Guidelines for the Management of Constipation: Adult Patients

This guidance does not override the individual responsibility of health professionals to make appropriate decisions 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 management of adult patients with constipation. Bowel preparation prior to endoscopy or surgery, as well as management of neurogenic bowel dysfunction are beyond the scope of this guideline.

This guideline is for use by the following staff groups:

Prescribers, nurses, midwives, pharmacists and other health care professionals caring for patients with constipation.

Lead clinician(s)

Chris Parry	Lead Surgical Pharmacist, WRH
Guideline approved by Medicines Safety Committee on:	14th August, 2024
Document extended on:	
Review date: This is the most current document and is to be used until a revised version is available:	14th August, 2026

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
June 2023	Document extended for 6 months whilst under review	Chris Parry
May 2024	Extensive restructuring. Addition of naloxegol, naldemedine, linaclotide & sodium citrate.	Chris Parry
14/08/2024	Document reapproved	MSC

Introduction

Constipation is defecation that is unsatisfactory because of infrequent stools, difficult stool passage, or seemingly incomplete defecation.

Diagnosis

Constipation is defined as passage of stools less frequently than is usual for this patient, typically less than three times a week – the patient and/or Sunrise monitoring will confirm this.

Associated symptoms may include:

- excessive straining
- lower abdominal pain, distension or bloating – if abdominal pain, consider IBS
- dry, hard stools which can be abnormally large or small
- confusion, delirium or urinary retention, particularly in frail elderly patients
- nausea or loss of appetite
- overflow faecal incontinence or a need for manual evacuation of stools, both of which could indicate faecal loading/impaction

Prevalence has been estimated at 10%, rising to 50% in nursing homes and 70% on long-stay wards. Incidence is relatively higher if female, elderly or immobile.

Assessment

- Assess for symptoms above and 'red flags' which may suggest sinister pathology and prompt referral for urgent investigation:

○ **sudden change in bowel habit**	○ **iron-deficiency anaemia**
○ **rectal bleeding**	○ **family history of bowel malignancy or IBD**
○ **unintentional weight loss**	○ **refractory constipation unresponsive to treatment**
○ **abdominal pain or palpable mass**	

- Perform abdominal and digital rectal examination to rule out fissure and impaction, particularly if hard stools/overflow incontinence. Abdominal X-ray is not routinely indicated
- Determine whether acute or chronic (over 4 weeks)
- Consider secondary causes (medications or organic causes) and mitigate if possible:

Medicines associated with constipation
Analgesia (e.g. opioids, gabapentin)
Iron, calcium or aluminium salts
Antimuscarinics (e.g. oxybutynin)
Antihistamines (e.g. chlorphenamine)
Antispasmodics (e.g. hyoscine)
Antidepressants (e.g. amitriptyline)
Antipsychotics (e.g. clozapine)
Diuretics (e.g. furosemide)
$5HT_3$ antagonists (e.g. ondansetron)
Calcium channel blockers (e.g. verapamil)

Organic causes of constipation
Bowel disease (e.g. obstruction, malignancy, diverticular disease, IBD, IBS)
Endocrine (e.g. diabetes, hypokalaemia, hypercalcaemia, hypothyroidism)
Neurological (e.g. MS, Parkinson's disease, spinal cord compression)
Structural abnormalities (e.g. anal stricture)
Pregnancy
Reduced intake (dehydration, anorexia)

Monitoring

Regularly monitor effectiveness and tolerability of treatment. If diarrhoea develops and is thought to be caused by laxatives, stool sampling (to exclude infections such as *C Diff*) is not indicated.

Discharge

Review all laxative prescriptions on discharge. If continued, GP to review at 2 weeks.

Consider non-pharmacological management initially – adequate hydration, dietary fibre intake, mobility, toilet routine

Avoid all laxatives if suspected bowel obstruction or perforation. Avoid lactulose, except in hepatic encephalopathy (see BNF dosing) or hyperkalaemia

