Worcestershire Acute Hospitals NHS Trust

Guidelines for the Management of Constipation: Adult Patients

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This is a guideline for the safe and effective treatment of patients with constipation. It includes the patient assessment, screening and monitoring required for this drug therapy.

This guideline is for use by the following staff groups :

This guideline has been developed to inform nurses and other health care professionals regarding the prescribing, administration and monitoring of patients who are constipated.

Lead clinician(s)

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Reviewed: This is the most current document and is to be used until a revised version is available:	4th November 2022

Key amendments to this guideline

Date	Amendment	by:
14th January 2014	New guideline	
September 2016	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
August 2017	Document extended for 6 months as per TMC paper approval	TMC
December 2017	Sentence added in at the request of the Coroner	
June 2017	Addition of lubipristone for chronic constipation	M Ladwa
August 2019	Removal of Lubiprostone after discontinuation Addition of “Summary of Laxative Use in Pregnancy and Breastfeeding” table	M Ladwa

Guidelines for the Management of Constipation in Adults

Introduction

Constipation is 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.

Details Of Guideline

Use of laxatives/drug therapy to relieve constipation should be considered as a cause for a change in bowel habit when assessing patients who develop diarrhoea/loose stools *before* making a decision whether sending a sample for diagnostic testing (to exclude infection, including *C difficile)* is clinically indicated. Where symptoms are clearly related to the use of aperients, the submission of a stool sample for testing is *not* routinely indicated.

Assessment

Choice of treatment for each patient may depend on several factors and it is essential that all patients are assessed before treatment is commenced.

- Clarify what the person understands by their constipation.
- Assess the presence and degree of faecal loading/impaction and faecal incontinence.
- Assess the severity and impact of the constipation and any faecal incontinence.
- Assess the role of predisposing factors (including drug treatment of co-morbidities).
- Identify any organic causes of constipation.
- Assess effectiveness of management to date.

There is no ideal treatment but the following flow chart gives guidance on how patients may be treated for constipation and impaction.

SUMMARY OF MANAGEMENT OF CONSTIPATION: FLOWCHART

Patient presenting with suspected constipation
Passage of hard stools less frequent than the patient's own normal pattern

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Confirm abnormal bowel function / altered routine
e.g. PR examination / Bowel Diary / Stool Chart

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Identify cause
Consider disease, immobility, diet, drugs (e.g. analgesics, calcium or aluminium antacids, anticholinergics, antidepressants, antiparkinsonian drugs, calcium supplements, diuretics, and iron)

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Initial Management
Counsel patient about ensuring adequate fluid intake, increasing dietary fibre, increasing exercise. Review medication and change to less constipating drugs where possible

↓

If drug therapy necessary

ACUTE
(Short term, prompt effect)
ENSURE ADEQUATE FLUID INTAKE and ENCOURAGE MOBILISATION
If drug-induced, avoid causative agent if possible

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Senna (stimulant) 7.5mg tablets. 2 – 4 tablets at night when required.
If necessary add **Docusate** (softener) 100mg capsules. 100mg two to three times daily or 200mg twice a day (up to 500mg /day if needed)

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Macrogol (Movicol)
Can be used if no response to above for severe constipation.
1-3 sachets daily in divided doses, adjust to 1-2 daily according to response

CHRONIC
(Long term use, delayed onset)

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Ispaghula Husk (Fybogel) 3.5g sachet. One sachet once or twice a day

↓

Senna. 2 tablets at night

↓

If needed add **Docusate** 100mg capsules. 100mg three times daily (up to 500mg/day if needed) **or glycerine** suppositories 4g daily

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Prucalopride may be used (see below) where other treatments have failed.

IMPACTION

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For hard stools use **Macrogol (Movicol)** sachets, 8 sachets daily for a max of 3 days (stop when bowels opened). Other regular laxatives e.g. senna and docusate sodium should also be given and continued until

↓

If impaction difficult to clear, use **Sodium Citrate enema** as necessary or **Phosphate enema**

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If ineffective try manual evacuation (caution in patients with spinal injury)

PALLIATIVE CARE

↓

SEE PAGE 4 FOR GUIDANCE

Use of Laxatives in Palliative Care

Step One

Confirmation of the presence of constipation is **not** a valid indication for an abdominal x-ray.
If the index diagnosis and recent history make them reasonable possibilities, exclude conditions such as

- Partial or complete bowel obstruction.
- Spinal cord compression.
- Hypercalcaemia of malignancy.
- Excessive anticholinergic burden or other pharmacological cause.

Treat the underlying cause appropriately, and also consider the on-going implications for bowel management. Obtain advice from the hospital palliative care team if necessary.

