Management of Constipation in Adults (Summary of NICE Guidance)

Please note:
NHS England have advised CCGs that a prescription for the treatment of infrequent constipation should **not** routinely be offered in primary care as the condition is appropriate for self-care.
The NHS England guidance applies to short term, infrequent constipation caused by changes in lifestyle or diet such as lack of water, movement or changes in diet.
GPs should continue to prescribe laxatives to manage acute constipation with more complex aetiology (e.g. iatrogenic) and chronic constipation.
The NHS England guidance does not apply to the management of children and laxatives for children should continue to be prescribed by GPs.

For patients prescribed an opiate always offer an osmotic laxative such as a **Laxido/Cosmocol** and a stimulant laxative such as **senna** (or docusate is an alternative which also has stool-softening properties)

Self-Management of Constipation

Encourage the person or carer to manage their symptoms by giving advice on:

Sources of information and support, such as:

- The NHS patient information leaflets on Constipation and Bowel incontinence.
- Eating a healthy, balanced diet and having regular meals:
  - The person's diet should contain whole grains, fruits (and their juices) high in sorbitol, and vegetables.
  - Fruits that have a high sorbitol content include apples, apricots, grapes (and raisins), peaches, pears, plums (and prunes), raspberries, and strawberries.
  - The Association of UK Dietitians has useful Food Fact Sheets on Fibre and Fruit and vegetables - how to get five-a-day.
  - Fibre intake should be increased gradually (to minimize flatulence and bloating) — adults should aim to consume 30 g of fibre per day.
  - Advise the person that the beneficial effects of increasing dietary fibre may take several weeks.

- Public Health England's booklet *The Eatwell Guide* has patient information on eating a healthy, balanced diet
- Drinking an adequate fluid intake, especially if there is a risk of dehydration, the Association of UK Dietitians has a useful Food Fact Sheet on Fluid
- Increasing activity and exercise levels, if needed
- Helpful toileting routines:
  - Advise on a regular, unhurried toilet routine, giving time to ensure that defecation is complete
  - Advise on responding immediately to the sensation of needing to defecate
  - Ensure that people with limited mobility have appropriate help to access the toilet and adequate privacy
  - Ensure the person has access to supported seating if they are unsteady on the toilet

For full NICE Guidance - https://cks.nice.org.uk/constipation#!scenario

NHS Medway Clinical Commissioning Group

NHS Swale Clinical Commissioning Group

Medway NHS NHS Foundation Trust

For the management of short-duration constipation

Manage any underlying secondary cause and reduce or stop any drug treatment that may be causing or contributing to symptoms

Advice on lifestyle measures

If these measures are ineffective, or symptoms do not respond adequately, offer treatment with oral laxatives using a stepped approach:

Offer a bulk-forming laxative first-line, such as **ispaghula**. Note: it is important for the person to drink an adequate fluid intake.

If stools remain hard or difficult to pass, add or switch to an osmotic laxative, such as a **Laxido/Cosmocol.**

If a macrogol is ineffective or not tolerated, offer treatment with **lactulose** second-line

If stools are soft but difficult to pass, or there is a sensation of inadequate emptying, add a stimulant laxative, such as **senna**

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.

Arrange to review the person regularly, depending on clinical judgement

Several days (2-3 days) of treatment may be needed in some patients before adequate treatment effect occurs

If the patient has opioid-induced constipation:

- Do not prescribe bulk-forming laxatives.
- Offer an osmotic laxative such as a **Laxido/Cosmocol** and a stimulant laxative such as **senna** (or docusate is an alternative which also has stool-softening properties)
- Naloxegol is recommended as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives.

Red Flag Symptoms - indicative of a serious underlying condition

* Persistent unexplained change in bowel habits?
* Palpable mass in the lower right abdomen or the pelvis?
* Persistent rectal bleeding without anal symptoms?
* 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?

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For the initial management of chronic constipation

Manage any underlying secondary cause and reduce or stop any drug treatment that may be causing or contributing to symptoms

Manage any faecal loading and/or impaction first, if present.

Advice on lifestyle measures

Offer a bulk-forming laxative first-line, such as **ispaghula**. Note: it is important for the person to drink an adequate fluid intake.

If stools remain hard or difficult to pass, add or switch to an osmotic laxative, such as a **Laxido/Cosmocol.**

If a macrogol is ineffective or not tolerated, offer treatment with **lactulose** second-line

If stools are soft but difficult to pass, or there is a sensation of inadequate emptying, add a stimulant laxative, such as **senna**

Several days (2-3 days) of treatment may be needed in some patients before adequate treatment effect occurs

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 consider the use of drug treatment with **prucalopride**, offer a prescription for 4 weeks and if there is no symptom response following this trial, reconsider the benefit of continuing treatment.

