Constipation in Adults

Red flags

- Colorectal cancer symptoms
- Onset at aged 60 years or older

Background

About constipation in adults

About constipation in adults

- Constipation may relate to one or more of the following:
    - Infrequent passage of stools
    - Difficulty in passing a stool including straining or needing digitation
    - Passage of hard stools
    - Sensation of incomplete evacuation or anorectal blockage
- Most patients do not have a structural bowel cause for constipation symptoms.

Assessment

1. History – ask about constipation and associated features:
    - Frequency and consistency of motions, presence of alternating diarrhoea
    - Rectal bleeding, lumps, pain, soiling of underwear
    - In the elderly, may present as confusion, overflow diarrhoea, abdominal pain, urinary retention, nausea, and loss of appetite
    - Medications

      Medications

      - Antacids containing aluminium or calcium

- Antimuscarinic drugs, e.g. hyoscine butylbromide, oxybutynin, procyclidine, tolterodine
- Antipsychotics, e.g. clozapine
- Antispasmodics, e.g. mebeverine
- Antidepressants, e.g. tricyclics
- Anti-epileptics, e.g. carbamazepine, gabapentin, pregabalin, phenytoin
- Calcium channel blockers, particularly verapamil
- Diuretics
- Dopaminergic drugs used in Parkinsonism
- 5-HT antagonists, e.g. ondansetron
- Iron or calcium supplements
- Opioids, e.g. codeine, morphine
- Sedating antihistamines, e.g. chlorpheniramine

(Not an exhaustive list)

- Symptoms of hypothyroidism or depression

2. Assess for concerning features:
    - Colorectal cancer symptoms, e.g. rectal bleeding, weight loss, anaemia
    - Onset at aged 60 years or older
3. Consider primary causes and secondary causes.

Secondary causes

- Neurological:
    - Multiple sclerosis
    - Parkinson's disease
    - Stroke
    - Spinal cord injuries or tumours
    - Cerebral palsy
    - Motor neurone disease
- Myopathic conditions
- Metabolic and endocrine:
    - Hypothyroidism

    - Coeliac disease
    - Diabetes
    - Hypercalcaemia
    - Hypokalaemia
    - Hypomagnesaemia
    - Uraemia
- Structural:
    - Anal fissure
    - Haemorrhoids
    - Rectal prolapse
    - Rectocoele
    - Postnatal damage
    - Diverticular disease
    - Colorectal cancer
- Psychological:
    - Abuse
    - Depression
    - Eating disorder
    - Pelvic pain disorder
- Other:
    - Hospitalisation
    - Dehydration
    - Immobility
    - Pregnancy

Primary causes

Include:

- Functional constipation
- Constipation predominant irritable bowel syndrome (IBS)
- Pelvic floor disorders

4. Examine abdomen and rectum. Consider bimanual pelvic examination.

5. Investigation – not usually needed for functional constipation unless underlying pathology is suspected:

    - If the patient has suspected lower gastrointestinal (GI) cancer, arrange a faecal immunochemical test (FIT). If the patient meets the criteria for referral or is a member of a vulnerable group, do not wait for FIT results. See Suspected Colorectal Cancer.

      Vulnerable group

      - Recognise that some groups may find it difficult to submit FIT samples, e.g.:
        - Frail, elderly patients with problems with cognition or dexterity
        - Patients with a language barrier
        - Patients of no fixed abode and other vulnerable groups
      - Vary the type of consultation accordingly to support decisions.
      - Be aware, if a test is not complete and there is a strong suspicion of colorectal cancer, a referral to secondary care will not be declined on this basis.

      Criteria for referral

      - Abdominal mass
      - Rectal mass
      - Anal mass or ulceration
      - Abdominal pain with obstructive symptoms
      - Iron deficiency anaemia in men and postmenopausal women

    - Arrange blood tests.

