Laxative Treatment Guideline for Adults

For more detailed information see the CKS Constipation Guideline (www.cks.nhs.uk)

NHS Nottinghamshire Area Prescribing Committee

This guideline covers:

- Treatment of short term and chronic constipation in adults (>18 yrs).
- Treatment of faecal impaction in adults (>18 yrs)
- Opioid induced constipation– see appendix 2

This guideline does NOT cover:

- Treatment of children (<18 yrs) - see NICE CG99
- Constipation in pregnancy and breastfeeding– see CKS
- Complex / very severe constipation

Diagnosis & assessment of patient with constipation (see page 2)

Any RED FLAGS (see page 2) or signs of obstruction? Refer to appropriate specialist

NO RED FLAGS

LIFESTYLE ADVICE—See appendix 1

Does the patient have faecal impaction? YES

NO

CONSTIPATION—short term or chronic

Bulk forming laxative: Ispaghula husk 3.5g.
Effect takes 48 –72 hours.
Adequate fluid intake is important. See page 3.

If unsuitable, unable to tolerate or ineffective

Add or switch to stool softener/stimulant: Docusate sodium
Effect takes 24—48 hours. See over.

If unsuitable, unable to tolerate or ineffective

Add stimulant laxative: Bisacodyl, senna or docusate (if not already used) **.** See page 3.
Bisacodyl & senna are least expensive option.

Severe constipation (resistant to at least 2 laxatives titrated appropriately)
Add osmotic laxative: Macrogol compound
- Warn patient to stop and seek advice if diarrhoea starts. (page 3)

Has patient responded to treatment? NO

YES

Maintenance treatment: Ispaghula husk (docusate if unable to tolerate high fibre) at lowest effective dose.

Review regularly and consider slow withdrawal when stools are soft and easily passed. Aim for 2 to 3 bowel movements a week

At all stages in treatment

- Advise patient about **lifestyle measures** which can treat and prevent constipation (see appendix 1)
- Gradually titrate dose of laxative upwards or downwards.
- **Titrate to maximum tolerated dose before adding / switching laxatives.**
- Adjust constipating medication if possible.
- Adjust dose, choice & combination of laxative according to symptoms, speed of relief required, response to treatment & individual preference.

FAECAL IMPACTION

For hard stools:
Consider using a high dose macrogol compound oral powder
8 sachets daily for max 3 days
For soft stools (or hard stools after a few days treatment with macrogol) consider starting or adding an oral stimulant laxative.

Has response been sufficient or fast enough? YES

NO

Add suppositories or a mini-enema
Suppositories:
Bisacodyl (soft stools)
Glycerol alone or with bisacodyl (hard stools)
Mini enema:
Docusate or sodium citrate
May be repeated for hard impacted faeces.

Has patient responded to treatment? YES

NO

Consider using Arachis (peanut) oil or sodium phosphate enema. See over.

Has patient responded to treatment? YES

NO

Consider appropriate referral.

1. Assessment

Be alert for red flags - See below	
1. Clarify what the patient understands by constipation, and confirm the diagnosis of constipation	
• What does the patient believe to be normal bowel movements? • What is their normal pattern of defecation?	• When did constipation first become a problem? • What is the frequency and character of stools?
2. Assess the presence and degree of faecal loading/impaction and faecal incontinence	
• Can faecal masses be felt when palpating lower left abdomen or rectal exam? • Is there faecal incontinence, or loose stools?	• Have manual measures been necessary to relieve faecal loading/impaction?
3. Assess the severity and impact of the constipation and any faecal incontinence	
• Is there nausea, vomiting, loss of appetite, or loss of body weight? • Is there abdominal pain or distension? • Is there pain or bleeding with passing stools?	• Is underwear regularly and involuntarily soiled? (if yes, what are the social consequences) • Are there any urinary symptoms and/or urinary incontinence?
4. Assess the role of predisposing factors	
• Is the diet low in fibre? • Is the patient dehydrated? • What are the patient's toileting habits? • Is access to the toilet difficult? (is there a lack of privacy?) • Is the patient on any constipating medication?	• Have there been changes in routine or lifestyle? • What is the patient's general level of activity and mobility? • Does the patient have an eating disorder, anxiety or depression?
5. Identify any organic causes of constipation. Does the patient have a history or features of:	
• Endocrine or metabolic disease, a myopathic or neurological condition? • Irritable bowel syndrome? (see alternative CKS guidance) • Anal fissure, haemorrhoids, rectal prolapse or rectocele? • Inflammatory bowel disease? • Does the patient have obstructive symptoms (use of digitation or vaginal pressure)	• Obstructive colonic mass lesions (e.g. colorectal cancer)? • Colonic strictures (following diverticulitis, ischaemia or surgery)? • Pelvic floor dyssynergia? (having to strain, feeling of incomplete evacuation) • Does the patient have slow transit constipation (onset in adolescence, infrequent call to stool)
6. Assess effectiveness of management to date	
• What measures (self-care and prescribed, non-drug and drug) have been tried?	• What has been the response?

