Surrey & North West Sussex Area Prescribing Committee

The Management of Uncomplicated Constipation in Adults

Approved by APC Oct 2019. Updated 09.09.20. Review date Oct 2022

The Management of Uncomplicated Constipation in Adults

Key Messages

- Refer patients with 'red flag' symptoms for further investigations
- Address underlying cause of constipation where possible (e.g. dose adjustment if drug-induced)
- Lifestyle advice (fluid intake, fibre and exercise) must be offered first and continued throughout laxative therapy if indicated
- Never use two of the same class of drug (i.e. lactulose and macrogol)
- Titrate to maximum tolerated dose before adding/ switching laxatives.
- Always add in another laxative type (not replace) as often the synergistic action of bulking, softening and stimulating is much more effective
- Investigations are not routinely required, however if secondary cause is suspected, special investigations may be required

Constipation is defined as *the passage of hard stools, less frequently than the patient's own normal pattern.* The initial assessment should involve investigation of possible causes of constipation, such as drugs or poor diet which are outlined in Figure 1.

Figure 1: Pre-disposing factors for constipation in adults

Psychological

- Anxiety/depression
- Eating disorders
- Cognitive impairment

Physical

- Dehydration
- Immobility
- Difficulty accessing the toilet

Social

- Low fibre intake
- Changes in routine/lifestyle.
- Lack of exercise
- Care home residents
- Recent hospital admission

Medications which may cause constipation

Remember to check the patient's drug history including drugs bought over the counter & herbal medications.

- Opioid containing analgesics e.g. codeine
- Calcium and Aluminium salts e.g. antacids
- Iron salts
- Antimuscarinic medicines e.g.: antihistamines, tricyclic antidepressants, oxybutynin.
- Antiparkinsonian drugs e.g. levodopa
- Antipsychotics e.g. clozapine
- Antidepressants e.g. amitriptyline, venlafaxine
- Diuretics e.g. furosemide, bendroflumethiazide
- Anti-diarrhoeals e.g. loperamide
- Anti-arrhythmics including calcium channel blockers and amiodarone
- Phenothiazines
- NSAIDs (more commonly cause diarrhoea).
- 5HT3 antagonists e.g. Ondansetron

Conditions which may cause constipation

- Endocrine diseases e.g. Diabetes, hypercalcaemia, hypokalaemia, hypothyroidism.
- Neurologic diseases e.g. Multiple sclerosis, Parkinson's disease, spinal cord injury
- Pregnancy including post-natal damage to pelvic floor/third degree tear
- Cancer/ Terminal illnesses
- Gastro-intestinal: Anal fissures, irritable bowel syndrome, bowel obstruction
- Post-operative

Red Flag Symptoms (based on NICE NG12)

Colorectal cancer should be suspected in any patient who presents with red flag symptoms. Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if:

- They are aged 40 and over with unexplained weight loss and abdominal pain or
- They are aged 50 and over with unexplained rectal bleeding or
- They are aged 60 and over with:
  - Iron-deficiency anaemia or
  - Changes in their bowel habit
- Tests show occult blood in their faeces (new NICE recommendation for 2015).
- Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer, in people with a rectal or abdominal mass (new NICE recommendation for 2015).
- Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in adults aged under 50 with rectal bleeding and any of the following unexplained symptoms or findings:
  - Abdominal pain
  - Change in bowel habit
  - Weight loss
  - Iron-deficiency anaemia (new NICE recommendation for 2015).

- Offer testing for occult blood in faeces to assess for colorectal cancer in adults without rectal bleeding or have unexplained symptoms but do not meet the criteria for a suspected cancer pathway.

Diagnosis

Use the trigger questions to confirm diagnosis of constipation

How does the patient define constipation?

What are the symptoms and how long have they been present?

What is the stool consistency?

How much dietary fibre and fluid is being taken?

Have there been any recent dietary or lifestyle changes?

What medicines is the patient taking (see Figure 1)?

Exclude RED FLAG symptoms

Using the 'Rome IV' diagnostic criteria for chronic constipation, two or more of the following symptoms should be present for at least three months:

- Straining at defecation at least 25% of the time.
- Lumpy and/or hard stools at least 25% of the time.
- A sensation of incomplete bowel evacuation at least 25% of the time.
- A sensation of bowel blockage at least 25% of the time.
- Manual evacuation required to facilitate defecation at least 25% of the time.
- Two or fewer bowel movements a week.

AND patient MUST have the following-

- Loose stools rarely present without a laxative
- Insufficient criteria to indicate IBS

Management

The process of managing uncomplicated constipation is outlined in Figure 2, with further guidance regarding some of the classes of medicines involved displayed in Table 1.
For more detailed information https://www.nhs.uk/conditions/constipation/

For full prescribing guidance, always refer to the manufacturer's literature and the BNF.

