Community HealthPathways North Cumbria

Constipation in Adults

See also Colorectal Symptoms.

Red flags

- Unexplained weight loss
- Iron deficiency anaemia

Background

About constipation in adults

About constipation in adults

Constipation is often defined as the passage of stools less easily or frequently than a person's normal habit.

Patients may describe:

- infrequent passage of stools.
- difficulty in passing a stool including excessive straining.
- passage of hard stools.
- sensation of incomplete evacuation.
- distension, abdominal pain.

In the elderly constipation may present as confusion, functional decline, anorexia, nausea, urinary retention, or overflow diarrhoea.

Most patients do not have a structural bowel cause for constipation symptoms.

Assessment

1. Take a history – ask about:
   - what the patient means by constipation, frequency, and consistency of motions – the Bristol Stool Chart can be useful.
   - how symptoms affect the person and the impact on functioning and quality of life.

- duration of constipation or change in bowel habit.
- diarrhoea or soiling – overflow of liquid stool is a common symptom of significant underlying constipation.
- rectal bleeding, anorectal or abdominal pain, dyspareunia.
- urinary symptoms such as incontinence or retention.
- nausea, vomiting, or unexplained weight loss.
- food and fluid intake, any changes to dietary habits.
- exercise or level of mobility.
- over-the-counter medication used for constipation and its effectiveness.
- prescribed and over-the-counter medications that may cause constipation .

> **Medications that may cause constipation**
>
> - 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. chlorphenamine

- toileting habits, e.g. feeling hurried, fear of being disturbed, access to toilet at home or work, lack of privacy.
- associated psychological or mental health conditions, e.g. anxiety, depression, cognitive impairment, eating disorder.
- past medical history including previous colonoscopies, findings, and histology (if available), inflammatory bowel disease, hypothyroidism.
- family history, e.g. bowel, ovarian, or breast cancer, or colonic polyps.
- symptoms of hypothyroidism or depression.

2. Be aware of:
   - colorectal cancer risk factors .

Colorectal cancer risk factors

- Smoking
- Human papilloma virus (HPV) exposure (anal sex increases anal cancer risk)
- Personal or family history of colorectal cancer
- Personal history of inflammatory bowel disease, adenoma
- Older age

Not an exhaustive list.

- signs or symptoms suggestive of colorectal cancer .

Signs or symptoms suggestive of colorectal cancer

- Rectal bleeding or melaena
- Altered bowel habit for at least 6 weeks
- Unexplained weight loss
- New abdominal pain not otherwise explained by a more likely differential
- Unexplained iron deficiency anaemia

Not an exhaustive list.

3. Perform an examination .

Examination

- Check pulse, blood pressure (BP).
- Check height, weight, BMI.
- Check for pallor.
- Palpate for any abdominal mass or organomegaly.
- Inspect for haemorrhoids or anal fissure in perianal region.
- Obtain consent and perform digital rectal examination to assess for faecal impaction, palpable masses or ulceration, and blood in stool or melaena. Follow the recommended protocol .

Recommended protocol

- Only perform a rectal examination if there is a specific and clear clinical indication.
- Always seek voluntary consent. Consider the capacity to consent of patients who are physically, mentally, or intellectually impaired, and those of culturally or linguistically diverse backgrounds (among others).

- Always consider:
  - the presence of a chaperone in the room.
  - the patient's specific needs, e.g. if disabled or culturally or linguistically diverse.
- If relevant, discuss and explain the limits of confidentiality.

4. Consider primary causes and secondary causes of constipation.

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
  - Rectocele
  - Perineal trauma following vaginal delivery
  - Diverticular disease
  - Colorectal cancer
- Psychological:
  - Physical or sexual abuse

    - Depression
    - Eating disorder
    - Disorders associated with pelvic pain, e.g. endometriosis
  - Other:
    - Hospitalisation
    - Dehydration
    - Immobility
    - Medication
    - Pregnancy

Primary causes

Include:

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

5. Arrange investigations:
   - Do not arrange investigations for functional constipation unless underlying pathology is suspected.
   - Do not arrange plain abdominal X-rays or other imaging to diagnose constipation.
   - Arrange blood tests as clinically indicated – FBC, urea and electrolytes, LFT, calcium, HbA1c, CRP, ferritin, thyroid function tests (TFT), anti-tissue transglutaminase (tTG) antibodies and IgA, faecal calprotectin, magnesium.

