Constipation in Adults

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Background

About constipation

- Constipation is a reduced frequency or ease of stool passage. There may be 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
- Diabetes
- Hypothyroidism
- Pregnancy
- Hypopituitarism
- Hypercalcaemia
- Hyperkalaemia

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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