Lancashire Medicines Management Group

NHS

Primary Care Constipation Guidelines

Version 1.2 – May 2018

VERSION CONTROL		
Version	**Date**	**Amendments made**
Version 1	November 2016	New guideline
Version 1.1	December 2016	Bisacodyl removed from the children's pathway and replaced with sodium picosulphate. Approved at LMMG. Minor amendments to formatting.
Version 1.2	May 2018	Minor changes to the layout. Additional information relating to the prescribing of laxatives and self-care added to the adult pathway.

Contents

Please note:

NHS England have advised CCGs that a **prescription for the treatment of infrequent constipation should not routinely be offered in primary care** as the condition is appropriate for **self-care**.

The NHS England guidance applies to short term, infrequent constipation caused by changes in lifestyle or diet such as lack of water or movement or changes in diet.

GPs should continue to prescribe laxatives to manage acute constipation with more complex aetiology (e.g. iatrogenic) and chronic constipation.

The NHS England guidance **does not apply** to the management of children and laxatives for children should continue to be prescribed by GPs.

Bibliography: 1) NHS England and NHS Clinical Commissioners. Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs. NHS England. March 2018. Accessed via: https://www.england.nhs.uk/wp-content/uploads/2018/03/otc-guidance-for-ccgs.pdf [accessed online 15th May 2018].

Management of Constipation in Adult Patients: Acute and Chronic Treatment Pathways

Lancashire Medicines Management Group — NHS

Please note: Patients presenting with short term, infrequent constipation caused by changes in lifestyle or diet, such as lack of water or movement or changes in diet, **should be advise to self-mange by purchasing laxatives over-the counter**

Adult Patient with Constipation

Acute (symptoms present < 3 months) or Chronic (symptoms present > 3 months)

If Present, relieve faecal loading/impaction. **Treat first using**:

Macrogols 4 sachets on first day,

Increased in steps of 2 sachets per day up to a max of 8 sachets per day

Total daily dose to be drunk within a 6 hour period.

Review and consider initiating further management once disimpacted

Consider Iatrogenic Causes:

Review medication – see box 1

Offer Dietary and Lifestyle Advice – see box 2

Consider commencing regular laxatives – see box 3

1st Line: Bulk forming laxative (ensure adequate hydration) – **see box 4**

Or if a rapid effect clinically necessary:

2nd Line : Osmotic laxative – **see box 4**

(NB. Do not start a bulk forming laxative if the constipation may be opioid induced – **See Figure 2**).

Management in pregnancy – see box 6

If stools remain difficult to pass or if there is inadequate emptying

Consider adding a stimulant laxative to existing therapy – see box 4

Review after 3 – 4 weeks

Advise that laxatives should be continued until effective and can be discontinued once stools become soft and easily passed again.

Reassess if symptoms persist for > 6 months

If at least TWO different class laxatives have been used for 6/12 at the highest tolerated dose consider the use of

Lubiprostone NICE TA318 as per NICE initiation by a clinician experienced in treatment of chronic idiopathic constipation

or

Prucalopride (**women only**) TA211 as per NICE can be initiated in primary care only on the advice of someone experience in the treatment of chronic idiopathic constipation. Amber0 colour classification – **further detail see box 5**

Box 1: Medication commonly prescribed that may cause constipation:

Opioids
Calcium channel blockers
Diuretics
Iron preparations
Anti-cholinergic drugs
Tricyclic antidepressants
Verapamil
Clozapine

(note: It is essential that constipation is actively treated in patient receiving clozapine [fatalities reported]).

Box 2: Lifestyle and dietary advice:

- Defecation should be unhurried and appropriate defecation technique encouraged.
- Attempt defecation first thing in the morning or 30minutes after a meal
- Respond immediately to the call to toilet
- Consideration should be given to those with mobility issues – increased physical activity is beneficial.
- Diet should be balanced and contain whole grains, fruits and vegetables.
- Fibre intake should be increased gradually and maintained:
  - Adults should aim to consume 18 – 30gram of fibre per day.
  - Effects may take up to four weeks.
- Adequate fluid intake is important, although there is no evidence that increased fluid intake will improve symptoms in those that are already well hydrated
- Natural laxatives, such as fruit and fruit juices, high in sorbitol can be recommended. Dried fruit has a higher sorbitol content than fresh fruit (5 – 10 times higher).

Box 3: Criteria for commencing regular laxative therapy:

- If lifestyle measures are ineffective
- If a patient is taking a constipating drug that cannot be stopped
- For those with other secondary causes of constipation
- As a 'rescue' for episodes of faecal loading

Box 4: Classes of laxatives

Bulk-forming

Ispaghula Husk 3.5gram ONE sachet TWICE a day

Osmotic

Laxido (macrogols) Orange one to three sachets daily

Stimulant

Bisacodyl 5 – 10mg at night

Softener

Docusate sodium 100mg – 200mg twice a day (up to 500mg a day in divided doses)

Patients presenting with short term, infrequent constipation caused by changes in lifestyle or diet, such as lack of water or movement or changes in diet, **should be advise to self-mange by purchasing laxatives over-the counter**

Box 5: Prucalopride:

NICE TA 211 relates to the use of prucalopride in woman **only**. Prucalopride is now **licensed** for use in both men and women. NICE has **not** reviewed prucalopride for the management of chronic idiopathic constipation in men. Trial data was not representative and 90% of the study population were women when the drug was first licensed. Local arrangements for the use of prucalopride should be followed where available.