Appropriate use of laxatives

Overuse of stimulant laxatives can lead to dependence. Therefore, patients with chronic constipation should be maintained on osmotic or bulk forming laxatives where long term therapy is necessary.

Where a laxative is required, it should be prescribed at the lowest dose necessary and discontinued once constipation has resolved, to avoid dependence. In addition, prescriptions for acute constipation should only be prescribed as acute prescriptions, to avoid overuse.
In order to prevent abuse, frequent requests for laxative prescriptions or requests for large quantities should be queried.

On 18.8.20 MHRA introduced pack size restrictions, revised recommended ages for use, and new safety warnings for over-the-counter stimulant laxatives (orally and rectally administered) following a national safety review. Patients should be advised that dietary and lifestyle measures should be used first-line for relieving short-term occasional constipation and that stimulant laxatives should only be used if these measures and other laxatives are ineffective.

https://www.gov.uk/drug-safety-update/stimulant-laxatives-bisacodyl-senna-and-sennosides-sodium-picosulfate-available-over-the-counter-new-measures-to-support-safe-use#:~:text=The%20safety%20of%20stimulant%20laxatives,term%20use%20may%20be%20harmful

Figure 2

Management of constipation in adults: Acute and Chronic

NB-chronic constipation is not a 'regular' condition – usually patients manage to keep their stools soft with diet and medication, but something, even dehydration, can push the patient into impaction and the treatment needs to be escalated

Patient presenting with suspected constipation

Assess & identify cause using trigger questions. Exclude ***RED FLAG*** symptoms and colorectal cancer

Treat underlying cause (if possible) - review medication (see page 2). Identify patients with evacuatory disorder (e.g. rectocele) that may need surgical review and dyssynergic defecation that may benefit from biofeedback.

Blood tests when required: FBC,CRP, Ca125, coeliac screen, TFTS, CA2+

Step 1: Patient education and lifestyle advice

(Allow about a month for results, dependant on patient and severity of symptoms)

- Increase fluids: >2 litres per day
- Gradually increase dietary fibre: at least one fibre rich food per meal e.g. Prunes, Weetabix®, figs, jacket potatoes (with skins). The Association of UK Dietitians as useful Food Fact Sheets on Fibre and Fruit and vegetables - how to get five-a-day
- Increase exercise
- Advice on toilet positioning and not to ignore call to stool.

Consider contraindications to advice e.g.: patients with heart failure, colonic obstruction.

Step 2: Offer oral laxatives if dietary measures are ineffective, or while waiting for them to take effect.
Consider any treatments the patient may have already purchased OTC

Advise the person to gradually reduce and stop laxatives once the person is producing soft, formed stool without straining at least three times per week.

Short-term Constipation- Advise patient to purchase treatment- Pharmacists can suggest an over the counter laxative. Most laxatives work within 3 days. They should only be used for a short time only.

Bulk forming laxative

First line: Ispaghula husk

If stools remain hard, add/switch to an osmotic laxative (***First line: Macrogol)***

If stools are soft but difficult to pass add stimulant laxative ***(First line: Bisacodyl)***

Pregnancy: **Ispaghula husk**. If chronic constipation or faecal impaction, seek Specialist opinion

Chronic Constipation

Adults/ fit elderly:

First line: Ispaghula husk (additional stimulant laxative if required) Second line: macrogol

Frail elderly/ Immobile

Osmotic laxative

First line: Macrogol (additional stimulant laxative if required) Second line: Lactulose

Faecal Impaction

Use high-dose **macrogol.**

For soft stools, or for hard stools after a few days treatment with a **macrogol,** consider a stimulant laxative **(First line: bisacodyl)**

If the response to oral laxatives is insufficient or not fast enough, consider **a suppository: bisacodyl for soft stools; glycerol alone, or glycerol plus bisacodyl for hard stools.**

https://www.nhs.uk/conditions/constipation/

Opioid Induced Constipation (OIC)

See Fig. 3, page 6

Prucalopride-Consider the use of drug treatment with prucalopride if at least two laxatives from different classes have been tried at the highest tolerated recommended doses for at least 6 months, and failed to relieve symptoms, where invasive treatment (such as suppositories, enemas, rectal irrigation and/or manual disimpaction) is being considered.

Offer a prescription for 4 weeks and if there is no symptom response following this trial, reconsider the benefit of continuing treatment.

Refer for bowel management if no improvement within 6-8 weeks or if symptoms get significantly worse

Figure 3.