     Urea and electrolytes

     When requesting urea and electrolytes, the laboratory will automatically test:

     - Sodium
     - Potassium – blood sample must be spun down or analysed within 6 hours of collecting, or the lab will omit potassium analysis
     - Urea
     - Creatinine
     - eGFR
   - If indicated, arrange a faecal immunochemical test (FIT).

Management

1. Request 2-week wait colorectal surgery assessment if the patient meets the 2-week wait criteria for colorectal cancer.

> **2-week wait criteria**
>
> - Abdominal, rectal, anal mass or ulceration.
> - Rectal bleeding in association with unexplained:
> - abdominal pain.
> - change in bowel habit.
> - weight loss.
> - iron deficiency anaemia. IDA is defined as haemoglobin less than 130 g/L for men or less than 115 g/L for women and low MCV, low MCH, or low ferritin. [1] Consider iron deficiency may also be present if ferritin is between 23 to 75 microgram/L in the presence of systemic inflammation, e.g. elevated CRP.
> - Rectal bleeding in a patient older than 50 years.
> - A patient:
> - older than 40 years with unexplained weight loss with abdominal pain.
> - with high-risk iron deficiency anaemia (IDA) – Defined as all men with IDA, women older than 50 years, or women who are older than 40 years and are non-menstruating.
> - a positive FIT test.

Note that the patient may be offered direct to test colonoscopy or CT unless a clinic option is chosen. Check performance status and co-morbidities and discuss with the patient before selecting an option.

2. If positive coeliac serology, follow the Coeliac Disease in Adults pathway.
3. Provide patient education:
 - Advise them to avoid medications that may cause constipation if possible.
 - Advise about simple measures to relieve and prevent recurrence of constipation.

> **Simple measures**
>
> - Advise the patient to:
> - eat a healthy, balanced diet with whole grains, fruits, and vegetables. Increase dietary fibre slowly to avoid bloating and flatulence, and maintain adequate fluid intake.
> - adopt helpful toileting routines .
>
> > **Helpful toileting routines**
> >
> > - Advise:
> > - regular unhurried toileting.
> > - responding to the sensation to defecate without delay.

- Ensure people with limited mobility have appropriate access to the toilet and privacy.
- Ensure toilet seating is adjusted for patients with mobility or balance problems.

- exercise regularly and lose weight.
- maintain good perianal hygiene.
- avoid straining or lingering (reading) on the toilet.
- limit alcohol and fatty foods (these may exacerbate constipation).
- consider taking a sitz bath (a warm, shallow bath that cleanses the perineum). This can relax the sphincter and soothe symptoms when symptomatic.

- Consider requesting adult continence assessment from the Community Bladder and Bowel Service if needed.

4. Give advice about and manage laxative use .

Laxative use

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 initially. Prescribe osmotic enemas cautiously in the elderly because of the risk of electrolyte disturbance.
- Consider stool softeners if unable to increase fluid intake.

Titrate laxative according to symptoms:

- Review the patient regularly and 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 useful if the patient is unresponsive to a single laxative:

- Do not use 2 drugs from the same class, e.g. 2 osmotic agents.
- Consider a stool softening agent plus stimulant laxative, or a stool softening agent plus bulking agent.

Laxative reduction

- Do not discontinue laxatives abruptly.
- 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 is 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 and that sometimes it is necessary to continue laxatives long-term.
- Relapses are common – treat early with increased doses.

