The Newcastle upon Tyne Hospitals NHS Foundation Trust

Treatment of Constipation (in Adults)

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1 Introduction

These guidelines have been developed to facilitate the standardisation of care for Adult patients with constipation throughout the Newcastle upon Tyne Hospitals NHS Foundation Trust.

The key aims of this document are:

- To standardise appropriate prescribing of laxatives within the Trust
- To assist Registered Nursing, Midwifery, Medical staff and Pharmacist staff to prescribe the most appropriate laxative
- To identify key factors in the assessment of constipation
- To ensure that patients receive evidence based care in the management of constipation

2 Guideline Scope

This document **does not** encompass the management of adult critical care patients. For those with palliative care needs it should be read in conjunction with local Palliative and End of Life Care Guidelines (NECN, 2016).

3 Definition and Symptoms

3.1 Definition

There is no accepted definition for constipation. The term is most commonly used to mean difficult and/or infrequent defaecation. Constipation may be associated with a variety of symptoms besides difficulty in evacuating rectal contents.

3.2 Symptoms Associated with the term Constipation

Defaecation	Abdomen	General
Infrequent stools	Bloating (distension) Decreased or absent bowel sounds	Bad taste in mouth
No urge	Discomfort or pain, related or unrelated to defaecation	Headache
Stools difficult to pass		Nausea/Vomiting
Ineffective straining		Malaise
Need to digitate/splint perineum		Anorexia
Sense of incomplete evacuation		Haemorrhoids or Fissure
Anal or perianal pain		
Prolapse 'comes down' at the anus		
Soiling of clothes		
Flatus (increase or decrease)		
Rectal bleeding		

Be alert for any red flags that might indicate a serious underlying condition.

- Unexplained change in bowel habit
- Rectal bleeding in the absence of haemorrhoids or anal fissure
- Family history of colon cancer or inflammatory bowel disease
- Unexplained weight loss or iron deficiency anaemia
- Inability to pass flatus
- +/- severe vomiting or abdominal pain

3.3 Patient Assessment

The key to successful management of constipation is the assessment and identification of the underlying cause. There are many contributory factors associated with constipation and individuals often experience more than one underlying problem. Assessment should be made through observation and/or questioning. The assessment should include the following:

- Assessment of bowel function
- Mobility
- Dexterity
- Dietary intake and the ability to chew/swallow
- Fluid intake
- Mouth care
- Pregnancy
- Neurological conditions
- Mechanical obstruction
- Underlying disease (Figure 1)
- Previous treatment for constipation

- Medication (refer to Figure 2)

A digital rectal examination must only be performed by a qualified nurse/midwife and doctor who has received training and is competent in digital rectal examination (RCN 2019).

A digital rectal examination should be performed as part of the assessment of constipation. A gentle digital examination of the rectum will provide information about any stool present (use the Bristol Stool Form Scale, Figure 3) and any local discomfort, which may be inhibiting the individual's bowel activity for fear of inducing pain. The rectum is usually empty until the 'call to stool', but often contains hard stools if suffering from constipation.

(Figure 1)

Conditions which may cause or contribute to constipation include:

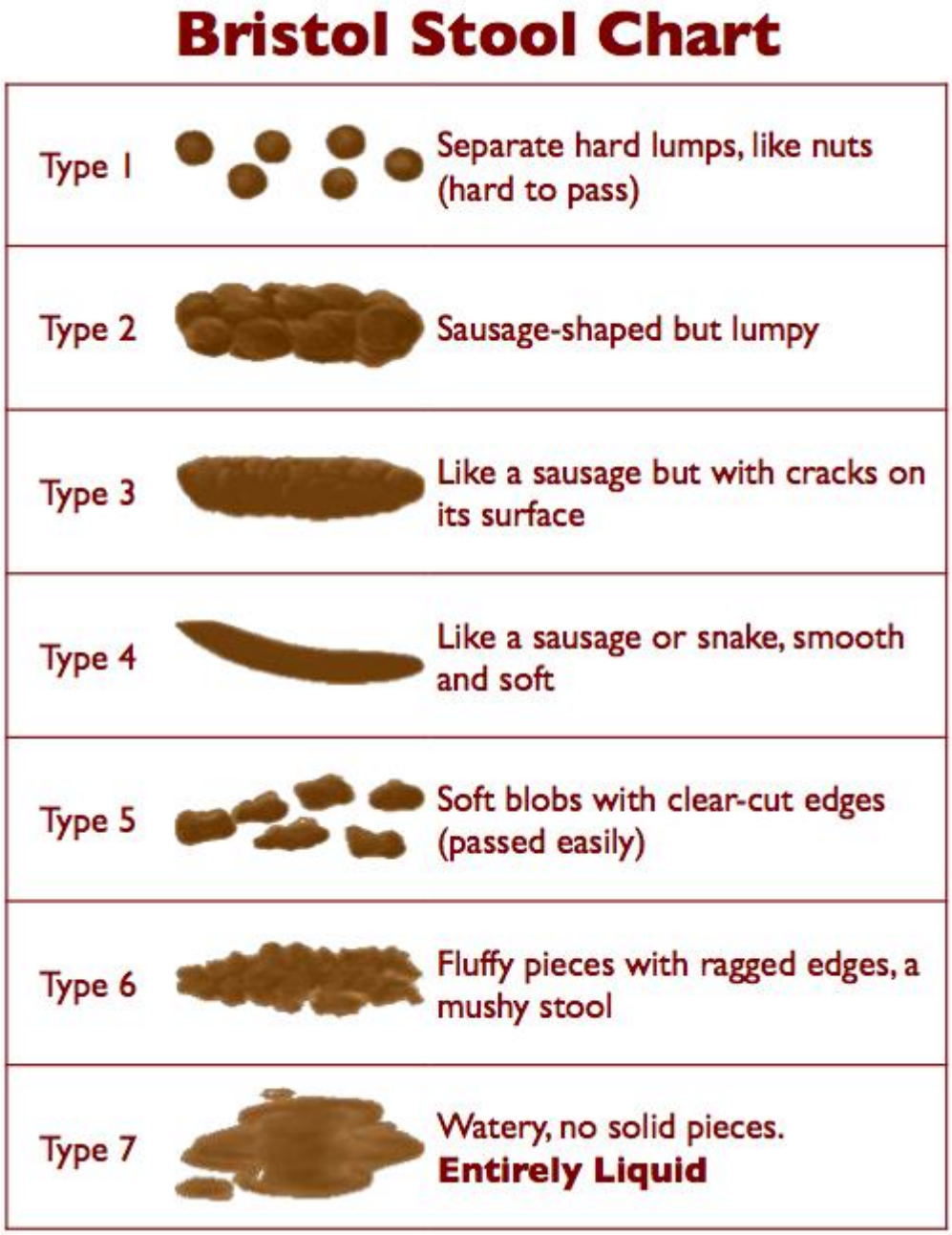
- Bowel obstruction
- Irritable bowel syndrome
- Cancer
- Diverticular disease
- Dehydration
- Hospitalisation
- Medication
- Immobility
- Hypothyroidism
- Neurological
- Stimulant laxative abuse
- Eating disorders
- Hypercalcaemia
- Pregnancy
- Depression

(Figure 2)

Drugs which may cause constipation include

- Opioid analgesics, including compound products e.g. Co-codamol, Co-dydramol
- Drugs with antimuscarinic (anticholinergic) effects – particularly tricyclic/ antidepressants; also SSRI/SNRI antidepressants, antipsychotics (especially Clozapine); antimuscarinic anti-parkinsonian drugs, e.g. Orphenadrine, Procyclidine and also dopaminergic agents, e.g. pramipexole and entacapone; sedative antihistamines e.g. promethazine and chlorphenamine, antispasmodics, e.g. hyoscine
- Calcium salts (note: contained in some antacids & phosphate binders)
- Aluminium salts (in many antacids)
- Iron salts
- Calcium channel blockers (mainly verapamil)
- NSAIDs (more commonly cause diarrhoea)
- $5HT_3$ antagonists, e.g. Ondansetron
- Diuretics
- Some antiepileptics e.g. phenytoin, carbamazepine
- Colestyramine

