Management of Constipation in Adults

Definition

Constipation is defecation that is unsatisfactory because of infrequent stools, difficult stool passage, or seemingly incomplete defecation. Stools are often dry and hard, and may be abnormally large or abnormally small.

Assessment (see Flowchart on page 5 and http://cks.nice.org.uk/constipation)

- Clarify what the person understands by their constipation.
- Assess the presence and degree of faecal loading/impaction and faecal incontinence.
- Assess the severity and impact of the constipation and any faecal incontinence.
- Assess the role of predisposing factors (including drug treatment of co-morbidities – *see Table 1*).
- Identify any organic causes of constipation *(see Table 1)*
- Assess effectiveness of management to date.

Be alert for any 'red flags' that might indicate a serious underlying condition.

- **Persistent unexplained change in bowel habits?**
- **Palpable mass in the lower right abdomen or the pelvis?**
- **Persistent rectal bleeding without anal symptoms?**
- **Narrowing of stool calibre?**
- **Family history of colon cancer, or inflammatory bowel disease?**
- **Unexplained weight loss, iron deficiency anaemia, fever, or nocturnal symptoms?**
- **Severe, persistent constipation that is unresponsive to treatment?**

Referral

- Refer for suspected cancer if 'red flags' are present (see NICE CG27).
- Consider surgical referral when there is pain and bleeding on defecation (e.g. from an anal fissure) that is severe or does not respond to treatment for constipation.
- Refer for assessment by a specialist with an interest in constipation when:
  - An underlying cause is suspected.
  - Treatment is unsuccessful.
  - Management may require further tests.
  - Assessment is required prior to referral for other interventions (such as psychology, psychiatry).
- Consider referral to a Continence Service (when available) if faecal incontinence is a problem.
- Consider dietetics referral for more detailed support of diet.

Table 1

Conditions which may cause or contribute to constipation	Commonly prescribed drugs which may cause constipation
• Bowel obstruction • Irritable bowel syndrome • Cancer • Diverticular disease • Dehydration • Admission to hospital for any cause • Hypothyroidism • Neuromuscular disorders • Stimulant laxative abuse • Anorexia • Hypercalcaemia • Pregnancy	• Opioid analgesics, including compound products e.g. co-codamol, co-dydramol. • Drugs with antimuscarinic (anticholinergic) effects – Tricyclic/ SSRI/SNRI antidepressants; antipsychotics; antimuscarinic anti-parkinsonian drugs e.g. orphenadrine, benzatropine, trihexyphenidyl, procyclidine; antihistamines – especially older sedating antihistamines e.g. chlorphenamine, promethazine and cyclizine; antispasmodics e.g. propantheline, hyoscine. • Calcium salts (note: contained in some antacids & phosphate binders). • Aluminium salts (in many antacids). • Iron salts. • Calcium channel blockers (mainly verapamil). • Phenothiazines • NSAIDs (more commonly cause diarrhoea). • $5HT_3$ antagonists e.g. Ondansetron

RECOMMENDED TREATMENT OF CONSTIPATION IN ADULTS

For information on contraindications, cautions, drug interactions, and adverse effects, see the electronic Medicines Compendium (eMC) (http://emc.medicines.org.uk), or the British National Formulary (BNF) (www.bnf.org).

- **Assess patient, identify and manage any underlying cause** *(see Table 1)*

- Lifestyle advice and modifications

- If faecal impaction – *see section on Treatment of Faecal Impaction*

- If opioid induced – *see section on Prophylaxis and Treatment of Opioid Induced Constipation*

- **If IBS –** consider prescribing antispasmodic (mebeverine, alverine, or peppermint oil)

http://cks.nice.org.uk/irritable-bowel-syndrome

- Pregnancy and Breast-feeding: *Follow 1st and 2nd line treatment, as below, occasional use of glycerol or bisacodyl suppositories are also considered safe*

ALL PATIENTS: Lifestyle advice

- increase dietary fibre, ensure adequate fluid intake, exercise, advise on toileting routines

When drug treatment is required a review after 1-2 weeks is necessary to assess response and modify drug treatment as required.

1st line: BULK FORMING LAXATIVES

- **Ispaghula husk, 1 sachet twice daily.**

Not suitable for chronic constipation (> 6 months duration), intestinal obstruction, reduced motility or where fluid intake is not adequate (e.g. debilitated or elderly patients)

2nd line: OSMOTIC +/- STIMULANT LAXATIVE

- **Macrogols** (e.g. *Laxido, Movicol)* **1 – 3 sachets daily in divided doses**

PLUS/MINUS

- **Senna Tabs (=7.5mg sennosides / tablet) 2 - 4 tablets at night OR**

Bisacodyl Tabs, 5-10mg at night (increased if necessary to 20mg at night)

Use where stools are soft but difficult to pass

3rd line: REFER

Where patient has failed to response to respond to the maximum tolerated dose of 1st and 2nd line treatments.