Faecal impaction

- Consider the possibility of impaction with overflow in patients with diarrhoea. Patients may present with a history of severe constipation, be taking laxatives and complain of bloating, and the feeling of needing to evacuate stool.
- Advise the patient or carers that diarrhoea or soiling is likely to increase during the disimpaction process but should then improve. Review the patient regularly to assess progress and adjust choice, dose, and combination of laxatives accordingly.
- If the patient has hard stools, start 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 the patient has soft stools or ongoing hard stools, start or add an oral stimulant laxative.
- If the response to this approach is inadequate or too slow consider a suppository, e.g. bisacodyl (for soft stools) or glycerol for hard stools, or consider adding a micro-enema, e.g. docusate or sodium citrate.
- If the response remains inadequate, consider a retention enema, e.g. sodium phosphate or arachis oil. This may need repeating several times.

5. Consider using a stepped approach for laxatives:
   - Step 1 – Advise over-the-counter or prescribe bulk-forming laxatives .

     Bulk-forming laxatives

     - Increase faecal mass, which stimulates peristalsis.
     - Full effect may take some days to develop.
     - Valuable in patients with small hard stools, if increase in dietary fibre is not sufficient to relieve constipation.
     - Adequate fluid intake must be maintained.
     - Common side-effects include flatulence and abdominal distension.
     - Common preparations include:
       - ispaghula husk, e.g. Fybogel.
       - sterculia, e.g. Normacol, Normacol Plus (also has stimulant action).

   - Step 2 – If stools remain hard, cease bulk-forming laxatives and introduce osmotic laxatives .

     Osmotic laxatives

- Oral osmotic laxatives include macrogol, lactulose, magnesium sulfate (used for rapid bowel evacuation).
- Valuable in slow transit constipation.
- 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.
- Common side-effects include bloating, abdominal pain, nausea – may exacerbate symptoms in patients with irritable bowel syndrome.
- Rectal osmotic diuretics are available as well.
- 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 – If stools are soft but difficult to pass, or there is a sensation of inadequate emptying, add in stimulant laxatives .

Add in stimulant laxatives

Stimulant laxatives:

- include oral bisacodyl, senna/sennosides. Rectal bisacodyl is also available.
- are valuable in patients with episodic reduced frequency stool.
- cause peristalsis by stimulating colonic nerves.
- are common side-effects includes abdominal cramps.
- may damage colonic mucosa and prolonged use should be avoided.

- Step 4 – If stools are hard and difficult to pass, add stool-softening agents .

Stool-softening agents

- Docusate sodium, e.g. Dioctyl, DulcoEase, probably acts as both a stimulant and a softening agent.
- Combining products with stimulant laxatives, e.g. with senna, often causes abdominal cramps.

6. Review the use of laxatives in pregnancy .

Use of laxatives in pregnancy

- If dietary and lifestyle changes fail to control constipation in pregnancy, moderate doses of poorly absorbed laxatives may be used.
- A bulk-forming laxative should be tried first.
- An osmotic laxative, such as lactulose, can also be used.
- 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

7. Manage secondary causes:
   - Anal fissure
   - Haemorrhoids
   - Hypothyroidism
   - Hypercalcaemia
   - Diabetes
   - Chronic kidney disease
   - Irritable bowel syndrome
8. 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.

> **Dyssynergic defecation**
>
> - Digitation
> - Prolonged or excessive straining
> - Feeling of incomplete evacuation
> - Previous obstetric injury

Request

- Request 2-week wait colorectal surgery assessment if the patient meets the 2-week wait symptom criteria for colorectal cancer.

  Note that the patient may be offered direct to test colonoscopy or CT unless a clinic option is chosen. Check performance status and co-morbidities and discuss with the patient before selecting an option.

- 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.
- Consider requesting adult continence assessment from the Community Bladder and Bowel Service if needed.

Information

For health professionals

Education

North Cumbria HealthPathways – Continuing Professional Development

Further information

Patient – Constipation in Adults

For patients

- NHS:
  - Bowel Incontinence
  - Constipation
- Patient – Constipation

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SOURCES

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