

Treatment of Constipation (in Adults)

Aims of the guidelines

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. This document does not encompass the management of adult critical care patients (NUTH NHS Trust 2004) and should be read in conjunction with local documentation pertaining to the needs of palliative care patients (NCN 2005). The key aims of this document are:

- To standardise appropriate prescribing of aperients within the Trust
- To assist qualified nursing, midwifery, medical and pharmacist staff to prescribe the most appropriate aperients
- To identify key factors in the assessment of constipation
- To ensure that patients receive evidence based care in the management of constipation

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. (Figure 1)

Symptoms Associated with the term Constipation (Figure 1)

Defaecation	Abdomen	General
Infrequent stools	Bloating (distension)	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		Anorexia
Sense of incomplete evacuation		
Anal or perianal pain		
Prolapse 'comes down' at the anus		
Soiling of clothes		

Patient Assessment

The key to successful management of constipation lies in 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

Diet - ability to chew/swallow
Fluid intake
Mouth care
Medication (Figure 3)
Pregnancy
Stroke
Mechanical obstruction
Underlying disease (Figure 2)

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 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.

A digital rectal examination should only be performed by a qualified nurse/doctor who is competent to do so (RCN 2000).

(Figure 2)

Conditions which may cause or contribute to constipation

- Bowel obstruction
- Irritable bowel syndrome
- Cancer
- Diverticular disease
- Dehydration
- Admission to hospital for any cause
- Hypothyroidism
- Neuromuscular disorders
- Stimulant laxative abuse
- Anorexia
- Hypercalcaemia
- Pregnancy

(Figure 3)

Drugs which may cause constipation

- Opioid analgesics, including compound products e.g. co-codamol, co-cydramol.
- Drugs with antimuscarinic (anticholinergic) effects – Tricyclic/ SSRI/SNRI antidepressants; antipsychotics; antimuscarinic anti-parkinsonian drugs e.g. orphenadrine, benztropine, trihexyphenidyl, procyclidine; antihistamines – especially older sedating antihistamines e.g. chlorphenamine, promethazine and cyclizine; antispasmodics e.g. propantheline, hyoscine.
- Calcium salts (note: contained in some antacids & phosphate binders).
- Aluminium salts (in many antacids).
- Iron salts.
- Calcium channel blockers (mainly verapamil).
- Phenothiazines
- NSAIDs (more commonly cause diarrhoea).
- 5HT₃ antagonists e.g. Ondansetron

Notes

a) 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.

b) Long-term Use in Chronic Constipation

Bulk forming laxatives are generally suitable where chronic treatment is thought to be necessary. 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 ensue. They should not be taken immediately before bed (the recommended times are 8am and 6pm).

c) 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 unsuitable for those who are immobile, chronically ill or disabled. In such patients a stimulant laxative such as senna is a rational choice.

d) Chronic Opioid Use (not in patients with malignancy)

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 sodium docusate. High doses may be needed in these patients.

e) Rapid Evacuation

If rapid evacuation is required (within 1 to 2 hours) oral magnesium salts are suitable (**e.g. magnesium sulphate**). Enemas are usually effective within minutes and bisacodyl or glycerol suppositories usually act within 1 to 2 hours. Picolax and bowel cleansing solutions (e.g. 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.

f) Palliative Care and Constipation

Palliative care patients and other patients taking opioids should be prescribed regular laxative treatment. A preparation containing a stimulant (e.g. senna) and a softener (e.g. docusate sodium) should be prescribed. Co-danthramer, a combination product containing the stimulant laxative, dantron and the faecal softener poloxamer or Co-danthrusate (dantron and docusate sodium) may be used to treat opioid induced constipation, but are only licensed for use in terminally ill patients.

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

g) Macrogols (Movicol)

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 with Movicol: Staff to inform GP and GP to review medication in one month.

h) 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.

i) Lactulose

Avoid use of lactulose as this preparation commonly causes bloating, flatulence and cramping. Lactulose is also very sweet and unpalatable to some patients. It must be taken regularly for up to 3 days before an effect is seen, making it unsuitable for rapid relief of constipation or for "as required" dosing.

In addition, it is also relatively expensive and there is no convincing evidence that lactulose provides an advantage over other, less expensive laxatives.

J) Note

Please note Senna and Docusate Sodium is available in suspension

All medications must be prescribed prior to administration.

Membership group:

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Consultation with all members of the multidisciplinary team including:

Consultant Colorectal Surgeons

Palliative Care Consultants – Claud Regnard and Kath Mannix

Consultants in Elderly Care

Formulary Pharmacist, Mr G Trueman

Future Management of constipation

Future audit work will include audit of prescribing practice and management of constipation within a year of disseminating the guidelines.

References

British National Formulary 2005 <http://webapp1/bnf/lform1/current/>

Northern Cancer Network (2005) N.C.N. Guidelines. Palliative Care. Section 2.5

NUTH NHS Trust (2004) Critical Care Service Guidelines for use in Critical Care. Section 2 Gastrointestinal Topics

Petticrew M., Watt I., Sheldon T. (1997) Systematic review of the effectiveness of laxatives in the elderly. NHS for Reviews and Dissemination, University of York, York

Reginard C., Hockley J. (2003) A guide to symptom Relief in Palliative Care. Radcliffe 5 Edition

Royal College of Nursing (2005) Digital Rectal Examination and Manual Removal of Faeces

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Treatment of Constipation (in Adults)

Assess patient and identify possible cause(s)

Faecal Impaction

1st line
Movicol 3 to 8 sachets for up to 3 days.
Review daily

Opioid Induced Constipation (see note (d))

1st line
Senna 7.5mg tablets 2 at night
Docusate Sodium 100mg BD if stool is hard up to 500 mg daily

2nd line
Senna 7.5mg tablets 2 BD
Docusate Sodium up to 500mg daily in divided doses

3rd line
Movicol (see note G)

Acute Constipation (see note (a))

1st line
Senna 7.5mg tablets 2 to 4 at night
Docusate Sodium 100mg BD initially.
Can increase up to 500 mg daily in divided doses if required.

2nd line
Consider Bisacodyl/ Glycerol suppositories (See note H)

Chronic Constipation (see notes (b) and (c))

1st line (treat as for acute initially)
Ispaghula (Fybogel) 1 sachet bd

2nd line
Movicol 1-3 sachets daily for 2 weeks followed by 1-2 sachets daily maintenance

3rd line
Consider Bisacodyl/ Glycerol suppositories (See note H)

Palliative Care

1st line
Senna 7.5mg tablets 2 to 4 at night
Docusate Sodium 100mg BD initially.
Can increase up to 500mg daily in divided doses if required.

2nd line
Movicol (discuss with palliative care team)

3rd line
Consider Bisacodyl/ Glycerol suppositories (See note H)

Refractory Cases and Impaction Arachis oil enema to soften faeces at night followed by phosphate enema in the morning. Exclude obstruction or ileus.

NOTE: Any medications can only be administered as prescribed.