# Constipation

## *Executive summary*

## Introduction

Constipation is infrequent and difficult defecation of hard stools and a sensation of incomplete evacuation or straining. Constipation may also refer to a decrease in the volume or weight of stool, and the need for enemas, suppositories, or laxatives to maintain bowel regularity. However there is no objective definition of constipation because of great individual variation in normal bowel habits.

Constipation can be divided into:

* Functional (cannot be explained by any known organic cause).
* Organic (constipation due to an organic cause)

Constipation lasting longer than 8 weeks is termed chronic.

## Target users

* Doctors
* Nurses

## Target area of use

* Gate clinic
* Outpatient department
* Ward

## Key areas of focus / New additions / Changes

This guideline provides advice on lifestyle and dietary modifications to treat constipation as well as add-on medications where needed. It also provides advice on when to be concerned about the presentation of constipation and who should be referred to a doctor.

## Limitations

None

## Presenting symptoms and signs

Constipation itself is a symptom.

Always ascertain what the patient means by constipation. Patients may use the term constipation to mean that their faeces are too hard, they do not defaecate often enough, defaecation causes straining or there is a sense of incomplete evacuation. Some may need digital manipulation to facilitate evacuation.

*When associated with inability to pass flatus, severe abdominal pain, or vomiting there may be the need for urgent referral to a surgeon.*

Ask about other symptoms including:

* Hard, pebbly, rocklike stools
* Painful defecation
* Abdominal pain
* Weight loss
* Blood in stools

A diagnosis of constipation in a child must include 2 or more of the following:

* < 3 bowel movements per week
* A history of painful or hard bowel movements
* At least 1 episode of faecal incontinence per week
* A history of excessive stool retention or retention posturing
* Presence of large faecal mass in rectum

This must be present for **4 weeks** in infants and children < 4 years and for **8 weeks** in children over 4 years.

Normal bowel function according to age:

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| **Age** | **Mean per day** | **Range per week** |
| 0-3 years | 2.9 | 5-40 |
| 3 years and over | 1.0 | 3-14 |

## Examination findings

Consider looking for anaemia, hypothyroidism, malnutrition, hernias, spinal abnormalities.

Examine abdomen for altered bowel sounds, tenderness, masses and organomegaly.

Do a rectal examination to identify masses, anal conditions and to confirm impaction or faecal loading.

## Management in Gate Clinic

**What to look out for**

The following features may indicate a more serious condition and these patients should be *referred* to the doctor:

For children:

* Symptoms began at birth or soon after
* There was delayed passage of meconium more than 48 hours
* Ribbon stools
* Weakness in legs
* Abdominal swelling and vomiting

For adults

* Change of calibre of stools
* Blood mixed in stools
* New onset of symptoms
* Rectal prolapse
* Abdominal swelling and vomiting
* Failure to pass flatus
* Weight loss
* Weakness in legs

Also refer patients who do not respond to either lifestyle advice or lactulose.

### Management

For adults:

When the patient is first seen, recommend simple lifestyle advice:

* Increase fluid intake (minimum 10 cups of water a day for a healthy teenager and adult)
* Increase intake of food rich in fibre such as: fruits and vegetables
* Advise to visit the toilet immediately he/she has the urge and usually after eating.

If the symptoms persist despite this, then try lactulose 15 ml BD for 3-5 days. Patients with symptoms persisting despite this should be referred to the doctor.

For children:

Do not use dietary interventions alone as first-line treatment for idiopathic constipation.

Treat constipation with lactulose for no more than 3 days – dose as per EMRS and a combination of:

* Dietary modifications.
* Negotiated and non-punitive behavioural interventions suited to the child or young person's stage of development.

Children with symptoms persisting despite this should be referred to the doctor.

## Management in OPD

Treatment objectives are:

1. To identify more complex causes of constipation.
2. To arrange necessary investigations.

Consider other causes:

#### ‘Medical' causes

* Diet deficient in roughage
* Ignoring the urge to defaecate e.g. due to immobility
* Myxoedema
* Irritable bowel syndrome
* Hypercalcaemia
* Drugs e.g. atropine, codeine phosphate, morphine, tricyclic antidepressants, disopyramide
* Lazy bowel from chronic laxative use including 'herbal' preparations
* Lack of exercise

#### ‘Surgical' causes

* Anal fissure and other painful perianal lesions
* Carcinoma of the rectum and sigmoid colon
* Foreign body in the gut
* Pelvic mass e.g. fibroid, foetus
* Any gastrointestinal obstruction
* Aganglionic and acquired megacolon

#### Other diagnoses

* Hypothyroidism
* Psychosocial dysfunction
* Neurological disorders including multiple sclerosis or spinal cord injury
* Diabetes (chronic dysmotility)

### Investigations

No tests are required for unless there is reason to consider an underlying diagnosis.

In those circumstances, tests which may be considered include:

* FBC
* TSH
* Potassium and calcium
* Urine dipstick
* Barium enema or flexible sigmoidoscopy (check guideline before requesting this)
* Stool for occult blood.

### Management of simple constipation

Check the patient is following the lifestyle advice above.

Medication should be given according to the probable cause. In all cases, it should only be given on a long term basis if there is a clear irreversible reason for problem. Most other patients will be able to taken medicine intermittently for 3-5 days at a time when they have problems.

* **Lactulose** – is first line option – it is not absorbed, so is safe in pregnancy and diabetes. Start with 15 ml BD for adults (dose is age dependent in children – see BNF or EMRS).
* **Bisacodyl** – should only be used when you suspect motility problems. It is first-line when the patient is taking opiates. 5-10 mg nocte (max of 5 mg per day below age of 10 years).
* **Glycerine** suppositories – useful where the cause is an underlying neurological problem. 1 nocte.
* **Enemas** can be considered in cases undergoing treatment who do not have the required result from the medicine regime, if they are on maximum medication, and have been compliant with treatment.

Patients with surgical causes will usually require referral to the surgeons.

### Treatment failure

The following factors indicate treatment failure after 2 weeks of adequate treatment:

* Bowel opening less than 3 per week.
* Straining required on most occasions.
* Stool consistency has not improved.
* Complaining of another symptom.
* Poorly tolerated current therapy.

### Management of constipation in pregnancy

Constipation is very common in pregnancy secondary to progesterone and the enlarging uterus.

Constipation that results from iron supplementation can be avoided by increasing the intake of fluid and high­fibre foods, and increasing physical activity such as walking.

Bulking agents and lactulose will not enter breast milk. Senna, in large doses, will enter breast milk and may cause diarrhoea and colic in infants.

## References

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[NICE guidelines (Constipation in childhood) May 2010](https://www.nice.org.uk/guidance/CG99). Last updated July 2017.

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| **Reviewed by:** | Name: Bubacarr Susso | Date: 24 July 2020 |
| **Version:** | **Change history:** | **Review due date:** |
| 1.0 | New document |  |
| 2.0 | Adapted from previous version to expand relevance beyond gate clinic. | 31 July 2020 |
| 2.1 | Executive summary added | 31 July 2020 |
| 3.0 | Reviewed and information about childhood constipation added | 01 November 2022 |
| Review Comments (*if applicable)* |  |  |