MIL

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This Medicines Information Leaflet is produced locally to optimise the use of medicines by encouraging prescribing that is safe, clinically appropriate and cost-effective to the NHS.

Management of Constipation in Adults

Diagnosis

Constipation is the passing of stools less often than a patient's normal frequency. A normal frequency varies from three times a day to twice a week. As well as reduced frequency, patients may experience hard stools and straining, which can be accompanied by a sensation of pain or incomplete evacuation. Prevalence is difficult to measure, but reports indicate it can be as high as 79%. Constipation is more common in women and in the elderly, particularly over the age of 65 years. Patients should be aiming for a stool that is easy to pass without excessive straining.

Definitions

Constipation in general terms may encompass any, or all, of the following:

- The passage of hard stools
- The infrequent passage of stools (less than three times per week)
- The need for straining to pass stools
- A sense of incomplete evacuation
- Excessive time spent on the toilet
- Unsuccessful defecation

Acute Constipation: any of the above occurring with an abrupt change in bowel habit and typically lasting less than 3 months.

Chronic Constipation: hard stool and difficulty with evacuation that lasts longer than 3 months, but with normal stool transit time

Slow transit constipation: Bowel movements less than weekly with infrequent urge to defecate. Associated with bloating and abdominal pain, due to slow stool transit through the colon

Opioid constipation: acute or chronic constipation as a result of opioid use.

Defecation disorder: constipation due to poor co-ordination of the muscles of the pelvic floor, or anatomical abnormalities such as rectal intussusception, rectocele or enterocele. Risk factors include previous vaginal delivery (especially with episiotomy) and pelvic surgery. Often associated with urinary incontinence. Patients may digitate to help them evacuate their bowel and have a feeling of incomplete emptying.

Causes

Causes include a low fibre diet, medications (table 1), and other factors, such as immobility, stress and anxiety.

Medical conditions such as irritable bowel syndrome (IBS), spinal cord injuries or tumours, pregnancy, hormonal disturbances e.g. hypothyroidism and diabetes, hypercalcaemia, hypokalaemia, depression, Parkinson's disease, multiple

sclerosis, lupus and stroke can all cause constipation.

Other factors such as laxative abuse over time can make the colon atonic and unable to peristalse normally. Ignoring and suppressing the urge to defecate as a result of painful disorders such as anal fissures and haemorrhoids, or changes in lifestyle and daily routine may all contribute to the problem.

Table 1: Drugs which may cause constipation

Antacids (aluminium or calcium)	Carbamazepine and Oxcarbazepine
Alpha-blockers	Diuretics
Amiodarone	Gabapentin and Pregabalin
Anticholinergics, e.g. tricyclic antidepressants	Iron preparations
Antihistamines and antipsychotics	Lithium
Anti diarrhoeals	NSAIDs
Anti parkinsonian drugs	Opiates
Calcium channel blockers	Proton Pump Inhibitors

Complications

Complications may include haemorrhoids, faecal impaction, volvulus, stercoral colitis, rectal prolapse, anal fissures and faecal incontinence.

Warning Signs

Warning signs that should prompt further investigation include blood in stools, anaemia, severe abdominal pain, unintentional weight loss, co-existing faecal incontinence, persistent symptoms or treatment failure as these can be signs of more complex conditions e.g. colorectal cancer. New onset constipation, especially in those over 50 years of age with or without accompanying symptoms as listed above should also be investigated.

Non drug interventions

Fluid intake is important although there is no evidence that increased fluid intake will improve symptoms in those that are already adequately hydrated. Achieving adequate fluid intake can be difficult in frail and elderly patients. Fibre intake which includes fruit, vegetables, fruit juices (especially those high in sorbitol), cereals, wholegrain foods, wholemeal bread, golden linseed and bran should be increased gradually to 30 grams per day (two tablespoons). However this must be continued for a month to determine effect.

A high fibre diet is not, however, recommended for those with mega colon or hypotonic colon/rectum or those with opiate induced, obstructive or impaction constipation. Helpful toileting routines which include attempting defecation first thing in the morning and responding immediately to the sensation of needing to defecate should also be encouraged. There is limited evidence that increased levels of exercise improve constipation, however it can improve bowel symptoms and quality of life.

