NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

# Management of Constipation in Adults (Updated September 2015)

**Constipation** can be defined as 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.

**Faecal loading/impaction** is defined as retention of faeces to the extent that spontaneous evacuation is unlikely. Retained faeces are usually palpable on abdominal examination, and may be felt on internal rectal examination or by external palpation around the anus.

## Lifestyle

- Adjust any constipating medication, if possible. See suggested drugs associated with constipation below.
- Advise patient about lifestyle measures — increasing dietary fibre (including the importance of regular meals), drinking an adequate fluid intake, and exercise.
- Aim for a balanced diet containing whole grains, fruits, and vegetables.
- Fibre intake increased gradually (to minimize flatulence and bloating) and maintained for life.
- Adults should aim to consume 18–30 g fibre per day.
- Although effects of a high fibre diet may be seen in a few days, it may take up to 4 weeks.
- Adequate fluid intake is important (particularly with a high fibre diet or fibre supplements), but can be difficult for some people, e.g. frail or elderly.
- Fruits high in fibre and sorbitol, and fruit juices high in sorbitol, can help prevent and treat constipation, e.g. apples, apricots, grapes (and raisins), peaches, pears, plums (and prunes), raspberries, strawberries. Note the concentration of sorbitol is about 5–10 times higher in dried fruit.

## When should I refer?

- Cancer suspected (Refer for colonoscopy in > 50 years of age if 'red flags' are present).
- Underlying cause suspected.
- Pain and bleeding on defecation (such as from an anal fissure) is severe or does not respond to treatment for constipation.
- Treatment unsuccessful.
- Assessment required prior to referral for other interventions, e.g. psychology, psychiatry.
- Faecal incontinence is present (Continence service).
- More detailed support with diet is required (dieticians).

## Red Flags

- Persistent unexplained change in bowel habit?
- 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?

## Medicines optimisation

- Laxatives can be *slowly* withdrawn when regular bowel movements occur without difficulty, e.g. 2–4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established.
- Rate at which doses are reduced should be guided by the frequency and consistency of the stools.
- Wean gradually to minimise risk of requiring 'rescue therapy' for recurrent faecal loading.
- If > 1 laxatives have been used, reduce and stop one at a time.
- Begin by reducing stimulant laxatives first, if possible. However, it may be necessary to also adjust the dose of the osmotic laxative to compensate.
- Advise the person that it can take several months to be successfully weaned off all laxatives.
- Relapses are common. Treat early with increased laxative doses.
- Laxatives need to be continued long term for:
  - People taking a constipating drug that cannot be stopped, such as an opioid.
  - People with a medical cause of constipation.
- **Liquid paraffin and magnesium salts are not recommended.**

## Drugs commonly causing constipation

- Aluminium antacids.
- Antimuscarinics.
- Antidepressants, e.g. tricyclic antidepressants
- Some antiepileptics, e.g. carbamazepine, gabapentin, oxcarbazepine, pregabalin, phenytoin.
- Sedating antihistamines.
- Antipsychotics.
- Antispasmodics.
- Calcium supplements.
- Diuretics.
- Iron supplements.
- Opioids.
- Verapamil.


