Gateshead Health NHS
NHS Foundation Trust

NHS
Gateshead Network
Commissioning Consortium

Prescribing Guidance for the Treatment of Constipation in Adults

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GATESHEAD MEDICINES MANAGEMENT COMMITTEE

PRESCRIBING GUIDANCE FOR THE TREATMENT OF CONSTIPATION IN ADULTS

1. Development

This guideline was developed by the Gateshead Medicines Management Committee in consultation with GPs, Community Nurse Prescribers, Nurse Specialists and the Gastroenterologists.

The key contact at GHFT for information is Mr Gavin Mankin, Medicines Governance Pharmacist Tel. 0191 445 2818

2. Background

There is no single definition of constipation, but it is generally described as infrequent defecation, often with straining and passage of hard, uncomfortable stool. Constipation is often not optimally managed with the laxatives available. Laxatives are frequently used at sub-therapeutic doses, in inappropriate dosage regimens or in appropriate combinations. A prescription for a laxative is not always necessary and education/advice on fluid intake and diet should always be the first step in the treatment on all constipated patients. These guidelines have been developed to help healthcare professionals with the decision-making progress of how to treat constipation in adults.

3. Aim

To promote the rational use of laxatives across both primary and secondary care so that the treatment of constipation is optimally managed in a patient.

4. Implications

Implementation of the attached guidance will improve the safe and effective use of laxatives in Gateshead, thus improving the management of patients with constipation. There will be an improvement in the management of these patients resulting in a decrease in the inappropriate use of expensive 2nd and 3rd line agents.

5. Implementation & Audit

Copies of the guidelines will be circulated to all practices and community pharmacies in Gateshead. The guidelines will also be widely circulated through out Gateshead Health NHS Foundation Trust to all wards and clinics.

This policy will be reviewed on a biannual basis or in the intervening period if new evidence is published that means an update or revision is required before two years have passed.

6. References

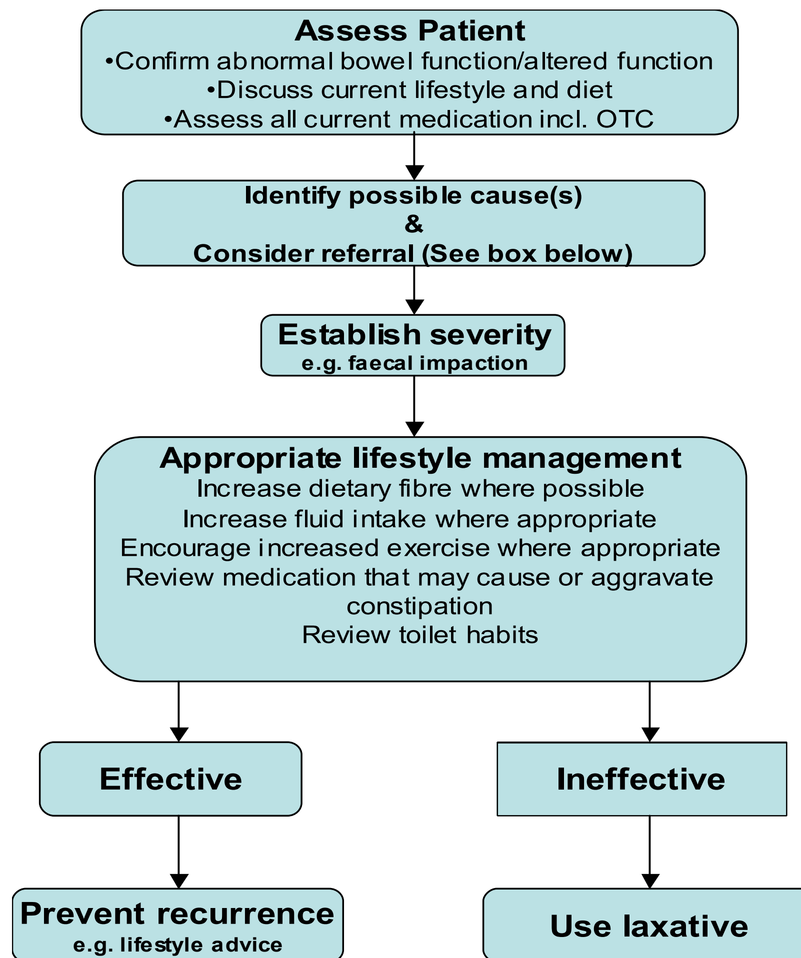
1. Ramkumar D and Rao S. Efficacy and safety medical therapies for chronic constipation: systematic review. Am J Gastroenterol 2005;100:936-971.

