Adult Constipation Primary Care Protocol

Version: 1.3 May 2018
Review Date: post-Covid

Definition:
Symptom based disorder which describes defecation that is unsatisfactory because of infrequent stools, difficulty passing stools or the sensation of incomplete emptying. Constipation is a passage of stools less frequent than a person's normal pattern. Associated symptoms include: excessive straining, lower abdominal pain/ discomfort and bloating.

Patient history and examination:
* Clarify what patient "means by constipation" and their normal pattern of defecation
* Duration of constipation; frequency and consistency of stools.
* Is the patient on any drugs that cause constipation? (see overleaf)
* Any nocturnal symptoms or associated symptoms (rectal discomfort, excessive straining, feeling of incomplete evacuation, rectal bleeding, abdominal pain or distension.)
* Any associated urinary symptoms or incontinence, and dyspareunia.
* Any underlying illness/disease/infection causing secondary constipation? Any past history of IBS-C?
* Consider Anismus or other anal condition as potential cause of constipation.
* Any FH colorectal cancer or IBD - *if appropriate increased risk thresholds met, refer for screening colonoscopy*
*Has patient tried any self-help measures or drug treatments and symptom responses to this?
* Assess patient's diet – fibre and fluid intake, normal routine/lifestyle, level of activity / mobility
* Assess patient's toileting habits
* Any associated psychological or mental health conditions
* Measure weight – any unexplained weight loss
* Examine for abdominal mass
* Digital rectal examination (stool presence and consistency, anal fissures?)

N.B. Remember, diarrhoea may be due to overflow

Key

- "Must do" actions for GPs (triaged by referral service)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public Health intervention
- Audio-visual aids for patients and GP
- Click icon for clinical evidence

Investigations: FBC, TFT, calcium levels and coeliac screen (anti TTG Ab / anti endomysial Ab with IgA measurement)
qFIT (if available)

Consider CA 125 (not measured during menstruation) / pelvic USS in a female with constipation and suspected ovarian cancer.

Are there any alarm symptoms?

Yes

Symptoms / signs of OBSTRUCTION (absolute constipation, vomiting, abdominal pain and bloating) require urgent same day admission.

Refer under 2-week wait pathway to colorectal team if 2-week waits symptoms criteria met:

- Any age with suspicious abdominal/rectal mass or unexplained anal mass/ulceration
- > or equal to 40 years with unexplained abdominal pain AND weight loss
- > or equal to 40 years with unexplained iron deficiency anaemia
- < or equal to 50 years with rectal bleeding AND any of the following UNEXPLAINED symptoms: abdominal pain, change in bowel habit, weight loss or iron deficiency anaemia
- > or equal to 50 years with UNEXPLAINED rectal bleeding or abdominal pain or weight loss or change in bowel habit
- > or equal to 60 years with unexplained anaemia, even in the absence of iron deficiency
- raised / positive qFIT test suggestive of cancer

Yes

2 Week Wait / Urgent referral

No

Lifestyle Advice

* Healthy balanced diet with regular meals https://patient.info/health/constipation
* Diet high in soluble fibre and fluids – adults should aim to consume 30g of soluble fibre per day
* Increase activity and exercise levels
* Helpful toileting routines (regular, unhurried routine, respond immediately to sensation to defecate)
* Optimal Toileting position

Manage underlying secondary cause of constipation
Reduce / stop any drug treatment that may be causing / contributing to symptoms, if possible/ appropriate

Short duration constipation (< 3 months)
Stepped approach to oral laxatives
1) bulk-forming laxative e.g. Isphagula (must drink adequate fluids)
2) add/switch to osmotic laxative e.g. macrogol (lactulose 2nd)
3) if stools are soft but difficult to pass / sensation of inadequate emptying, add a stimulant laxative e.g. Bisocodyl or Senna or Docusate (See overleaf for prescribing advice)

Opioid-induced constipation:

1) Macrogol AND Bisocodyl (avoid bulk-forming laxatives)
2) Docusate
3) Naloxegol (NICE TA345)

Review

No improvement

Improvement

Chronic constipation
No Improvement after highest tolerated recommended doses for at least 3 months

Continue medication at maintenance doses for several weeks after bowel habit is established – this may take several months.
Please warn patients of this.

Advise the patient to gradually wean off laxatives once the patient is producing soft, formed stool without straining at least three times per week.

Discuss with Gastroenterologist or consider a referral for assessment when symptoms cause severe interference with patients quality of life or underlying secondary cause is suspected or symptoms persist despite optimal management in primary care.

If TWO different class laxatives have been used in combination at highest tolerated doses for at least 6 months, a specialist might consider using Prucalopride (in both men and women). If on review a month later, Prucalopride is found to have been beneficial, it can then be continued in primary care.

Where a GP has some uncertainty about how to proceed with management of patient with Constipation, but also feels secondary care referral for further investigation or higher level management is not required, the GP may request Advice and Guidance from a secondary care specialist through the Electronic Referrals Service.

Drugs that commonly cause constipation.
* Aluminium-containing antacids; iron or calcium supplements.
* Analgesics, such as opiates and nonsteroidal anti-inflammatory drugs (NSAIDs).
* Antimuscarinics, such as procyclidine and oxybutynin.
* Antidepressants, such as tricyclic antidepressants; antipsychotics, such as amisulpride, clozapine, or quetiapine. It is vital to recognise and treat Clozapine induced constipation actively MHRA Oct 17 Drug Safety Update: Clozapine: reminder of potentially fatal risk of intestinal obstruction, faecal impaction, and paralytic ileus)
* Antiepileptic drugs, such as carbamazepine, gabapentin, oxcarbazepine, pregabalin, or phenytoin.
* Antihistamines, such as hydroxyzine.
* Antispasmodics, such as dicycloverine or hyoscine.
* Diuretics, such as furosemide; calcium-channel blockers, such as verapamil.