Opioid induced constipation

Constipation is a well-known side effect of opioids. **Concurrent laxative prescribing**

is essential. All patients prescribed a regular opioid should be prescribed a regular stimulant and osmotic laxative at first opioid prescription rather than waiting for constipation to be established. Bulk forming laxatives should be avoided in this patient group

General considerations

Management of constipation is patient specific; different medications work for different people. It is important to establish what the patient's 'normal' bowel habit is. Some people only pass stools once a week and this is normal for them so trying to give laxatives for twice daily bowel motion may be unrealistic and unachievable.

Always consider what laxatives the patient has used before. If laxatives are indicated, the choice is dependent on individual patient factors, the cause of constipation and their usual bowel habit.

Laxatives should be titrated up to the maximum dose before second agents are added in. Some require regular use rather than as required to have an effect. If additional agents are needed, they should be from a different class.

Laxative abuse may lead to hypokalaemia.

Discharge planning

It is essential patients have a clear discharge plan for managing their constipation.

Templates for suggested plans are in figure 6. This is just a guide and should be modified for individual use.

For more information and guidance on specialist products please refer to the OUH formulary and your ward pharmacist.

For further specialist advise i.e. if the guidelines below have failed, considering the complexity and frailty of your patient, speak with gastroenterology (via EPR consults), medicine or geratology on call

Outlined below are several reference tables and flowcharts for the management of constipation in different settings;

- **Table 2: Drug treatment options for constipation in adults**
- **Figure 1: Flowchart for management of acute constipation in adults**
- **Figure 2: Flowchart for management of faecal impaction in adults**
- **Figure 3: Flow chart for management of chronic constipation in adults**
- **Figure 4: Flow chart for management of opioid induced constipation in adults**
- **Figure 5: Red flag signs and how to investigate**
- **Figure 6 . Example discharge plan for patient with constipation**
- **Figure 7: Bristol Stool Chart**

Table 2: Drug Treatment Options for Constipation in Adults

Class	Laxative Name	Standard dose	Time to take effect	Indications	Contraindications	Additional Info
Osmotic	Macrogol (e.g. laxido)	1-2 sachets twice a day Max dose 8 sachets daily	1-3 days	Acute, chronic, opioid induced, IBS, impaction (at higher doses)	Intestinal obstruction, perforation, ileus or patients with severe GI inflammation	Monitor fluid balance and ensure no electrolyte disturbance (may need to be stopped). Reconstituted solution should be used immediately.
	Lactulose Oral Solution	15ml twice a day regular Max dose for constipation is 45ml daily. Doses may exceed this in management/prevention of hepatic encephalopathy	1-3 days	Acute, chronic, opioid induced, IBS. Useful if patients cannot tolerate high fluid volume associated with a macrogol	Galactosaemia; GI obstruction and perforation or those at risk of perforation	May cause flatulence, abdominal pain, bloating, and nausea. (this may limit the dose) **Suitable for diabetics** (no GI absorption)
Stimulant	Senna 7.5mg Tablets Senna Liquid 7.5mg/5ml	2-4 tablets at night 10-20ml at night	8-12 hours	Acute and opioid induced	Intestinal obstruction, undiagnosed abdominal symptoms	Only licensed for short term use (2 weeks) as chronic use may lead to colonic atony, intolerance and fluid/ electrolyte imbalances. Can cause abdominal cramping
	Bisacodyl 5mg Tablets Bisacodyl 10mg suppository Sodium picosulphate 5mg/5ml oral solution	1-2 tablets at night 1 suppository in the rectum in the morning 5-10mg once a day at night	10-12 hours 20-60 minutes	Low or distal impaction	Contraindicated in severe dehydration and an acute abdomen including obstruction, ileus, perforation and acute inflammation Can cause abdominal cramping	
Bulk Forming	Ispaghula Husk 3.5g Sachets	1 sachet twice a day	Up to 72 hours	Diverticulosis, if dietary fibre cannot	Colonic atony; faecal impaction; intestinal	Can cause flatulence, bloating and

