Managing constipation in older patients

First evaluate the cause(s) of constipation

Identify symptoms
- Infrequent stools
- Difficulty passing hard/lumpy stools
- A sensation of incomplete evacuation

Discuss lifestyle and consider medical history for possible causes (Figure 1)

Perform abdominal and rectal examinations in all older patients unless there is an obvious cause for constipation

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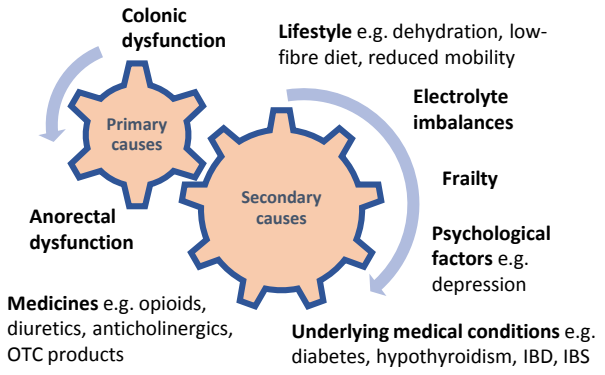
Consider need for additional investigations e.g. full blood count and ferritin*, TSH, HbA_{1c}, serum electrolytes, abdominal X-ray†

Figure 1. The causes of constipation can overlap



Colorectal cancer red flags
- Unintentional weight loss
- Blood in or with the stool
- An abdominal or rectal mass
- Iron deficiency anaemia
- Family history of bowel cancer or IBD

→ **Colonoscopy**

* Generally recommended in all older patients, particularly if colorectal cancer is suspected
† Not routinely recommended but may be useful if proximal faecal loading or obstruction is suspected

A systematic approach is recommended to resolve symptoms based on potential cause(s)

Address reversible causes
- Review any medicine use and interactions
- Optimise the treatment of co-morbidities

Recommend lifestyle changes
- Encourage exercise, a caffeinated beverage and a high-fibre breakfast each morning
- Target: 20–30 g fibre and 1.5–2 L of fluid each day (not suitable for all patients)
- Give advice on an optimal toileting routine

Initiate laxatives if needed (Table 1)
- Lifestyle changes alone may not be enough
- Duration of use depends on patient response

Table 1. Laxatives for constipation in older patients

Laxative class	Description
Osmotic E.g. macrogols, lactulose (fully subsidised)	• **Often first-line in patients not taking opioids** • Onset of action is 24–96 h
Bulk-forming E.g. Psyllium husk powder (fully subsidised)	• **Must be taken with ≥ 500 mL fluid** • Not appropriate if patients cannot meet the required fluid intake or are taking opioids • Onset of action is 12–72 h
Stimulant E.g. Bisacodyl, docusate sodium with sennoside B (fully subsidised)	• **First-line for treatment and prevention of opioid-induced constipation** • Avoid if intestinal obstruction is suspected or if osmotic/bulk-forming laxatives can be used • Onset of action is 6–12 h
Opioid-receptor antagonists E.g. Methylnaltrexone (fully subsidised with Special Authority only in palliative care)	• **Subcutaneous injection; for use in palliative care if oral/rectal laxatives are not working** • Antagonises the effects of opioids in the colon without reducing analgesic effects

Avoid in older patients where possible: Epsom salts, mineral oil, soap enemas, phosphates, sodium citrate

Guidance for laxative use

Discuss goals + adverse effects

Apply a stepped approach
1. Begin with a single laxative
2. Increase dose if response is insufficient
3. Consider switching laxatives
4. Consider a combination

Review

Unsuccessful? → Apply a stepped approach

Refractory? → **Further investigation and discussion with a gastroenterologist**

Goals achieved? → **Withdraw laxative(s) gradually**

2–4 weeks after the patient begins producing soft, fully-formed stools 3x/week
- Withdraw one laxative at a time if taking multiple (stimulant laxatives first)

Relapses can occur during withdrawal and should be treated by re-instating the dose

Faecal impaction becomes more likely with chronic constipation; see the full article for guidance on treating this patient group

For detailed information on managing constipation in older patients, read the full article at: https://bpac.org.nz/2019/constipation.aspx.
For more information regarding specific laxatives and their associated adverse effects, refer to the New Zealand Formulary: https://nzf.org.nz.
HbA_{1c}, glycated haemoglobin; IBD, inflammatory bowel disease; IBS, irritable bowel syndrome; OTC, over the counter; TSH, thyroid stimulating hormone.

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