Treatments suitable for prescribing by general practitioner, **following initiation or recommendation by specialist** include:

- **Prucalopride tabs 1 – 2mg daily**

  - as per NICE TA 211 (for women only – following 6 months treatment of at least 2 classes of laxative at maximum tolerated doses, review after 4 weeks)

- **Linaclotide tabs 290 micrograms daily**

  - for IBS-C (constipation with pain symptoms)

Treatment of faecal impaction

1st line (Oral):

- **Macrogols** (e.g. *Laxido, Movicol)* **8 sachets daily in divided doses**

PLUS/MINUS

- **Senna Tabs (=7.5mg sennosides / tablet) 2 - 4 tablets at night**
  Bisacodyl Tabs, 5-10mg at night (increased if necessary to 20mg at night)
  Use where stools are soft but difficult to pass

2nd line (Suppositories)

- **Bisacodyl suppositories 10mg daily**
  Use where stools are soft but difficult to pass

PLUS/MINUS

- **Glycerol suppositories 4g daily**

3rd line (Micro-enemas):

Docusate sodium micro-enema, STAT

OR

Sodium citrate micro-enema, STAT

4th line
Retention enemas

Sodium phosphate retention enema, STAT

OR

Arachis oil retention enema, STAT

For hard stools use at Arachis oil night + sodium phosphate retention enema or sodium citrate Micro-enema in morning

Prophylaxis and Treatment of Opioid Induced Constipation

LIFESTYLE ADVICE

- increase dietary fibre, ensure adequate fluid intake, exercise, advise on toileting routines

PRESCRIBE LAXATIVES FOR PROPHYLAXIS OF CONSTIPATION

- **Senna Tabs (=7.5mg sennosides / tablet) 2 - 4 tablets at night OR**
  Bisacodyl Tabs, 5-10mg at night (increased if necessary to 20mg at night)
  AND
- **Macrogols** (e.g. *Laxido, Movicol)* **1 – 3 sachets daily in divided doses**

TREATMENT

When drug treatment is required a review after 1-2 weeks is necessary to assess response and modify drug treatment as required.

- If faecal impaction – *see section on Treatment of Faecal Impaction*

- Bulk laxatives not suitable

1st line : STIMULANT LAXATIVE +/- OSMOTIC

- **Senna Tabs (=7.5mg sennosides / tablet) 2 - 4 tablets at night OR**
  Bisacodyl Tabs, 5-10mg at night (increased if necessary to 20mg at night)
  AND
- **Macrogols** (e.g. *Laxido, Movicol)* **1 – 3 sachets daily in divided doses**

2nd line: ALTERNATIVE OR ADDITIONAL LAXATIVES

- **Docusate sodium** (alternative or additional stimulant with softener) **up to 500mg daily in divided doses**
- **Sodium picosulfate** (alternative stimulant) initially **5 – 10mg at night, increased to 15mg-30mg at night (split to BD dose in frail elderly patients)**

3rd line: REFER

On specialist prescriber advice only

- **Methylnaltrexone subcutaneous injection dose by weight, all once daily on alternate days** (2 consecutive doses can be given 24 hours apart if no response, frequency can be reduced depending on response) – up to 38kg: 150 micrograms per kg, 38-62kg: 8mg , 62-114kg: 12mg, 115kg and above: 150 micrograms per kg
- **Naloxegol tabs 25 mg daily** (initial dose 12.5mg daily in renal impairment, drug interactions) - as per NICE TA 345 is an option for treating opioid induced constipation in palliative care in adults whose constipation has not adequately responded to laxatives.

How should I follow up a person in primary care?

Arrange regular follow-up of the person depending on clinical judgement.

1. **If oral laxatives have been prescribed, advise that:**
    a. Laxatives should not be stopped suddenly, and weaning off all laxatives may take several months. The rate of laxative dose reduction should be guided by the frequency and consistency of stools.
    b. Laxative doses should be reduced gradually, for example after 2–4 weeks when regular bowel movements are comfortable, with soft formed stools.