Box 6: Pregnancy:

Avoid osmotic laxatives (except lactulose). Senna should be avoided near term or if there is a history of unstable pregnancy. Offer dietary advice.

Bibliography: 1) National Institute for Health and Clinical Excellence (NICE), "Clinical Knowledge Summary: Constipation," NICE, Manchester, 2015. 2) National Institute for Health and Clinical Excellence (NICE), "NICE technology appraisal 211: Prucalopride for the treatment of chronic constipation in women", NICE, Manchester, 2010. 3) National Institute for Health and Clinical Excellence (NICE), "NICE Technology appraisal 318: Lubiprostone for treating chronic idiopathic constipation" NICE , Manchester, 2014. 4) Ford et al, "Laxatives for chronic constipation in adults," The British Medical Journal, vol. 345, no. e6168, 2012

Management of constipation in adult patients: opioid-induced constipation pathway

Lancashire Medicines Management Group

Adult patient presenting with potential opioid-induced constipation

Review current medication and identify potential cause of constipation. Review need for opioid-based medication. Discontinue if no-longer indicated – **see box 1**

Offer dietary and lifestyle advice to all patients - **see Box 2**

Consider commencing an osmotic laxative AND a stimulant laxative (do not commence a bulk forming laxative) - see box 3

The dose of laxatives should be gradually titrated upwards (or downwards) to produce one or two soft stools per day.

Review after 2 weeks

Patient remains symptomatic despite treatment with an osmotic and stimulant laxative at the highest tolerated dose for at least four days over the last TWO week period?

No

Continue laxative therapy

Review laxative use if opioids are discontinued or if the patient presents with loose stools

Yes

Commence naloxegol 25mg ONCE daily – discontinue all other laxative therapy to determine clinical effect – **see box 4**

If the patient remains symptomatic refer to gastroenterology service for specialist review

Box 1: Medication commonly prescribed that may cause constipation:

Opioids
Calcium channel blockers
Diuretics
Iron preparations
Anti-cholinergic drugs
Tricyclic antidepressants
Verapamil
Clozapine
(note: It is essential that constipation is actively treated in patient receiving clozapine [fatalities reported]).

Box 2: Lifestyle and dietary advice:

- Defecation should be unhurried
- Attempt defecation first thing in the morning or 30minutes after a meal
- Respond immediately to the call to toilet
- Consideration should be given to those with mobility issues
- Diet should be balanced and contain whole grains, fruits and vegetables.
- Fibre intake should be increased gradually and maintained:
  - Adults should aim to consume 18 – 30gram of fibre per day.
  - Effects may take up to four weeks.
- Adequate fluid intake is important. Although there is no evidence that increased fluid intake will improve symptoms in those that are already well hydrated
- Natural laxatives, such as fruit and fruit juices, high in sorbitol can be recommended. Dried fruit has a higher sorbitol content (5 – 10times higher)

Box 3: Classes of laxatives and lowest cost July 2016 (eMIMs):

Osmotic
Laxido Orange One to Three sachets Daily
Stimulant
Bisacodyl 5 –10mg At Night
Softener
Docusate sodium 100mg – 200mg Twice a Day (up to 500mg a Day in divided doses)

