PrescQIPP Community Interest Company

Constipation

This project reviews the treatment of short term and chronic constipation in adults (over 18 years). The current annual cost of all laxative preparations across England and Wales is over £93 million (ePACT October to December 2015). In line with the National Institute of Health and Care Excellence (NICE) Key Therapeutic Topics, this project provides guidance to review and if appropriate, revise prescribing of laxatives for adults to ensure that they are prescribed routinely only for the short-term treatment of constipation when dietary and lifestyle measures have proven unsuccessful or if there is an immediate clinical need.[1] This project also reviews cost effective alternatives. This guideline does not cover treatment of children (<18 years) or constipation in pregnancy and breastfeeding. Laxatives should be prescribed for treating children and young people with constipation in line with NICE clinical guideline 99.[2] Newer products for the treatment of constipation are discussed.

Recommendations

- Ensure a clear diagnosis of constipation before considering a laxative, and that the constipation is not secondary to an underlying undiagnosed complaint. Bowel habit can vary considerably in frequency without the patient suffering any harm.[3]
- Adopt a stepwise approach to the management of constipation, starting with diet and lifestyle factors.[4]
- Avoid or adjust drugs that cause constipation if possible.[4]
- Review and, if appropriate, revise prescribing of laxatives for adults to ensure that they are prescribed routinely only for the short-term treatment of constipation when dietary and lifestyle measures have proven unsuccessful or if there is an immediate clinical need.[1]
- Stimulant laxatives should only be used short term.[4] They should be added to acute prescribing systems (not repeat medication records). Bisacodyl tablets and senna liquid are the least costly stimulant oral preparations.[5]
- Review continued need of laxatives after discharge from secondary care, e.g. post surgery, when they have been prescribed with short term opioids.
- Do not use bulk forming laxatives in opioid induced constipation.[4]
- If an osmotic laxative is appropriate, a macrogol is the preferred option.[4] Prescribe as generic or a less costly branded formulation (if branded prescribing appropriate and agreed at CCG). See MIMS for current prices.[6]
- Use of two drugs in the same class should be avoided, i.e. lactulose and macrogols.[4]
- Laxatives can be slowly withdrawn when regular bowel movements occur without difficulty.[4]
- Lubiprostone and prucalopride should only be prescribed by a clinician with experience of treating chronic constipation.[7,8]
- Ensure that the NICE criteria are fulfilled for prucalopride, lubiprostone, naloxegol and linaclotide.[7,8,9,10]
- Care homes should have a robust ordering system and checking process in place to ensure that laxatives and other medicines are only ordered if they are needed.[11]

Background

Constipation is defecation that is unsatisfactory because of infrequent stools, difficult stool passage, or seemingly incomplete defecation. Stools are often dry and hard, and may be abnormally large or abnormally small.[4] The BNF states that a useful definition of constipation is the passage of hard stools less frequent than the patient's own normal pattern. This should be explained to the patient. Misconceptions about bowel habits have led to excessive laxative use. Stimulant laxatives carry the risk of metabolic problems and an atonic, non-functioning colon or diarrhoea. Abuse may lead to hypokalaemia. Thus, laxatives should generally be avoided except where straining will exacerbate a condition (such as angina) or increase the risk of rectal bleeding as in haemorrhoids.[3] Laxative use can occasionally mask the symptoms of more serious disease such as bowel neoplasia.[3]

Because different definitions of constipation are in use, attempts continue to be made to develop and agree more objective criteria for the definition of functional constipation, most notably by the Rome criteria.[12]

1. Functional constipation is chronic constipation without a known cause. Functional constipation is also known as primary constipation and idiopathic constipation.
2. Secondary constipation is constipation caused by a drug or medical condition. Lists of these can be found in appendix 1 and 2 (page 16). Secondary constipation is also known as organic constipation.

