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

<table>
<thead>
<tr>
<th>Conditions which may cause or contribute to constipation</th>
<th>Commonly prescribed drugs which may cause constipation</th>
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<tbody>
<tr>
<td>Bowel obstruction</td>
<td>Opioid analgesics, including compound products e.g. co-codamol, co-dydramol.</td>
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<tr>
<td>Irritable bowel syndrome</td>
<td>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.</td>
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<tr>
<td>Cancer</td>
<td>Calcium salts (note: contained in some antacids &amp; phosphate binders).</td>
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<tr>
<td>Diverticular disease</td>
<td>Aluminium salts (in many antacids).</td>
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<tr>
<td>Dehydration</td>
<td>Iron salts.</td>
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<tr>
<td>Admission to hospital for any cause</td>
<td>Calcium channel blockers (mainly verapamil).</td>
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<tr>
<td>Hypothyroidism</td>
<td>Phenothiazines</td>
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<tr>
<td>Neuromuscular disorders</td>
<td>NSAIDs (more commonly cause diarrhoea).</td>
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<tr>
<td>Stimulant laxative abuse</td>
<td>5HT₃ antagonists e.g. Ondansetron</td>
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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 alvcelor 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 respond 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*
Hull and East Riding Prescribing Committee

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

Patient presents with constipation symptoms (e.g. infrequent bowel movements, hard/lumpy stools, straining, feelings of incomplete evacuation, bloating, history of anaemia, GI bleeding)

Consider IBS

Abdominal pain

Assess for ‘red flags’ and potential causes of constipation.

Red flags

REFER

Primary constipation

Treat faecal impaction first, if needed.

- Diet and lifestyle changes
  - increase dietary fibre, fluid intake, exercise.
  - ritualised bowel habit
  + Bulk forming laxative
    (e.g. Ispaghula husk 1 sachet BD)

Secondary constipation

(e.g. GI tract disorders, lifestyle factors, endocrine/metabolic disorders, neurologic disorders, medication use, systemic conditions, psychological disorders, pregnancy, ovarian cancer)

Treat accordingly or refer to a specialist if necessary

Non-responders

Change treatment regime
- Macrogols (e.g. Laxido or Movicol) 1-3 sachets daily
  AND/OR
- Senna tabs 2- 4 ON or Bisacodyl tabs 5-10mg ON (up to 20mg prn)

Opioid induced constipation – alternative options include Docusate sodium, sodium picosulphate
Consult with or refer to specialist for further assessment and consideration of the following treatments:
For IBS-C (constipation with pain symptoms) consider Linaclotide 290 micrograms daily.
For slow-transit constipation patients consider Prucalopride 1-2 mg daily
Lubiprostone is an option for chronic constipation where invasive treatment is being considered
Naloxegol and methylnaltrexone are options for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives.

Responders

Continue treatment. Reassess as needed.

Non-responders

- Opioid induced constipation – alternative options include Docusate sodium, sodium picosulphate
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For slow-transit constipation patients consider Prucalopride 1-2 mg daily
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Naloxegol and methylnaltrexone are options for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives.
Tailoring laxatives to the patients based on their Symptoms and diagnosis

Episodic hard stool → Bulk Fibre
Episodic Reduced Frequency → Stimulant
Slow Transit Constipation → Osmotic Laxative
Difficulty Evacuating → Glycerol or stimulant suppository
Megarectum or Megacolon → Osmotic

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:


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

NICE (Dec 2011) Technology Appraisal Guidance 211: Prucalopride for the symptomatic treatment of chronic constipation in women

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

United European Gastroenterology Educational course on Constipation, Released May 2017

APPROVAL PROCESS

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