Box 4: Naloxegol

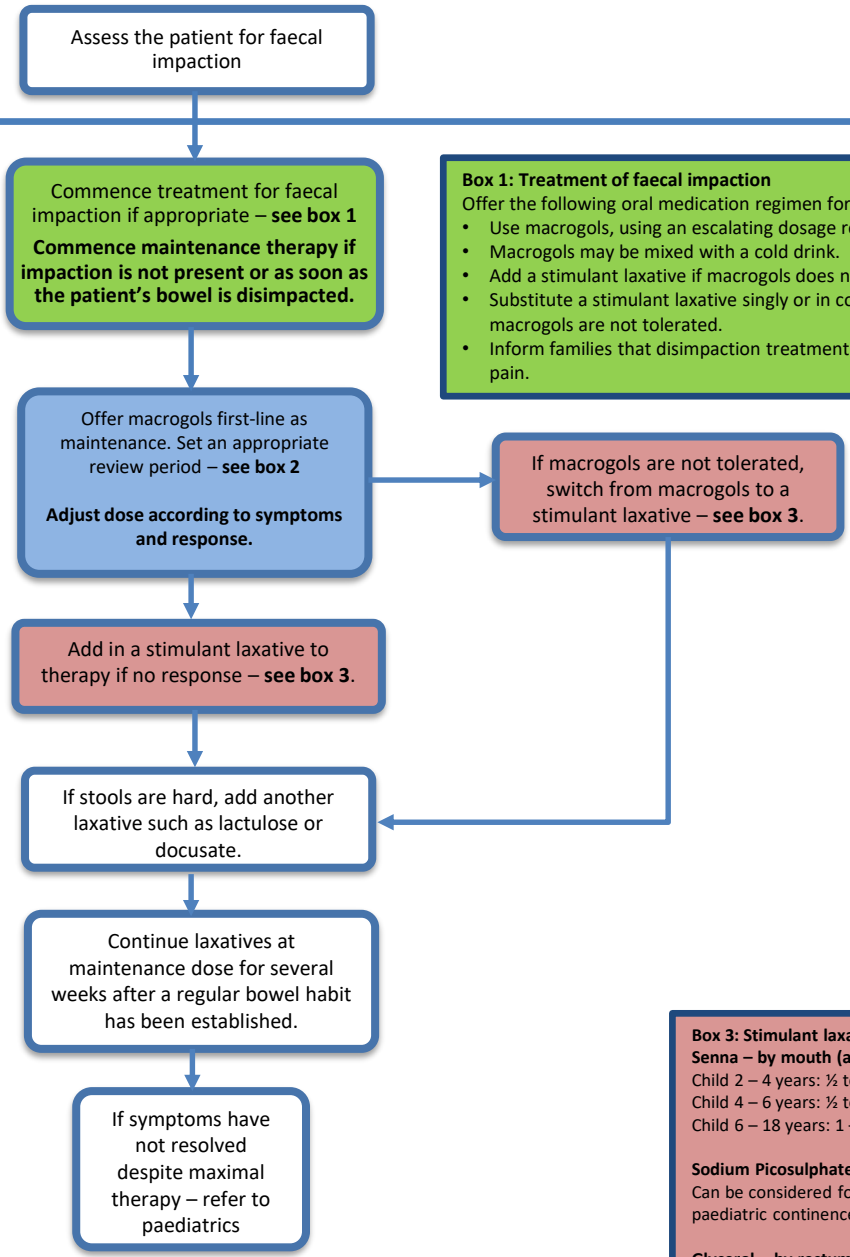
Naloxegol can be used to treat opioid-induced constipation (NICE TA 345) in primary care for patients whose constipation has not adequately responded to laxatives. An inadequate response is defined as: opioid-induced symptoms of at least moderate symptoms severity in at least one of the **four stool symptom domains (see below)** while taking at least one laxative class for at least four days during the prior two weeks.

The four stool symptoms domains are:
Incomplete bowel movement, hard stools, straining or false alarms.

Bibliography: 1) National Institute for Health and Clinical Excellence (NICE), "Clinical Knowledge Summary: Constipation," NICE, Manchester, 2015. 2) National Institute for Health and Clinical Excellence (NICE), "NICE technology appraisal 345: Naloxegol for treating opioid-induced constipation", NICE, Manchester, 2015.

Management of constipation in children: NICE Clinical Guideline 99

Lancashire Medicines Management Group



Box 1: Treatment of faecal impaction

Offer the following oral medication regimen for disimpaction if indicated:

- Use macrogols, using an escalating dosage regimen, as the first line treatment (see NICE CG99).
- Macrogols may be mixed with a cold drink.
- Add a stimulant laxative if macrogols does not lead to disimpaction after two weeks.
- Substitute a stimulant laxative singly or in combination with an osmotic laxative such as lactulose if macrogols are not tolerated.
- Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain.

Box 2: Patient management – maintenance therapy

- Children with constipation should be reassessed frequently during maintenance treatment to ensure they do not develop impaction and assess issues in maintaining treatment such as taking medicine and toileting.
- Laxative therapy may be needed for several months or years. Each case should be assessed individually.
- Laxative therapy should not be stopped suddenly but gradually withdrawn.
- Diet and behavioural interventions are important additional measures e.g. ensure adequate fluid and fibre intake. Cows milk exclusion diet should only be initiated on the advice of a specialist.

Laxido Paediatric – by mouth (refer parent/carer to PIL for instructions on dilution):
Child under 1 year: ½–1 sachet daily

Child 1–6 years: 1 sachet daily; adjust dose to produce regular soft stools (max. 4 sachets daily)

Child 6–12 years: 2 sachets daily; adjust dose to produce regular soft stools (max. 4 sachets daily)

Box 3: Stimulant laxatives that can be used in children
Senna – by mouth (all doses adjusted according to response):
Child 2 – 4 years: ½ to 2 tablets once a day
Child 4 – 6 years: ½ to 4 tablets once a day
Child 6 – 18 years: 1 – 4 tablets once a day

Sodium Picosulphate
Can be considered for use in primary care on the advice of the local specialist paediatric continence service (or equivalent)

Glycerol – by rectum:
Child 1 month – 1 year: 1gram suppository as required.
Child 1 – 12 years: 2gram suppository as required.

Bibliography: National Institute for Health and Clinical Excellence (NICE), "NICE Clinical Guideline 99: Constipation in Children and Young People NICE, Manchester, 2015. Royal Pharmaceutical Society, British National Formulary, vol. 70, London: Pharmaceutical Press, 2016.

Midlands and Lancashire Commissioning Support Unit,
Jubilee House, Lancashire Business Park, Leyland, PR26 6TR
Tel: 01772 644 400 | www.midlandsandlancashirecsu.nhs.uk