Management of Opioid Induced Constipation (OIC) in adults

On initiation of an opioid, patients should be also be given prescription for senna to avoid OIC. Some patients may have no need to take the laxative, others may need further intervention-

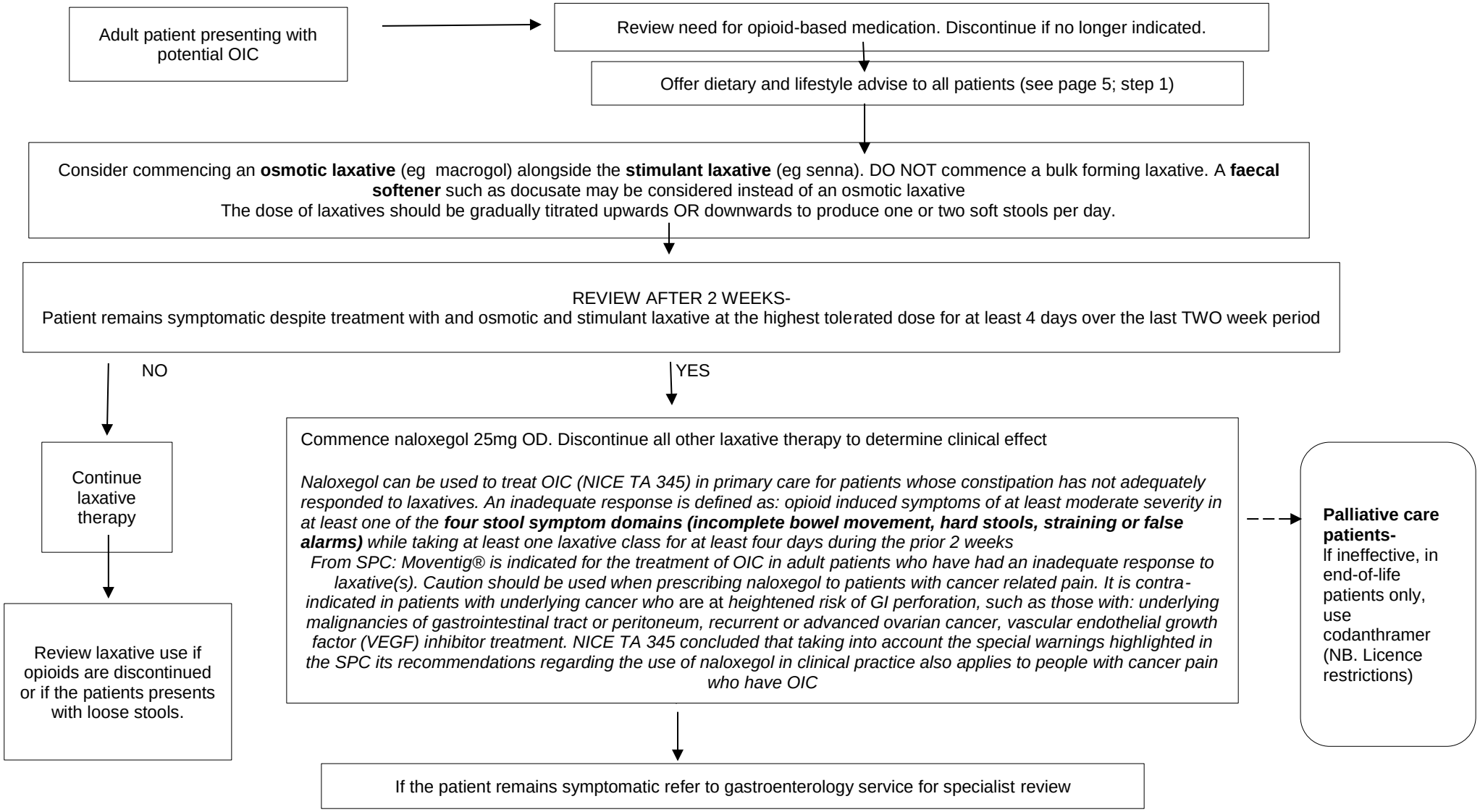


Table 1 **Summary of common laxatives and mode of action**

Class and Generic/Brand Name	Recommended Indications	Additional Information
Bulking Agents- Increase faecal mass thus stimulating peristalsis.		
Ispagula (e.g. Fybogel®, Isogel®, Manevac®, Regulan®)	Diverticular disease, functional constipation, irritable bowel syndrome.	• Introduce gradually. • Onset to action 2-3 days. • Best taken in the morning. • Should be taken with plenty of fluids. • Swell in contact with liquid. • Should not be taken before going to bed. • May not help in elderly as difficulty increasing fluids. • Inform patient that may take several days to work. • Side effects include flatulence, abdominal distension and GI obstruction or impaction. • **Not to be used** where there is faecal impaction, intestinal obstruction, swallowing difficulty, colonic atony or for palliative patients (due to long onset of action)
Sterculla (e.g. Normacol®)	Constipation due to insufficient dietary fibre	
Methylcellulose (e.g. Celevac®)	Constipation	
Stimulant Laxatives- Increase GI tract secretion and motility-active metabolites created by action of colonic flora.		
Senna (e.g. Senakot®)	Constipation	• Effective in 6-12 hours. • Best at bedtime. • Useful with opioid analgesics. • Avoid in intestinal obstruction. • May cause abdominal cramp. • Excessive use may cause diarrhoea and hypokalaemia. • Senna should not be used for prolonged periods since they may decrease the sensitivity of the intestinal mucous membranes, so larger doses have to be taken and the bowel fails to respond to normal stimuli. • Prolonged use may produce watery diarrhoea with excessive loss of fluid and electrolytes, particularly potassium, muscular weakness and weight loss. Changes in the intestinal musculature associated with malabsorption and dilation of the bowel, similar to ulcerative colitis and to megacolon, may also occur • Antacids or milk products may affect the absorption of bisacodyl. Concomitant use with diuretics may increase the loss of electrolytes, particularly potassium, causing increased toxicity of cardiac glycosides • **Not to be used** where there is intestinal obstruction, recent abdominal, patient has undergone surgery or in Acute inflammatory bowel disease
Bisacodyl	Constipation, Bowel clearance before surgery, labour or radiological examination	
Danthron (e.g. Co-danthramer, Co-danthrusate, Normax®)	Only for constipation in terminally ill (end of life) of all ages. Will colour urine red.	
Osmotic Laxatives- Alter osmotic environment of GI tract-osmotic pressure altered to oppose the absorption of water; faeces softened, bulk increased or becomes liquid.		
Macrogols (e.g.Cosmocol®, Laxido ®, Movicol®,	Faecal impaction (bowel cleansing e.g. Klean-Prep®)	• Take with adequate fluids. • Lactulose may take up to 48 hours to act and needs to be taken regularly. • Lactulose is not recommended for long term use. • Sodium salts should be avoided as they may give rise to sodium and water retention in susceptible individuals.
