B137. Constipation

Constipation

This briefing reviews the treatment of short term and chronic constipation in adults (over 18 years). It focuses on reviewing therapy to reduce inappropriate treatment and also ensure cost-effective prescribing.

Key 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.[1]
- Adopt a stepwise approach to the management of constipation, starting with diet and lifestyle factors.[2]
- Avoid or adjust drugs that cause constipation if possible.[2]
- 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.[3]
- Stimulant laxatives should only be used short term.[2] They should be prescribed as acute (not repeat) prescriptions. Bisacodyl tablets and senna liquid are the least costly stimulant oral preparations.[4]
- Review continued need of laxatives after discharge from secondary care, e.g. post surgery, when they have been prescribed short term opioids.
- Do not use bulk forming laxatives in opioid induced constipation.[2]
- Use of two drugs from the same class should be avoided, i.e. lactulose and macrogols.[2]
- Lubiprostone and prucalopride should only be prescribed by a clinician with experience of treating chronic constipation. Ensure that the NICE criteria are fulfulfilled for prucalopride, lubiprostone, naloxegol and linaclotide.[6-9]
- 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.[9]

Additional resources available: https://www.prescqipp.info/resources/category/296-constipation

Bulletin

Data pack

Audit, letters

Supporting information

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. If laxative treatment is indicated for the treatment of chronic constipation, start treatment with a bulk-forming laxative. If stools remain hard, add or switch to an osmotic laxative. Use macrogols as first choice of an osmotic laxative. Use lactulose if macrogols are not effective, or not tolerated. If stools are soft but the person still finds them difficult to pass or complains of inadequate emptying, add a stimulant laxative.[2]

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.

Review the prescribing of laxatives. Laxatives can be slowly withdrawn when regular bowel movements occur without difficulty, e.g. 2-4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established. If more than one laxative has been used, reduce and stop one at a time.[2]

Laxatives need to be continued long term for people taking a constipating drug that cannot be stopped such as an opioid or people with a medical cause of constipation.[2]

Savings available

The current annual cost of all laxative preparations across England and Wales is over £93 million (ePACT October to December 2015).

A 30% reduction in laxative prescribing (reviewing long term use and reducing prescribing as appropriate) could result **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.**

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References

1. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press; April 2016. Available at https://www.evidence.nhs.uk/formulary/bnf/current/1-gastro-intestinal-system/16-laxatives Accessed 31/05/16
2. National Institute for Health and Clinical Care Excellence (NICE) Clinical Knowledge Summaries. Constipation. Last revised October 2015. Available at http://cks.nice.org.uk/constipation
3. National Institute for Health and Care Excellence (NICE). Key therapeutics topics (KTT1). Laxatives. Options for local implementation. January 2015. Available at http://www.nice.org.uk/advice/ktt1/chapter/Options-for-local-implementation
4. Prescription Pricing Division (PPD). NHS Business Services Authority. Drug Tariff May 2016. Available at http://www.drugtariff.nhsbsa.nhs.uk/ Accessed 31/05/16
5. MIMS. May 2016. Available at www.mims.co.uk Accessed 31/05/16
6. National Institute for Health and Care Excellence. Technology Appraisal Guidance 318. Lubiprostone for treating chronic idiopathic constipation. July 2014. Available at www.nice.org.uk Accessed 31/05/16
7. National Institute for Health and Clinical Excellence. Technology Appraisal Guidance 211. Prucalopride for the treatment of chronic constipation in women. December 2010. Available at www.nice.org.uk Accessed 31/05/16
8. National Institute for Health and Care Excellence. Technology Appraisal Guidance 345. Naloxegol for treating opioid-induced constipation. July 2015. Available at www.nice.org.uk Accessed 31/05/16
9. National Institute of Health and Care Excellence. CG 61. Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care. February 2015 Available at https://www.nice.org.uk/guidance/cg61 Accessed 31/05/16

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