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For further information and references, please contact the Medicines Management Team
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| Oral laxative | Pack size | Cost | Cost per dose |
|---|---|---|---|
| **Bulk-forming** | | | |
| Ispaghula husk 3.5g effervescent granules sachets gluten free sugar free | 30 | 2.29 (DT) | One sachet twice daily (8p - 15p) |
| Methylcellulose 500mg tablets | 112 | 3.22 (DT) | 3 – 6 tablets twice daily (8p - 17p) |
| **Osmotic** | | | |
| Lactulose 3.1-3.7g/5ml oral solution | 500ml | 3.22 (DT) | 15ml twice daily (10p – 20p) |
| Macrogols compound oral powder sachets sugar free | 30 | 4.27 (DT) | 1–3 sachets daily in divided doses usually for up to 2 weeks; maintenance, 1–2 sachets daily (14p – 43p)<br><br>**Faecal impaction:** 4 sachets on first day then increased in steps of 2 sachets daily to max. 8 sachets daily; total daily dose to be drunk within a 6 hour period (57p - £1.14) |
| **Stimulant** | | | |
| Bisacodyl 5 mg | 60 | £2.30 (DT) | 5mg – 10mg at night (4p – 8p) |
| Senna Liquid 7.5mg/5ml | 500 | 2.99 (DT) | 10 – 20ml at bedtime (6p – 12p) |
| Docusate 100mg capsules<br>*Probably acts both as a softening agent and a stimulant. May be a useful alternative for people who find it hard to increase their fluid intake.* | 30 | 2.09 (DT) | 100mg – 200mg twice daily<br>(7p – 14p) |
| Senna 7.5mg tablets | 60 | 3.52 (DT) | 15mg – 30mg, usually at night (12p – 24p) |
| **Rectal laxative** | **Pack size** | **Cost** | **Cost per dose** |
| **Faecal softeners** | | | |
| Arachis (peanut) oil retention enema **Should not be used in people with peanut allergy.** Further information on its use in patients with peanut allergy | 130ml | 7.98 (BNF) | 130ml (single dose) (£7.98) |
| **Stimulant** | | | |
| Glycerol 4g suppositories | 12 | £1.94 (DT) | One suppository (single dose) (16p) |
| Bisacodyl 5mg suppositories<br>Bisacodyl 10mg suppositories | 5<br>12 | 99p (DT)<br>£3.53 (DT) | 5 – 10mg in the morning (19p – 29p) |
| Docusate sodium 120mg enema | 10g | 66p (BNF) | 10g (single dose) (66p) |
| **Osmotic** | | | |
| Sodium citrate compound mini enema (Micolette enema) | 5ml | 41p (BNF) | 5 – 10ml (single dose) (41 – 82p) |
| Sodium acid phosphate/sodium phosphate enema | 133-mL pack (delivers 118 mL dose) | 68p (BNF) | 118ml (single dose) (68p) |
| **Other Drugs for Constipation** | **Pack size** | **Cost** | **Cost per dose)** |
| Lubiprostone ▼Specialist initiation NICE TA318 (formulary) | 24 micrograms (56) | £53.48 (BNF) | 24 micrograms twice daily (96p) |
| Prucalopride ▼ (women only) NICE TA211<br>Specialist initiation (formulary) | 1mg (28)<br>2mg (28) | £38.69 (BNF)<br>£59.52 (BNF) | 1mg – 2mg once daily (£1.38 - £2.13) |
| Linaclotide ▼ (IBS only) NICE CG61<br>Specialist initiation (formulary) | 290 micrograms (28) | £37.56 (BNF) | 290 micrograms ( 1 capsule) once daily (£1.34) |
| Naloxegol ▼Specialist Initiation NICE TA345 | 25mg (30) | £55.20 (eMIMs) | For opioid induced constipation; 25mg ONCE daily in the morning, at least 30 mins before or 2 hrs after the first meal of the day. Stop other laxatives initially. Reduce dose to 12.5mg in moderate to severe renal impairment (£1.84) |

**All prices are correct at the time of publication and their source indicated: DT: Drug Tariff; BNF: British National Formulary**

**Short-term**

**When should I prescribe a laxative?**

- Lifestyle measures ineffective.
- Waiting for dietary measures to take effect.
- Advise the patient that laxatives can be stopped once stools become soft and easily passed.

**Chronic**

- Relieve faecal loading/impaction if present.
- Set realistic expectations with the patient for the results of treatment of chronic constipation.
- Adjust the dose, choice, and combination of laxative according to symptoms, speed with which relief is required, response to treatment, and individual preference.
- The patient should be advised to gradually titrate the laxative dose upwards (or downwards) to produce one or two soft, formed stools per day.
- If at least two laxatives (from different classes) have been tried at the highest tolerated recommended doses for at least 6 months, consider referring for specialist review.

**When should I prescribe a laxative?**

- If lifestyle measures insufficient, or whilst waiting for them to take effect.
- Patients taking a constipating drug that cannot be stopped.
- Patients with other secondary causes of constipation.
- As 'rescue' medicines for episodes of faecal loading.

**Opioid-induced constipation**

Ispaghula husk

**Important:** maintain good hydration (may be difficult for frail or elderly).

Stools remain hard

Stools soft but patient still has difficulty passing/complains of inadequate emptying.

**Short-term constipation:**
Ispaghula husk + Lactulose

**Chronic constipation:**
Ispaghula husk + Macrogols

**OR**

**Short-term constipation:** Lactulose
**Chronic constipation:** Macrogols

Ispaghula husk+ Bisacodyl

**Review need for laxatives**

**Medicines Optimisation**

**AVOID** bulk-forming laxatives

**Prescribe WITH opioid**

Docusate OR
Macrogols + Docusate

Adjust the laxative dose to optimise the response.

**PREGNANCY**
If there is a poor response to lifestyle measures consider the following:

- Ispaghula husk
- Lactulose
- Glycerol suppositories
- Bisacodyl
- Senna (avoid near term, or if a history of unstable pregnancy).
- Low doses of docusate.



Ori 1st choice laxatives listed. Alternatives provided on page 2.