Lactulose	Constipation, portal systemic encephalopathy	

Phosphates (rectal) (e.g. Carbalax®, Fleet® ready-to-use Enema)	Rectal use in constipation; bowel evacuation before abdominal radiological procedures, endoscopy and surgery.	• Side effects include nausea, flatulence and abdominal pain and discomfort. • Patients with cardiovascular impairment should not have more than 2 sachets of macrogol in any 1 hour. • Macrogol raises the solubility of medicinal products that are soluble in alcohol and relatively insoluble in water. There is a possibility that the absorption of other medicinal products could be transiently reduced during use with macrogols. There have been isolated reports of decreased efficacy of other drugs when concomitantly administered with macrogols e.g. anti-epileptics due to increased GI transit. • A course of treatment for constipation with a macrogol does not normally exceed two weeks although this can be repeated if required after patient has been reviewed. • Prolonged use is not usually recommended, however, extended use may be necessary in the care of patients with neurological disorders or learning disabilities.(continued on next page) • Macrogols may be used for faecal impaction: 8 sachets daily over a 6-hour period for up to 3 days. • Avoid oral magnesium salts in patients with renal impairment. • Oral magnesium preparations should be taken an hour after all other medicines.
Sodium citrate (rectal) (e.g. Micralax® Micro-enema.	Rectal use in constipation	
Faecal softeners- Lubricate, soften and wet stool.		
Docusate sodium (e.g. Dioctyl®, Docusol®, Fletcher's Enemette®, Norgalax®)	Prevention and treatment of chronic constipation, pre/post operative constipation.	• Oral preparations act within 1-2 days. • Side effects include nausea and abdominal cramps.
5HT$_4$-receptor agonists- acting as a selective, high affinity 5-HT$_4$ receptor agonist which targets the impaired motility associated with chronic constipation, thus normalising bowel movements.		
Prucalopride (Resolor®)	Chronic constipation in women when other laxatives fail to provide an adequate response.	1. **Patient should have been treated with at least 2 laxatives from different classes, at the highest tolerated recommended doses for at least 6 months, and these treatments have failed to provide adequate relief and invasive treatment for constipation is being considered.** 2. If treatment is not effective after 4 weeks then consider stopping treatment.
Peripherally-acting mu-opioid receptor antagonist		
Naloxegol (Moventig®)	For patients with OIC, who have had inadequate response to other laxatives indicated for the treatment of OIC e.g. senna, docusate, bisacodyl and macrogol.	1. **When naloxegol is initiated all other laxative treatment should be stopped and the effectiveness of naloxegol should be assessed after a maximum of 7 days.** 2. Patients should be advised that if they develop any sudden severe abdominal pain they should stop taking naloxegol and let the GP know. 3. They should also be warned of the potential of opioid withdrawal symptoms which should also be reported to their GP immediately.

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