2. Investigations

No investigations are routinely required in an adult with constipation unless a secondary cause is suspected.

3. Referral and 'red flags'

Constipation in adults can usually be managed in primary care, however referral is indicated when:

- **RED FLAG(s)** identified
- Cancer is suspected
- An underlying cause is suspected
- Pain and bleeding on defecation (e.g. from anal fissure) is severe or does not respond to treatment for constipation
- Treatment is unsuccessful
  - Treatment failure may be early, when attempts to relieve faecal loading fail or late failure if there is difficulty maintaining remission
  - Management may require further tests
- Assessment is required prior to referral for other interventions (such as psychology, psychiatry)
- Faecal incontinence is present
- More detailed support with diet is required

RED FLAGS - Colorectal Cancer (ref: NICE CG131)

≥40 yrs: Rectal bleeding with a change in bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more.

≥60 yrs: 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.

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 100 g/L or less.*

Man of any age : Unexplained iron deficiency anaemia and haemoglobin 110 g/L or less.*

* Anaemia considered on the basis of history and examination in primary care not to be related to other sources of blood loss (e.g. ingestion of non-steroidal anti-inflammatory drugs) or blood dyscrasia.

RED FLAGS - General

- Clozapine patients should **only** use stimulant laxatives
- Persistent unexplained change in bowel habits
- Palpable mass in the abdomen or the pelvis
- Persistent rectal bleeding without anal symptoms
- Narrowing of stool calibre
- Family history of colon cancer, or inflammatory bowel disease
- Unexplained weight loss, iron deficiency anaemia, fever, or nocturnal symptoms
- Severe, persistent constipation that is unresponsive to treatment

Ref: MeReC Bulletin vol. 21 no. 2

Laxatives for constipation and relative cost (GP price*) of 28 days treatment (Drug Tariff/MIMs Jun 17)
*Prices were correct in May 2017. For up to date prices please check the cost comparison chart on the Joint Formulary or refer to the Drug Tariff or MIMs.

Type	Formulations	Dose[2]	Other information
Bulk Forming	**Ispaghula** sachets 3.5g (1 BD = £5.44)	One sachet once or twice a day.	Increases faecal mass – stimulates peristalsis. Effect takes 48 – 72 hours. Adequate fluid intake is important to prevent obstruction (6 – 8 cups per day) & not immediately before bed. **Not suitable for frail patients who are unlikely to be able to drink the required volume of fluid.** Note: The fluid is quite thick and should be taken as soon as possible as it gets thicker on standing.
Stool softener & weak stimulant	**Docusate** sodium capsules 100mg (200mg BD = £8.36) **Docusate** sodium liquid 50mg/5ml (200mg BD = £32.44)	Up to 500mg per day in divided doses	Increases intestinal motility and softens stools. Effect takes 24 – 48 hours. Stimulant at higher doses. Note: Liquid taste may be unacceptable to some patients.
Stimulant	**Bisacodyl** tablets 5mg (10mg ON = £1.96)	5 to 10mg at night, increased if necessary to max. 20mg at night	Increases intestinal motility. Effect takes 8 – 12 hours. Initial dose should be low then gradually increased. Senna liquid has a strong taste that may be disliked by some.
	Senna liquid 7.5mg/5ml (15mg BD = £9.52) **Senna** tablets 7.5mg (15mg BD = £3.71)	15mg to 30mg daily, usually at night, but dose can be divided.	

