NHS
Rotherham
Clinical Commissioning Group

Laxative Guidelines for Adults

Key Messages:

- Lifestyle advice of **fluid intake**, fibre & exercise **must** be continued throughout laxative therapy
- Never use two of the same class of drug (i.e. lactulose & macrogol)
- Always use a stimulant first line for drug induced (esp. opioids) as osmotics just cause bloating
- Always add in another laxative type (not replace) as often the synergistic action of softening, bulking and stimulant is much more effective and lowers the side-effects of individual agents.
- **Always consider impaction and overflow if patient reports diarrhoea on laxatives**

Printable resources: Patient.co.uk Constipation in adults Patient information leaflet
Nutrition & dietetic Patient information leaflets

Start at the top and use **ONE** option in category

Then **ADD** in the next step (unless otherwise stated)

Reduce & remove the last step when controlled

Drug induced	**Chronic** (>12 weeks)	**Chronic (with IBS [1])**	**Chronic frail / low mobility**	**Pregnancy/ breastfeeding**
** Increase fluid intake, dietary fibre and exercise **				
Start laxatives on initiation of opioids. [2] **DO NOT use bulk forming**	Investigate possible causes (incl. medication)	Antispasmodics Use soluble fibre [3]	Still encourage fibre, fluid & exercise **Bulk forming may cause blockage**	Ensure non-drug interventions first
Stimulant	Bulk forming with plenty of fluid	Softener	Softener	Bulk forming With plenty of fluid
Softener	Softener	Macrogol (NOT lactulose)	Stimulant	Osmotic
Osmotic	Stimulant	Stimulant	Osmotic	Senna [4] or glycerin supp PRN
Opioid antagonists	Osmotic	**STOP LAXATIVES** then start **Linaclotide**	**Bulk forming may cause blockage**	Seek consultant advice if above medication is insufficient
Palliative use only: Methylnaltrexone, Co-danthrusate & co-danthramer	REFER to Secondary care to consider prucalopride			

A referral can be made to the continence service for assessment, advice and support at all stages.
Especially consider for impacted, neurological conditions or failure of traditional laxatives.
GP & Nurses can send written referral to RCHS, or contact for advice on 01709 423369

Bulk forming Ispaghula one sachet twice a day
Softener Docusate 200mg twice a day
Stimulant Bisacodyl 2 at night (max 4 daily) OR senna 2 at night (max 2 BD) OR glycerin suppositories PRN
Osmotic Macrogol 1 to 3 sachets daily lactulose 15ml BD (not recommended)
Linaclotide / Opioid antagonists (See overleaf)
Prucalopride Consultant initiation only (See over)

RED flags:

- Persistent unexplained change in bowel habit?
- Persistent rectal bleeding without anal symptoms?
- Narrowing of stool calibre?
- Palpable mass in the lower right abdomen or the pelvis?
- Unexplained weight loss, iron deficiency anaemia, fever, or nocturnal symptoms?
- Family history of colon cancer, or inflammatory bowel disease?
- Severe, persistent constipation that is unresponsive to treatment?

[1] Irritable Bowel Syndrome www.patient.co.uk leaflet
[2] Greater than 120mg codeine /day (i.e. co-codamol 30/500) or strong opioids (i.e. morphine MR)
[3] fruit, root vegetables & oats – NOT insoluble fibre of bran, whole grains & cereals
[4] not near term or unstable pregnancy

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Impaction - Prevent reoccurance with lifestyle advice and regular laxatives. Exact treatment depends on cause and size of impaction, advice maybe required from the Colorectal Advanced Nurse Practioner Or the continence service **Options include:**

- Glycerin or bisacodyl suppositories
- Phosphate or arachis (peanut) oil enemas
- Macrogol disimpaction regimen (use with caution)

Neurological / MS / Stroke / spinal injuries etc
These patients may require a more complicated regime including rectal stimulation and manual evacuation. Over use of traditional laxatives (especially osmotics) can result in faecel incontinence. Seek advice from their specialist team or the continence service.

