabetes because it contains galactose and lactose impurities depending on formulation.

It is essential to recognize that treatments differ in their mechanisms, the timing of relief, and their tolerance within the gastrointestinal system. Osmotic laxatives are commonly prescribed for chronic constipation due to their ability to enhance water retention in the intestinal lumen, thereby softening stool and facilitating improved digestive motility. MoM, polyethylene glycol (PEG), and lactulose are widely recognized substances.⁷ All three employ osmotic techniques, yet their fermentation capabilities, gas production, and patient tolerance differ. Comprehending these distinctions enables healthcare professionals to select the most appropriate treatment based on patient characteristics, comorbid conditions, and rapid symptom relief. MoM (magnesium hydroxide) is commonly prescribed as an osmotic laxative for acute and chronic constipation in adults. The typical recommended dose ranges from 30 mL to 60 mL, with titration based on individual response. Initiating therapy at the lower end of the range (15 mL) is advisable, particularly in first-time users or patients with mild symptoms, to minimize the risk of diarrhea or cramping. Nighttime dosing is generally preferred, as it allows for bowel movement the following morning, aligning with natural circadian rhythms of colonic motility.⁵⁹ Dose adjustments should be guided by stool consistency, frequency of bowel movements, and patient comfort rather than a rigid schedule. The goal is to

achieve soft, formed stools without urgency or incontinence.⁶⁰

GUIDELINE RECOMMENDATIONS

The 2023 joint American Gastroenterological Association (AGA)/American College of Gastroenterology guideline for chronic idiopathic constipation includes a conditional recommendation for magnesium oxide over no treatment in adults.⁶¹ Randomized controlled studies have shown that magnesium-based therapy can improve spontaneous bowel movements, stool form, colonic transit time, constipation symptoms, and quality of life compared with placebo in adults with chronic constipation.⁵³ Although these studies were conducted with magnesium oxide, they support the osmotic laxative role of magnesium hydroxide, since both belong to the magnesium-based saline laxative class and increase intraluminal water content.⁶² For liquid paraffin, the therapeutic rationale is based on its recognized role as a lubricant laxative, coating the stool and intestinal mucosa and thereby reducing water absorption, retaining stool moisture, and easing stool passage.^{62,63} Taken together, the available literature suggests that the magnesium hydroxide-liquid paraffin combination is supported by the complementary pharmacologic roles of its individual components.

Magnesium contributes to osmotic stool softening and improved bowel movement frequency, whereas liquid paraffin contributes lubrication and easier evacuation of hard stools. This complementary mechanism may explain

the continued clinical use of the combination, particularly in constipation associated with hard stools, straining, and anorectal discomfort, even though direct high-quality combination-specific studies remain limited.

Table 4: Guideline recommendation.

Guideline (Year)	Key recommendation	Clinical relevance
World gastroenterology organization (WGO-2025)⁵⁴	Simple osmotic agents such as MoM are appropriate first-line options for adults without alarm features.	Supports early use of safe, simple osmotic laxatives in uncomplicated constipation.
American College of Gastroenterology (ACG)⁶¹	Recommends a stepwise approach: dietary fiber → osmotic laxatives (including magnesium-based agents) → stimulants/secretagogues if needed. ¹²	Positions osmotic laxatives as a key second step after lifestyle measures.
AGA technical review (2023)⁶⁴	Confirms efficacy and tolerability of osmotic agents, including magnesium hydroxide, in improving stool frequency and consistency.	Reinforces evidence base for clinical effectiveness and patient tolerability.
Indian consensus statement on chronic constipation (2018)⁶⁵	Recommend osmotic laxatives (including MoM) in the initial treatment phase, tailored to patient profile.	Relevant in Indian women; emphasizes gentle stool softening and reduced straining.
FOGSI recommendation (2024)¹	Advises pharmacologic therapy when lifestyle measures fail; recommends bulk-forming or osmotic laxatives to soften stool and reduce straining.	Focuses on women-centric care (hemorrhoids, fissures, post-surgical recovery)

DISCUSSION

Constipation in women represents a multifaceted and frequently under-recognized clinical burden, arising from diverse etiologies including anorectal disorders, iron therapy, hormonal fluctuations (menstrual cycle and menopause), metabolic syndrome, low dietary magnesium intake, and postoperative recovery following gynecologic or anorectal surgery. Across these varied clinical contexts, common pathophysiological themes emerge—hard stools, impaired colonic transit, pelvic floor strain, and painful or incomplete defecation—necessitating therapeutic strategies that go beyond simple laxation to address stool consistency, ease of passage, and mucosal protection.^{6,12,41,51} The combination of MoM (magnesium hydroxide) and liquid paraffin offers a complementary dual-action mechanism that directly aligns with these needs. MoM acts as a saline osmotic laxative, increasing intraluminal water content and promoting bowel motility, while liquid paraffin provides luminal lubrication, reducing friction and facilitating smooth stool passage.⁵⁵ This integrated mechanism underpins its relevance across a broad spectrum of patient profiles.