Gradually titrate the laxative dose(s) up or down aiming to produce soft, formed stool without straining at least three times per week.

Arrange to review the person regularly, depending on clinical judgement

If the patient has opioid-induced constipation:

- Do not prescribe bulk-forming laxatives.
- Offer an osmotic laxative such as a **Laxido/Cosmocol** and a stimulant laxative such as **senna** (or docusate is an alternative which also has stool-softening properties)
- Naloxegol is recommended as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives.

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* Severe, persistent constipation that is unresponsive to treatment?

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For the management of faecal loading and/or impaction

Red Flag Symptoms - indicative of a serious underlying condition

* Persistent unexplained change in bowel habits?
* Palpable mass in the lower right abdomen or the pelvis?
* Persistent rectal bleeding without anal symptoms?
* 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?

The aim is to achieve complete disimpaction with minimal discomfort. Adjust the dose, choice, and combination of laxatives used, depending on the person's response to treatment and their personal preference.

Following an assessment including examination of the patient

If there are hard stools, consider prescribing a high dose of an oral macrogol such as **Laxido/Cosmocol**

If there are soft stools, or ongoing hard stools after a few days of treatment with an oral **macrogol**, consider starting or adding an oral stimulant laxative such as **senna**

If the response to oral laxatives is inadequate or too slow, consider prescribing:

- A suppository such as bisacodyl for soft stools; glycerol for hard stools.
- A mini enema such as docusate (softener and weak stimulant) or sodium citrate (osmotic).

Note: enemas may need a district nurse or a carer to administer them. Warn the person that diarrhoea and faecal overflow may occur before disimpaction is complete.

If the response to treatment is still inadequate, consider prescribing:

- A **sodium phosphate** or **arachis oil** retention enema (placed high if the rectum is empty but the colon is full).
- For hard stool 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.

Note: enemas may need a district nurse or a carer to administer them.

Reinforce advice on lifestyle measures such as increasing dietary fibre, fluid intake, and activity levels, to help maintain regular bowel movements

Consider the need for regular laxative use to maintain regular bowel movements, or the use of intermittent laxatives for episodes of faecal loading.

Arrange to review the person every few days to assess the response to treatment, depending on clinical judgement.

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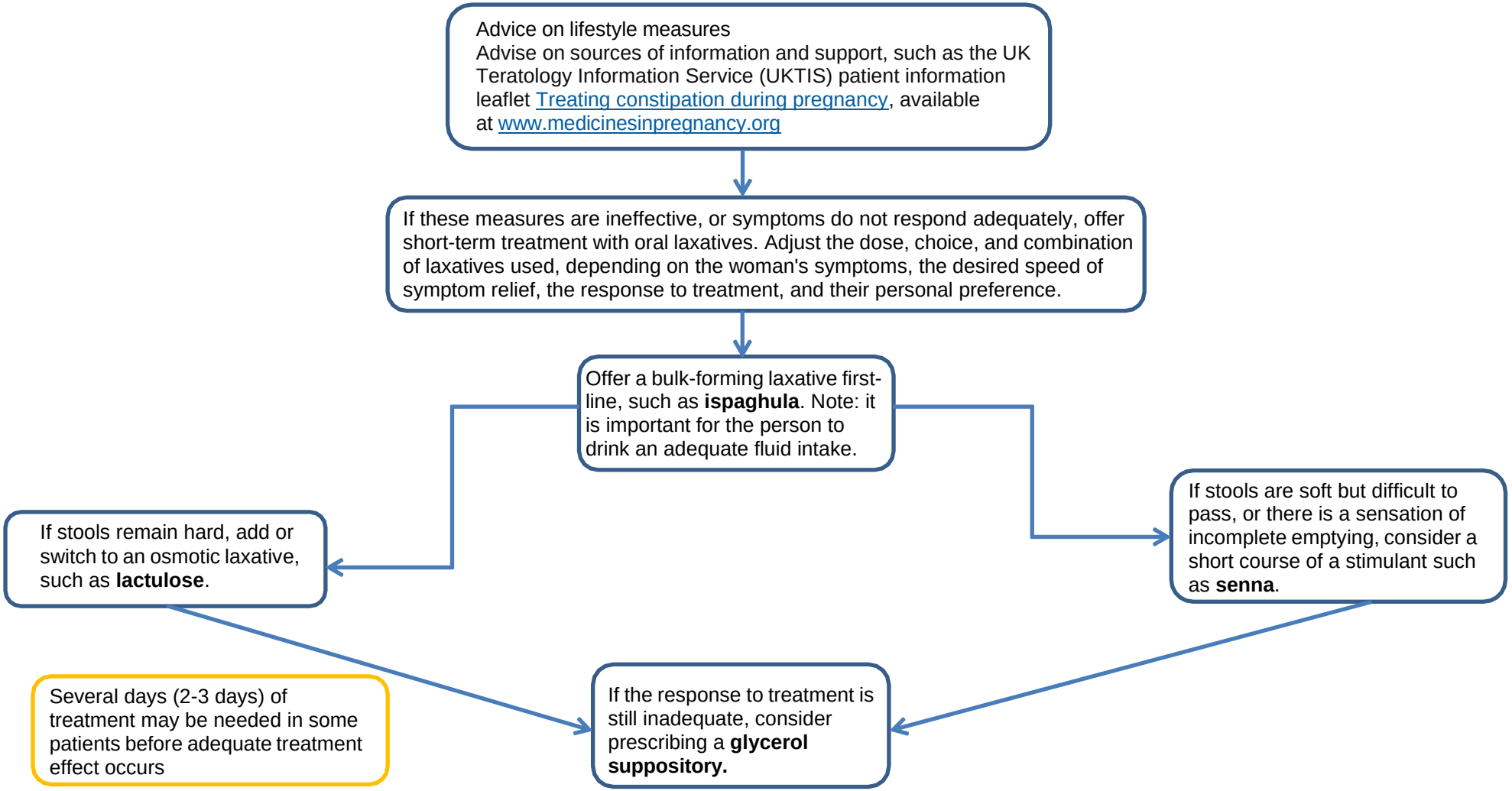
For the management of constipation during pregnancy and breastfeeding