Drugs causing constipation:
Common – Opioids, Iron supplements & Anti-psychotics (Clozapine – MRHA warning of fatal obstruction)
Others – Antacids (containg aluminium)
• anti-muscarinics (such as procyclidine, oxybutynin)
• anti-depressants (most commonly tricyclic antidepressants)
• anti-spasmodics (such as dicycloverine, hyoscine)
• some antiepileptics (e.g. carbamazepine, gabapentin, oxcarbazepine, pregabalin, phenytoin)
• calcium supplements
• diuretics
• sedating antihistamines
• verapamil

<table>
<tr><td colspan="2">Research suggests that 40-50% of individuals taking opioids for chronic pain will experience opioid induced constipation (OIC) and in cancer related pain this can be as high as 70-85% (See SMC reference below). Non-cancer pain OIC should be treated by reducing / stopping opioids where possible and using other non-pharmacological approaches of pain management.
Peripherally acting opioid antagonists combat the mechanism of OIC by blocking the gastro-intestinal tract effects of opioids, without altering their central analgesic effects.</td></tr>
<tr><td colspan="2">Naloxegol 25mg daily (NICE TA345) Is an option for treating OIC in adults who constipation has not adequately responded to laxatives. (Reduce dose to 12.5mg daily in renal insufficiency)</td></tr>
<tr><td>Naldemedine 200mcg daily (NICE TA651) Can be used with or without conventional laxatives as an option for treating OIC (both pure & mixed) in adults who constipation that has not adequately responded to laxatives.</td><td>Naldemedine has been shown to reduce opioid-induced constipation compared to placebo. There is limited data indirectly comparing naldemedine to naloxegol or methylnaltexone and it shows no significant difference, It also has limited data in opioid doses above 400mg morphine equivalent or with partial opioid mu-agonists (e.g. buprenorphine)</td></tr>
<tr><td colspan="2">Methylnaltrexone subcutaneous injection is licensed in palliative care and for OIC when response to laxative therapy has not been sufficient. It should only be initiated by a specialist. (NICE TA277 has been terminated due to no evidence submission at review)</td></tr>
<tr><td colspan="2">Targinact (and generic oxycodone/naloxone) is an “item that should not routinely be prescribed in primary care” by NHS England, and should also be actively de-prescribed. It is more cost-effective to prescribe pain relief and laxative treatment separately allowing for dose titration of both.</td></tr>
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<tr><td rowspan="2">Prucalopride is a selective, high-affinity, serotonin (5HT4) receptor agonist, and has enterokinetic effects, enhancing intestinal motility.</td><td>Amber lighted so initiation by consultant only. As per NICE TA211. Only, after 6 months treatment of at least two classes of laxatives at maximum tolerated doses. Review after 4 weeks (then can be passed to GP).</td></tr>
<tr><td>The most common side effects are headache and GI symptoms (abdominal pain, nausea or diarrhoea)</td></tr>
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<tr><td rowspan="2">Linaclotide 290mg daily</td><td>Linaclotide is ONLY licensed for patients with Irritable Bowel Syndrome (IBS) with constipation and ONLY recommended patients in whom ALL other laxative treatment options have been ineffective or contraindicated. (Antispasmodics may still be used.) Review after 4 weeks & at regular intervals thereafter.</td></tr>
<tr><td>a Guanylate cyclase-C receptor agonist causing decreased visceral pain, increased intestinal fluid secretion and accelerated intestinal transit.</td></tr>
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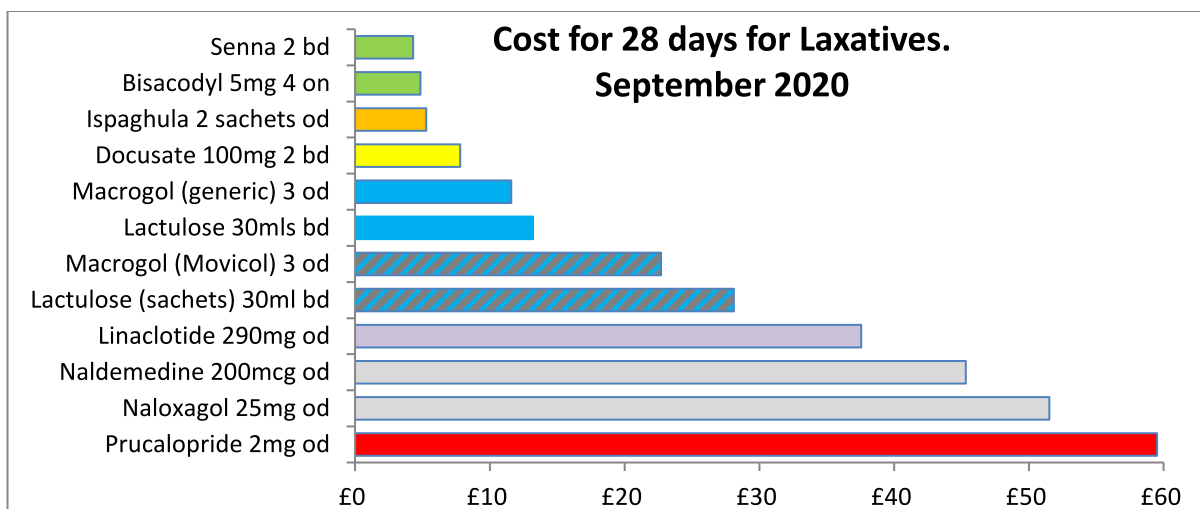