2. National Prescribing Centre. The management of constipation. Prescribing Nurse Bulletin 1999; 1:21-24.

3. British National Formulary 65th Edition. The Pharmaceutical Press / British Medical Association 2013.

4. NICE Techonology Apprasial TA 211: Prucalopride for the treatment of chronic constipation in women. December 2010.

5. www.cks.nhs.uk NHS **Clinical Knowledge Summaries** Guidance on Constipation. Date accessed 17/02/2010.



Conditions which may cause or contribute to constipation

Bowel/Intestinal obstruction	Hypothyroidism
Irritable bowel syndrome	Neuromuscular disorders
Cancer	Stimulant laxative abuse
Diverticular disease	Anorexia
Dehydration	Hypercalcaemia
Pregnancy	Neurological disorders
Anal fissure/ Haemorrhoids	

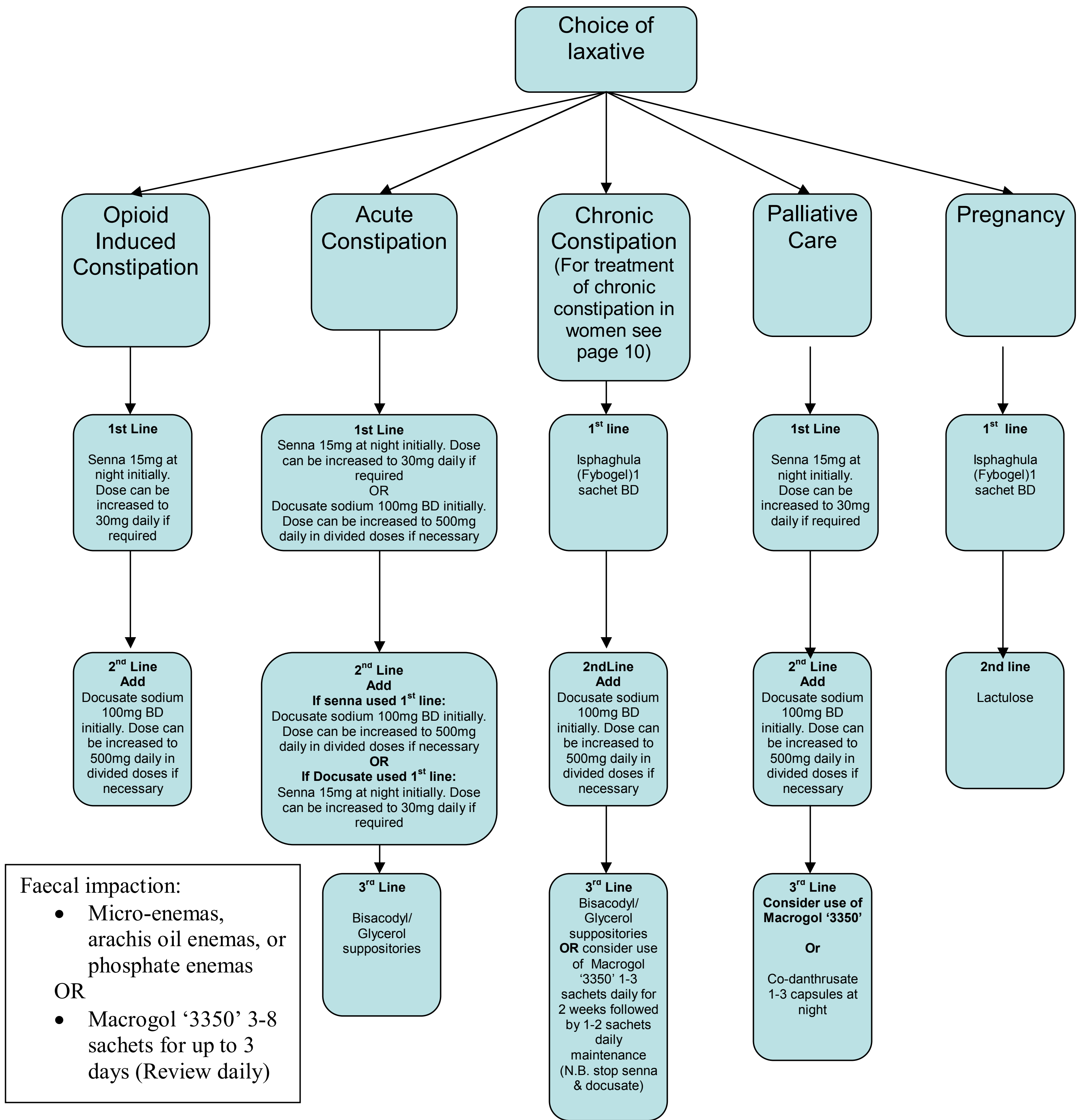
Drugs that may cause constipation

Aluminium	Iron
Amiodarone	Diuretics
Anticholinergics	Phenothiazines
Antihistamines	L-dopa
Calcium	MAOIs
Clonidine	Calcium channel blockers
Opioids	Tricyclic antidepressants

When to refer

Patients over the age of 45 years with the following symptoms should be referred for further investigations e.g. colonoscopy

- New onset or worsening of constipation
- Blood in the stools
- Weight loss or anorexia
- Abdominal pain
- Nausea & vomiting



Faecal impaction:

- Micro-enemas, arachis oil enemas, or phosphate enemas

OR

- Macrogol '3350' 3-8 sachets for up to 3 days (Review daily)

Prescribing notes

1. Laxatives are recommended if dietary measures fail or if treatment is necessary while dietary measures take effect.

2. Laxatives are recommended for constipation resulting from drug treatment e.g. opioids.

3. Lactulose is expensive and offers no advantage over other laxatives & must be used regularly. Reserve for hepatic encephalopathy and patients who do not respond to other laxatives.

4. Avoid high fibre/bulking agents in Hypotonic colon, Megacolon/rectum, and Colonic obstruction.

5. Glycerol suppositories should be administered when there is faeces in the rectum.

6. Bisacodyl suppositories should be administered when the rectum is empty.

7. A course of treatment with Macrogol ‘3350’ does not normally exceed 2 weeks.

8. Patients discharged on Macrogol ‘3350’ should be reviewed by their GP after one month to see if continuation with therapy is appropriate.