Prescribing Information					
Indication		**Laxative**	**Dose**	**Time to take effect**	**Additional information**
Acute or Chronic constipation	1st line	Ispaghula Husk – "Fybogel"	One sachet in the morning and afternoon. Do not give at bedtime. Contra-indicated in phenylketonuria.	2-3 days	Ensure adequate fluid intake (may be necessary to monitor frail, elderly patients to ensure adequate fluid intake). Avoid in intestinal obstruction, decreased muscle tone, impaction and following bowel surgery.
	2nd line If stools remain hard, add or switch to an osmotic laxative.	1st choice: Macrogols – "Laxido" Chronic constipation: 2nd choice: Lactulose	1-3 sachets daily in divided doses usually for up to two weeks, maintenance: 1-2 sachets daily. 15ml twice daily.	2-3 days 48 hours	Contents of each sachet should be dissolved in half a glass (approx. 125ml) water. Should not be used on a PRN basis.
	2nd line If stools are soft but the person still finds them difficult to pass or complains of inadequate emptying, add a stimulant laxative.	Bisacodyl tablets 5mg Sodium Picosulfate liquid 5mg/5ml Senna tablets Senna liquid	1-2 at night (max 4 at night) 5-10mls at night 1-2 at night (max 4 at night) 5-10mls at night	6–12 hours 6- 12 hours 8–12 hours 8–12 hours	Chronic use of stimulant laxatives may lead to colonic atony, tolerance, and hypokalaemia. Initial doses should be low and gradually increased if necessary.
Chronic opioid therapy or Acute constipation due to short-term Opioid use	Osmotic laxative (or docusate which also softens stools) and a stimulant laxative.	**Osmotic:** Macrogols – "Laxido" Docusate sodium 100mg capsules **Stimulants:** Bisacodyl tablets 5mg Sodium Picosulfate liquid 5mg/5ml Senna tablets Senna liquid	1-3 sachets daily in divided doses. Usual dose in extended use is 1-2 sachets daily. One capsule every 8 to 12 hours 1-2 at night (max 4 at night) 5-10mls at night 2 – 4 tablets at night 10-20ml at night	2-3 days 1-2 days 6- 12 hours 6- 12 hours 8-12 hours 8-12 hours	Avoid using bulk-forming laxatives for opioid-induced constipation. Chronic use of stimulant laxatives may lead to colonic atony, tolerance and hypokalaemia. Initial dose should be low and gradually increased as necessary-high doses (off label) may be required to achieve effect.
• For short term opioid treatment, advice the patient that laxatives can be stopped once the stools become soft and easily passed again. • The dose of laxative should be gradually titrated upwards (or downwards) to produce one or two soft, formed stools per day.					
For hard stools		High dose of an oral **macrogol "Laxido"** (licensed for use in faecal loading/impaction).	8 sachets daily for a maximum of 3 days.	2-3 days	**8 sachets may be dissolved in 1 litre of water, all of which should be consumed within a 6 hour period.** Patients with a cardiac condition should not take more than two sachets (in 250ml of water) in any one hour. Once reconstituted store in a fridge and discard any solution remaining after 6 hours.
For soft stools or for hard stools after a few days treatment with a macrogol consider starting or adding an oral stimulant laxative.		**Bisacodyl tablets 5mg** **Sodium Picosulfate liquid 5mg/5ml** **Senna tablets** **Senna liquid**	1-2 at night (max 4 at night) 5-10mls at night 2 – 4 tablets at night 10-20ml at night	6- 12 hours 6- 12 hours 8-12 hours	Chronic use may lead to colonic atony, tolerance and hypokalaemia. Initial dose should be low and gradually increased as necessary.
If the response to oral laxatives is insufficient or not fast enough, consider: Using a suppository: For soft stools; bisacodyl alone. For hard stools: glycerin alone or with bisacodyl. Using a mini enema: Docusate sodium (Norgalax) or sodium citrate		**Bisacodyl suppositories** **Glycerin 4g suppositories** **Docusate sodium "Norgalax"** **Sodium citrate micro enema**	One to be used as necessary	15-60 mins 15-30 mins 15-30 mins 5-15 mins	Bisacodyl suppositories should not be used when anal fissures or ulcerative proctitis with mucosal damage are present. Glycerin suppositories need to be moistened with water before use Norgalax is not suitable if haemorrhoids or anal fissure is present.
If the response is still insufficient: Sodium phosphate enema or Arachis (peanut) oil enema		**Sodium phosphate enema** **Arachis (peanut) oil retention enema (place high if the rectum is empty but the colon is full).**	One to be used as necessary	2-5 minutes Used overnight.	Repeated in rare cases if necessary. For hard faeces it can be helpful to give the arachis oil enema overnight before giving a sodium phosphate (large volume) or sodium citrate (small volume) enema the next day. Enemas may need to be repeated several times to clear hard impacted faeces. Enemas may need a district nurse or a carer to administer them.
If the specialist considers using Prucalopride in men and women for clinically appropriate patients as per NCL formulary guidance, this must be initiated by the specialist and reviewed after a month and can then be continued in primary care.					