Laxatives for Faecal Impaction

Osmotic – oral preparation	**Macrogol compound oral powder** sachets e.g. Laxido® (2 daily = £8.54) • Dissolve each sachet in half a glass of water (approx. 125ml). • Solution to be kept in fridge once made (discard if unused after 6 hours).	**Faecal impaction dose:** 4 sachets on first day then increased in steps of 2 sachets daily up to max. of 8 sachets per day. Total daily dose to be drunk within 6 hour period. **Severe constipation dose:** Initially 1 to 3 sachets daily in divided doses usually for up to 2 weeks. Maintenance, 1 to 2 sachets daily.	For patients with **faecal impaction and severe constipation only**. • Effect takes 2 – 3 days. • Ensure that patient is capable of drinking the required volume. • Patients may adjust dose according to stool consistency. • Warn patient to seek advice if diarrhoea starts and advise faecally impacted patients that faecal overflow may occur before impaction is resolved and they should seek further advice if unsure. • Should only be used in patients with constipation resistant to least two laxatives at optimal doses. • Patients currently prescribed macrogols for constipation should be reviewed and if they have not previously received two other laxatives as above, be treated according to the flow chart on page 1.
Stimulant suppository	**Bisacodyl** suppository 10mg (10mg OD = £10.59)	10mg in the morning	Use if stools are already soft. Effect takes 20 – 60 minutes.
	Glycerol suppositories 4g (4g OD = £3.48)	1 suppository moistened with water before use.	Use along with bisacodyl if stools are hard. Effect takes 15-30 minutes.
Stimulant mini enema	**Docusate** sodium 120mg in 10g (1 enema = £4.66)	The contents of one mini enema	Also acts as a softener. Effect takes 15-30 minutes.
Osmotic micro- enema	**Sodium citrate** 5ml micro-enema (Micolette® micro-enema) (1 enema = £0.36)	The contents of one micro enema	Effect takes 5 -15 minutes.
Arachis enema (Faecal softener)	**Arachis (peanut) oil** retention enema 130ml ***DO NOT give to patients with peanut allergy*** (1 enema = £47.50)	Contents of one enema at bedtime (place high if the rectum is empty but the colon is full)	**Warm before use.** For hard faeces it can be helpful to give the arachis oil enema overnight before giving a sodium citrate enema the next day.
Phosphate enema	**Sodium Phosphate enema** e.g. Fleet® Ready-to-use enema (133ml, dose delivered=118ml) (1 enema = £2.37)	The contents of one enema (place high if the rectum is empty but the colon is full)	Can produce effect within 2-5 minutes. Use with caution in the elderly and debilitated. Contraindicated in clinically significant renal impairment. Can cause electrolyte disturbance and local irritation.

Specialist products for sub-groups of patients.

Serotonin $5HT_4$ receptor agonist with prokinetic properties.	**Prucalopride** (Amber 2 specialist initiation) (2mg OD = £59.52)	2mg once daily (1mg OD in certain patient groups)	Specialist initiation for male and female patients with intractable constipation unresponsive to two or more laxatives at maximum doses for at least 6 months as per NICE TA211. GPs may continue the prescribing only if a review after a month's therapy demonstrates benefit- see formulary
Dantron (with softener)	**Co-danthramer** (GREY) **Co-danthramer Strong liquid** (contains dantron 75mg, poloxamer '188' 1g/5ml) (5ml ON= £293.63)	**Not generally recommended**	Not generally recommended due to risk of dantron burns if patient's mobility deteriorates and control usually achieved with alternative laxatives. Avoid in patients with urine or faecal incontinence- prolonged contact with the skin can cause a dantron burn — an erythematous rash with a sharply demarcated border May colour urine red Effect takes 6–12 hours
Opioid antagonist (with oxycodone)	**Targinact® (MR oxycodone with naloxone)** (Amber 2 specialist initiation) (10mg/5mg BD = £42.32, 20mg/ 10mg BD = £84.62)	1 tablet BD (usual starting dose for adults is 10mg/5mg BD. Patients already receiving opioids may be started on higher doses depending on their previous opioid experience)	Restricted to pain or palliative care consultant initiation in patients with intractable constipation despite optimal laxatives, and who are unable to tolerate other opioids but have obtained benefit from oxycodone- see formulary.
Opioid antagonist	**Methylnaltrexone subcutaneous injection** (7x 12mg/ 0.6ml injections=£147.35)		Classified RED and restricted for use by palliative care teams for the management of intractable opioid induced constipation in patients not responding to usual laxative treatment.
Peripheral opioid-receptor antagonist	**Moventig® (Naloxegol)** (Amber 2 specialist initiation) (25mg OD = £55.20)	25mg OD (12.5mg in certain patient groups)	Naloxegol (Moventig®) to be prescribed in line with NICE TA345. Use a lower starting dose of 12.5 mg once daily in patients taking concomitant moderate inhibitors of CYP3A4 (such as diltiazem and verapamil), increasing to 25 mg if well tolerated.
Guanylate Cyclase-C receptor agonist	**Constella®(Linaclotide)** (Amber 2 specialist initiation) (1 OD = £37.56)	1 capsule OD	Indicated for patients with moderate to severe IBS-C which has not responded adequately. Initiated and prescribed by consultant gastroenterologist for the first 8 weeks of treatment, who will then review to assess efficacy and tolerability. GP to review patient every 3 months and stop if patient no longer benefitting from treatment.
Locally acting chloride channel activator	**Amitiza®(Lubiprostone)** (Amber 2 specialist initiation) (1 BD = £53.48)	1 capsule BD	For gastroenterology consultant initiation only in line with NICE TA318. Consultant review after 2 weeks for first course (telephone consultation is acceptable). If effective, GPs may prescribe further courses.