				be increased	obstruction; reduced gut motility; sudden change in bowel habit that has persisted more than two weeks; undiagnosed rectal bleeding	abdominal cramping. Must be able to maintain adequate fluid intake (risk of obstruction)
Softener/ lubricant /rectal stimulant	Glycerol suppositories	4 grams when required	15-30 minutes	Low Impaction	Moisten with water before insertion	
Softener/ Stimulant	Docusate sodium 100mg Capsules Docusate Sodium Liquid 50mg/5ml	maximum 500mg daily in divided doses	1-2 days	Colic	Intestinal obstruction	
Bowel Cleansing Preparations	Phosphate Enemas	1 enema daily	30 minutes	Bowel evacuation	Conditions causing increased absorption capacity or decreased elimination capacity; undiagnosed GI pathology; dehydration;	
	Other agents e.g. citramag, picolax, moviprep, kleanprep	As per endoscopy or specialist advice Primarily used prior to colonic surgery, colonoscopy or radiological examination	Rapid onset	Bowel evacuation	Acute GI ulceration, acute severe colitis, GI obstruction or perforation, toxic megacolon. Renal impairment	Other oral drugs should not be taken 1 hour before, or after, administration of bowel cleansing preparations because absorption may be impaired. Can cause abnormal electrolytes so caution in known electrolyte disturbance. MHRA warning
Other drugs to manage constipation such as prucalopride, lubipristone, linaclotide and naloxegol should only be used in line with the OUH formulary status and after discussion with a senior/specialist. Co-danthrumer and co-danthrusate are limited to terminally-ill patients and are no longer routinely used unless advised by palliative care (check with local policy)						