      Blood tests

      - FBC
      - Ferritin
      - Electrolytes and renal function

        Electrolytes and renal function

        When requesting creatinine and Na/K, the laboratory will automatically test:

        - Sodium
        - Potassium
        - Creatinine
        - eGFR

- Bone profile
- Thyroid function tests (TFT)
- Anti-tissue transglutaminase (tTG) antibodies
- Immunoglobulin A (IgA)

Management

1. Request urgent suspected cancer colorectal surgery assessment if the patient:
    - meets the criteria for referral, or is a member of a vulnerable group, without waiting for FIT results.
    - has a positive FIT test.
    - has gastrointestinal (GI) symptoms other than rectal bleeding and suspicion of colorectal cancer, based on clinical judgement.
    - has suspected bowel cancer and unsure if radiological investigations are required.
2. If positive coeliac serology, request urgent gastroenterology assessment for a gastroscopy and duodenal biopsies. Advise the patient not to restrict diet before endoscopy.
3. If hypothyroidism or hypercalcaemia, manage as per result, and consider seeking endocrinology advice.
4. Advise the patient:
    - to avoid constipating medications if possible.
    - about simple lifestyle measures to relieve and prevent recurrence of constipation.

    Simple lifestyle measures

    - Optimise fluid intake – 1.5 to 2 L per day.
    - Increase dietary fibre intake. See BDA – Food Fact Sheet: Fibre.
    - Advise correct toileting positions.
    - Advise regular exercise.
    - Discourage avoidance of defecation.
5. If symptoms are unresponsive to simple lifestyle measures and at least 2 classes of laxative for more than 6 months or suggestive of dyssynergic defecation, consider requesting routine general surgery assessment (nurse-led functional clinic).

    Dyssynergic defecation

    - Digitation
    - Prolonged or excessive straining

- Feeling of incomplete evacuation
- Previous obstructive injury

6. Treat secondary causes:
    - Anal fissure
    - Haemorrhoids
7. Consider medications using a stepped approach
    - Step 1 – Bulk-forming laxatives

      Bulk-forming laxatives

      - Valuable in patients with episodic hard stools.
      - Retain fluid within the stool and increase faecal mass, which stimulates peristalsis.
      - Adequate fluid intake must be maintained to avoid intestinal obstruction.
      - Common side-effects include flatulence and bloating.
      - Common preparations include – ispaghula husk, e.g. Fybogel.

      Not recommended for patients taking constipating drugs.

      May cause difficulty for frail, elderly patients.

    - Step 2 – Osmotic laxatives

      Osmotic laxatives

      - If stools remain hard, cease bulk-forming laxatives and introduce osmotic laxative, e.g. macrogol.
      - If osmotic laxative is ineffective or not tolerated, offer lactulose second line.
      - Be aware, osmotic laxatives are valuable in slow transit constipation.
      - Be aware, macrogols are first-line for megarectum and megacolon.
      - Increase the amount of fluid in large bowel, by retaining fluid in the bowel and drawing fluid from the body into the bowel. This leads to bowel distension and peristalsis.
      - Be aware, common side-effects include bloating, abdominal pain, nausea – may exacerbate symptoms in patients with irritable bowel syndrome.
      - Be aware, enemas (e.g., rectal phosphate or sodium citrate enema) can cause electrolyte disturbance and local irritation – use with caution in the elderly or frail.

    - Step 3 – Add in stimulant laxatives

      Add in stimulant laxatives

If stools are soft but difficult to pass, or there is a sensation of inadequate emptying, add in a stimulant laxative, e.g. senna.

Stimulant laxatives:

- are valuable in patients with episodic reduced frequency stool.
- cause peristalsis by stimulating colonic nerves.
- are common side-effects includes abdominal cramps.