Most cases of mild or acute functional (idiopathic) constipation in adults can be managed by dietary and lifestyle changes. In adults, laxatives should be reserved for constipation that has not responded adequately to simple interventions, or for when rapid relief of symptoms is needed. The evidence from trials for the efficacy and safety of all laxatives is limited, mainly because these agents have been in use for a long time. Clinical trials were far less robust at the time they were originally licensed, and few trials have addressed clinically relevant questions such as what approach is effective in terms of acceptability, relief of symptoms, and restoration of comfortable bowel movements without the aid of laxatives.[4] For example a combination of bowel-friendly diet, fluids, exercise, behaviour training, bowel disimpaction, and then regular laxatives adjusted according to the response.[4]

A clinical evidence review found no clinically important results from RCTs for: magnesium salts, methylcellulose, senna, sterculia, docusate, paraffin, glycerol suppositories, phosphate enemas, sodium citrate enemas, or arachis oil enemas.[4] A 2010 Cochrane review of studies in adults and children concluded that polyethylene glycol (macrogols) were superior to lactulose for outcomes such as stool frequency per week, form of stool, relief of abdominal pain and the need for additional laxatives.[13]

Experts are in agreement on the general approach to treating constipation:

- Use a stepped approach to treatment.
- Clear faecal loading/impaction before starting to treat chronic constipation.
- Adjust the dose, frequency, and combination of laxatives according to individual preference and response to treatment.

It is recommended that the dose, choice and combination of laxatives are tailored to symptoms, the speed with which relief is required, response to treatment, and individual preference.

The dose of laxative should be adjusted gradually to produce one or two soft, formed stools per day. The use of multiple laxatives should be avoided unless necessary, titrating individual doses to the maximum before adding an additional laxative.[4]

Management

The management of constipation is defined as shown below and summarised in attachment 1, pathway for chronic constipation in adults. Prescribing choice mainly depends on the presenting symptoms, the person's preference, and cost. Table 1 on page 5 highlights the different laxatives available within different drug class groups.

Short duration constipation[4]

1. Adjust any constipating medication, if possible. See appendix 2, page 16.
2. Advise the person about increasing dietary fibre, drinking an adequate fluid intake, and exercise. Further information is found in attachment 2: patient information leaflet.
   - » Aim for a balanced diet containing whole grains, fruits and vegetables.
   - » Increase fibre intake gradually (to minimise flatulence and bloating) and continue as part of normal diet.
   - » Adults should aim to consume 18-30g of fibre per day, e.g. one medium sized bowl of All Bran cereal contains 9.8g of fibre.
   - » Although the effects of a high fibre diet may be seen in a few days, it may take up to four weeks.
   - » Adequate fluid intake is important (particularly with a high fibre diet or fibre supplements), but can be difficult for some people, e.g. frail or elderly.
   - » Fruits high in fibre and sorbitol (natural occurring sugar), and fruit juices high in sorbitol, can help prevent and treat constipation, these include apples, apricots, grapes (and raisins), peaches, pears, plums (and prunes), raspberries and strawberries. The concentration of sorbitol is about 5-10 times higher in dried fruit. This is however cautioned in patients with diabetes.
3. Offer oral laxatives if dietary measures are ineffective, or while waiting for them to take effect.
   - » Start treatment with a bulk-forming laxative (adequate fluid intake is important).
   - » If stools remain hard, add or switch to an osmotic laxative.
   - » If stools are soft but the person still finds them difficult to pass or complains of inadequate emptying, add a stimulant laxative.[4]

Chronic constipation in adults[4]

