LAXATIVE GUIDELINE - ADULTS

Identify possible causes

- Poor diet
- Dehydration
- Intestinal obstruction (e.g. gastrointestinal carcinoma, ileus, ovarian or uterine tumours, benign stricture)
- Painful anal conditions (e.g. anal fissure, haemorrhoids)
- Metabolic conditions (e.g. hypothyroidism, hypercalcaemia, hypokalaemia)
- Neurological conditions (e.g. spinal or pelvic nerve injury, Parkinson’s disease, MS, autonomic neuropathy - most commonly due to diabetes mellitus)
- Psychiatric conditions (e.g. depression)
- Adverse effects of drugs (e.g. opioids, anticholinergics, iron preparations)
- Pregnancy, due to the muscle relaxing effect of progesterone

Chronic constipation in primary care

- **Fibre** - high dietary fibre is effective in increasing stool weight, and reduces faecal transit time. A high-fibre diet, about 30 g per day, (e.g. high in fruit, vegetables, wholemeal bread, cereals, and grain foods) should be tried for at least one month before its effects on constipation are determined, although most people will notice an effect within 3-5 days
- Adding oats or linseeds to breakfast cereal can be an effective first line option in primary care
- **Two litres of water** each day is also recommended for people on a high-fibre diet. *If adequate fluid intake is not possible, avoid increasing dietary fibre.*
- **High fibre is not recommended in certain groups of people:**
  - those with mega colon or hypotonic colon or rectum will not respond to bulk in the colon
  - those taking opioids as increasing bulk may lead to obstruction
- **Increase mobility**

Drug treatments

Indications for laxative use are:

- No response to adequate non-drug treatment (e.g. after 1 month)
- Faecal impaction
- Constipation or painful defecation associated with illness, surgery, or pregnancy
- Elderly people with a poor diet
- Drug-induced constipation
- Medical conditions in which bowel strain is undesirable

- **The smallest effective dose of a laxative should be used**, and this dose reduced once symptoms resolve
- Glycerin suppositories must be retained by the patient to be effective
- Lactulose should only be used to treat hepatic encephalopathy in liver failure
**Laxative Treatment Algorithm**

**Examine rectum**

- **Impacted**
  - **Glycerin suppository** (4g) or **Phosphate enema** in the morning. Do not use for more than 7 days.
  - If no response: **Laxido®** up to 8 sachets daily – titrate to response.
  - Do not use for longer than 3 days.

- **Non-impacted**
  - **Docusate sodium** up to a maximum of 500mg/day (start at 200mg BD).
  - If no response, add: **Senna** or **Bisacodyl** at night (2-4 tablets)*
  - Avoid stimulants if bowel obstruction or impaction. Unsuitable for long term use.
  - *NOTE: bisacodyl is more cost-effective than senna in primary care.
  - If ineffective, switch to **Laxido®** 1-3 sachets daily (adjust according to response).

Once patients have responded to initial treatment, consider changing to a bulking agent if indicated i.e. Ispaghula (Fybogel®) 1 sachet bd or sterculia (Normacol®) 1-2 sachets bd to prevent recurrence.

**Types of commonly used laxatives**

<table>
<thead>
<tr>
<th>Bulk-forming</th>
<th>Stimulants</th>
<th>Faecal softeners</th>
<th>Osmotic</th>
<th>Bowel cleansing solutions</th>
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</thead>
<tbody>
<tr>
<td>Ispaghula (Fybogel®)</td>
<td>Bisacodyl</td>
<td>Docusate sodium Linseeds</td>
<td>Macrogols (Movicol®/Laxido®)</td>
<td>Fleet®</td>
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<tr>
<td>Sterculia (Normacol®) (Oats)</td>
<td>Dantron (Co-danthramer®, Co-danthrusate® - palliative care)</td>
<td>Senna</td>
<td>Phosphates (rectal) Lactulose</td>
<td>Klean-prep®</td>
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<td></td>
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<td>Glycerol</td>
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<td>Picolax®</td>
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<td>Moviprep®</td>
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Other drugs used in constipation

Prucalopride – as per NICE TA 211, for specialist initiation only
– Chronic constipation in women that has failed to respond to at least 2 laxatives from different classes at the highest tolerated doses for at least 6 months and where invasive treatment is being considered.
– Efficacy of prucalopride to be reviewed after 4 weeks and drug discontinued if ineffective.

Lubiprostone – as per NICE TA 318, for specialist initiation only
– Chronic constipation that has failed to respond to at least 2 laxatives from different classes at the highest tolerated doses for at least 6 months and where invasive treatment is being considered.
– Efficacy of lubiprostone to be reviewed after an initial 2 week course. Subsequent courses should not be prescribed if initial course is ineffective.

Linaclotide
– Third-line for IBS-C in patients who have failed on a combination of laxatives and antispasmodics (first-line) and antidepressants (second-line).
– Patients must be reviewed at 4 weeks and treatment should be discontinued if ineffective / not-tolerated.

Naloxegol – as per NICE TA 345, Consultant use only
– Opioid-induced constipation which is resistant to usual laxative therapy

Methylnaltrexone - restricted to Palliative Care Team
– Opioid-induced constipation which is resistant to usual laxative therapy (and where naloxegol has failed or is unsuitable), in patients receiving palliative care.