Common preparations include:

- Senna
- Bisacodyl
- Sodium picosulfate
- Glycerol suppositories

- Step 4 – Stool-softening agents

Stool-softening agents

Common preparations include:

- Docusate sodium:
  - A surface wetting agent that reduces tension of the stool, allowing water to penetrate and soften.
  - Useful for patients who find it difficult to increase their fluid intake.
- Arachis oil enema:
  - Lubricates and softens faeces and promotes a bowel movement.
  - Useful for hard impacted stools.
  - Not appropriate in patients with peanut allergy.
  - Common side-effects include stomach pain and skin irritation around the anus.
- Use of laxatives

Use of laxatives

General advice:

- Continue long-term for patients who are taking a constipating drug that cannot be stopped or who have a medical cause of constipation.
- Avoid lactulose in patients with IBS as it often exacerbates symptoms.
- If hard stool is filling the rectum, consider suppositories or enemas.

Titrate according to symptoms:

- Adjust dose, choice, and combination.
- Increase or decrease dose gradually to produce 1 to 2 soft formed stools a day.
- Add another laxative type rather than replace as the synergistic effect is more effective.

Combination treatments are used if unresponsive to a single laxative:

- Do not use 2 drugs from the same class, e.g. Laxido and magnesium hydroxide.
- Consider stool softening agent plus stimulant laxative, or stool softening agent plus bulking agent.

Laxative reduction

- Reduce dose according to the frequency and consistency of the stools. Wean gradually to minimise risk of requiring rescue therapy for recurrent faecal loading.
- Slowly withdraw laxatives when regular bowel movements occur without difficulty, e.g. 2 to 4 weeks after defecation has become comfortable and a regular bowel pattern with soft-formed stools has been established.
- If more than 1 laxative used, reduce and stop one at a time. Reduce stimulant laxatives first, if possible. However, it may be necessary to also adjust the dose of the osmotic laxative to compensate.
- Advise the patient that it can take several months to successfully wean off all laxatives.
- Relapses are common – treat early with increased doses.

Faecal impaction

- Consider the possibility of impaction with overflow in patients with diarrhoea taking laxatives. Patients often present with a history of severe constipation, bloating, and the feeling of needing to evacuate stool.
- Treat with high-dose oral macrogol – 4 sachets on day 1, increasing by 2 sachets each day to a maximum of 8 sachets per day. If inadequate response, consider adding a micro-enema at night to soften stool, then phosphate enema the next morning.

8. Review the use of laxatives in pregnancy.

Pregnancy

If the patient is pregnant:

- prescribe moderate doses of poorly absorbed laxatives if dietary and lifestyle changes fail to control constipation.

- try a bulk-forming laxative first.
- also use an osmotic laxative, such as lactulose.
- Senna or bisacodyl may be suitable, if a stimulant effect is necessary.

See:

Best Use of Medicines in Pregnancy (BUMPS) – Treating Constipation During Pregnancy

Breastfeeding Network – Constipation Treatment in Breastfeeding Mothers

9. For management of clozapine-related constipation, see NHS Wales – Constipation and Clozapine: Prophylaxis and Treatment Guideline.

Request

- Request urgent suspected cancer colorectal surgery assessment:
  - without waiting for FIT results, if the patient meets the criteria for referral, or is a member of a vulnerable group.
  - if the patient has a positive FIT test.
  - if the patient has gastrointestinal (GI) symptoms other than rectal bleeding and suspicion of colorectal cancer, based on clinical judgement.
  - if the patient has suspected bowel cancer and unsure if radiological investigations are required.
- If positive coeliac serology, request urgent gastroenterology assessment.
- If suspected hypothyroidism or hypercalcaemia consider seeking endocrinology advice.
- If symptoms are unresponsive to simple lifestyle measures and at least 2 classes of laxative for more than 6 months or suggestive of dyssynergic defecation, consider requesting routine general surgery assessment in a nurse-led functional clinic.

Information

For health professionals

Further information

- NHS Wales – Symptomatic FIT testing in Primary Care: Updated Guidance
- NICE Clinical Knowledge Summaries (CKS) – Constipation

For patients

Patient – Constipation

SEND FEEDBACK

SOURCES

PAGE INFORMATION

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