1. Begin by relieving faecal loading/impaction, if present.
2. Set realistic expectations for the results of treatment of chronic constipation.
3. Advise people about lifestyle measures — increasing dietary fibre (including the importance of regular meals), drinking an adequate fluid intake, and exercise. See attachment 2, patient information leaflet.
4. Adjust any constipating medication, if possible. See appendix 2, page 16.
5. Laxatives are recommended:
   - » If lifestyle measures are insufficient, or whilst waiting for them to take effect.
   - » For people taking a constipating drug that cannot be stopped.
   - » For people with other secondary causes of constipation.
   - » As 'rescue' medicines for episodes of faecal loading.
6. **If laxative treatment is indicated:**
   - » Start treatment with a bulk-forming laxative: It is important to maintain good hydration when taking bulk-forming laxatives. This may be difficult for some people (for example the frail or elderly).
   - » If stools remain hard, add or switch to an osmotic laxative.
   - » Use macrogols as first choice of an osmotic laxative.[4]
   - » Use lactulose if macrogols are not effective, or not tolerated.[4]
   - » If stools are soft but the person still finds them difficult to pass or complains of inadequate emptying, add a stimulant laxative.
   - » Adjust the dose, choice, and combination of laxative according to symptoms, speed with which relief is required, response to treatment, and individual preference.
   - » The dose of laxative should be gradually titrated upwards (or downwards) to produce one or two soft, formed stools per day.

» If at least two laxatives (from different classes) have been tried at the highest tolerated recommended doses for at least six months, consider the use of prucalopride or lubiprostone.

7. Before prescribing prucalopride or lubiprostone, ensure NICE guidance are fulfilled.[7,8]

Opioid-induced constipation[4]

- Advise the person to increase the intake of fluid and fruit and vegetables if necessary.
- Avoid bulk-forming laxatives.
- Use an osmotic laxative (or docusate which also softens stools) and a stimulant laxative.
- Adjust the laxative dose to optimize the response.

Advise the person that laxatives can be stopped once the stools become soft and easily passed again. The NICE clinical guideline on the use of strong opioids in palliative care in adults advises that laxatives should be prescribed for everyone initiating strong opioids. It recommends that laxatives should be taken regularly at an effective dose and that people should be informed of the importance of medicines adherence.[14] Naloxegol may be considered if NICE criteria are fulfilled - see below.[9]

Table 1: Laxatives for constipation and relative cost of 30 days treatment. Refer to SPC for additional information

Formulations		Dose[3]	Onset of action	Contra-indication[3]	Other information[3] See individual SPCs	Cost/30 days at max dose unless specified[5,6]
Bulk forming Increases faecal mass – stimulates peristalsis	Ispaghula sachets 3.5g	One sachet 1-3 times daily	2-3 days	• Faecal impaction • Intestinal obstruction • Swallowing difficulty • Colonic atony • Palliative patients (due to long onset of action)	Adequate fluid intake is important to prevent obstruction (6 – 8 cups per day) and do not take immediately before bed. Not suitable for frail patients who are unlikely to be able to drink the required volume of fluid. Note: When mixed with water, the resulting mixture is quite thick and should be taken as soon as possible as it gets thicker on standing.	£6.87 (Ispagel most cost effective brand at £5.07)
	Sterculia granules	1-2 spoonfuls daily or twice daily				£6.85 (500g)
	Methylcellulose 500mg	3-6 tablets twice daily				£14.89
Stimulant Increases intestinal motility	Bisacodyl tablets 5mg	5 to 10mg at night, increased if necessary to max. 20mg at night	8-12 hours	• Intestinal obstruction • Recent abdominal • Surgery • Acute inflammatory bowel disease	Initial dose should be low then gradually increased. Senna liquid has a strong taste that may be disliked by some.	£2.29
	Bisacodyl suppository	10mg in morning	20-60min			£8.83
	Senna tablets or liquid	15mg to 30mg daily, usually at night, but dose can be divided	8-12 hours			£6.94 – tabs £3.59 - liquid