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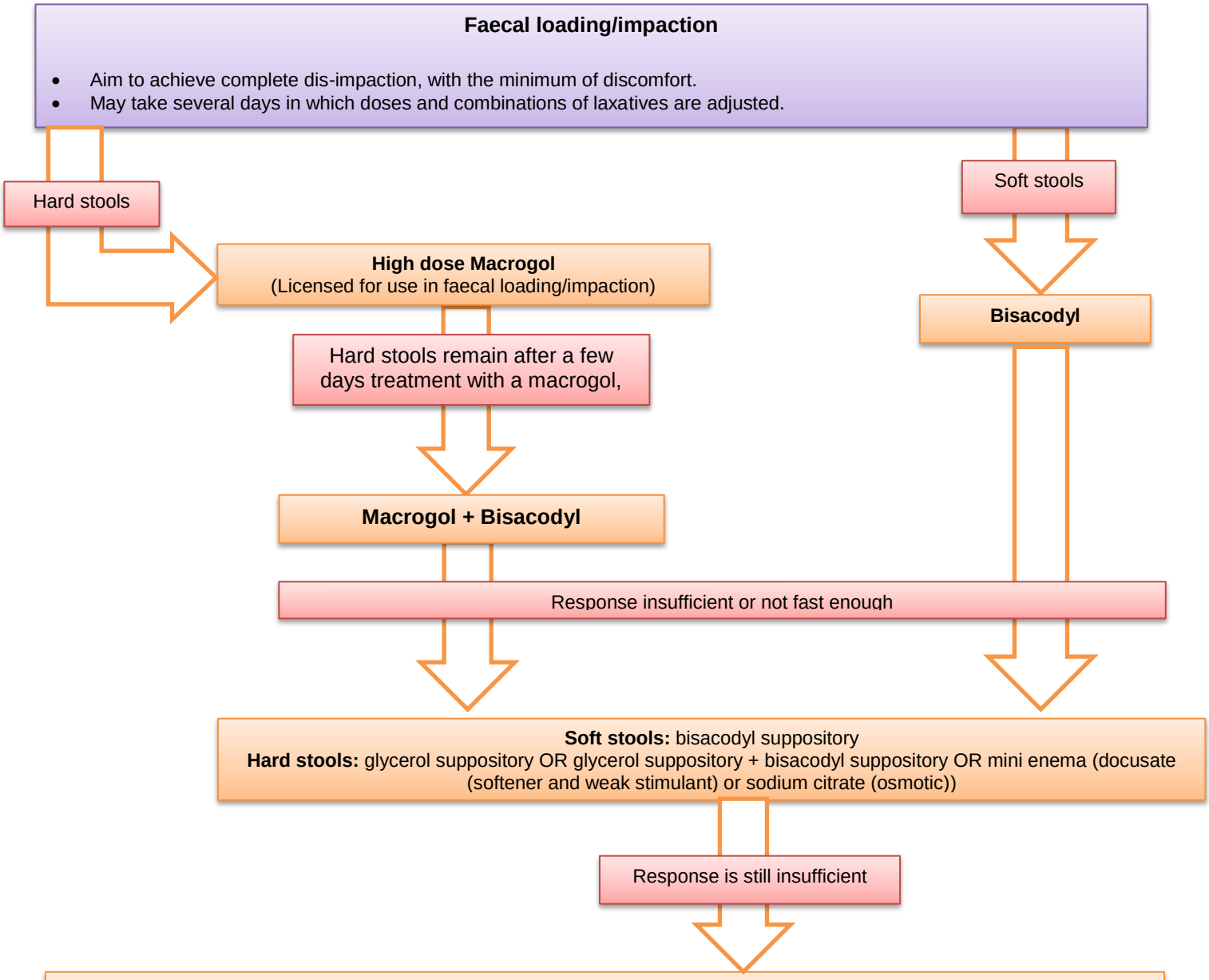


- Use retention enema- sodium phosphate or arachis oil (place high if the rectum is empty but the colon is full).
- **Arachis oil enema should not be used in people with peanut allergy -** Further information on its use in patients with peanut allergy
- Hard faeces - helpful to give arachis oil enema overnight prior to sodium phosphate (large volume) or sodium citrate (small volume) enema the next day.
- Enemas may need to be repeated several times to clear hard impacted faeces.
- Final choice of laxative will depend on individual preference and what has previously been tried.
- Reinforce lifestyle interventions to maintain regular bowel movements + preventing problems from recurring.
- Regular use of a laxative may also be needed to maintain comfortable defecation.

## References

1. National Institute for Health and Clinical Excellence (NICE). Clinical Knowledge Summaries (CKS) – Constipation. Last revised January 2013. Accessed 18.07.14 via http://cks.nice.org.uk
2. PrescQIPP. Optimising safe and appropriate medicines use – briefing; June 2013. Accessed 18.07.14 via http://www.prescqipp.info/safe-appropriate-medicines-use-deprescribing/finish/190-safe-and-appropriate-medicines-use/671-bulletin-8-safe-and-appropriate-medicines-use-briefing
3. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press; March 2015. Accessed 02.04.15 via http://www.medicinescomplete.com
4. Drug Tariff (April 2015). Accessed 02.04.15 via http://www.ppa.org.uk/ppa/edt_intro.htm
5. UK Teratology Information Service. Treatment of constipation in pregnancy; August 2010. Accessed 18.07.14 via http://www.uktis.org/docs/constipation.pdf
6. Lee-Robichaud H, Thomas K, Morgan J, Nelson RL. Lactulose versus Polyethylene Glycol for Chronic Constipation. Cochrane Database of Systematic Reviews 2010, Issue 7. Art. No.: CD007570. DOI: 10.1002/14651858.CD007570.pub2. Accessed 21.07.14 via http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007570.pub2/abstract