If there is uncertainty about the use or safety of laxatives during pregnancy, contact the UKTIS:

- To discuss with a teratology specialist, telephone 0344 892 0909.
- For information on the safety of specific laxatives, see the website at www.uktis.org.

If there is uncertainty about the use or safety of laxatives during breastfeeding, contact the UK Drugs in Lactation Advisory Service (UKDILAS) provided by the UK Medicines Information Network:

To discuss with a specialist pharmacist, telephone 0116 2586491 or 0121 4247298. For information on the safety of specific laxatives, see the website at www.sps.nhs.uk.

Common Medications that may cause constipation
Some common medications that may cause constipation are: antacids, antidepressants, antiepileptics, antipsychotics, calcium supplements, opiates, diuretics, iron supplements.

This is not a full list – please consider all current medication for potential constipation side effect s. The use of these medications in constipated person should be reviewed and modified where possible.

How should I follow up a person in primary care?
Arrange regular follow-up of the person depending on clinical judgement.
If oral laxatives have been prescribed, advise that:

- Laxatives should not be stopped suddenly, and weaning off all laxatives may take several months. The rate of laxative dose reduction should be guided by the frequency and consistency of stools.
- Laxative doses should be reduced gradually, for example after 2–4 weeks when regular bowel movements are comfortable, with soft formed stools. This is to minimize the risk of requiring rescue laxative treatment for recurrent faecal loading and/or impaction.
- If a combination of laxatives has been used, reduce and stop one laxative at a time, starting with stimulant laxatives, if possible. Note: it may be necessary to also adjust the dose of other laxatives used to maintain regular bowel movements.
- Relapses are common and should be treated early with increased doses of laxatives.
- Laxatives may need to be continued long term for people with a medical condition or taking a medication (if it cannot be reduced or stopped) causing secondary constipation.

If symptoms are ongoing or refractory to laxative treatment, consider:

- Checking blood tests for full blood count, thyroid function tests, HbA1c, and serum electrolytes and calcium, to look for an underlying cause, and manage appropriately.
- Whether a defecatory disorder, such as pelvic floor dyssynergia, may be contributory.

Seek specialist advice or arrange referral to a gastroenterologist or colorectal surgeon for specialist investigations and management, depending on clinical judgement, if:

- A serious underlying cause such as colorectal cancer is suspected. See the CKS topic on Gastrointestinal tract (lower) cancers - recognition and referral for more information.
- An underlying secondary cause of constipation is suspected, which cannot be managed in primary care.
- Symptoms persist or recur despite optimal management in primary care.

Arrange referral to a local continence service if there are symptoms of faecal incontinence which have been fully investigated and are ongoing. The Medway continence service can be contacted on MEDCH.ContinenceCare@nhs.net or 0300 1233444
Arrange referral to a dietitian if support with dietary changes and increasing fibre content is needed. The medway dietetics service can be contacted on medway.dietitians@nhs.net or 0300 123 3444