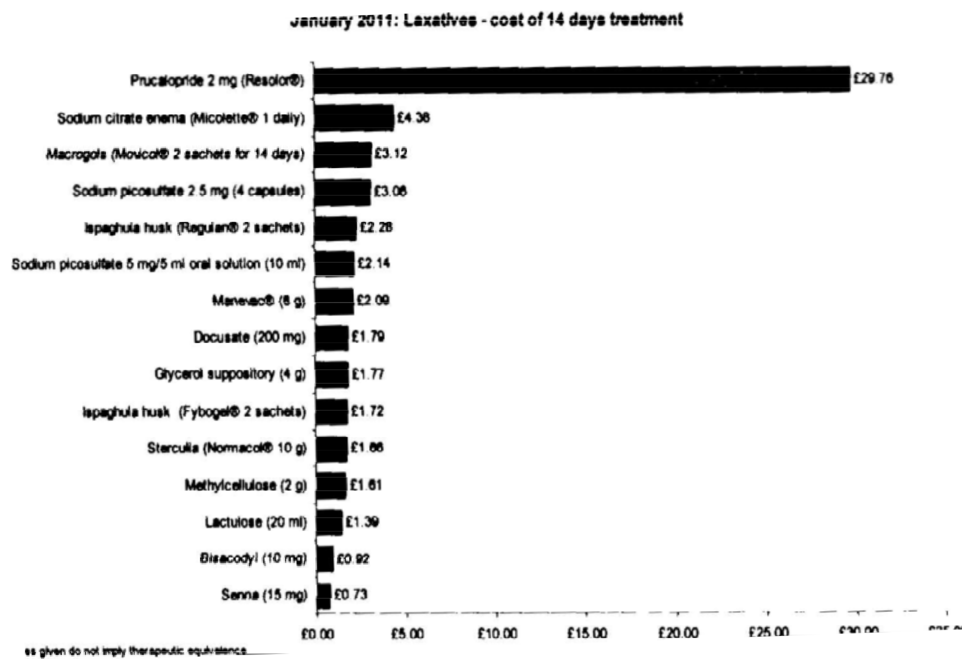
9. Microenemas, arachis oil enemas, or phosphate enemas may be considered for hard impacted stools.

10. Co-danthrusate may colour body fluids red.

11. Adequate fluid intake should be maintained with Ispaghula husk (Fybogel®) to avoid intestinal obstruction especially in the elderly.

12. The 3rd line choices of laxative should be prescribed on their own and not as ‘add-on’ therapy. (i.e. patients should not be prescribed senna + docusate + Macrogol ‘3350’)

Based on costs as of January 2011



Guidelines for urgent referral of suspected lower gastrointestinal cancer.

Person	Symptoms and signs
Aged 40 years and older	Rectal bleeding with a change in bowel habit towards looser stools and/or increased stool frequency persisting 6 weeks or more.
Aged 60 years and older	Rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms. A change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more without rectal bleeding.
Of any age	A right abdominal mass consistent with involvement of the large bowel. A palpable rectal mass (intraluminal and not pelvic; a pelvic mass outside the bowel would warrant an urgent referral to a urologist or gynaecologist).
Woman (not menstruating)	Unexplained iron deficiency anaemia and haemoglobin 10 g/100 ml or below.*
Man of any age	Unexplained iron deficiency anaemia and haemoglobin 11 g/100 ml or below.*
* Anaemia considered on the basis of history and examination in primary care not to be related to other sources of blood loss (e.g. ingestions of nonsteroidal anti-inflammatory drugs) or blood dyscrasia.	

Constipation in Pregnancy

Constipation can commonly occur in pregnancy and is usually managed in primary care. Any conditions and medication e.g. iron preparations or aluminium-containing antacid, which predispose to constipation should be investigated and managed appropriately.

Treatment of Constipation in Pregnancy

1st Choice: Lifestyle advice e.g. high-fibre diet with adequate fluid intake, increased levels of exercise.

2nd Choice: Short course of oral laxative, if lifestyle measures fail.