(Figure 3)



4 Main body of the guidelines

4.1 Short-term Use in Acute Constipation

For general short-term use stimulant laxatives such as senna are a rational choice. They are usually taken at bedtime to produce a bowel movement the following morning (8 to 12 hours after oral administration). It is generally advisable to start with low doses to avoid abdominal pain.
In patients with peri-anal problems or following rectal surgery, in whom straining at defaecation is to be avoided, a stool softener such as docusate may be all that is required. Addition of a stool softener should also be considered if stools are hard and impacted.

Note: Rectal docusate preparations should not be used in these circumstances.

4.2 Long-term Use in Chronic Constipation

Bulk forming laxatives are generally suitable where chronic treatment is thought to be necessary and patients find it difficult to increase fibre content of the diet. They take several days to be effective and must be taken with an adequate amount of fluid.

They should not be used in patients with atonic bowel as obstruction may occur. They should not be taken immediately before bed (the recommended times are 8am and 6pm).

4.3 The older patient

Whilst bulk forming laxatives are suitable for use as bowel regulators in relatively fit older patients, they should not normally be used in those with atonic bowels (risk of obstruction), and are not always suitable for those who are immobile, chronically ill or disabled. In such patients a stimulant laxative such as senna is a rational choice.

4.4 Chronic Opioid Use (not in patients with malignancy see palliative care section)

Patients taking opioid analgesics should be prescribed regular laxative treatment to prevent and treat opioid induced constipation. A preparation containing a stimulant laxative, e.g. Senna is recommended and a faecal softener may also be beneficial such as Docusate Sodium. High doses may be needed in these patients.

4.5 Rapid Evacuation

Fleet Phosphate enemas are usually effective within minutes and Bisacodyl or Glycerol Suppositories usually act within 1 to 2 hours.

Bowel cleansing solutions including, Moviprep, Picolax and Klean prep are usually used for bowel preparation prior to diagnostic tests or surgery, but can also be used with caution in difficult cases of constipation where other agents have failed or are unsuitable (unlicensed use). They are **not** suitable for regular use.

4.6 Palliative Care and Constipation

Constipation is common in patients with advanced illness. In this patient group reversible causes of constipation should be considered. This may include fluid depletion, medications, electrolyte imbalances (hypercalcemia, hypokalaemia), reduced food intake, immobility and environmental considerations i.e. lack of privacy (NECN, guidelines 2016).

A preparation containing a stimulant (e.g. senna or bisacodyl) or a softener (e.g. Docusate Sodium) should be prescribed 1st line. Current stool consistency should guide which agent to give (e.g. harder stools – use docusate, softer stools – use senna). If constipation continues these 2 agents can be used in combination. Following this, adding macrogols can be considered but the patient must be able to tolerate the necessary volume of oral fluids. PR examination and intervention is indicated if constipation continues or if the patient is have swallowing difficulties.

Use of Suppositories and Enemas should only be given after consultation with Medical staff and/or appropriate Nurse Specialist. Glycerin suppositories +/- Arachis oil enema will help soften hard impacted faeces. Soft stool or an empty rectum on PR examination may suggest higher faecal impaction and bisacodyl suppositories +/- phosphate enema should be considered (NECN guidelines 2016). PR examination and intervention should be avoided in patients on chemotherapy who may be neutropenic due to risk of serious infection (NICE CKN 2016).

In some complex cases Co-danthramer (Danthron and Poloxamer) may be used to treat constipation, but this should be guided by a specialist team. Danthron may cause temporary harmless pink or red colouring of the urine. It may also cause perineal erythema in patients with urinary and/or faecal incontinence and should not be used in patients who are incontinent.

