Constipation guidance for adults 2019

This guideline covers treatment of short term and chronic constipation, faecal impaction & opioid induced constipation in adults >18 yrs.

Signposting to guidance for other types of constipation:

- Treatment of children <18 yrs: See NICE CG99 for advice.
- Constipation in pregnancy & breastfeeding: See CKS constipation in pregnancy or breastfeeding (June 2017) for advice.
- Complex/ very severe constipation: seek specialist advice

Lifestyle & Dietary Advice – ALL PATIENTS SHOULD BE GIVEN THIS ADVICE

- Defecation should be unhurried and appropriate defecation technique encouraged.
- Attempt defecation first thing in the morning or 30minutes after a meal
- Respond immediately to the call to toilet
- Consideration should be given to those with mobility issues – increased physical activity is beneficial.
- Diet should be balanced and contain whole grains, fruits and vegetables.
- Fibre intake should be increased gradually and maintained:
    - Adults should aim to consume 18 – 30gram of fibre per day.
    - Effects may take up to four weeks.
- Adequate fluid intake is important, although there is no evidence that increased fluid intake will improve symptoms in those that are already well hydrated
- Natural laxatives, such as fruit and fruit juices, high in sorbitol can be recommended. Dried fruit has higher sorbitol content than fresh fruit (5 – 10 times higher).
- Resources for patients: https://patient.info/health/constipation-in-adults-leaflet

Red Flags as per NICE Suspected cancer: recognition and referral guideline [NG12] for lower GI tract cancers:

Refer adults 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, or tests show occult blood in their faeces.*

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in adults with a rectal or abdominal mass.

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.*

Refer in the following circumstances:

- **RED FLAG(s)** identified
- Pain and bleeding on defecation (e.g. from anal fissure) is severe or does not respond to laxative treatment
- Treatment failure which may be early, when attempts to relieve faecal loading fail or late failure if there is difficulty maintaining remission
- Faecal incontinence is present (see continence service contact details p5)
- Consider dietetics referral if support with diet is required.

Dr Rachel Hobson, Formulary Pharmacist, NHS Wiltshire CCG on behalf of NHS BaNES CCG.
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Constipation management in adults: Acute or Chronic

Prior to treatment, identify underlying cause, adjust constipating medication if possible and give lifestyle advice, increase fluid intake and exercise if possible. Ensure no red flags are present.

If laxative therapy is necessary:

Acute (short term and prompt effect)

Stimulant laxative e.g. Senna time to effect 8-12 hrs (exclude intestinal obstruction): 15mg ON (can increase to 30mg ON)

If ineffective: Add in docusate (time to effect 12-72hrs)**:** Up to 500mg daily in divided doses

If rapid relief needed: (if rectum is full, can be used at any step):

- Glycerol 4g suppository PRN or
- Phosphate enema PRN or
- Bisacodyl 10mg suppository PRN

Review treatment:
Advise that laxatives can be stopped once the stools become soft and can be passed easily (Bristol stool chart type 3-4)

Chronic (long-term use, delayed onset)

Bulk laxative: Ispaghula husk (Fybogel®/Isogel®):
1 sachet BD (not suitable for pts with inadequate fluid intake) for 2 months.
Time to effect: 2-3 days. *Avoid in pts with chronic slow transit constipation*

If ineffective (stools remain hard) or frail/elderly pts with poor fluid intake, add or switch to an osmotic laxative:
Macrogol (Laxido®): 1 sachet OD-TDS (Time to effect 2-3 days).
Use lactulose if macrogols are not effective or not tolerated.

If stools are soft but the person still finds them difficult to pass or complains of inadequate emptying, add a stimulant laxative, e.g. senna for a further 2 months (exclude intestinal obstruction): 15mg ON (can increase to 30mg ON).
Time to effect 8-12 hrs
Adjust the dose, choice & combination of laxative according to symptoms, speed with which relief is required, response to treatment & individual preference.

Treatment failure: Consider referral to specialist

If at least 2 laxatives from different classes have been tried at the highest tolerated recommended doses for at least 6 months, prucalopride (women only, as per NICE TA211) may be considered by a clinician with experience of treating chronic constipation. For these patients, invasive treatment would otherwise be considered.

AMBER (Initiation by clinician with experience of treating chronic constipation)
Prucalopride:
(*Note that Prucalopride is now licensed for men and women to use, but only approved by NICE for women*).
Dose: 2mg tablet OD; >65 yrs of age: 1mg OD, increased to 2mg OD if necessary.
1mg tablet: £38.69 for 28 days
2mg tablet: £59.52 for 28 days
Review at 4 weeks for efficacy (via advice given at initiation so the patient knows to stop it if it isn't working). If effective & well tolerated, review every 8 weeks.
If it is ineffective or not tolerated: stop & refer back to specialist.

