Guidelines for the management of constipation in adults

Before prescribing laxatives it is important to be sure that the patient is constipated and that the constipation is not secondary to an undiagnosed underlying complaint.

Red flags - colorectal cancer NICE NG12. People who present with symptoms and signs suggestive of colorectal or anal cancer should be urgently referred (for an appointment within 2 weeks) to a team specialising in the management of lower gastrointestinal cancer.	
Patient age	**Symptoms and signs**
All patients	A rectal or abdominal mass. An unexplained anal mass or unexplained anal ulceration.
40 and over	Unexplained weight loss and abdominal pain.
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.
50 and over without rectal bleeding	Unexplained weight loss and abdominal pain.
50 and over	Unexplained rectal bleeding.
Under 60	Changes in their bowel habit or iron-deficiency anaemia.
60 and over	Iron-deficiency anaemia or changes in their bowel habit, or tests show occult blood in their faeces. Anaemia even in the absence of iron deficiency.

Where no red flag signs are present, refer to the algorithm on page 2 for managing constipation.

The aim is soft, well-formed stools (Bristol stool type 4); please refer to the following link Bristol Stool chart.

Where faecal incontinence is present, referral to the Continence Service should be considered.

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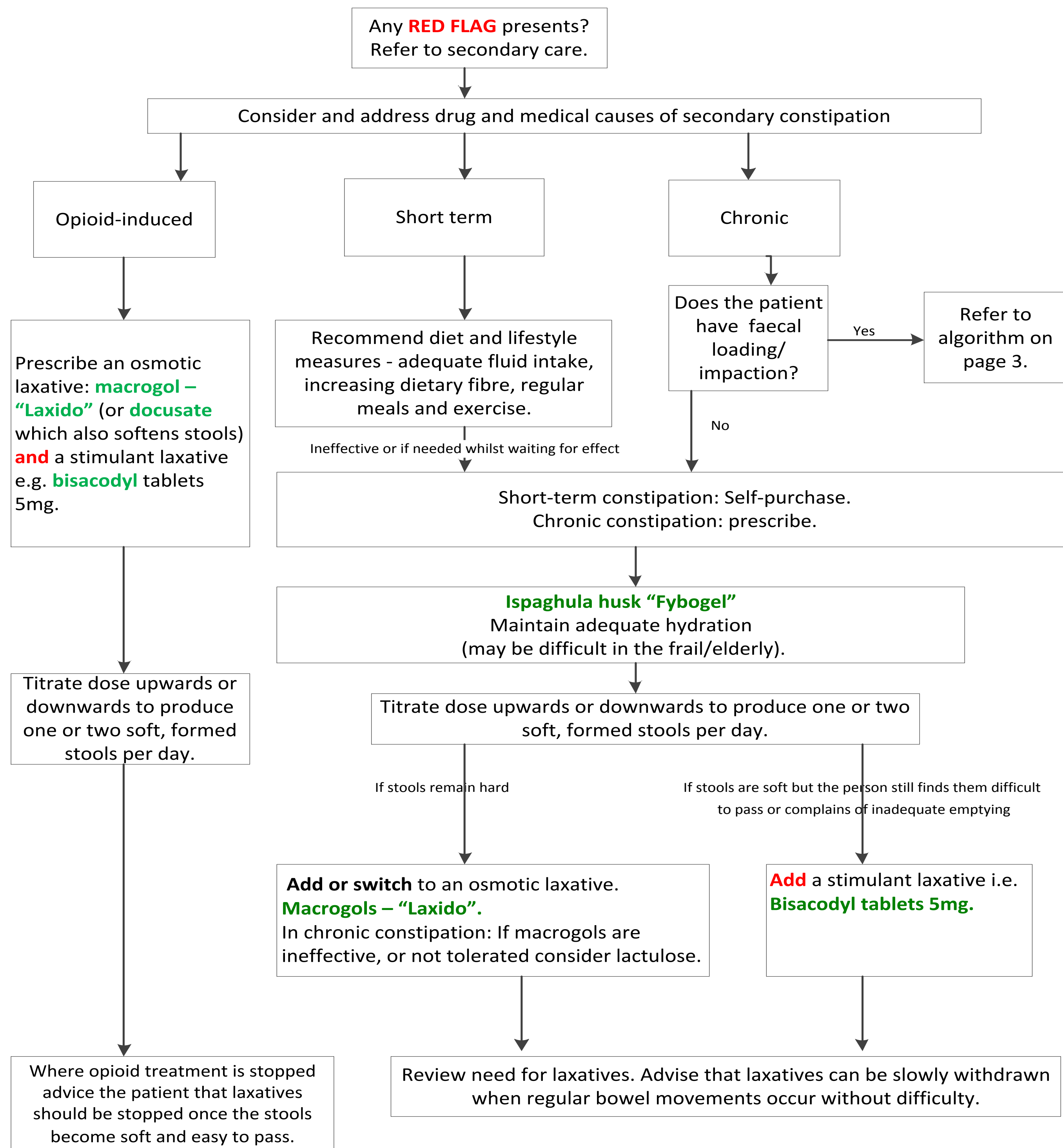
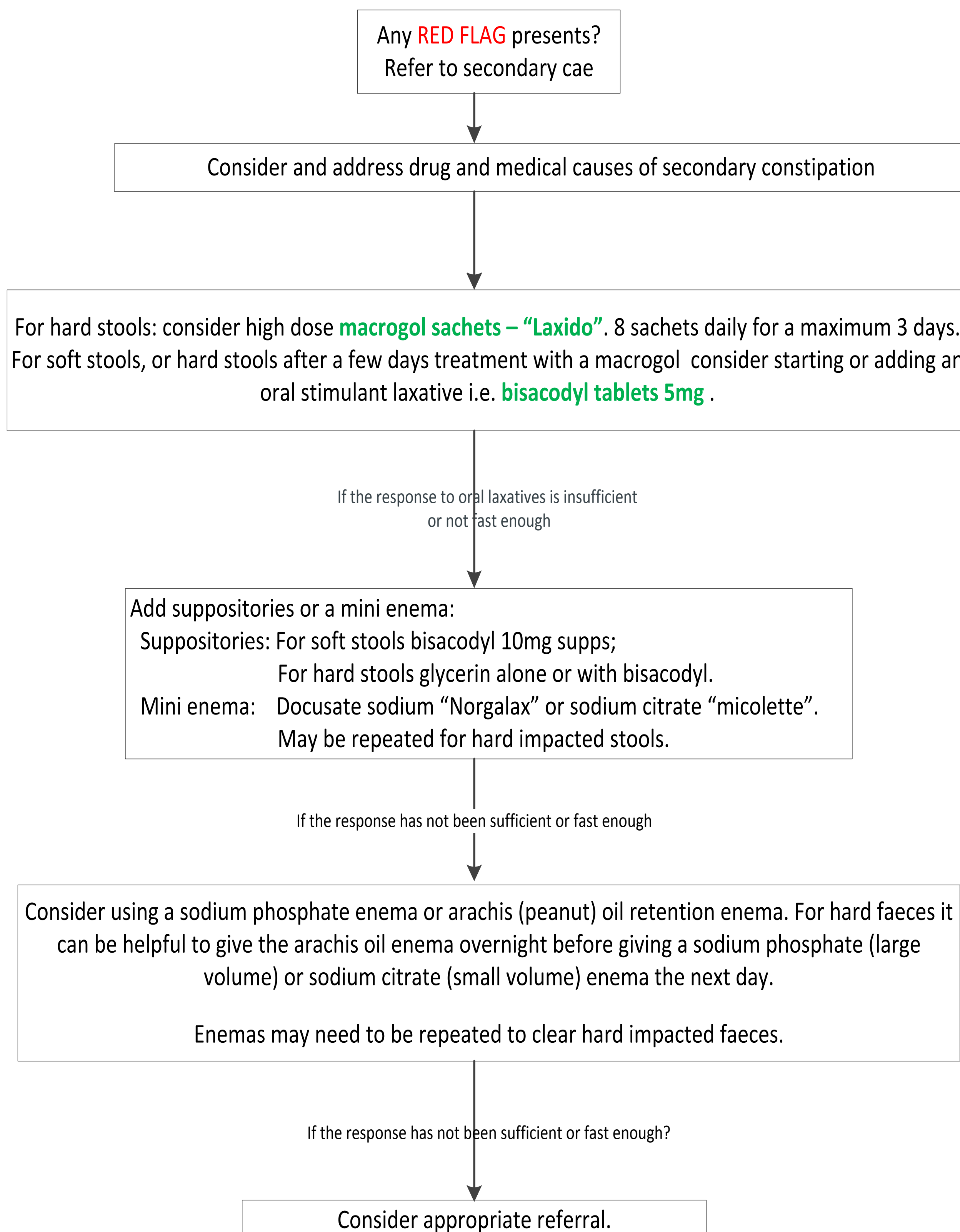
For the management of constipation in palliative care, please refer to the "Essex Palliative & Supportive Care Network formulary and guidelines for management".
http://www.neessexccg.nhs.uk/library_uploads/files/palliative_care_formulary_and_guidelines.pdf



Prucalopride and Lubiprostone
NICE guidelines prescribing criteria must be met:
- Failed treatment with at least two laxatives from different classes, at the highest tolerated recommended doses for at least 6 months.