Constipation as a result of neurological compromise (e.g. spinal cord compression) is common and stool softeners (docusate) are recommended. Some patients require a ‘3-day bowel regime’ where suppositories are used every 1-3 days to regulate bowel motions. Caution is recommended with stimulant laxatives as this can cause uncontrolled bowel emptying (NECN 2016).

Constipation is a common side effect of Opiate use and co-prescribing a laxative (e.g. Senna) is recommended with the aim of achieving a regular bowel movement without straining every 1-3 days (NICE CKN 2016).

If there is poor response to treatment, or uncertainty regarding cause of constipation, seek advice from the palliative care team.

4.7 Macrogols

For chronic constipation 1-3 sachets daily in divided doses usually for up to 2 weeks. Contents of each sachet should be dissolved in **exactly 125ml of fluid**; a maintenance dose of 1-2 sachets daily may be given.

For faecal impaction, 8 sachets daily dissolved in 1 litre of water and drunk within 6 hours, usually for a maximum of 3 days. Reduce to maintenance dose subsequently if required.

Daily assessment of bowel function should be undertaken.

Caution: patients with impaired cardiovascular function should not take more than 2 sachets in any one hour.

Patients being discharged on macrogols: Staff to inform GP and GP to review medication in one month.

4.8 Suppositories

Glycerol suppositories should be administered when there are hard faeces in the rectum.

Bisacodyl suppositories should be administered when the rectum is empty, but the colon is still loaded.

4.9 Sodium Citrate

(Microlax Enema) Useful to remove hard, impacted stools. Correct administration important to prevent damage to rectal mucosa. Licensed for occasional use Sodium Citrate has a low risk of habituation so it can be used every day for acute constipation or as a preparation for investigations over a short period. However, it is not intended for chronic constipation and long-term use.

4.10 Lactulose

Lactulose can only be prescribed to prevent hepatic encephalopathy.

4.11 Note

Please note Senna sugar free syrup and Docusate Sodium oral solution are available for use in patients who have difficulty swallowing tablets/capsules.

There are new drugs available, e.g Prucalopride, Linaclotide and Lubiprostone. Also Naloxegol is an option for chronic induced constipation. These drugs should only be prescribed by a clinician with experience of treating chronic constipation.

All medications must be prescribed prior to administration.

5 Training, implementation and resources

The Registered nurse/midwife, doctor or pharmacist is responsible for ensuring that safe and effective prescribing for the treatment of constipation is maintained for all appropriate patients within the Trust.

The Trust will provide training for the Registered nurse/midwife and qualified medical staff. This can be achieved as follows: -

- Nurse Specialists Colorectal care, Nurse Specialist Continence Care, Nurse Consultant Continence Care, Nurse Specialist Palliative Care
- By providing formal teaching programmes, using teaching models in the Clinical Skills Lab to develop practical skills

6 Future Management of constipation

Future audit work will include an audit of multidisciplinary staff knowledge about the management of constipation prescribing practice and management of constipation within a year of disseminating the guidelines.

7 References:

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- NICE (2016) Clinical Knowledge Summaries, Palliative Care – Constipation https://cks.nice.org.uk/palliative-care-constipation
- NICE (2019) Constipation Pathway
- NICE (2017) Clinical guideline CG61. Irritable bowel syndrome in adults diagnosis and management https://www.nice.org.uk/guidance/cg61?UNLID=43729385720205185535

- Royal College of Nursing September 2019; Bowel Care Management of Lower Bowel Dysfunction, including Digital Rectal Examination and Digital Removal of faeces file:///C:/Users/reesj/Downloads/007-522%20(3).pdf

- Palliative Care Formulary 4th Edition (2012) Robert Tycross & Andrew Wilcock
- North of England Clinical Networks Palliative and End of Life Care Guidelines. Fourth Edition: 2016.

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