Prescribing for constipation

Professor Christine Norton explains what prescribing options are available for this common condition

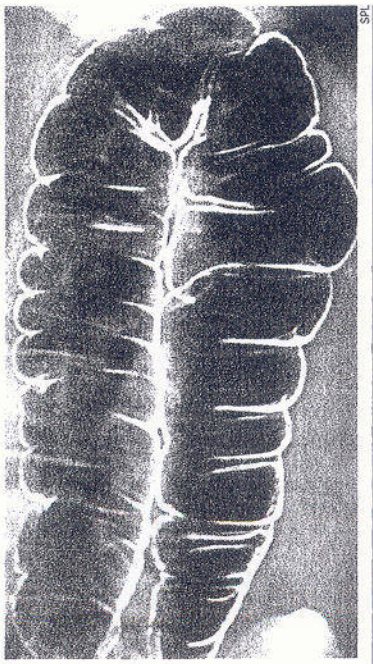
Constipation is common and troublesome, costing the UK over £43 million per year in laxatives.[1] District nurses spend up to 1 per cent of their time treating constipation, at an estimated annual cost of £810,000.[2] Healthcare professionals and the general public maintain many myths about constipation and its treatment.[3]

There are many definitions and prevalence depends on which is adopted. Two main 'types' are often distinguished: slow transit constipation (prolonged colonic transit time) and evacuation difficulty (stool reaches the rectum but is difficult to expel). These often coexist and can present with various symptoms (see box).

Identifying those at risk

Brought up in an era abounding in myths about toxins accumulating and the need for daily bowel action to maintain health, many older people become concerned if this is not achieved.[4] Many more report constipation and self-medicate for it than are in fact constipated,[5,6] with straining rather than infrequent bowel action influencing this.[6]

Constipation in older people is associated with depression, immobility[7] and psychological distress,[6] but cause and effect are difficult to disentangle. Prevention is definitely better than treatment. Known risk factors include immobility, dehydration, polypharmacy and a poor diet. Neurological disease and poor toilet access can compound the problem. Attention to these factors can prevent many cases, or treat mild ones without medication.



Colon: try stimulant for slow transit

Healthy old people are no more likely to be constipated than younger people.[5] However, contributing factors are more common, especially in the frail and in nursing home populations.

Individual assessment is crucial in identifying and addressing which factors are relevant. Once unexplained changes in bowel habit and rectal bleeding have been excluded, the majority of patients can be safely managed in primary care.

Patient education is an important first step, including information on normal bowel function, the fact that daily bowel action is not essential, capitalising on the normal gastrocolic response by trying to establish a regular habit, adopting a semi-squat position where feasible and optimising diet, fluids and mobility.

Prescribing for constipation is largely based on habit and tradition rather than evidence-based principles because evidence is sparse. Three major reviews failed to find convincing studies to indicate which drug works for which patients.[1,8,9]

If non-medication options fail to resolve the constipation, the choice of medicine should target the primary problem: hard stool usually need a stool softener; slow transit indicates a stimulant is preferable.

Start with a cheap laxative and keep the dose as low as feasible. If long-term use is likely, try to find two or three different preparations that work, as nearly all become less effective with time. Evacuation difficulty may respond best to a suppository or evacuant.

A rational basis for laxative prescribing in older people has been suggested but not formally evaluated.[1] Unfortunately, there is often no alternative to trial and error to determine what dose and timing works for each patient.

Re-evaluation is vital

Over-prescription of laxatives occurs in many instances, and can contribute to faecal incontinence in nursing homes.[10] Laxatives are often prescribed in combination, for unclear indications and are continued without re-evaluation as to whether they are working or still needed. Some symptoms attributed to constipation such as bloating, flatus and abdominal pain may owe more to laxatives themselves.

Suppositories may produce more predictable results, but can be difficult for those with impaired dexterity. Phosphate enemas can (very rarely) produce electrolyte disturbance in frail individuals,[11] and should probably be a last resort while water enemas and rectal irrigation could be used more.[12,13]

A few specific groups, such as the terminally ill taking opiates and those with neuro-disability, often need regular laxatives to prevent constipation becoming a serious problem. Others need only short courses to address specific situations. Any patient prescribed laxatives must be regularly re-evaluated and many will be found not to need ongoing medication if other factors are given adequate attention.

Symptoms

Common symptoms include:

- Infrequent defaecation (<3 bowel movements per week is a commonly used threshold for constipation).
- Difficult evacuation (difficulty initiating defaecation, needing to strain or digitate, taking a long time to empty the bowel, or a feeling of incomplete evacuation afterwards).
- Hard, pellet or lumpy stools.

Other symptoms include:

- Abdominal pain or bloating.
- Lethargy and malaise.
- Impacted stool and 'overflow' faecal incontinence can develop in the frail or disabled.

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● The Gut Week public awareness campaign runs from 18–24 July

Resources

Core (digestive disorders foundation) www.corecharity.org.uk
St Mark's Hospital: www.bowelcontrol.org.uk
IBS Network: www.ibsnetwork.org.uk
Gut Week: www.gutweek.org.uk; helpline 020 8743 4287 (6–10pm every evening and 10am–12pm Sat between 18–31 July)

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