PAN MERSEY AREA PRESCRIBING COMMITTEE
PRESCRIBING GUIDELINE
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NHS Pan Mersey Area Prescribing Committee

Management of Chronic Constipation in Adult Patients in Primary Care

[NB/] Not applicable for palliative care patients with far advanced and/or terminal disease

Symptoms of functional constipation (Rome III criteria) [1]

1. Two or more of the following*:

- Straining during >25% of defecation.
- Sensation of incomplete evacuation for >25% of defecation.
- Lumpy or hard stool for >25% of defecation.
- Sensation of anorectal obstruction/blockage for >25% defecation.
- Less than three bowel movements per week.
- Manual manoeuvres to facilitate at least 25% of defecations (e.g. digital evacuation, support of the pelvic floor)

2. Loose stool rarely present without the use of laxatives*.

3. Insufficient criteria to indicate IBS*.

* Symptoms fulfilled for last 3 months with onset at least 6 months prior to diagnosis.

FAECAL IMPACTION [2]

A rectal examination should be performed to exclude faecal loading and/or impaction. If present, relieve faecal loading and/or impaction adjusting dose, choice and combination of laxatives depending on patient's response to treatment and personal preference:

- If there are hard stools, consider prescribing a high dose oral macrogol.
- If there are soft stools, or ongoing hard stools after a few days of treatment with oral macrogol, consider starting or adding an oral stimulant laxative.
- If the response to oral laxatives is inadequate or too slow, consider prescribing a suppository such as bisacodyl for soft stools; glycerol alone or glycerol plus bisacodyl for hard stools.

STEP ONE: EXISTING TREATMENTS

Review existing treatments and, where appropriate, offer alternatives.

Some common medications which may cause constipation [3]:

- Calcium channel blockers
- Diuretics
- Tricyclic antidepressants
- Iron preparations
- Anti-cholinergic medications
- Sedating antihistamines
- Antimuscarinics
- Opioids – see opioid induced constipation below.
- Clozapine – needs active treatment due to fatalities reported see MHRA guidance.

STEP TWO: DIETARY & LIFESTYLE ADVICE

- Normal bowel movements range from once every three days to three times per day. Establish what is 'normal' for the patient.
- Advise patients to respond immediately to their need to defecate.
- Advise patients to increase their physical activity as this has been shown to provide a benefit.
- Diets should be balanced and contain whole grains, fruits and vegetables, with fibre intake gradually increased and maintained. Adults should aim to consume 18-30g of fibre each day.
- Adequate fluid intake to maintain hydration should be encouraged. European Food Safety Authority (EFSA) recommends 2.5litres for water for men and 2.0 litres of water for women with 70 – 80% of that coming via drinks [4].
- Natural laxatives, i.e. fruit and fruit juices, higher in sorbitol can be recommended.

STEP THREE: CONSIDER COMMENCING REGULAR LAXATIVES [2]

Should only be considered if:

1. Lifestyle measures are insufficient.
2. Patient is taking a constipating medication that can't be stopped.
3. For those with secondary causes of constipation.
4. As a rescue for episodes of faecal loading.

Bulk forming laxative:	**Ispaghula Husk 3.5g**	**ONE sachet TWICE per day [3].**	

If stool remains hard or difficult to pass add or switch to:

Osmotic Laxative:	**1st line**	**Macrogol**	**ONE to THREE sachets daily [3].**	Ineffective / not tolerated
	2nd line	**Lactulose**	**15ml TWICE per day then adjust [3].**	

If stool remains difficult to pass or if inadequate emptying consider adding a stimulant to existing therapy.

Stimulant:	**Bisacodyl tablets 5mg**	**1-2 at NIGHT**	**[Can increase to max 20mg] [3].**
or	**Senna 7.5mg tablets**	**1-2 at NIGHT**	**[Can increase to max 30mg daily] [3].**
or	**Docusate sodium 100mg capsules ***		**UP TO 5 daily in divided doses [3]**

***A stool softener with some stimulant effect.**

Review after 3 – 4 weeks – Advise patient to continue until effective and once stools are soft and easily passed again withdraw laxatives slowly.

Use ONLY ONE laxative from each category and reassess if symptoms persist for > 6 months

STEP FOUR: CONSIDER COMMENCING SECOND CHOICE OPTIONS

Should **ONLY** be considered if **at least two** laxatives from different classes have been taken regularly at the highest tolerated/ recommended doses for at least 6 months, they have failed to relieve symptoms and invasive treatment is being considered.

Second Choice Green **Linaclotide [3]** **290microgram ONCE daily taken 30mins before meals.**
Constipation with irritable bowel syndrome – review after 4 weeks if no response.

Second Choice Green **Prucalopride (NICE TA 211) [5]** **2mg ONCE daily [1mg daily if several renal impairment or + 65 years].**
Review treatment after 4 weeks if no response.

Second Choice Green **Lubiprostone (NICE TA 318) [6]** **24microgram TWICE per day.**
Initial treatment course is 2 weeks after which response should be assessed.

FOR OPIOID-INDUCED CONSTIPATION [7]:

- Inform patients that constipation affects nearly all patients receiving strong opioid treatment.
- Prescribe **softener and stimulant first line** (taken regularly at effective dose) for patients on strong opioids.
- Inform all patients that treatment for constipation takes time to work and adherence is important.
- Optimise laxative treatment for managing constipation before considering switching strong opioids.

Second line for opioid induced constipation when not adequately responded to laxatives:

Green Naloxegol (NICE TA 345) [8] 25mg to be taken ONCE per day [12.5mg renal impairment]

All currently used maintenance laxatives therapy should be halted, until clinical effect of naloxegol is determined.

Green Naldemedine (NICE TA651) [9] 200 micrograms ONCE per day

REFERENCES:

[1] Rome III diagnostic criteria for function gastrointestinal disorders available here.
[2] NICE CKS; June 2017; Constipation available here.
[3] BNF online; accessed September 2017 here.
[4] Dietary reference value for water; EFSA Journal; March 2010; European Food Safety Authority; available here.
[5] NICE TA 211; Prucalopride for the treatment of chronic constipation in women; December 2010.
[6] NICE TA 318; Lubiprostone for treating chronic idiopathic constipation; July 2014.
[7] NICE CG 140; Palliative care for adults: strong opioids for pain relief; August 2016.
[8] NICE TA 345; Naloxegol for treating opioid-induced constipation; July 2015. [9] NICE TA 651; Naldemedine for treating opioid-induced constipation