Step Two

If, compared to the patient's recent habitual pattern of defaecation, no formed stool has been passed for a considerable time then

- Exclude faecal impaction by performing a PR examination.
  This becomes particularly important if recent stool has been very hard or if there has been involuntary passage of diarrhoea suggestive of overflow incontinence.

Possible approaches to faecal impaction include:

- High dose oral **macrogo**l (e.g. **4-8 sachets/day in divided doses**, with plenty of water. Not suitable for heart failure patients).
- **One glycerine suppository 4g** combined with **10mg bisacodyl** suppository **stat**.
- Phosphate enema stat.
- Manual disimpaction of faeces.

Always prescribe regular oral laxative to prevent the problem from returning.
Consider obtaining advice from the hospital palliative care team if your initial intervention is ineffective.

Step Three

In the non-moribund palliative care patient:

- Encourage a suitable level of hydration and mobility.
- Review the continued need for any potentially constipating drugs (e.g. diuretics, anticholinergics, tricyclic antidepressants, opioids, etc)
- Introduce a suitable oral laxative regimen such as
  - **Macrogol 1 sachet twice a day**
  - **Co-danthramer 2 capsules at night** (Contraindicated for patients with urinary or faecal incontinence)
  - **Senna 15mg at night** plus/minus **Docusate 200mg twice a day**
- Monitor the impact of the laxative and titrate the dose up or down according to clinical response.
- Unless there are good grounds for their use, ***avoid***
  - Lactulose (risk of bloating and abdominal discomfort)
  - Ispaghula (the fluid intake of most palliative care is insufficient for the use of this approach).
- ***Always remember to review the laxative requirements whenever an opioid is introduced or its dose is changed***.

Step Four

In the obviously moribund patient

- It is clearly inappropriate to induce defaecation.

- Use **hyoscine butylbromide**, plus or minus opioid, by syringe driver to palliate abdominal pain/colic during the closing hours of life.

Additional Information

Laxative	Onset of action
Senna tablets (or liquid)	8 to 12 hours
Ispaghula Husk	Up to 48 hours
Movicol sachets	1 to 2 days
Docusate capsules (or liquid)	1 to 2 days
Glycerin suppositories	1 to 2 hours
Phosphate enema	30mins to 1 hour

Senna tablets (or liquid)
Stimulant laxative. Stimulant laxatives can increase intestinal mobility and often cause abdominal cramp therefore should be avoided in intestinal obstruction. Excessive use can cause diarrhoea and related effects such as hypokalaemia. Can be given as a Patient Group Direction (see PGD DA/AG/14).

Ispaghula Husk
Bulk forming laxative. Useful in the management of patients with colostomy, ileostomy, haemorrhoids, anal fissure, chronic diarrhoea associated with diverticular disease, irritable bowel syndrome and as an adjunct in ulcerative colitis. Adequate fluid intake should be ensured to avoid intestinal obstruction. Contra-indicated in patients with swallowing difficulties, intestinal obstruction, colonic atony and faecal impaction. Should not be taken prior to going to bed, therefore last dose should be given at 6pm. Side effects include flatulence and abdominal distension.

Macrogol sachets
Osmotic laxative. Ensure adequate fluid intake to avoid dehydration. Contra-indicated in patients with intestinal perforation or obstruction, paralytic ileus and severe inflammatory conditions of the intestinal tract (e.g. crohn's disease, ulcerative colitis, toxic megacolon)

Docusate capsules (or liquid)
Stimulant laxative but also a softening agent. Stimulant laxatives can increase intestinal mobility and often cause abdominal cramp therefore should be avoided in intestinal obstruction. Excessive use can cause diarrhoea and related effects such as hypokalaemia. Can be given as a Patient Group Direction (see PGD DA/AG/12).

Glycerin suppositories
Moisten with water prior to use. Acts as a rectal stimulant by virtue of the mildly irritant action of glycerol. Can be given as a Patient Group Direction (see PGD DA/AG/16).

Phosphate enema
Osmotic laxative. Use with caution in elderly and debilitated patients. Contra-indicated in acute gastro-intestinal conditions. Useful in bowel clearance before radiology, endoscopy and surgery. Can be given as a Patient Group Direction (see PGD DA/AG/13).

Prucalopride
This is recommended as an option for the treatment of chronic constipation in adults for whom 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 and invasive treatment for constipation is being considered. If treatment with prucalopride is not

effective after 4 weeks, continuing therapy should be reviewed. Prucalopride should only be initiated in secondary care by a clinician with experience of treating chronic constipation, who has carefully reviewed the patient's previous courses of laxative treatments. If treatment is deemed appropriate for continuation, patients can obtain further supplies from their GP.

