VERSION CONTROL

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Amendments made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 1</td>
<td>November 2016</td>
<td>New guideline</td>
</tr>
<tr>
<td>Version 1.1</td>
<td>December 2016</td>
<td>Bisacodyl removed from the children’s pathway and replaced with sodium picosulphate. Approved at LMMG. Minor amendments to formatting.</td>
</tr>
<tr>
<td>Version 1.2</td>
<td>May 2018</td>
<td>Minor changes to the layout. Additional information relating to the prescribing of laxatives and self-care added to the adult pathway.</td>
</tr>
</tbody>
</table>

Contents
1. Management of constipation in adults: acute and chronic treatment pathways
2. Management of constipation in adults patients: opioid-induced constipation pathway

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.
Adequate fluid intake is important, although there is no evidence that increased fluid intake will improve symptoms in those that are already well hydrated.

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 experienced in the treatment of chronic idiopathic constipation. Amberol 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 30 minutes 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 – 30 gram 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 3.5 gram ONE sachet TWICE a day
- Osmotic
  - Laxido (macrogols) Orange one to three sachets daily
  - Stimulant
  - Bisacodyl 5 – 10 mg at night
  - Softener
  - Docusate sodium 100 mg – 200 mg twice a day (up to 500 mg 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 advised to self-manage by purchasing laxatives over-the-counter

Box 5: Prucalopride:
NICE TA211 relates to the use of prucalopride in women 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.
Management of constipation in adult patients: opioid-induced constipation pathway

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

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- 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 30 minutes 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 18–30 gram 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 – 10 times 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 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 symptom domains are:
- Incomplete bowel movement, hard stools, straining or false alarms.

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.