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NHS Wiltshire Clinical Commissioning Group

Constipation management in adults: Faecal impaction or opioid induced

Faecal Impaction

Exact treatment depends on cause & size of impaction. Advice may be required from the continence service (contact details on p.5.)

Aim of treatment is to achieve complete disimpaction, with the minimum of discomfort. This may require several days in which doses & combinations of laxatives are adjusted.

For hard stools: Consider using a high dose macrogol compound oral powder: 8 sachets in 1 litre of water drunk over 6hrs, for up to 3 days.
For soft stools (or hard stools after macrogol treatment): Consider starting/ adding an oral stimulant laxative.

Has response been sufficient or fast enough? If yes: follow chronic constipation pathway on page 2. If no, see below:

Add suppositories or a mini-enema:
Suppositories:
- Bisacodyl (soft stools)
- Glycerol alone (4g) or with bisacodyl (hard stools)

Mini-enemas:
- Docusate or sodium citrate. *May be repeated for hard impacted faeces.*

If response: Go to chronic constipation pathway on page 2.
If no response:
- Consider using arachis (peanut) oil or sodium phosphate enema (place high if rectum is empty but colon is full).

Repeat as necessary to clear hard impacted faeces.
For hard faeces it can be helpful to give the arachis oil enema overnight before giving a sodium phosphate enema the next day.
If response: Go to chronic constipation pathway on page 2. If no response: REFER

Opioid induced constipation

All patients taking regular opioids should be prescribed a regular stimulant laxative (senna or bisacodyl) at first opioid prescription rather than waiting until constipation is established.

- Give lifestyle advice, ↑ fluid & dietary fibre intake & exercise.
- If a patient presents with opioid-induced constipation on treatment:
  - Review the need for on-going opioid analgesics.
  - Assess baseline Bowel Function Index score (www.exchangecme.com/resourcePDF/chronicpain/BowelFunctionIndex.pdf if <30, constipation is controlled) & Bristol Stool chart score to allow monitoring (http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20100606160522260465).

Consider initiating an osmotic laxative AND a stimulant laxative (do not commence a bulk forming laxative):
- E.g. Macrogol (Laxido®): 1 sachet OD-TDS (Time to effect 2-3 days).
- *Use lactulose if macrogols are not effective or not tolerated (NB lactulose may exacerbate bloating).*
- E.g. Senna tablets 15mg-30mg nocte (Time to take effect 8-12 hrs).

Titrate dose of laxatives up or down to produce 1-2 soft stools/day.

Review after 2 weeks. If patient remains symptomatic despite treatment with an osmotic & stimulant laxative at the highest dose for at least 4 days over the last 2 week period?

No: continue laxative therapy
Review laxative use if opioids are discontinued or if the patient presents with loose stools

Yes: commence Naloxegol tablets 25mg OD (12.5mg OD if renal insufficiency)
Discontinue all other laxative therapy to determine clinical effect.
Naloxegol can be used to treat opioid-induced constipation (NICE TA345) in primary care for those patients who haven't responded adequately to laxatives. This is defined as: "opioid-induced symptoms of at least moderate symptoms severity in at least one of the four stool symptom domains whilst taking at least 1 laxative class for at least 4 days during the prior 2 weeks".
The four stool domains are:
- Incomplete bowel movement
- Hard stools
- Straining
- False alarms

£55.20 for 30 tablets

If the patient remains symptomatic refer to gastroenterology service for specialist review

Prevent reoccurrence with lifestyle advice & regular laxatives as per flowchart on p.2.

Dr Rachel Hobson, Formulary Pharmacist, NHS Wiltshire CCG on behalf of NHS BaNES CCG.
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Opioid-induced constipation (OIC):

Alternative strategies if there is continued constipation problems: One option for managing analgesia is by rotating one opioid with another (i.e. change either the drug or route of administration). However, although this is used often in clinical practice, there is limited support in the literature. Such changes in analgesia would need to be done in conjunction with the specialist if the patient is under the care of a specialist.
There is some data to suggest that transdermal buprenorphine or fentanyl may cause less constipation than oral opioids, if a patient has persistent constipation problems on oral opioids.

