Mid and South Essex Health and Care Partnership

NHS

Management of chronic constipation in adults

Any red flags present? — Yes → Urgent specialist referral

No

Manage any underlying secondary cause and reduce or stop any medicine that may be causing or contributing to symptoms, if possible and appropriate. See *Box 1* for the management of opioid induced constipation

Life style and dietary advice – increase dietary fibre, fluid intake and activity levels.

Manage **faecal loading and/or impaction** if present

For hard stools – consider high dose oral macrogol.
For **soft stools** consider oral stimulant laxative.

Oral stimulant laxative
If no disimpaction after a few days treatment with high dose oral macrogol.

If the response to oral laxatives is inadequate or too slow, use:
Soft stools; Bisacodyl suppository for soft stools.
Hard stools: Glycerol or glycerol plus bisacodyl suppositories for hard stools.
Treatment failure: Lecicarbon A suppositories- onset of action is between 15 to 30minutes. Can be repeated after 30 to 60 minutes, if needed.

If on-going symptoms, offer drug treatment with oral laxatives[2] using a stepped approach.

Bulk forming laxative – suitable for self-care	**Bulk forming laxative** such as isphagula. Ensure adequate fluid intake. Avoid in intestinal obstruction, decreased muscle tone, faecal impaction and reduced gut motility.
If stools remain hard or difficult to pass add or switch to an **osmotic laxative**	Oral macrogol. If a macrogol is ineffective or not tolerated, offer treatment with lactulose.
If stools are soft but difficult to pass, or there is a sensation of inadequate emptying, add a **stimulant laxative**	First choice - Senna or bisacodyl Second choice – Oral Docusate sodium

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 and invasive treatment is being considered

Prucalopride (TA211- women only) – Review after 4 weeks.
Consider withdrawing treatment if no response and refer to specialist Community continence service or secondary care

Box 1

Opioid induced constipation
On initiation of an opioid analgesic provide dietary, fluid & exercise advice and co-prescribe a stimulant laxative (senna or bisacodyl) and stool softener (docusate sodium). Review the need for opioids on a regular basis and titrate laxative dose to effective / maximum tolerated dose (avoid bulk forming laxative).

If inadequate response[1], prescribe oral macrogol

If inadequate response[1], consider Naldemedine (TA651) or Naloxegol (TA345)

[1] An inadequate response is defined as opioid-induced constipation symptoms of at least moderate severity in at least 1 of the 4 stool symptom domains (that is, incomplete bowel movement, hard stools, straining or false alarms) while taking at least 1 laxative class for at least 4 days during the prior 2 weeks.
[2]Choice depends on the person's symptoms, the desired speed of symptom relief, the response to treatment, and their personal preference

Constipation is defecation that is unsatisfactory because of infrequent stools, difficulty passing stools, or the sensation of incomplete emptying.

- The Rome IV diagnostic criteria for constipation include spontaneous bowel movements occurring less than three times a week.
- Stools are often dry, hard, or lumpy, and may be abnormally large or small.
- In reality, constipation is often defined as passage of stools less frequently than the person's normal pattern.

Chronic constipation usually describes symptoms which are present for at least 12 weeks in the preceding six months.
Faecal loading/impaction describes retention of faeces to the extent that spontaneous evacuation is unlikely.
Overflow faecal incontinence is leakage of liquid stool from the proximal colon around impacted faeces, where small quantities of stool may be passed frequently and without sensation.
Initial assessment should involve investigation of possible causes of constipation. Assessment should include the following:

Assessment of bowel function	Mobility
Dexterity	Dietary intake and ability to chew/ swallow
Fluid intake	Mouth care
Underlying disease	Medication

Manage any underlying secondary cause and reduce or stop any medicine that may be causing or contributing to symptoms, if possible and appropriate**.**

Medications which can cause constipation include:

- Aluminium-containing antacids
- Analgesics, such as opiates and nonsteroidal anti-inflammatory drugs (NSAIDs).
- Antimuscarinics, such as procyclidine and oxybutynin
- Antidepressants, such as tricyclic antidepressants
- Iron or calcium supplements
- Sedating antihistamines
- Antipsychotics, such as amisulpride, clozapine, or quetiapine,
- Antispasmodics, such as dicycloverine or hyoscine.
- Diuretics, such as furosemide
- Calcium-channel blockers, such as verapamil.

Refer for further investigation in all cases where:

- Constipation is a new symptom which is not due to changes in lifestyle, diet or drug therapy and the patient is aged 60 and over.
- Symptoms persist despite optimal management in primary care
- Alarm symptoms (‘red flags’) are present

Red flag symptoms

- 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 e.g. constipation alternating with diarrhoea, rectal bleeding, passing mucus per rectum,

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.

References	- NICE Clinical Knowledge Summaries – Constipation: https://cks.nice.org.uk/topics/constipation/#!topicSummary - Prucalopride for the treatment of chronic constipation in women Technology appraisal guidance [TA211] Published date: 15 December 2010 https://www.nice.org.uk/guidance/ta211 - Naloxegol for treating opioid-induced constipation Technology appraisal guidance [TA345] Published date: 22 July 2015 https://www.nice.org.uk/guidance/ta345 - Naldemedine for treating opioid-induced constipation Technology appraisal guidance [TA651] Published date: 30 September 2020 https://www.nice.org.uk/guidance/ta651
Acknowledgements	Mid and South Essex CCGs Medicines Management Teams
Version	1
Author	HCPMSEMOC working group
Approved by	MSEMOC; MSE Joint Committee
Date Approved	December 2020
Review Date	December 2025 or sooner if subject to any new updates nationally