Background information	Advantages	Disadvantages
Bulk-forming laxatives (such as ispaghula) retain fluid within the stool and increasing faecal mass, leading to stimulation of peristalsis. They also have stool-softening properties.	First-line choice in adults when it is difficult to get enough fibre in the diet. Better tolerated than bran. **2-3 days to effect**	**Adequate fluid intake** is important, to prevent intestinal obstruction. Must not be taken immediately before bed. This may be difficult for the frail and elderly. Not recommended for people taking constipating drugs. Side-effects of flatulence and bloating
Surface-wetting agents (docusate) reduces the surface tension of the stool, allowing water to penetrate and soften it. It also has a weak stimulant effect.	Does not require a large fluid intake. **12-72 hours to effect**	Side-effects of abdominal cramps and diarrhoea. Often needs an additional laxative to be added (either stimulant or osmotic).
Stimulant laxatives cause peristalsis by stimulating colonic nerves (senna) or colonic and rectal nerves (bisacodyl).	Rapid effect. Restarts peristalsis in drug-induced constipation **6-12 hours to effect**	Requires the stool to be softened by increasing dietary fibre and liquid or another laxative (softener / osmotic). Side-effects include cramps & diarrhoea, and should be avoided in intestinal obstruction
Osmotic laxatives (macrogols & lactulose) increase fluid in the large bowel. This produces distension, leading to stimulation of peristalsis. ***Prescribe macrogol generically, and do not use lactulose sachets.***	Produce very soft stools with a large volume. **2-3 days to effect**	Macrogols require a large volume to drink and if **adequate fluid** is not taken it can lead to dehydration. They may be counter-productive in patients with IBS. Side-effects include flatulence, bloating, cramping and nausea. Lactulose causes colic due to breakdown by bacteria, and is NOT recommended for IBS patients.

Lubiprostone is a chloride-channel activator that acts in the gut to increase intestinal fluid secretion which increases motility	Withdrawn from the UK market late 2018

References:

- NICE Clinical knowledge Summaries
- NICE TA's
- Scottish Medicines Consortium (SMC) Naldemedine March 2020
- The management of constipation MeReC bulletin July 2004
- COMPASS Therapeutic notes on the management of constipation in Primary Care January 2012

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