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*.

**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
- Iron preparations
- Antimuscarinics
- Clozapine – needs active treatment due to fatalities reported see MHRA guidance.

- Diuretics
- Anti-cholinergic medications
- Tricyclic antidepressants
- Sedating antihistamines
- Opioids – see opioid induced constipation below.

**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

**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.

<table>
<thead>
<tr>
<th>Bulk forming laxative:</th>
<th>Ispaghula Husk 3.5g</th>
<th>ONE sachet TWICE per day [3].</th>
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</table>

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

<table>
<thead>
<tr>
<th>Laxative:</th>
<th>1st line</th>
<th>2nd line</th>
<th>Ineffective / not tolerated</th>
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<tbody>
<tr>
<td>Osmotic</td>
<td>Macrogol</td>
<td>Lactulose</td>
<td>ONE to THREE sachets daily [3],</td>
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<td></td>
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<td></td>
<td>15ml TWICE per day then adjust [3].</td>
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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.

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<tbody>
<tr>
<td>Constipation with irritable bowel syndrome – review after 4 weeks if no response.</td>
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<thead>
<tr>
<th>Second Choice</th>
<th>Prucalopride (NICE TA 211) [5]</th>
<th>2mg ONCE daily [1mg daily if several renal impairment or + 65 years].</th>
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<td>Review treatment after 4 weeks if no response.</td>
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<tr>
<th>Second Choice</th>
<th>Lubiprostone (NICE TA 318) [6]</th>
<th>24microgram TWICE per day.</th>
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<td>Initial treatment course is 2 weeks after which response should be assessed.</td>
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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:**

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<tr>
<th>Green</th>
<th>Naloxegol (NICE TA 345) [8]</th>
<th>25mg to be taken ONCE per day [12.5mg renal impairment]</th>
</tr>
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All currently used maintenance laxatives therapy should be halted, until clinical effect of naloxegol is determined.

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<tr>
<th>Green</th>
<th>Naldemedine (NICE TA 651) [9]</th>
<th>200 micrograms ONCE per day</th>
</tr>
</thead>
</table>

REFERENCES:
[2] NICE CKS, June 2017; Constipation available here.
[4] Dietary reference value for water; EFSA Journal; March 2010; European Food Safety Authority; available here.