Figure 1: Flowchart for the management of acute constipation in adults

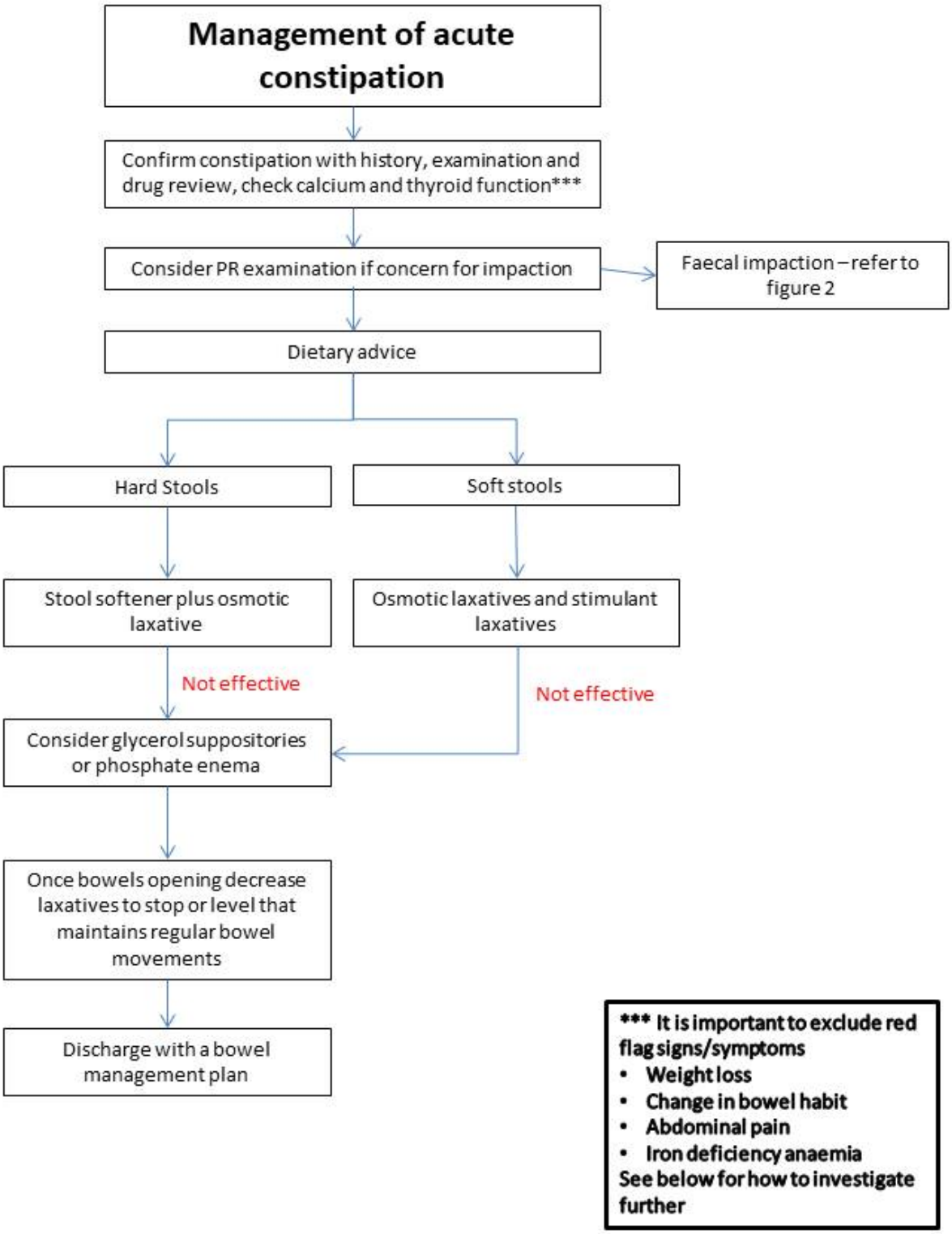


Figure 2: Flowchart for the management of faecal impaction in adults

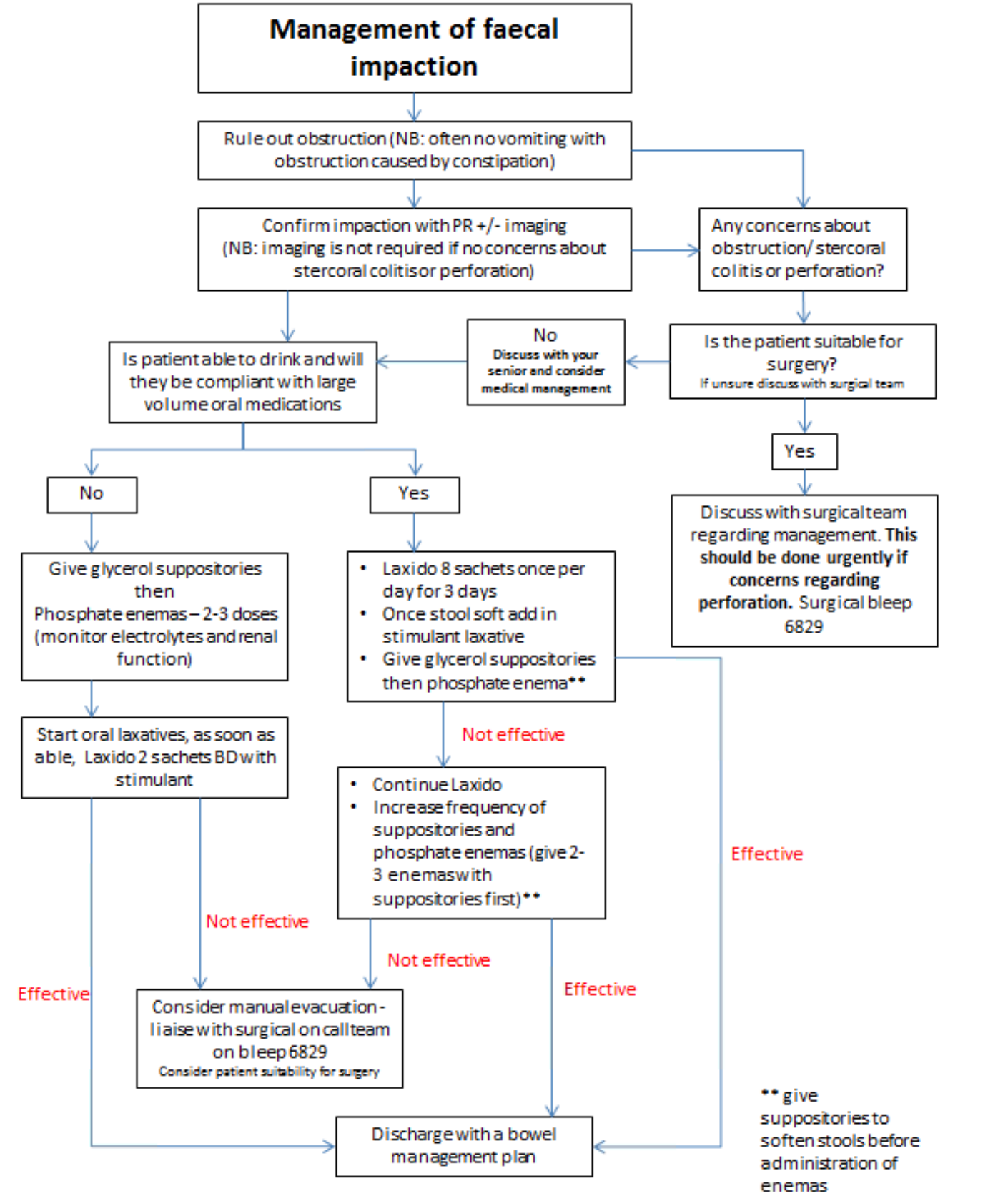


Figure 3: Flowchart for the management of chronic constipation in adults

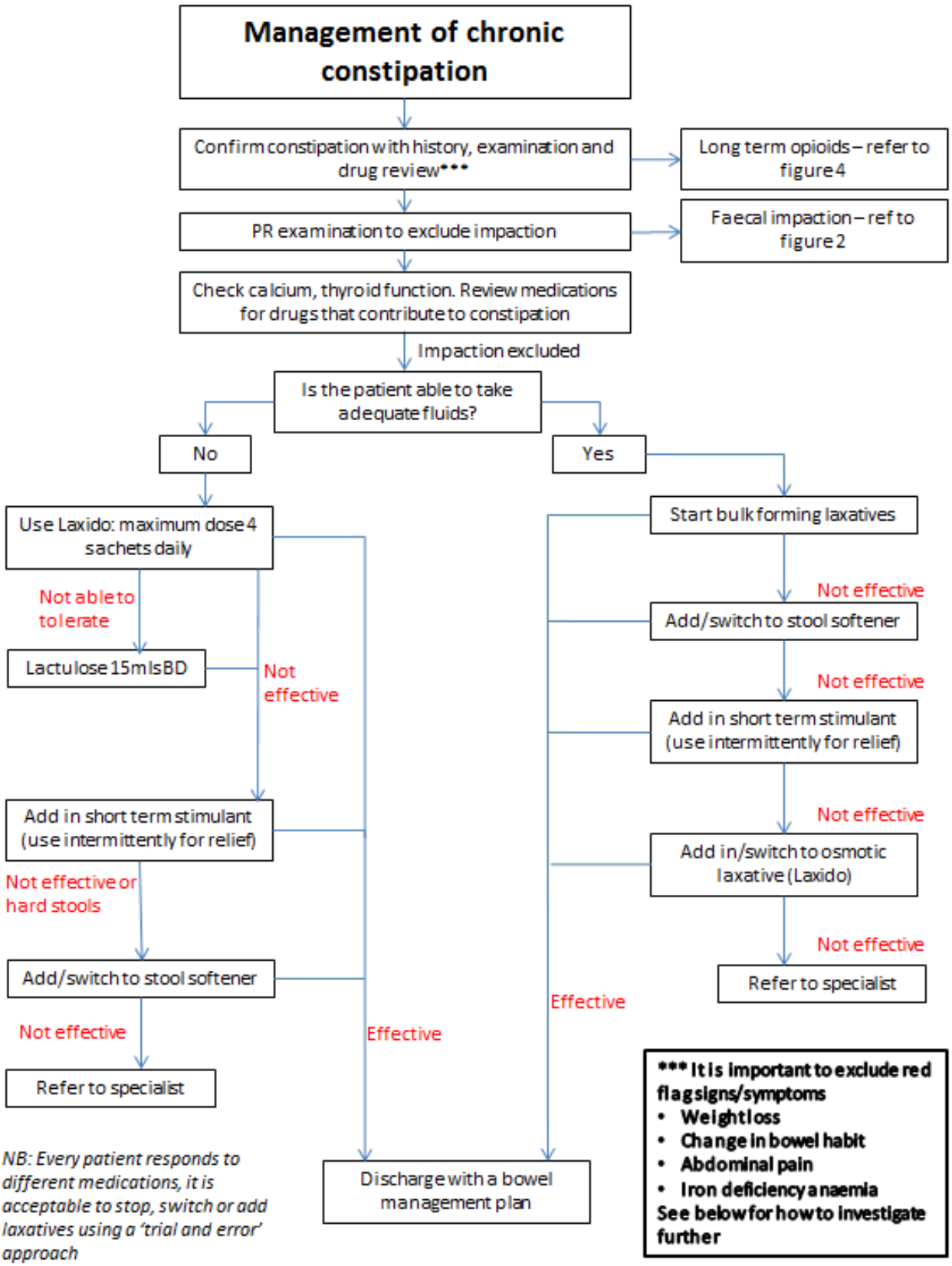


Figure 4: Flowchart for the management of opioid induced constipation in adults

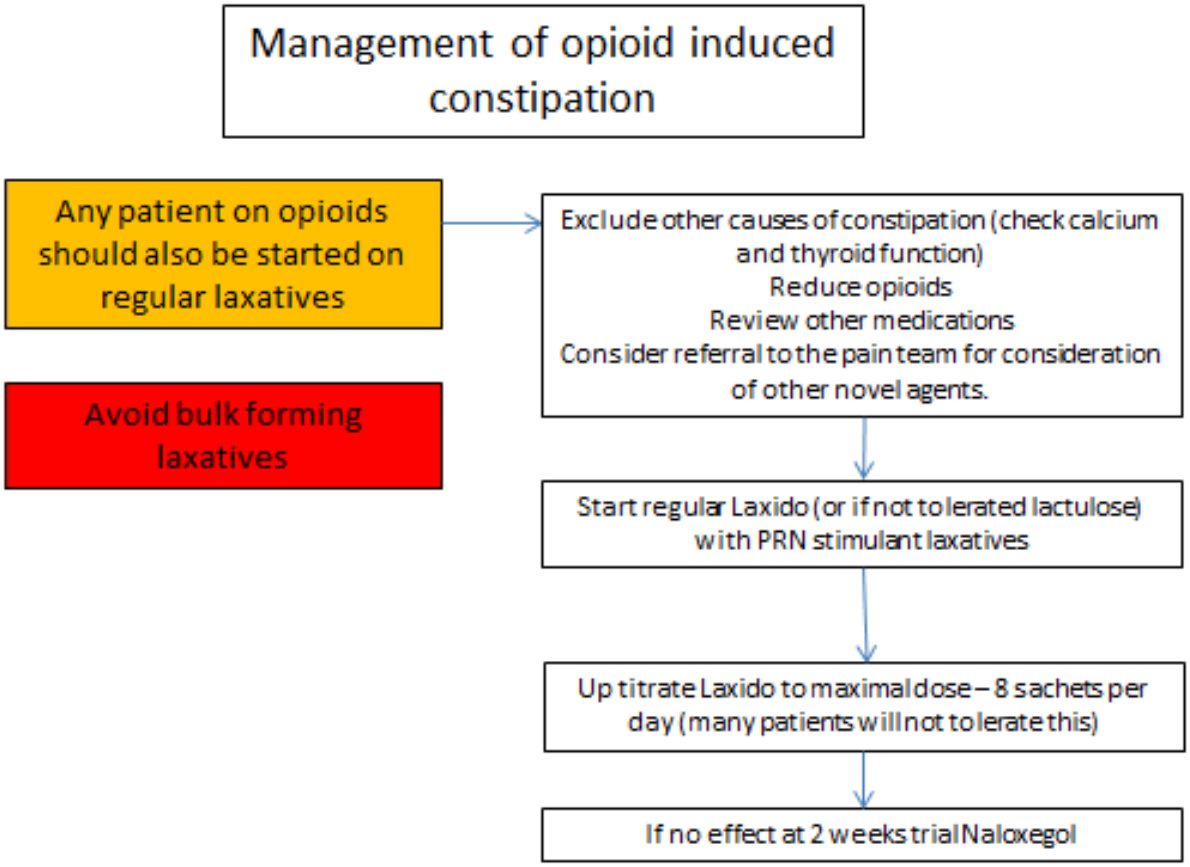


Figure 5: Red flag signs and how to investigate

Patients should be investigated in line with NICE guidelines for colorectal cancer (NICE Colorectal guideline).

Red flag signs/symptoms include unexplained:

- Weight loss
- Change on bowel habit
- Abdominal pain
- Iron deficiency anaemia
- Rectal bleeding

These need to be interpreted in line with age following the above NICE guideline.

Figure 6: Example discharge bowel management plan