In anorectal disorders such as fissures, hemorrhoids, and obstructed defecation syndrome (ODS), where straining and trauma exacerbate disease severity, the combination’s dual effect—softening plus lubrication—plays a critical role. It minimizes mechanical injury, reduces pain during defecation, and enhances patient comfort, thereby supporting both symptom relief and healing.^{10,22,51,52} Similarly, in general chronic constipation, while osmotic agents alone improve stool frequency and hydration, the addition of lubrication improves ease of evacuation,

addressing a key unmet need in patients who struggle with difficult stool passage despite adequate hydration.^{9,22,51,61} The combination is particularly valuable in iron deficiency anemia (IDA), where iron supplementation commonly causes hard, difficult-to-pass stools.²¹ MoM counteracts stool desiccation through osmotic softening, while liquid paraffin further reduces straining and discomfort, improving treatment adherence.^{22,51,53,55} In populations such as women with low magnesium intake, MoM also contributes to restoring physiologic bowel motility via its osmotic and neuromuscular effects, with the combination providing reliable symptomatic relief when dietary correction alone is insufficient.

A significant area of value is seen in postoperative and hospital settings, especially following gynecologic or anorectal surgery.^{14,15} Here, gentle, non-stimulant bowel regimens are preferred to avoid stress on surgical sites.^{17,19} The MoM-liquid paraffin combination promotes early, painless defecation, reduces the risk of straining-related complications, and supports faster bowel recovery, often enabling return of bowel function as early as day 1 compared to the typical discomfort seen in days 3-5 with conventional regimens.^{52,62} The lubrication component is especially critical in protecting healing tissues during the first postoperative bowel movements, resulting in improved patient comfort and quality of life, and a very low risk of ileus (<1%).^{18,19}

In pelvic reconstructive surgery, where delicate pelvic floor dynamics must be preserved, combination provides a gentle, titratable alternative to stimulant laxatives, potentially shortening the time to a comfortable first bowel movement compared with non-lubricant regimens.^{19,22,47,51}

Likewise, in menopausal constipation, driven by hormonal changes and reduced motility, MoM provides predictable osmotic relief, while lubrication is particularly beneficial in women experiencing pelvic discomfort.^{12,13,51-53,55}

In metabolic syndrome and sedentary states, where slower colonic transit is common, the osmotic restoration of bowel hydration combined with non-fermentative action offers relief without the bloating often associated with fermentable agents such as lactulose. This positions the combination as a well-tolerated option in patients prone to gas-related discomfort.^{26,33,55,57,58,63}

Overall, the evidence consistently supports that the MoM + liquid paraffin combination extends beyond symptomatic constipation relief to a more holistic bowel care approach, targeting stool consistency, transit, evacuation dynamics, and mucosal protection simultaneously. Its rapid, predictable action, low risk of dependency when appropriately used, minimal fermentation-related side effects, and suitability for sensitive clinical scenarios make it particularly valuable in women-centric care pathways.^{1,19,22,51,53-55,57,58,60,63}

CONCLUSION

Constipation in women represents a multifactorial and often under-recognized clinical challenge, driven by diverse non-pregnancy etiologies including anorectal disorders, hormonal changes, iron therapy, and postoperative states. Across these contexts, common features such as hard stools, impaired transit, and painful defecation highlight the need for therapeutic strategies that address not only stool frequency but also consistency and ease of evacuation. MoM in combination with liquid paraffin offers a complementary dual-action approach, integrating osmotic stool softening with luminal lubrication to facilitate comfortable, strain-free defecation. This is particularly relevant in clinical scenarios where minimizing discomfort and mechanical stress is essential, such as anorectal conditions, postoperative recovery, and iron-induced constipation. With its predictable efficacy, favorable tolerability, minimal bloating, and suitability across sensitive patient populations, this combination demonstrates broad clinical applicability and represents a practical, patient-centric option for comprehensive constipation management in women.

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