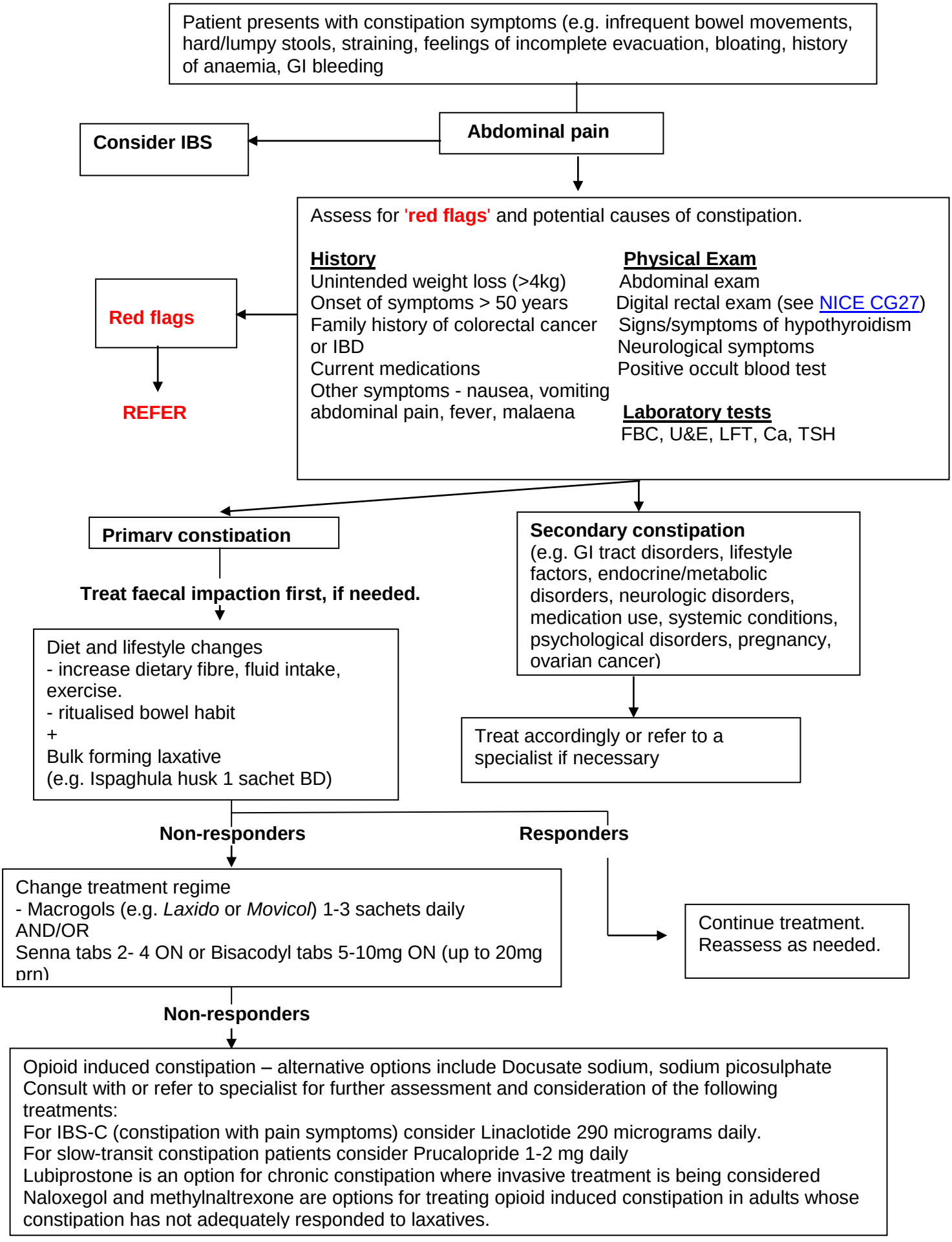
        - This is to minimize the risk of requiring rescue laxative treatment for recurrent faecal loading and/or impaction.
        - If a combination of laxatives has been used, reduce and stop one laxative at a time, starting with stimulant laxatives, if possible. Note: it may be necessary to also adjust the dose of other laxatives used to maintain regular bowel movements.

    c. Relapses are common and should be treated early with increased doses of laxatives.
    d. Laxatives may need to be continued long term for people with a medical condition or taking a medication (if it cannot be reduced or stopped) causing secondary constipation.