The approach suggested in this guideline is based on local expert opinion, NICE CKS guidance[1] and recommendations from the National Prescribing Centre (MeReC bulletin)[3]. Trial evidence is limited mainly because these agents have been in use for a long time and few new clinical trials have been done.[1]

References

1. CKS Constipation Guideline www.cks.nhs.uk, [accessed 15.03.2017]
2. British National Formulary 72, September 2016
3. MeReC Bulletin Vol 21; No 2. January 2011. The management of constipation. National Prescribing Centre.
4. CKS Palliative Care Constipation Guideline www.cks.nhs.uk, [accessed 15.06.2017]
5. PANG Guidelines, [accessed 15.06.2017]

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Appendix 1

Constipation – patient information

Preventing constipation

Although constipation is common, you can take several steps to prevent it, including making diet and lifestyle changes.

Fibre

Make sure you have enough fibre in your diet. Most adults do not eat enough fibre. You should have approximately 18g of fibre a day. Pre-packed foods usually state the amount of fibre they contain on the label. As a guide, a slice of wholemeal bread, an apple with the skin on or a banana contain about 2g of fibre each. You can increase your fibre intake by eating more:

- fruit
- vegetables
- beans
- wholegrain rice
- wholewheat pasta
- wholemeal bread
- seeds
- nuts
- oats
-

Eating more fibre will keep your bowel movements regular because it helps food pass through your digestive system more easily. Foods high in fibre also make you feel fuller for longer. Make sure you drink plenty of fluids to help your body to process the fibre.

If you are increasing your fibre intake, it is important to increase it gradually. A sudden increase may make you feel bloated. You may also produce more flatulence (wind) and have stomach cramps.

Fluids

Make sure that you drink plenty of fluids to avoid dehydration and steadily increase your intake when you are exercising or when it is hot. The European Food Safety Authority suggested that the minimum levels of water consumption should be 2 litres for men and **1.6 litres** for women or between eight and ten glasses. Try to cut back on the amount of caffeine, alcohol and fizzy drinks that you consume.

Toilet habits

Never ignore the urge to go to the toilet. Ignoring the urge can significantly increase your chances of having constipation. The best time for you to pass stools is first thing in the morning, or about 30 minutes after a meal.

When you use the toilet, make sure you have enough time and privacy to pass stools comfortably.

Exercise

Keeping mobile and active will greatly reduce your risk of getting constipation. Ideally, do at least 150 minutes of physical activity every week.
Not only will regular exercise reduce your risk of becoming constipated, but it will also leave you feeling healthier and improve your mood, energy levels and general fitness.

This information is taken from the NHS Choices website, for more information about constipation visit the website at www.nhs.uk/conditions/constipation.

Appendix 2– Opioid induced constipation in adults

All patients taking regular opioids should be prescribed a regular stimulant laxative (senna or bisacodyl) at first opioid prescription rather than waiting until constipation is established.
Titrate as needed to maximum tolerated dose —see page 3.
Aim for a regular bowel movement, without straining, every 1–3 days.

At all stages in treatment

- Advise patient about **lifestyle measures** which can treat and prevent constipation (see appendix 1)
- **Titrate to maximum tolerated dose before adding / switching laxatives. For doses see pages 3 -4.**
- Maximise use of non-opioid analgesics eg. paracetamol, NSAIDs to reduce opioid dose.
- Gradually titrate dose of laxative

LIFESTYLE ADVICE– encourage fluids generally, fruit and fruit juice- See appendix 1

Does the patient have faecal impaction?

YES → **See algorithm on page 1. Once treated patient will require regular laxative therapy**

NO

Add regular stool softener/stimulant: docusate
Titrate as needed to maximum tolerated dose —see page 3

Add osmotic laxative: Macrogol compound oral powder
Titrate as needed to maximum tolerated dose —see page 3

Has patient responded to treatment?

YES

Gradually decrease dose/ remove laxatives. Review regularly. Aim for comfortable defecation.

Patient should continue to receive regular prophylactic laxative therapy

NO

Review choice of opioid. Transdermal fentanyl may be less constipating than other strong opioids. See Guideline on opioids for persistent non-cancer pain

Consider appropriate referral.