Bowel management plan template – this could be included on a discharge summary.

Each patient is different and needs different laxatives at different times. This bowel management plan may need further review dependent on outcome. It is important to monitor closely and change the plan based on the stool chart. If the below regime is not working please liaise with GP.

1. Daily bowel monitoring: Document bowel motions daily including type of stool based on Bristol stool chart and volume.
2. Based on Bristol stool chart do the following:

If ***bowel not open (BNO) or stool type 1-3:*** Use the following laxative regimen [insert relevant laxatives]. If there has been no bowel movement after 48 hours please liaise with GP as patient may need one, or more, suppositories or enemas.

If ***bowels type 4-5:*** please use following regimen [insert relevant laxatives] and stop [laxatives, if relevant].

If ***bowels type 6-7;*** please review stool chart and if there have been no bowel movements, or bowels are types 1-2, in the days prior to the patient developing type 6-7 stool this may be indicative of overflow diarrhoea (see below description). If type 6-7 follows a period of bowels of more normal motions (type 4-5) then continue to reduce laxatives – [insert relevant laxative regimen].

3. Diet: ensure adequate fruit, vegetable, fibre and fluid intake

Overflow diarrhoea: This is diarrhoea in patients with profound constipation. The watery stool passes around the hard constipation which cannot be passed. If there are concerns that the patient has overflow diarrhoea please liaise with the GP about constipation management which may require enemas and suppositories.

Below is an ***example*** **bowel management plan** sent home with a patient from residential care who had been admitted with acute severe constipation under the surgical team. It is important to note it had been explained to the patient's carers prior to discharge. She required multiple laxatives which had been trialled both in and out of hospital before the plan was devised.

This should not be used as standard.

'Each patient is different and needs different laxatives at different times. This bowel management plan may need further review dependent on outcome. It is important to monitor closely and change the plan based on the stool chart. If the below regime is not working please liaise with GP

1. Daily bowel monitoring: carers to document bowel motions daily including type of stool based on Bristol stool chart and volume.
2. Based on Bristol stool chart do the following:

If ***bowel not open (BNO) or stool type 1-3:*** use laxido 2 sachet BD, docusate 200mg BD, and Senna 15mg nocte. If there has been no bowel movement after 48 hours please liaise with GP as patient may need one, or more, suppositories or enemas.