Formulations		Dose[3]	Onset of action	Contra-indication[3]	Other information[3] See individual SPCs	Cost/30 days at max dose unless specified[5,6]	Most cost effective brand if applicable Cost/30 days[5,6]
Stimulant Increases intestinal motility.	Sodium picosulphate elixir	5-10mg night	10-14hr	• Intestinal obstruction • Recent abdominal • Surgery • Acute inflammatory bowel disease	Initial dose should be low then gradually increased.	£6.94 - liquid	N/A
	Glycerol suppository	1 x 4g moistened with water before use when required	15-30mins			£4.08 for 30 suppositories, £0.14 each suppository	
	Dantron in co-danthramer 25/200 (with poloxamer 188) suspension	5-10ml at night	6-12 hours		Restricted for patients with terminal disease, but not generally recommended due to risk of dantron burns (see below) if patient's mobility deteriorates. Control can usually be 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. Stimulant at higher doses. Note: Capsules now discontinued. Liquid taste may be unacceptable to some patients.	£276.64 – liquid	
	Dantron in co-dranthrusate (50/60 with docusate sodium) suspension	5-15ml at night				£202.32 – suspension	

Formulations		Dose[3]	Onset of action	Contra-indication[3]	Other information[3] See individual SPCs	Cost/30 days at max dose unless specified[5,6]
Stool softener and weak stimulant Increases intestinal motility and softens stools.	Docusate sodium capsules 100mg Liquid 50mg/5ml	Up to 500mg per day in divided doses	1-2 days	• Intestinal obstruction	Note: Liquid taste may be unacceptable to some patients.	200mg bd- £8.36 - caps, £21.96 – liquid based on dose of 200mg twice daily

Formulations		Dose[3]	Onset of action	Contra-indication[3]	Other information[3] See individual SPCs	Cost/30 days at max dose unless specified[5,6]	Most cost effective brand if applicable Cost/30 days[5,6]
Osmotic – oral preparation Increase the amount of water in the large bowel	Macrogol compound oral powder sachets	**Severe constipaton dose:** Initially 1 to 3 sachets daily in divided doses usually for up to 2 weeks. Maintenance, 1 to 2 sachets daily. **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.	2-3 days	Intestinal obstruction Paralytic ileus, severe inflammatory conditions of the intestinal tract.	For patients with faecal impaction and severe constipation only. 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. Caution – patients with cardiovascular impairment should not take more than 2 sachets in any 1 hour. 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).	£8.54 – 1 sachet twice daily	£7.90 Cosmocol

Formulations		Dose[3]	Onset of action	Contra-indication[3]	Other information[3] See individual SPCs	Cost/30 days at max dose unless specified[5,6]	Most cost effective brand if applicable Cost/30 days[5,6]
Osmotic – oral preparation Increase the amount of water in the large bowel	Lactulose	15ml twice daily	Up to 2 days	Intestinal obstruction	Contra-indicated in galactosaemia, intolerant to lactose	£5.69	N/A
Osmotic - rectal preparation increase the amount of water in the large bowel	Sodium citrate 5ml microenema (Mico- lette® microenema)	The contents of one micro enema	5-15 mins	Acute gastro-intestinal conditions	Should be avoided in individuals susceptible to sodium and water retention or elderly and debilitated.	1 enema - £0.33	N/A
	Sodium Phosphate enema ® e.g. Fleet Ready-to-use enema (133ml, dose delivered = 118ml)	The contents of one enema (place high if the rectum is empty but the colon is full)	2-5mins	Acute gastro-intestinal conditions (including gastro-intestinal obstruction, inflammatory bowel disease, and conditions associated with increased colonic absorption)	Use with caution in the elderly and debilitated. Caution with clinically significant renal impairment. Can cause electrolyte disturbance and local irritation.	1 enema - £0.46	N/A

Newer treatments

Chronic constipation - Lubiprostone

Lubiprostone is the subject of a NICE TA and is recommended as an option for treating chronic idiopathic constipation, that is, for adults in whom treatment with at least two laxatives from different classes, at the highest tolerated recommended doses for at least 6 months, has failed to provide adequate relief and for whom invasive treatment for constipation is being considered. Lubiprostone is only licensed for a two week course of treatment. If treatment with lubiprostone is not effective after two weeks, the person should be re-examined and the benefit of continuing treatment reconsidered. Lubiprostone should only be prescribed by a clinician with experience of treating chronic idiopathic constipation, who has carefully reviewed the person's previous courses of laxative treatments.[7]