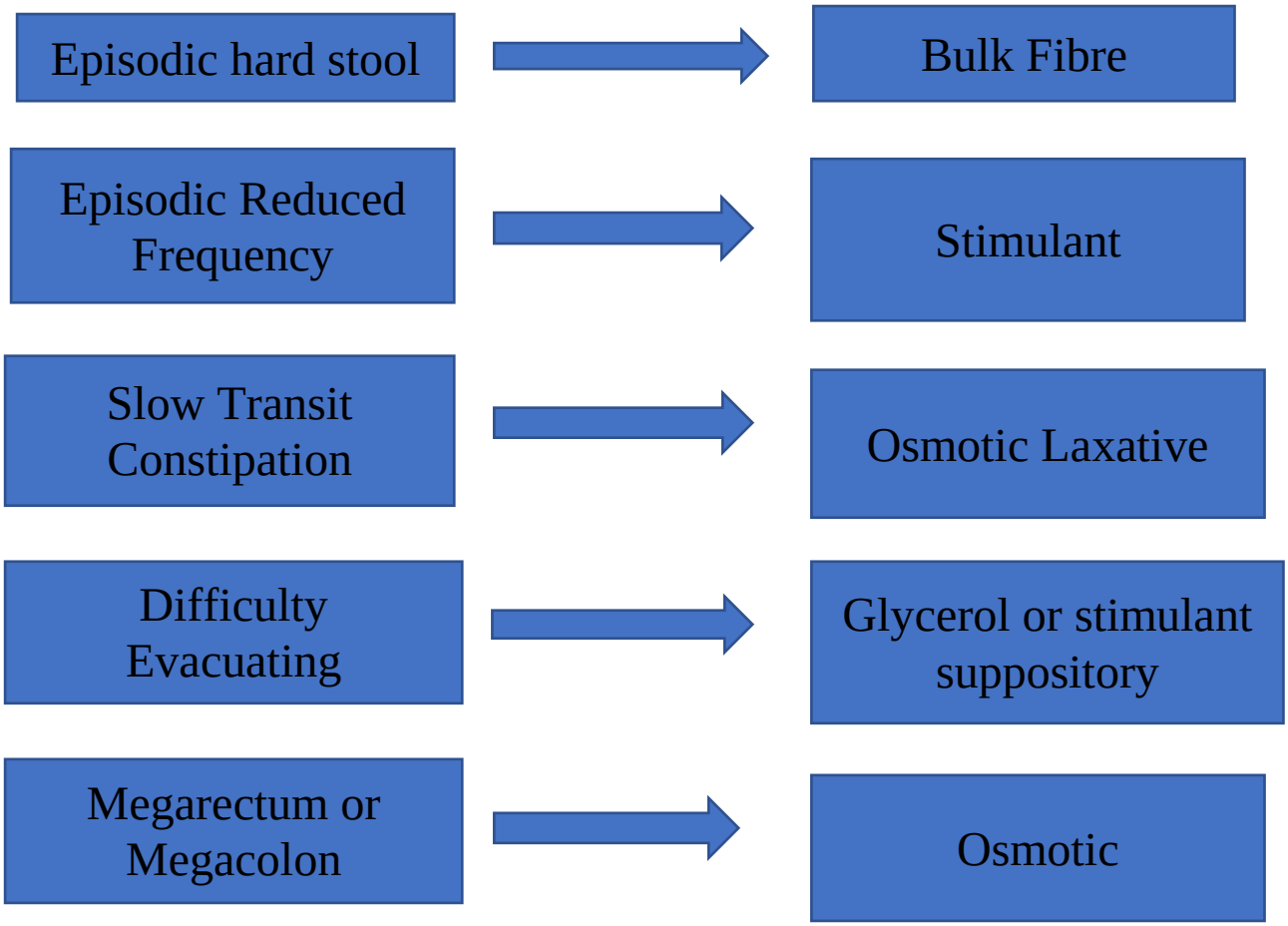
2. **If symptoms are ongoing or refractory** to laxative treatment, consider:

- Checking blood tests for full blood count, thyroid function tests, HbA1c, and serum electrolytes and calcium, to look for an underlying cause, and manage appropriately.
- Whether a defecatory disorder, such as pelvic floor dyssynergia, may be contributory.
- Seek specialist advice or arrange referral to a gastroenterologist or colorectal surgeon for specialist investigations and management, depending on clinical judgement

Summary of Management of Constipation: Flowchart



Tailoring laxatives to the patients based on their Symptoms and diagnosis



If No improvement:

- Increase dose
- Rational combination:
  - Stool softener and Stimulant Laxative
  - Bulking agent

From: Emmanuel A. Ther Adv Gastroenterol, 2011;4:32-48

References:

National Prescribing Centre (Jan 2011) The management of constipation MeReC Bulletin Vol 21, No 2.

NHS Clinical Knowledge Summaries: Constipation in adults
http://cks.nice.org.uk/constipation [accessed 08.11.13]

NICE (June 2005) Clinical Guideline 27 Referral criteria for suspected cancer
http://guidance.nice.org.uk/CG27/QuickRefGuide/pdf/English

NICE (Dec 2011) Technology Appraisal Guidance 211: Prucalopride for the symptomatic treatment of chronic constipation in women
http://guidance.nice.org.uk/TA211/QuickRefGuide/pdf/English

British Society of Gastroenterology Masterclass sessions, BSG Annual Meeting 2018 .

United European Gastroenterology Educational course on Constipation, Released May 2017

APPROVAL PROCESS

Written by:	**Marie Miller, Interface Pharmacist. Reviewed by Antonio Ramirez**
Consultation process:	**Dr. Maged Messiha, Locum Consultant Endoscopist, Gastroenterology Department. Dr Tsai, Consultant Gastroenterologist. Specialist palliative care teams**
Approved by:	***MMIG May 2016***
Ratified by:	***HERPC May 2016 Updated: May 2019***
Review date:	***May 2022***