Choice of Laxative in Pregnancy

1st Choice: Bulking-forming laxative e.g. ispaghula

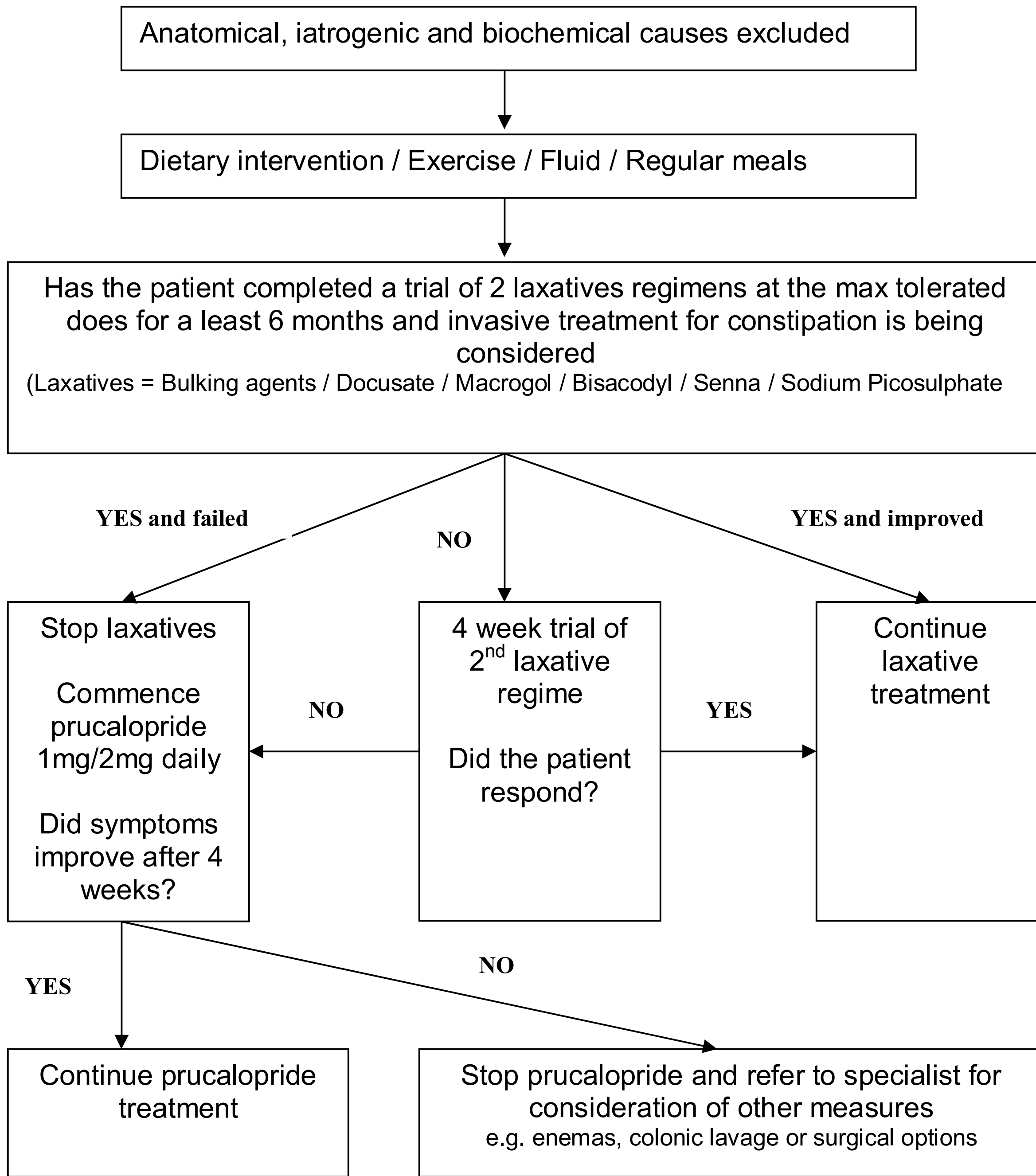
If ineffective consider:

2nd Choice: Lactulose

Prescribing Notes:

- Lactulose is considered to be safe & effective in pregnancy.

Treatment of Chronic Constipation in Women



Prucalopride (Resolor®) is indicated for symptomatic relief in treatment of chronic constipation in women in whom laxatives fail to provide adequate relief

Adults: 2mg once daily

Elderly (>65 years): 1mg once daily initially, if needed increase to 2mg daily