Chronic constipation - Prucalopride

Prucalopride is now indicated for the symptomatic treatment of chronic constipation in adults (both men and women) in whom laxatives fail to provide adequate relief.[15] The NICE technology appraisal on prucalopride recommends this as a possible treatment for chronic constipation only in women for whom treatment with at least two laxatives from different classes, taken at the highest tolerated recommended doses for at least six months, has failed to provide adequate relief and invasive treatment for constipation is being considered.[8]

Prucalopride should only be prescribed by a clinician with experience in treating chronic constipation. If treatment is not effective after four weeks, the patient should be reassessed and the benefit in continuing prucalopride reconsidered.[15]

Opioid induced constipation - Naloxegol

Naloxegol was licensed in December 2014 for the treatment of opioid-induced constipation in adult patients who have had an inadequate response to laxative(s).[16] Naloxegol is a form of naloxol which has been pegylated (that is, attached to a molecule of polyethylene glycol, or PEG). In this form, it selectively antagonises peripheral opioid receptors to relieve constipation. Naloxegol is the subject of a NICE TA and is recommended, within its marketing authorisation, as an option for treating opioid-induced constipation in adults whose constipation has not adequately responded to laxatives. An inadequate response is defined as opioid-induced constipation symptoms of at least moderate severity in at least one of the four stool symptom domains (that is, incomplete bowel movement, hard stools, straining or false alarms) while taking at least one laxative class for at least four days during the prior two weeks.[9] The SPC also recommends that all currently used maintenance laxative therapy should be halted, until clinical effect of naloxegol is determined.[16]

The most commonly reported adverse reactions to naloxegol are abdominal pain, diarrhoea, nausea, headache and flatulence. The majority of gastrointestinal adverse reactions are graded as mild to moderate, occur early in treatment and resolve with continued treatment.[16]

Irritable Bowel Syndrome (IBS) and linaclotide

NICE CG 61 guidance recommends self-help as a key component of the management of IBS, and advises that people should receive general information on lifestyle, physical activity and diet. If a person's IBS symptoms persist while following general lifestyle and dietary advice, offer advice on further dietary management. Such advice should include single food avoidance and exclusion diets (for example, a low FODMAP [fermentable oligosaccharides, disaccharides, monosaccharides and polyols] diet) and only be given by a healthcare professional with expertise in dietary management.[10]

Pharmacological management may be considered, with the choice of agent(s) depending on the predominant symptom(s). Treatments include antispasmodic agents for abdominal pain and laxatives or antimotility agents, depending on the presence of constipation or diarrhoea. People with IBS should be advised how to adjust their doses of laxative or antimotility agent according to clinical response. A tricyclic antidepressant or a selective serotonin reuptake inhibitor (off label) may be considered if

laxatives and antispasmodics are ineffective. Referral for psychological interventions may be considered for people with IBS who do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile.[10]

Linaclotide

Linaclotide is a first-in-class, oral, once-daily guanylate cyclase-C receptor agonist (GCCA), licensed for the symptomatic treatment of moderate-to-severe irritable bowel syndrome with constipation (IBS-C) in adults.[17] The NICE medicines evidence summary reports on two short-term placebo-controlled randomised trials showed that linaclotide was more effective than placebo in composite outcomes relating to abdominal discomfort and bowel movements.[18] There is no data comparing linaclotide with other treatments for IBS with constipation, e.g. laxatives, or antispasmodics, or antidepressants. There are no long term data for the efficacy of this treatment beyond 12 or 26 weeks. The NICE evidence summary states that local decision makers will need to consider the place of linaclotide alongside existing treatments that may be used to manage symptoms of IBS-C, such as the concomitant use of antispasmodics and laxatives.[18] As recommended in the SPC, patients receiving linaclotide should be reviewed for improvement of symptoms after the first four weeks of treatment and at regular intervals thereafter, and treatment discontinued if improvement is not sustained.[17] The 2015 update of NICE CG 61 states to consider linaclotide for people with IBS only if optimal or maximum tolerated doses of previous laxatives from different classes have not helped and they have had constipation for at least 12 months. The update also recommends to follow up people taking linaclotide after three months.[10]