Pregnancy
If there is poor response to lifestyle measures consider the patient self-care with either ispaghula husk, lactulose, glycerin suppositories or bisacodyl. For breast feeding refer to page 4.

Faecal impaction:



Most common drugs with constipation as a side effect are:

- Aluminium antacids
- Antimuscarinics (such as procyclidine, oxybutynin)
- Antidepressants (most commonly tricyclic antidepressants)
- Some antiepileptics (for example carbamazepine, gabapentin, oxcarbazepine, pregabalin, phenytoin)
- Sedating antihistamines
- Antipsychotics
- Antispasmodics (such as dicycloverine, hyoscine)
- Calcium supplements
- Diuretics
- Iron supplements
- Opioids
- Verapamil

Lifestyle advice:

These measures should precede the prescribing of laxatives. Offer oral laxatives if dietary measures are ineffective, or where appropriate - while waiting for dietary measures to take effect. This may be self-care.

- Adequate fluid intake,
- Increasing dietary fibre intake (increase intake gradually to avoid flatulence and bloating) aiming for 5 portions of fresh fruit and vegetables daily
- Regular meals
- Exercise

Withdrawal of laxatives:

- Laxatives can be slowly withdrawn when regular bowel movements occur without difficulty (2–4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established).
- Weaning should be gradual in order to minimize the risk of requiring 'rescue therapy' for recurrent faecal loading. **Laxative medication should not be suddenly stopped.** The rate at which doses are reduced should be guided by the frequency and consistency of the stools.
- **If a combination of laxatives has been used, reduce and stop one laxative at a time.**
- Reducing stimulant laxatives first if possible. However, it may be necessary to 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 and should be treated early with increased doses of laxatives.

Laxatives may need to be continued long term in some patients due to their condition or medication. For long-term use osmotic or bulk-forming laxatives should be preferred to stimulant laxatives.

Constipation in pregnancy

May be relieved through light exercise, and changing the diet accordingly.
If there is a poor response, consider **self-purchase** of either ispaghula husk, lactulose, glycerin suppositories or bisacodyl.

Constipation in breastfeeding women

If dietary measures and exercise do not relieve the constipation, **Ispaghula husk is first choice and should be self-purchased**. If stools remain hard, add or switch to lactulose or a macrogol. If stools are soft but still difficult to pass, consider a short course of stimulant laxative such as **bisacodyl** or **senna**. **These should be self-purchased**.

Prescribing information:

Indication		Laxative	Dose	Time to take effect	Additional information
Acute or Chronic constipation	1st line	Ispaghula Husk – “Fybogel”	One sachet in the morning and afternoon. Do not give at bedtime. Contra-indicated in phenylketonuria.	2-3 days	Ensure adequate fluid intake (may be necessary to monitor frail, elderly patients to ensure adequate fluid intake). Avoid in intestinal obstruction, decreased muscle tone, impaction and following bowel surgery.
	2nd line If stools remain hard, **add or switch** to an osmotic laxative.	1st choice: Macrogols – “Laxido” Chronic constipation: 2nd choice: Lactulose	1-3 sachets daily in divided doses usually for up to two weeks, maintenance: 1-2 sachets daily. 15ml twice daily.	2-3 days 48 hours	Contents of each sachet should be dissolved in half a glass (approx. 125ml) water. Should not be used on a prn basis.
	2nd line If stools are soft but the person still finds them difficult to pass or complains of inadequate emptying, **add** a stimulant laxative.	Bisacodyl tablets 5mg Sodium Picosulfate liquid 5mg/5ml Senna tablets Senna liquid	1-2 at night (max 4 at night) 5-10mls at night 1-2 at night (max 4 at night) 5-10mls at night	6– 12 hours 6- 12 hours 8–12 hours	Chronic use of stimulant laxatives may lead to colonic atony, tolerance, and hypokalaemia. Initial doses should be low and gradually increased if necessary.
Chronic opioid therapy or Acute constipation due to short-term Opioid use	Osmotic laxative (or docusate which also softens stools) **and** a stimulant laxative.	**Osmotic:** Macrogols – “Laxido” Docusate sodium 100mg capsules **Stimulants:** Bisacodyl tablets 5mg Sodium Picosulfate liquid 5mg/5ml Senna tablets Senna liquid	1-3 sachets daily in divided doses. Usual dose in extended use is 1-2 sachets daily. One capsule every 8 to 12 hours 1-2 at night (max 4 at night) 5-10mls at night 2 – 4 tablets at night 10-20ml at night	2-3 days 1-2 days 6- 12 hours 6- 12 hours 8-12 hours	Avoid using bulk-forming laxatives for opioid-induced constipation. Chronic use of stimulant laxatives may lead to colonic atony, tolerance and hypokalaemia. Initial dose should be low and gradually increased as necessary-high doses (off label) may be required to achieve effect.