	ACUTE (<3 months)	IMPACTION	OPIOID-INDUCED	CHRONIC (>3 months)	PALLIATIVE
1st line	**Macrogol[1]** 1-3 sachets daily *Onset 1-2 days*	**Macrogol[1]** 4 sachets day 1: max 8 daily *Onset 1-2 days* + **Docusate** 100mg *tds*/200mg *bd* *Onset 1-2 days*	**Macrogol[1]** 1-3 sachets daily *Onset 1-2 days* + **Senna[2]** 2-4 tabs at night *Onset 8-12hr* **[EDM]**	**Ispaghula husk[1]** 1 sachet *bd* (last dose before 6pm)	**Treat if impacted (see left)** **Non-moribund[4] & not impacted** **Macrogol[1]** 1 sachet *bd* *Onset 1-2 days*
2nd line	**If stools soft, add** **Senna[2]** 2-4 tabs at night *Onset 8-12hr* **[EDM]** **If stools hard, add** **Docusate** 100mg *tds*/200mg *bd* *Onset 1-2 days*	+ **Glycerin suppository** 4g *stat* *Onset: 1-2hr* +/- **Bisacodyl suppository** 10mg *stat*	+ **Docusate** 100mg *tds*/200mg *bd* *Onset 1-2 days*	**Switch to** **Macrogol[1]** 1-3 sachets daily *Onset 1-2 days* +/- **Docusate** 100mg *tds*/200mg *bd* *Onset 1-2 days*	+ **Senna[2]** 2-4 tabs at night *Onset 8-12hr* **[EDM]** +/- **Docusate** 100mg *tds*/200mg *bd* *Onset 1-2 days*
3rd line	**Glycerin suppository** 4g *Onset: 15-30 min* **[EDM]** or **Sodium citrate enema** 5mL *Onset: 5-15 min*	**[In delirium, use enemas first-line]** **Sodium citrate enema** 5mL *stat* *Onset: 5-15 min* or **Phosphate enema[1]** *Onset: 2-5 min* **+/- manual evacuation** **Add regular preventative laxative**	**If max tolerated laxative dose ineffective after 4+ days, trial** **Naloxegol[3]** 25mg *od* or **Naldemedine[3]** 200 microgram *od* **Avoid Ispaghula husk**	**If max tolerated dose of 2+ laxatives ineffective…** **at 6 months, trial** **Prucalopride[3]** 2mg *od* (1mg if elderly) *Onset 12h. Review 4 weeks* **if IBS, at 12 months trial** **Linaclotide[3]** 290 microgram *od* *Onset 24hr. Review 3 months*	+ **Co-danthramer[5]** 2 capsules at night or **Co-danthrusate[5]** 5-15mL at night **(and stop docusate)** **Avoid Ispaghula husk**

[1] Ensure plenty of water. Not suitable in heart failure. If elderly/immobile/poor fluid intake: avoid ispaghula husk, caution with macrogol and enemas
[2] or bisacodyl tablets or suppositories. Avoid long-term use of stimulant laxatives due to risk of damaging colon through loss of muscle tone.
[3] Only to be initiated by secondary care clinician experienced in management of chronic constipation
[4] If moribund, do not induce defecation - avoid all laxatives. Consider syringe driver of hyoscine butylbromide +/- opioid in last hours of life
[5] Contraindicated in urinary/faecal incontinence (risk of 'dantron burn')

Consult BNF for full prescribing information **[EDM] = can be given using Emergency & Discretionary Medicines policy (MedPolSOP35)**

Summary of Laxative Use in Pregnancy and Breastfeeding

Laxative	Use in Pregnancy	Use in Breastfeeding
Ispaghula husk	Safe	Safe
Lactulose	Safe	Safe
Macrogol	Safe	Safe
Glycerin suppository	No evidence for safety but commonly used	Safe
Bisacodyl suppository	No data. Use with caution in 3rd trimester. 2nd line	Safe in infants over 1 month
Sodium picosulfate	Limited data. 2nd line.	Safe in infants over 1 month
Senna	Safe during first 12 weeks. Use with caution in 3rd trimester. 2nd line.	Safe in infants over 1 month
Docusate	Safe during first 12 weeks. 2nd line	Safe
Sodium citrate enema	Consult Medicines Information*	Safe
Prucalopride	Consult Medicines Information *	Caution – small amounts present in breastmilk. Monitor infant
Linaclotide	Consult Medicines Information *	No data. Unlikely to pass into breastmilk. Consult Medicines Information*
Naloxegol	Avoid – high doses toxic in animal studies	Avoid – present in milk in animal studies. Risk of opioid withdrawal in infant
Naldemedine	Avoid unless benefit outweighs risk of opioid withdrawal in foetus	Avoid – present in milk in animal studies. Risk of opioid withdrawal in infant
Co-danthramer	Avoid	Avoid
Co-danthrusate	Avoid	Avoid

*Regional Medicines Information 01473 704431

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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- Specialist Pharmacy Service Using laxatives during breastfeeding. Last updated Nov 2023. Available at: https://www.sps.nhs.uk/articles/using-laxatives-during-breastfeeding [accessed 21/05/2024]
- UK Teratology Information Service. Best Use of Medicines in Pregnancy: treating constipation during pregnancy. Last updated June 2022. Available at: https://www.medicinesinpregnancy.org/leaflets-a-z/constipation [accessed 21/05/2024]

Contribution List

Key individuals involved in developing the document

Name	Designation
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Name	Committee / group
Alison Smith	Medicines Safety Officer

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Chris Parry**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Chris Parry	**Lead Pharmacist Surgery WRH**	**Christopher.parry3@nhs.net**
Date assessment completed	**16th July 2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Guideline for the Management of Constipation: Adult Patients**			
What is the aim, purpose and/or intended outcomes of this Activity?	To ensure consistent, evidence-based, cost-effective management of constipation in adult inpatients			
Who will be affected by the development & implementation	❑ x	Service User Patient	x ❑	Staff Communities

of this activity?	❑ ❑	Carers Visitors	❑ ❑	Other _____
Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Nil			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Not required – minor review of clinical content relative to previous version			
Summary of relevant findings	No new risks identified			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			Input from orthogeriatric team has been included so that frail patients with dementia are optimally managed
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity	X			Prescribing advice included for safety of each medicine in pregnancy.
Race including Traveling Communities		X		
Religion & Belief		X		
Sex		X		
Sexual		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	.		
How will you monitor these actions?	**N/A**			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**Next guidelines review**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	16th July 2024
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

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