Possible causes of constipation:

Conditions which may contribute to constipation

- Bowel obstruction
- Irritable bowel syndrome
- Cancer
- Diverticulitis
- Dehydration
- Hospitalisation
- Medication
- Immobility
- Hypothyroidism
- Neuromuscular disorder
- Stimulant laxative abuse
- Eating disorder
- Hypercalcaemia
- Pregnancy
- Depression
- Parkinsons disease

Drugs which may cause constipation

- Aluminium antacids
- Antimuscarinics (eg procyclidine, oxybutinin)
- Antidepressants (e.g. TCAs)
- Antiepileptics
- Sedating antihistamines
- Clozapine (essential to treat, fatalities reported)
- Antispasmodics (eg hyoscine, dicycloverine)
- Calcium & iron supplements
- Opioids
- Verapamil

Management

- Once constipation is confirmed, and any secondary causes have been addressed, most adults with mild or acute functional (idiopathic) constipation can be managed by dietary and lifestyle changes.
- In adults, laxatives should be reserved for cases where simple interventions have failed, or where rapid relief of symptoms is required. Prolonged treatment is seldom necessary, except occasionally in the elderly, in palliative care, or to prevent recurrence in children.
- With the exception of relatively recent evidence comparing the efficacy of macrogols with lactulose, there is limited clinical evidence on which to judge the comparative efficacy of individual laxatives. Therefore, prescribing choice mainly depends on the presenting symptoms, patient acceptability and cost.
- Titrate to maximum tolerated dose before adding/switching laxatives.
- Adjust constipating medication if possible.
- Always consider impaction and overflow if patient reports diarrhoea on laxatives.
- In the elderly, constipation may present as:
    - Confusion
    - Overflow diarrhoea
    - Abdominal pain
    - Urinary retention
    - Nausea & loss of appetite
- *Please see separate "Guidance on the Management of Irritable Bowel Syndrome with Constipation (IBS-C) in Adults" if the patient has IBS-C (found on the local formulary websites).*

Criteria for commencing regular laxative therapy

- If lifestyle measures are ineffective
- The constipating drug can't be stopped
- For those with other secondary causes of constipation
- As a 'rescue' for episodes of faecal loading

Investigations

No investigations are routinely required in adults with constipation unless a secondary cause is suspected.

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Neurological / MS / Stroke / spinal injuries etc.

These patients may require a more complicated regime including rectal stimulation and manual evacuation. Over use of traditional laxatives (especially osmotics) can result in faecal incontinence. Seek advice from their specialist team or the continence service.

Adverse effects of oral laxatives

Most adverse effects can be avoided or reduced by increasing the dose of oral laxatives gradually.

Common adverse effects include:

- Bulk laxatives: flatulence & bloating
- Lactulose: flatulence, cramps & bloating
- Macrogols: bloating, nausea
- Stimulant laxatives: abdominal cramps, diarrhoea

Avoid excessive doses of laxatives. This leads to diarrhoea and if prolonged, electrolyte disturbances such as hypokalaemia. Excessive doses of bulk-forming laxatives or inadequate fluid intake whilst taking them can cause intestinal obstruction rather than diarrhoea.

Discontinuing laxatives

- Laxatives can be slowly withdrawn 2–4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established
- Wean gradually to minimise risk of requiring 'rescue therapy' for recurrent faecal loading.
- If more than one laxative has been used, reduce and stop one at a time
- Begin by reducing stimulant laxatives first, if possible
- 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.

Complications

Chronic constipation can progress to:

- Progressive faecal retention, distension of the rectum, and loss of sensory and motor function.
- Faecal impaction, particularly in the immobile.

Chronic faecal loading/impaction can lead to:

- Faecal incontinence, UTI, Rectal bleeding & rectal prolapse

Continence service

A referral can be made to the continence service for assessment, advice and support at all stages. Consider especially for impacted, neurological conditions or failure of traditional laxatives. The continence formulary can be found here: https://prescribing.wiltshireccg.nhs.uk/search-files?q=continence&x=0&y=0
Continence service Salisbury Central Health Clinic: 01722 323196
Continence service St. Martins Hospital: 01225 831766
Continence service Trowbridge Community Hospital: 01225 711323
Clinical Manager Wiltshire Continence Service: karenredgrove@nhs.net
NHS BaNES CCG: Lead Nurse for Sirona Bladder & Bowel service: sonjasibun@nhs.net
NHS Swindon CCG: gwh.swindoncontinenceservice@nhs.net 01793 696671

References

- Clinical Knowledge Summaries: Constipation in adults (June 2017) https://cks.nice.org.uk/constipation#!scenario
- Best practice supplement. Pharmacological management of patients with opioid-induced constipation in primary and secondary care. A Davies et al. https://www.guidelines.co.uk/pharmacological-management-of-patients-with-opioidinduced-constipation-in-primary-and-secondary-care/453616.article
- NICE Suspected cancer: recognition and referral guideline [NG12] https://www.nice.org.uk/guidance/ng12

Useful resources for patients:

Fibre contents of food chart: www.bladderandbowel.org/bowel/bowel-resources/fibre-contents-of-food-chart

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