Table 2: Summary of newer laxative treatments that have been approved by NICE

	Drug	Dose[3]	NICE recommendation	Cost/28 days[5,6]
Chronic constipation	Prucalopride	2mg once daily (1mg daily in women > 65 years)	Recommended as an option for the treatment of chronic constipation in adults for whom treatment with at least two laxatives from different classes, at the highest tolerated recommended doses for at least six months, has failed to provide adequate relief and invasive treatment for constipation is being considered. Review treatment if no response after four weeks.[8]	£59.52 (for 2mg tablets)
	Lubiprostone	24 micrograms twice daily	Recommended as a possible treatment for people with chronic idiopathic constipation: who have previously been treated with two different types of laxatives at the highest possible recommended dose, for at least six months, but these haven't worked well enough, and when invasive treatment is being considered. Take twice daily for two weeks.[7]	£53.48

	Drug	Dose[3]	NICE recommendation	Cost/28 days[5,6]
Opioid Induced constipation	Naloxegol	25mg daily or 12.5mg daily in people with renal insufficiency	Treatment of opioid induced constipation in adults whose constipation has not adequately responded to laxatives. An inadequate response is defined as opioid-induced constipation symptoms of at least moderate severity in at least one of the four stool symptom domains (that is, incomplete bowel movement, hard stools, straining or false alarms) while taking at least one laxative class for at least four days during the prior two weeks.[9] The SPC recommends that all currently used maintenance laxative therapy should be halted, until the clinical effect of naloxegol is determined.[16]	£51.52
Irritable Bowel Syndrome	Linaclotide for IBS	290 micrograms once daily	For people with IBS only if optimal or maximum tolerated doses of previous laxatives from different classes have not helped and they have had constipation for at least 12 months. Review treatment if no response after four weeks. Follow up people taking linaclotide after three months.[18]	£37.56

Actions

Review: Stopping laxative treatment for chronic constipation.

Laxatives need to be continued long term for:

- People taking a constipating drug that cannot be stopped such as an opioid.
- People with a medical cause of constipation.[4]

The following recommendations are based on pragmatic advice. The NICE CKS topic on constipation provides advice about lifestyle measures:

- Laxative medication should not be suddenly stopped.
- Laxatives can be slowly withdrawn when regular bowel movements occur without difficulty, e.g. two to four weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established.[4]
- The rate at which doses are reduced should be guided by the frequency and consistency of the stools.
- Wean gradually to minimise risk of requiring “rescue therapy” for recurrent faecal loading.
- If more than one laxative has been used, reduce and stop one at a time.
- Begin by reducing stimulant laxatives first, if possible. However, it may be necessary to also adjust the dose of the osmotic laxative to compensate.

- Advise the person that it can take several months to be successfully weaned off all laxatives.
- Relapses are common. Treat early with increased laxative doses.
- It is recommended that care homes have a robust ordering system and checking process in place to ensure that laxatives and other medicines are only ordered if they are needed. In some care homes "as required" (prn) medicines, including laxatives, are routinely ordered on a monthly basis, even if they have not been used up.

An audit for review and patient Invite letters for review are available in attachments 3 and 4.

Review: Further savings

Macrogols

A switch from an expensive branded preparation to a generic or a more cost effective branded formulation (please note: Cosmocol lemon and lime flavor is more expensive) can result in potential savings. Further to this, where products contain multiple ingredients, brand name prescribing aids identification.

