Constipation

Key Points

Constipation can be a difficult problem to manage.

It is estimated that the prevalence of constipation in North American adults ranges from 2-27 percent in community dwelling older adults and 50 to 75 percent in older adults in nursing homes (Fox-Orenstein, McNally & Odunai, 2008; Talley, 2004).

Laxatives are used daily by 10 to 18 percent of community dwelling older adults and 74 percent of nursing home residents (Ruby, Fillenbaum, Kuchibhatia, & Hanlon, 2003).

Overview

Primary or idiopathic constipation can be categorized as:

- Functional chronic idiopathic constipation and constipation-predominant irritable bowel syndrome,
- Slow-transit constipation (or delayed-transit constipation),
- Outlet dysfunction (Barish, Drossman, Johanson, & Ueno, 2010).

Secondary etiologies for constipation are:

- Endocrine or metabolic disorders,
- Neurologic disorders,
- Myogenic disorders, and
- Medications, such as opioid induced constipation.

Assessment

Detailed history about bowel habits, medication use, hypothyroidism, back trauma or neurologic problems (multiple sclerosis, spinal cord injury), psychiatric disorders and recent immobility.

Perianal inspection for scars, fistulas, fissures, hemorrhoids.

Rectal exam to palpate for mass, stricture, or stool impaction, also note sphincter tone.

Diagnosis

Patient without alarm symptoms:

- Routine blood tests, x-rays, or endoscopy not recommended.
- Secondary cause suspected (or patient is ≥ 50 years old) - consider complete blood count (CBC), basic metabolic panel (BMP) including serum calcium, TSH, blood sugar testing.
Patient with alarm symptoms or patient is ≥ 50 years old, additionally consider

- Fecal occult blood test.
- Inspection of full length of colon (using colonoscopy or flexible sigmoidoscopy with barium enema).

**Intervention**

**Non-pharmacological treatment:**

- America Society of Colon and Rectal Surgeons (ASCRS) recommends dietary modifications as initial management, including daily fiber intake of 25 g/day
- Fluid intake of 1.5-2 L/day
- Increase physical activity
- Other non-pharmacologic Interventions include:
  - Biofeedback in adults with pelvic floor dysfunction;
  - Abdominal massage therapy (Lamas, Lindholm, Stenlund, Engstrom, & Jacobsson, 2009);
  - Surgical consideration for slow-transit constipation unresponsive to other therapy, consider total abdominal colectomy with ileorectal anastomosis.

**Pharmacological treatment:**

- Bulk laxatives, e.g., Psyllium and methylcellulose are first line treatment choices;
- Osmotic laxatives, e.g. Polyethylene glycol, lactulose, are second line treatment choices when first line agents are not effective;
- Stimulant Laxatives, e.g. senna, bisacodyl, are reserved for utilized when bulking agents and osmotic laxatives fail (Lembro & Camiller, 2003);
- Lubiprostone is best reserved for patients with severe constipation in whom other approaches have been unsuccessful (Barish, Drossman, Johanson & Ueno, 2010).

**Opioid Induced Constipation:**

- Laxatives and stool softener recommended for prevention of constipation in patients taking opioid analgesics;
- Subcutaneous methyl naltrexone (Relistor) may rapidly relieve opioid-induced constipation without affecting pain relief or opioid withdrawal.

**Prevention**

Laxative prophylaxis may prevent constipation in critically ill ventilated patients (Masri, Abubaker & Ahmed, 2010).

Health care providers should consider the following when their patient is taking opioid analgesics:

- Constipation may occur within 3-5 days, especially in inactive patients;
• Stool softeners and stimulant laxatives are recommended;
  o Titrate dose to produce one soft bowel movement every 1-2 days;
  o If goal is not attained, add bisacodyl;
• Reserve enemas for fecal impaction

In older adults, if feasible avoid medications that contribute to constipation, such as, anticholinergics, tricyclic antidepressants, iron, calcium, verapamil.

References


