Constipation in Adults

Disclaimer

Contents

Background

About constipation

- *Constipation is a reduced frequency or ease of stool passage. There maybe sensation of incomplete evacuation, bloating, and straining.*
- *Constipation is the difficult passage of small, hard stools.*
- *Constipation is common, with a prevalence of 15 to 20% in the general population.*

Assessment

1. Take a history of frequency and consistency of bowel actions – the Bristol stool chart can be useful. Ask about:
    - ***medications.***

Medications

Many medications affect bowel habits. Consider:

- *antacids.*
- *anticholinergics.*
- *antidepressants and antipsychotics.*
- *calcium channel blockers.*
- *iron and calcium supplements.*
- *NSAIDs.*
- *analgesics.*

    - recent changes in bowel habit, soiling, perianal pain, rectal bleeding, abdominal pains.
    - dietary changes.
    - unintentional weight loss.

2. Ask about family history e.g., bowel, ovarian or breast cancer, inflammatory bowel disease (IBD), coeliac disease.
3. Ask about ***constipation factors in aged care.***

Constipation factors in aged care

- *Diet – decreased fibre in softened food, or decreased intake*
- *Activity – decreased or bed bound*
- *Ability to self toilet*
- *Medications contributing to constipation*
- *Constipation contributing to challenging behaviour in dementia*

4. Perform examination:
    - Check weight and vitals.
    - Perform abdominal examination.
    - Perform rectal examination if recent onset.

5. Consider ***secondary causes*** and arrange investigations***:***

Secondary causes

- ***Anorectal disorders***

- *Carcinoma*
- *Fissures*
- *Haemorrhoids*
- *Worms*
- *Crohn's disease*
- *Irritable bowel syndrome (IBS)*

- Coeliac disease
- Connective tissue disorders
- Depression
- Dietary
- Eating disorder e.g., anorexia nervosa, bulimia
- ***Metabolic disorders***

Metabolic disorders

- *Diabetes*
- *Hypothyroidism*
- *Pregnancy*
- *Hypopituitarism*
- *Hypercalcaemia*
- *Hyperkalaemia*

Neurological disorders

Neurological disorders

- *Cerebrovascular accident (CVA)*
- *Autonomic neuropathy*
- *Spinal lesion*
- *Multiple sclerosis*
- *Parkinson's disease*
- *Hirschsprung's disease*

- Poisons e.g., lead
- Disrupted circadian rhythm e.g., shift work or travel

- Blood tests including electrolytes, calcium, thyroid function tests, FBE, iron studies, coeliac serology
- Faecal occult blood test (FOBT)
- Avoid unnecessary abdominal X-ray which is not indicated for diagnosis of constipation.

Management

1. Arrange immediate gastroenterology referral or admission if:
   - suspected large bowel obstruction.
   - faecal impaction that has not responded to adequate medical management.

2. If ***concerning clinical features,*** arrange urgent or routine gastroenterology referral. If aged care, consider patient wishes and advance care plan or directive prior to referral.

Concerning clinical features

Constipation in patients aged > 40 years, with a duration of more than 6 weeks but less than 12 months, with one or more of the following:

- Rectal bleeding or positive faecal occult blood test
- Weight loss (≥ 5% of body weight in previous 6 months)
- Abdominal or rectal mass
- Patient or family history of bowel cancer (first-degree relative aged < 55 years)
- Iron deficiency that persists despite correction of causative factors

3. If functional idiopathic constipation:

- advise the patient on ***simple measures*** that can help relieve idiopathic constipation, and prevent recurrence. Provide patient handout.

Simple measures

- *Maintain adequate dietary fibre and fluid intake.*
- *Respond rapidly to urge to defecate.*
- *Exercise regularly.*

- commence medications if resistant or severe constipation:
  - ***Bulk-forming laxatives***

Bulk-forming laxatives

- *Increase faecal mass, which stimulates peristalsis.*
- *Full effect may take some days to develop.*
- *Valuable in patients with small hard stools, if increase in dietary fibre is not sufficient to relieve constipation.*
- *Adequate fluid intake must be maintained.*
- *Common side-effects include flatulence and abdominal distension.*
- *Common preparations include:*
  - *psyllium e.g., Metamucil, Benefibre, psyllium husks from health food stores.*
  - *sterculia e.g., Normacol, Normacol Plus (also has stimulant action).*

  - ***Osmotic laxatives***

Osmotic laxatives

- *Increase the amount of water in large bowel.*
- *Avoid in intestinal obstruction.*
- *Common preparations include:*
  - *oral lactulose – adults – 15 to 30 mL daily until response, then 10 to 20 mL daily.*
  - *rectal sodium citrate (microlax or micolette).*
  - *second-line option – macrogols e.g., Movicol, Lax-sachets, funded for certain conditions. Adults – 1 sachet or scoop a day. Maximum dose is 3 sachets or scoops per day.*
  - *magnesium sulphate (Epsom salts):*
    - *15 g in 240 mL water. Maximum dose is twice a day.*

- *Use with caution in renal and cardiovascular disease, and the elderly.*

- ***Stimulant laxatives***

Stimulant laxatives

- *Increase intestinal motility and often cause abdominal cramps.*
- *Avoid in intestinal obstruction and inflammatory bowel disease.*
- *Not suitable for long-term use due to stimulants causing atonic bowel.*
- *Common preparations include:*
  - *bisacodyl e.g., Lax-tabs, Dulcolax, Fleet*
  - *sennoside e.g., Laxsol, Coloxyl and senna, Senokot*
  - *glycerol suppositories.*

- ***Stool-softening agents***

Stool softening agents

- *Docusate sodium e.g., Coloxyl probably acts as both a stimulant and a softening agent.*
- *Combination products with additional stimulants (e.g., Coloxyl with Senna) often cause abdominal cramps.*

- ***Rectal therapies***

Rectal therapies

- *Osmotic, lubricating, and stimulating agents can also be administered per rectum. Common preparations include Microlax, Glycerol, Bisalax.*
- *Water enema therapies may also improve rectal emptying.*
- *Manual evacuation sometimes necessary.*

4. If pregnant, and dietary and lifestyle changes fail to control constipation:
   - try a bulk-forming laxative first.
   - consider also an osmotic laxative.
   - if a stimulant effect is necessary, consider bisacodyl or senna.

5. If chronic constipation, consider GP care plan and team care arrangement with referrals to appropriate allied health clinicians for assistance in ***management of symptoms.***

Role of physiotherapy in managing anorectal disorders

- *Patient education – intestinal health and routine, toileting, diet*
- *Exercise – pelvic and abdominal musculature*
- *Pain management*
- *Manual techniques*
- *Biofeedback techniques*

Referral

- Arrange immediate gastroenterology referral or admission if:
  - suspected large bowel obstruction.
  - faecal impaction that has not responded to adequate medical management.
- If concerning clinical features, arrange urgent or routine gastroenterology referral.
- If chronic constipation, consider GP care plan and team care arrangement with referrals to appropriate allied health clinicians.

Information

For health professionals

Further information

- Australian Doctor – How to Manage Medication-induced Constipation [subscription required]
- Australian Journal of General Practice (AJGP) – Management of Faecal Incontinence in Residential Aged Care
- Australian Medicines Handbook Aged Care Companion – Constipation [subscription required]
- Australian Prescriber – Managing Constipation in Adults
- Scandinavian Journal of Gastroenterology – Stool Form Scale as a Useful Guide to Intestinal Transit Time. Lewis SJ, Heaton KW.

For patients

- Better Health Channel – Constipation
- Continence Foundation of Australia – About Your Bowel
- Gastroenterological Society of Australia (GESA) – Constipation

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