- For short term opioid treatment, advice the patient that laxatives can be stopped once the stools become soft and easily passed again.
- The dose of laxative should be gradually titrated 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, the use of prucalopride or lubiprostone recommended by a gastroenterologist. Before prescribing, ensure NICE prescribing criteria are fulfilled, see page 6.

Other drugs for constipation

Prucalopride

- Recommended by NICE as an option for chronic constipation only if:
  - The prescribing clinician has experience of treating chronic constipation and has carefully reviewed the woman's previous laxative treatments.
  - Treatment with at least two laxatives from different classes, at the highest tolerated doses for at least 6 months has failed to provide adequate relief.
  - Invasive treatment for constipation is being considered.
- If treatment with prucalopride is not effective after 4 weeks, the patient should be re-examined and treatment stopped.
- The restriction for use in women only was removed in 2015, and so prucalopride is now licensed for all adults.

Drug	Dose (adults)	Additional information	
Prucalopride	2mg once daily. Age 18 up to 65. 1mg once daily 65 years and over. Can be increased to 2mg if needed.	Maximum dose 1mg once daily if GFR <30ml/min/1.73m^2. Patients with severe hepatic impairment start with 1mg once daily which may be increased to 2mg.	**If ineffective after 4 weeks patient should be re-examined and benefit of further use reconsidered.**

Lubiprostone

- Recommended by NICE as an option for chronic idiopathic constipation in adults only if:
  - Treatment with at least two laxatives from different classes, at the highest tolerated recommended doses for at least 6 months has failed to provide adequate relief.
  - Invasive treatment for constipation is being considered.
  - The prescribing clinician has experience of treating chronic idiopathic constipation and has carefully reviewed the person's previous laxative treatments.

Drug	Dose (adults)	Additional information	
Lubiprostone	In adults (>18 years of age) 24 mcg capsule twice daily. The SPC recommends a course of treatment is 2 to 4 weeks.	Maximum dose 24mcg once daily in moderate to severe hepatic impairment.	**If ineffective after 2 weeks, the person should be re-examined and the benefit of continuing treatment reconsidered.**

Naloxegol

Drug	Dose	Additional information	
Naloxegol			For treating opioid-induced constipation is restricted locally to **palliative care initiation only**.

Impaction

Indication	Laxative	Dose	Time to take effect	
For hard stools	High dose of an oral **macrogol “Laxido”** (licensed for use in faecal loading/impaction).	8 sachets daily for a maximum of 3 days.	2-3 days	**8 sachets may be dissolved in 1 litre of water, all of which should be consumed within a 6 hour period.** Patients with a cardiac condition should not take more than two sachets (in 250ml of water) in any one hour. Once reconstituted store in a fridge and discard any solution remaining after 6 hours.
For soft stools or for hard stools after a few days treatment with a macrogol consider starting or adding an oral stimulant laxative.	**Bisacodyl tablets 5mg** **Sodium Picosulfate liquid 5mg/5ml** **Senna tablets** **Senna liquid**	1-2 at night (max 4 at night) 5-10mls at night 2 – 4 tablets at night 10-20ml at night	6- 12 hours 6- 12 hours 8-12 hours	Chronic use may lead to colonic atony, tolerance and hypokalaemia. Initial dose should be low and gradually increased as necessary.
If the response to oral laxatives is insufficient or not fast enough, consider: Using a suppository: For soft stools; bisacodyl alone. For hard stools: glycerin alone or with bisacodyl. Using a mini enema: Docusate sodium (Norgalax) or sodium citrate	**Bisacodyl suppositories** **Glycerin 4g suppositories** **Docusate sodium “Norgalax”** **Sodium citrate micro enema**	One to be used as necessary	15-60 mins 15-30 mins 15-30 mins 5-15 mins	Bisacodyl suppositories should not be used when anal fissures or ulcerative proctitis with mucosal damage are present. Glycerin suppositories need to be moistened with water before use Norgalax is not suitable if haemorrhoids or anal fissure is present.
If the response is still insufficient: Sodium phosphate enema or Arachis (peanut) oil enema	**Sodium phosphate enema** **Arachis (peanut) oil retention enema (place high if the rectum is empty but the colon is full).**	One to be used as necessary	2-5 minutes Used overnight.	Repeated in rare cases if necessary. For hard faeces it can be helpful to give the arachis oil enema overnight before giving a 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. Enemas may need a district nurse or a carer to administer them.

References:

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