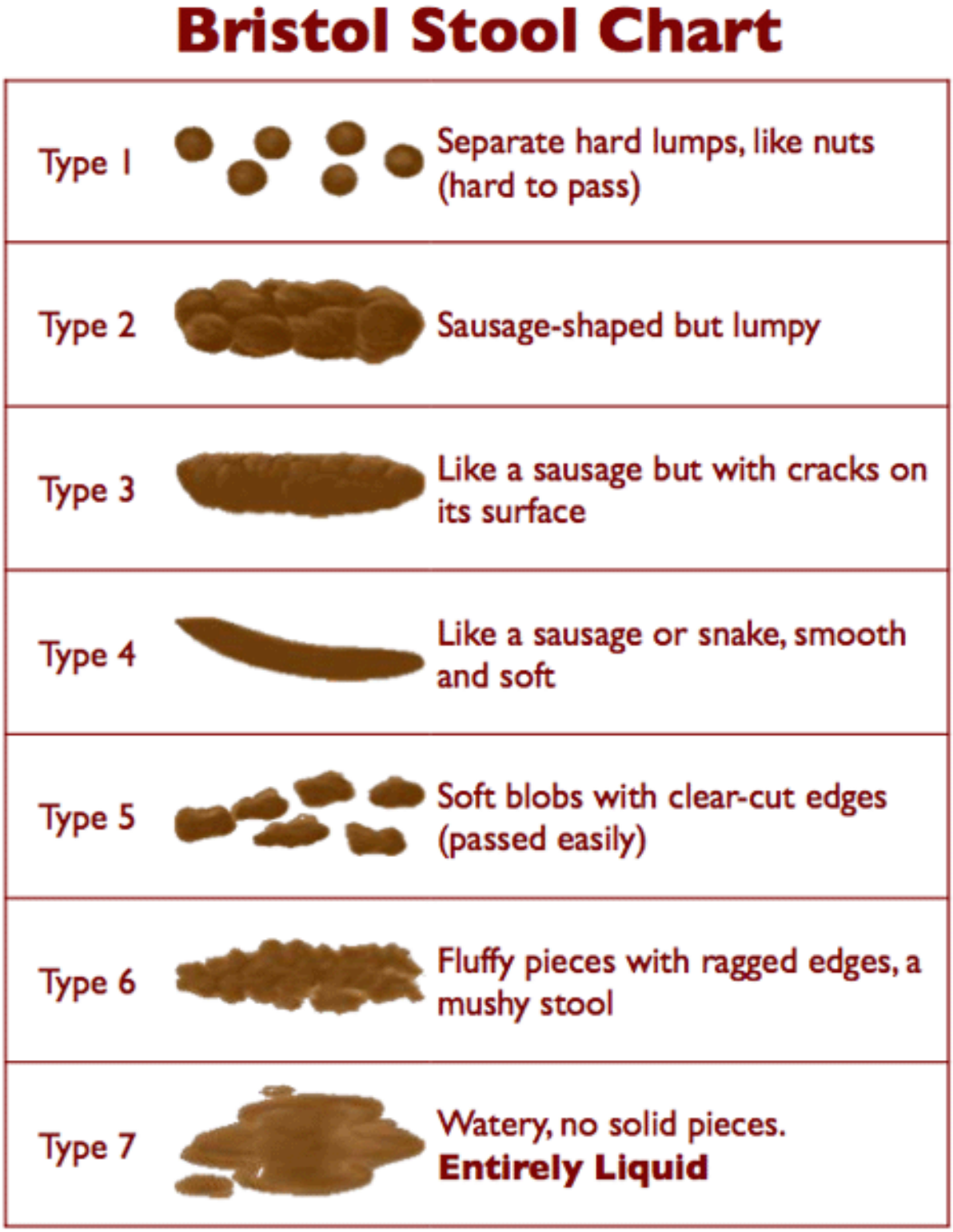
If ***bowels type 4-5:*** please use laxido 1 sachet BD and docusate 200mg BD. Stop senna.

If ***bowels type 6-7;*** please review stool chart and if there have been no bowel movements, or bowels are types 1-2, in the days prior to the patient developing type 6-7 stool this may be indicative of overflow diarrhoea (see below description). If type 6-7 follows a period of bowels of more normal motions (type 4-5) then continue to reduce laxatives - stop laxido and reduce docusate to 100mg BD.

3. Diet: ensure adequate fruit, vegetable, fibre and fluid intake

Overflow diarrhoea: This is diarrhoea in patients with profound constipation. The watery stool passes around the hard constipation which cannot be passed. If there are concerns that the patient has overflow diarrhoea please liaise with the GP about constipation management which may require enemas and suppositories.'

Figure 7: Bristol Stool Chart



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