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.

**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- Laxatives can be slowly withdrawn when regular bowel movements occur without difficulty, e.g. 2–4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed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.

**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.

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### Oral laxative

<table>
<thead>
<tr>
<th>Pack size</th>
<th>Cost</th>
<th>Cost per dose</th>
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<tbody>
<tr>
<td><strong>Bulk-forming</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ispaghula husk 3.5g effervescent granules sachets gluten free sugar free</td>
<td>30</td>
<td>2.29 (DT)</td>
</tr>
<tr>
<td>Methylcellulose 500mg tablets</td>
<td>112</td>
<td>3.22 (DT)</td>
</tr>
<tr>
<td><strong>Osmotic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactulose 3.1-3.7g/5ml oral solution</td>
<td>500ml</td>
<td>3.22 (DT)</td>
</tr>
<tr>
<td>Macrogols compound oral powder sachets sugar free</td>
<td>30</td>
<td>4.27 (DT)</td>
</tr>
<tr>
<td><strong>Stimulant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisacodyl 5 mg</td>
<td>60</td>
<td>£2.30 (DT)</td>
</tr>
<tr>
<td>Senna Liquid 7.5mg/5ml</td>
<td>500</td>
<td>2.99 (DT)</td>
</tr>
<tr>
<td>Docusate 100mg capsules</td>
<td>30</td>
<td>2.09 (DT)</td>
</tr>
<tr>
<td>Senna 7.5mg tablets</td>
<td>60</td>
<td>3.52 (DT)</td>
</tr>
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</table>

### Rectal laxative

<table>
<thead>
<tr>
<th>Pack size</th>
<th>Cost</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Faecal softeners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arachis (peanut) oil retention enema</td>
<td>130ml</td>
<td>7.98 (BNF)</td>
</tr>
<tr>
<td>Glycerol 4g suppositories</td>
<td>12</td>
<td>£1.94 (DT)</td>
</tr>
<tr>
<td>Bisacodyl 5mg suppositories</td>
<td>5</td>
<td>99p (DT)</td>
</tr>
<tr>
<td>Bisacodyl 10mg suppositories</td>
<td>12</td>
<td>£3.53 (DT)</td>
</tr>
<tr>
<td>Docusate sodium 120mg enema</td>
<td>10g</td>
<td>66p (BNF)</td>
</tr>
<tr>
<td>Sodium citrate compound mini enema (Micolette enema)</td>
<td>5ml</td>
<td>41p (BNF)</td>
</tr>
<tr>
<td>Sodium acid phosphate/sodium phosphate enema</td>
<td>133-mL pack (delivers 118 mL dose)</td>
<td>68p (BNF)</td>
</tr>
</tbody>
</table>

### Other Drugs for Constipation

<table>
<thead>
<tr>
<th>Pack size</th>
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<th>Cost per dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lubiprostone ▼ Specialist initiation NICE TA318 (formulary)</td>
<td>24 micrograms (56)</td>
<td>£53.48 (BNF)</td>
</tr>
<tr>
<td>Prucalopride ▼ (women only) NICE TA211 Specialist initiation (formulary)</td>
<td>1mg (28) 2mg (28)</td>
<td>£38.69 (BNF) £59.52 (BNF)</td>
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<tr>
<td>Linacotide ▼ (IBS only) NICE CG61 Specialist initiation (formulary)</td>
<td>290 micrograms (28)</td>
<td>£37.56 (BNF)</td>
</tr>
<tr>
<td>Naloxegol ▼ Specialist Initiation NICE TA345</td>
<td>25mg (30)</td>
<td>£55.20 (eMIMs)</td>
</tr>
</tbody>
</table>

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

Short-term constipation:
- Ispaghula husk + Lactulose

Chronic constipation:
- Ispaghula husk + Macrogols

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

Avoid bulk-forming laxatives
Prescribe WITH opioid
- Docusate OR
- Macrogols + Docusate
Adjust the laxative dose to optimise the response.

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

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

Stools remain hard

Ispaghula husk

Review need for laxatives
Medicines Optimisation

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.

Opioid-induced constipation

When should I prescribe a laxative?
- If lifestyle measures insuffcient, 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.

Short-term constipation: Ispaghula husk + Lactulose

Chronic constipation: Ispaghula husk + Macrogols

OR

Short-term constipation: Lactulose
Chronic constipation: Macrogols

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.

Important: maintain good hydration (may be difficult for frail or elderly).
Faecal loading/impaction

- Aim to achieve complete dis-impaction, with the minimum of discomfort.
- May take several days in which doses and combinations of laxatives are adjusted.

Hard stools

- 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.
- Regular use of a laxative may also be needed to maintain comfortable defecation.

Soft stools: bisacodyl suppository

Hard stools: glycerol suppository OR glycerol suppository + bisacodyl suppository OR mini enema (docusate (softener and weak stimulant) or sodium citrate (osmotic))

- Bisacodyl
- Macrogol + Bisacodyl
- Response insufficient or not fast enough
- Soft stools
- Hard stools remain after a few days treatment with a macrogol,