Other laxatives

Lactulose

Osmotic laxative. *Should only be used in hepatic encephalopathy* (recommended dose 30 to 50mls three times daily, subsequently adjusted to produce two to three loose stools daily). Unsuitable when rapid relief of constipation is required. Use with caution in patients with lactose intolerance and contra-indicated in patients with intestinal obstruction. Common side effects include flatulence, cramps, and abdominal discomfort. Requires adequate fluid intake to be effective.

Microlax / micro-enema (sodium citrate)

May give rise to sodium and water retention in susceptible individuals. Contra-indicated in patients with acute gastro-intestinal conditions. Can be given as a Patient Group Direction (see PGD DA/AG/15).

Bisacodyl

Stimulant laxative. Suppositories may cause local irritation. Can increase intestinal mobility and often cause abdominal cramp therefore should be avoided in intestinal obstruction. Excessive use can cause diarrhoea and related effects such as hypokalaemia.

Co-danthramer

Restricted for use in terminally ill patients. May colour urine.

Sodium picosulphate

Stimulant laxative. Caution in active inflammatory bowel disease (avoid if fulminant). Picolax® sachets to be used for bowel evacuation in radiological, endoscopic and surgical procedures.

Other patient groups

Children

Lactulose and Macrogol are commonly used in children. Consult the paediatric pharmacist for further advice or Medicines Information (via switchboard) or BNFC.

Pregnancy

Ispaghula husk should be used as first line. Lactulose is also safe in pregnancy, Sodium docusate has also been used with no evidence of adverse effects. Bisacodyl and Senna may be suitable for short term use if other treatments have been ineffective, but should be avoided in the third trimester. Further advice should be obtained from Medicines Information (via switchboard). See table below for summarised information.

Breastfeeding

Ispaghula husk should be used as first line, lactulose may also be used. Glycerin suppositories have a local action therefore pose no problem for the breastfed infant. Stimulant laxatives may cause colic and/or diarrhoea in the infant therefore should be avoided. See table below for summarised information.

Summary of Laxative Use in Pregnancy and Breastfeeding

Laxative	Use in Pregnancy	Use in Breastfeeding
Lactulose	Safe to use	Safe to use for short term
Movicol (Macrogol)	Safe to use	Safe to use for short term
Bisacodyl	Safe to use	Use as 2nd line
Sodium Picosulphate	Safe to use	Safe to use if infant is over 1 month old
Senna	Use with caution around term	Safe to use if infant is over 1 month old
Docusate Sodium	Safe to use	Orally – use with caution Rectally – Safe to use
Ispagula Husk (bulk forming)	Safe to use	Safe to use
Glyceryl Suppositories	No evidence for safety but commonly used	Local action, no effect on infant
Enemas	Use with caution, seek further advice	Use with caution, seek further advice
Linaclotide	Seek advice from MI*	Seek advice from MI*
Prucalopride	Seek advice from MI*	Seek advice from MI*

**Medicine Information (contact via switchboard)*

Elderly
Ispaghula husk is not suitable for immobile elderly patients or those with inadequate fluid intake. A stimulant such as Senna, with or without a softener such as docusate is more appropriate in these patients. Osmotic laxatives such as Lactulose and Macrogol may also be unsuitable if fluid intake is poor.

Haemorrhoidectomy / anal fissure patients
Post-operatively, give 2 weeks of sodium docusate and either Senna or Ispaghula husk.

Irritable Bowel Syndrome
Linaclotide – currently non-formulary

Hepatic encephalopathy
Lactulose is recommended (see notes above).

Discharge - All patients prescribed laxatives during their admission should be reviewed on discharge to assess whether or not they are still necessary. All patients subsequently discharged on laxatives should have a request for a review within 2 weeks included on their discharge letter.

Monitoring Tool

How will monitoring be carried out? Audit of 10 patient notes

Who will monitor compliance with the guideline? Member of the gastroenterology team or Gastroenterology pharmacist

STANDARDS	%	CLINICAL EXCEPTIONS
All patients will be treated for constipation using the above guidance	80%	Any intolerance to any of the suggested drug therapy

References

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4. Hull and East Riding Guideline on Management of Constipation. Updated May 2016. https://www.hey.nhs.uk/wp/wp-content/uploads/2016/03/treatmentConstipation.pdf (date accessed 04/07/2019)
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Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	No	Adult patients only
	• Disability	No	
	• Gender reassignment	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
	• Race	No	
	• Religion or belief	No	
	• Sex	No	
	• Sexual orientation		
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	No	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	No	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval