# SCCG Primary Care Laxative Guidelines for Adults

NHS Sunderland Clinical Commissioning Group

Patient presenting with symptoms of constipation

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Confirm constipation (abnormal or altered bowel movement routine)

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Identify cause. Consider disease, drugs, pregnancy, immobility, psychological problems

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Patient Education and Lifestyle advice - increasing dietary fibre (including the importance of regular meals), drinking an adequate fluid intake, and exercise

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Adjust any constipating drugs if possible

## Acute Constipation

1. **Stimulant** laxative

If stools remain hard:

2. Add **Softener**
3. **Glycerin suppository** (usually act within 1 hour) if more rapid evacuation required.

- **Laxatives can be stopped once stools become soft and easily passed again.**

## Impaction

1. **Macrogol** for hard stools - high dose oral.

If response to oral laxatives is insufficient / not fast enough consider:

2. **Suppository:**

- **Bisacodyl** (soft stools);
- **Glycerol**, or **glycerol + bisacodyl** (hard stools).

3. **Mini enema**:

- **Docusate** (**softener** and weak stimulant) or
- **Sodium citrate** (**osmotic**).

If response still insufficient:

4. **Retention enema**

- sodium phosphate or **arachis oil** retention enema (place high if the rectum is empty but the colon is full).

## Chronic Constipation

1. First line: **Bulk forming** laxative

If stools remain hard,

2. add/ switch to **Osmotic laxative**.
3. If stools are soft but remain difficult to pass, consider adding a **Stimulant** laxative

In **Elderly and/or Immobility:**

1. **Stimulant** laxative

- **Laxatives can be withdrawn gradually once bowel movements occur easily.**

**Prucalopride**, **Lubiprostone** and **Naloxegol** are only prescribed under limited NICE criteria (TA's 211, 318, 345 ) **Linaclotide** is only licensed for IBS with constipation and is recommended only if other laxative treatment options have been ineffective/contraindicated.

## Opioid Induced Constipation

- Avoid **Bulk-forming** laxatives.

1. Use an **Osmotic** laxative **+ Stimulant** laxative.
2. **Softener** laxative

- Adjust the laxative dose to optimise the response.
- Co-danthramer / co-danthrusate are licensed combination for terminally ill **only**

## Pregnancy

1. **Dietary/ lifestyle** changes. Moderate doses of poorly absorbed laxatives may be used. Consider:
2. **Bulk-forming laxative**
3. **Osmotic laxative**
4. If **Stimulant** effect necessary, **bisacodyl or senna** (but avoid near term or if history of unstable pregnancy)

# SCCG Primary Care Laxative Guidelines for Adults

**Local Implementation**

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.

For children and young people, laxatives should be prescribed in line with the NICE guideline on constipation in children and young people.

**Selection of laxative** should be based on symptoms, cost and patient acceptability. For more information see factors affecting choice of laxative.

- Recommended **Stimulant** laxative is Senna tablets 7.5mg 2 to 4 at night (for bowel movement next morning) or Bisacodyl 5–10 mg at night, increased if necessary to max. 20 mg at night.
- First line **Softener** laxative is Docusate sodium capsules100 to 200mg BD or TDS (max. 500mg daily)
- First line: **Bulk forming** laxative is Ispaghula 1-2 sachets daily (NB adequate fluid intake).
- First line **Osmotic** laxative are Macrogols1 to 3 sachets daily. Use lactulose 15ml BD if macrogols are not effective, or not tolerated.

**When and how should I stop treatment for chronic constipation in adults?**

Laxatives can be **slowly withdrawn** once bowel movements occur easily e.g. 2–4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established).

- **Laxative medication should not be suddenly stopped.**
- The frequency and consistency of the stools should inform the rate of dose reduction.
- Gradual weaning minimises the risk of needing 'rescue therapy' for recurrent faecal loading.
- If a combination of laxatives has been used, **reduce and stop one laxative at a time**.
- Reduce **stimulant** laxatives first, if possible. You may also need to adjust the dose of the **osmotic** laxative to compensate.
- Tell the patient it can take several months to be successfully weaned off all laxatives.
- Relapses are common and should be treated early with increased doses of laxatives.

Laxatives need to be **continued long term** for:

- People taking a constipating drug that cannot be stopped, such as an opioid or clozapine.
- People with a medical cause of constipation.

**Palliative Care**

The NICE 'St r ong opioids in palliative care in adults '(CG 140) and North of England Cancer Network 'Palliative and end of life care guidelines' **Management**:

- Check bowel function regularly – direct questions during assessment and review.
- Attempt to increase fluid/fibre intake e.g. fruit/prune juice and encourage mobility.
- Environmental measures e.g. provide privacy, avoid bedpans, assist a patient to the toilet where possible, use raised toilet seats if necessary.
- Anticipatory prescribing- prescribe a laxative when starting opioids.
- Stop/change constipating drugs where appropriate.
- Consider using a combination of laxatives e.g. stimulant and softener/osmotic agent.
- Titrate laxative to effect to achieve regular stool frequency and optimal consistency**.**

**THINK CAREFULLY BEFORE USING…**

- **Stimulant** laxatives if there is a possibility of bowel obstruction.
- **Lactulose** as it can cause flatulence, abdominal bloating, and can worsen abdominal cramps.
- **Bulk forming** laxatives (e.g. Fybogel) or **osmotic** laxatives (e.g. Movicol/Laxido) the volumes of which can be difficult for some patients to tolerate.

**NICE guidance on naloxegol, linaclotide, prucalopride, lubiprostone**

Naloxegol

- NICE TA 345 states that naloxegol is recommended, as an option for treating opioid-induced constipation in adults whose constipation has not adequately responded to laxatives.
- An inadequate response is defined as symptoms of at least moderate severity in at least 1 of the 4 symptoms (incomplete bowel movement, hard stools, straining or false alarms) while taking at least 1 laxative class for at least 4 days during the prior 2 weeks.

**Prucalopride**

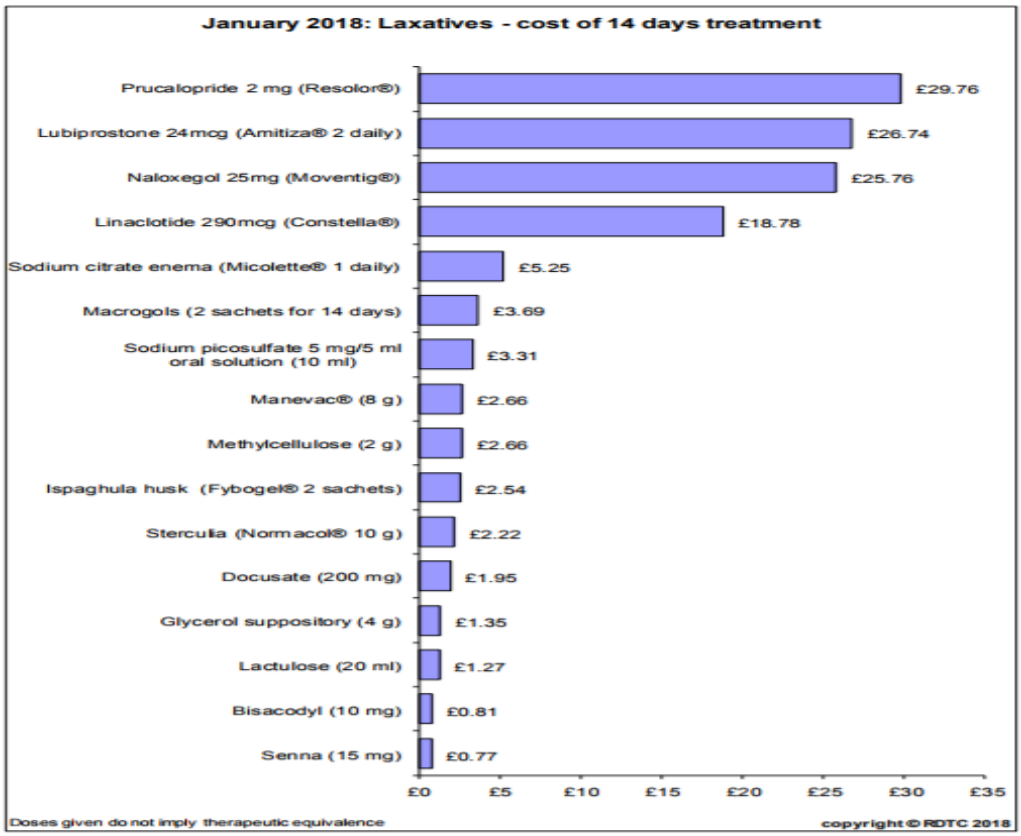
- For women only, after 6 months treatment of at least two classes of laxatives at maximum tolerated doses. Review after 4 weeks. As per NICE TA211

**Lubiprostone**

- For specialist initiation / recommendation only. As per NICE TA318
- For chronic idiopathic constipation in adults but only after 6 months treatment of at least two classes of laxatives at maximum tolerated doses.

**Linaclotide** ESNM16

- only licensed for patients with Irritable Bowel Syndrome (IBS) with constipation
- recommended for patients in whom ALL other laxative treatment options have been ineffective or contraindicated. Review after 4 weeks & at regular intervals thereafter.

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Re-approved by the MOGG Dec 17 due to lack of significant changes in accepted guidance