Product	Cost for 30 sachets[5,6]
Cosmocol® (orange and unflavoured only)	£3.95
Macrogol compound oral powder sachets NPF sugar free plain Drug Tariff (prescribed generically)	£4.27
Laxido®	£4.27
Macilax®	£4.81
Cosmocol (lemon and lime flavour)®	£5.34
Maloxole®	£5.68
Movicol®	£7.35

- Senna tablets to liquid or bisacodyl tablets.
- Fybogel®/ispaghula to Ispagel Orange
- Review patients on laxatives containing dantron (co-danthramer suspension, co-danthrusate suspension (capsules have been discontinued). This is only licensed for use in terminally ill patients due to potential carcinogenic risk.[19]
- Discuss changing stimulant laxatives to acute to prompt review.
- Review continued need of laxatives after discharge from secondary care, e.g. post surgery, when they have been prescribed short term opioids.

Savings available

Spend on laxatives is over £93 million across England and Wales (ePACT October to December 2015). Prescribing should be reviewed to ensure it is appropriate and treatment is effective/ still required. Laxative prescribing should mostly be for short term only. **A 30% reduction in prescribing could result in potential annual savings of £27.9 million across England and Wales or £46,124 per 100,000 population.**

Over £10 million is spent on macrogol preparations in England and Wales (ePACT October to December 2015). **A switch to generic prescribing, or the lowest cost brands, Cosmocol® and Laxido® could result in potential annual savings of over £3.8 million or £6,831 per 100,000 patients.**

Summary

Ensure a clear diagnosis of constipation before considering a laxative and that the constipation is not secondary to an underlying undiagnosed complaint or drugs e.g. opioids. Most cases of mild or acute functional (idiopathic) constipation in adults can be managed by dietary and lifestyle changes. In adults, laxatives should be reserved for constipation that has not responded adequately to simple interventions, or for when rapid relief of symptoms is needed. Bulking agents can be tried and then osmotic laxatives. Stimulant laxatives are not recommended for long term use. For short term and chronic constipation, laxatives can be slowly withdrawn when regular bowel movements occur without difficulty.

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Additional PrescQIPP resources

Briefing Data pack Implementation resources

Available here: https://www.prescqipp.info/resources/category/296-constipation

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Appendix 1: Medical conditions predisposing to constipation[4]

In adults with no drug cause for their constipation, consider:

- Endocrine and metabolic diseases:
  - Diabetes mellitus (with autonomic myopathy)
  - Hypercalcaemia
  - Hypokalaemia
  - Hyperparathyroidism
  - Hypothyroidism (severe)
  - Uraemia.
- Myopathic conditions:
  - Amyloidosis
  - Myotonic dystrophy
  - Scleroderma
- Neurologic diseases:
  - Autonomic neuropathy
  - Cerebrovascular disease
  - Hirschsprung's disease
  - Multiple sclerosis
  - Parkinson's disease
  - Spinal cord injury, tumours.
- Structural abnormalities:
  - Anal fissures, strictures
  - Haemorrhoids
  - Colonic strictures (following diverticulitis, ischaemia, surgery)
  - Inflammatory bowel disease
  - Obstructive colonic mass lesions (for example colorectal cancer) — careful examination can usually distinguish a faecal mass from a tumour or cyst: firm pressure exerted by a finger will leave a palpable indentation in hard faeces
  - Rectal prolapse or rectocele
  - Postnatal damage to pelvic floor or third degree tear.
- Other:
  - Irritable bowel syndrome
  - Colonic inertia
  - Pelvic or anal dyssynergia.

Appendix 2: Drugs that commonly cause constipation[3,4]

- Aluminium antacids
- Antimuscarinics (such as procyclidine, oxybutynin)
- Antidepressants (most commonly tricyclic antidepressants, but others may cause constipation in some individuals)
- Some antiepileptics (for example carbamazepine, gabapentin, oxcarbazepine, pregabalin, phenytoin)
- Sedating antihistamines
- Antipsychotics
- Antispasmodics (such as dicycloverine, hyoscine)
- Calcium supplements
- Diuretics
- Iron supplements
- Opioids