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REVIEW

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Bristol scale stool form. A still valid help in medical practice and clinical research

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Abstract The collection of clinical data concerning bowel habit is always empirical. A more extended use of visual descriptive stool form scales could contribute to a clearer and more standardized reporting of data about bowel function. This could be helpful for both clinical practice and research purposes.

Key words Stool form • Bristol scale stool • Bowel habit description

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Introduction

The term "stool" unconsciously brings to mind an unpleasant feeling leading to the concept of "refusal". The observation or the smell of stools causes a bad feeling similar to that of rummaging in a heap of garbage. Stools represent food decomposition and they unconsciously remind us of body decomposition to which all of us are destined and, therefore, in a figurative way, to death. Neither the idea that stools are just a pool of water, alimentary residues and bacteria seems to solace us. The individual relationship of each of us to our own stools is rather varying: patients affected by anxiety examine them meticulously, while the only thought of them arouses nausea and disgust in others.

The doctor-patient relationship is also subjected to this conditioning. The gastroenterologist will ask information on the rhythm of bowel movements, on modalities of expulsion and on feelings of satisfaction after defecation, to characterize the patient's bowel habits and to express the phenomenon in quantitative terms. Agachan et al. [1] proposed a Constipation Scoring System which has been validated and used by many coloproctology centres.

It is even more difficult to get a quantitative answer on stool aspect and consistency. The stool appearance and consistency, however, represent an important semeiologic tract in the medical approach to the gastroenterologic patient. A patient's description of his own stools gives only partial information, and the direct observation by the doctor would be optimal, although this is not easily practicable with outpatients. A compromise could be found in the availability of a descriptive scale representing the different modalities and aspects of stool expulsion.

Some descriptive visual scales have been proposed [2] and, in particular, Heaton and Thompson [3] presented a seven point scale which was called "Bristol scale stool form" from the city where they worked: 1. nuts-like; 2.

lumpy sausage; 3. sausage with cracks; 4. smooth snake; 5. soft blobs; 6. fluffy pieces; 7. watery. This scale was validated as being correlated with the whole gut transit time [4–6]. Its introduction not only made the dialogue between patient and doctor simpler, but it also was useful in clinical research. For instance, Heaton and O'Donnell [4] in 1994 showed that intestinal transit time was correlated to stool aspect and not to the frequency of bowel movements. "Whole-gut transit time, stool form and frequency were significantly different in patients reporting constipation compared with those who reported diarrhea, diarrhea and constipation, or neither, but in the last three groups these parameters were not significantly different from each other. Patients' recollection of stool form is a reasonable guide to their transit time and can be used in the office to identify pseudodiarrhea and true constipation" [7].

The Bristol scale has also been used for longitudinal evaluations in constipated patients treated with laxatives and/or prokinetic drugs [8]. The scale has been recommended for research by an international working party [9].

In conclusion, with the use of the Bristol scale stool form, anamnesis will be more detailed and will be performed more quickly. It will perhaps be useful to avoid questions such as: "Excuse me, doctor, you are asking me if my stools are goat-like; I have never been to the country, how do goat stools look like?" We recommend that these delicate sketches not be substituted with an excessively realistic photographic catalogue!

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