

RGH Pharmacy E-Bulletin

Volume 39 (6): August 30, 2010

A joint initiative of the Patient Services Section and the Drug and Therapeutics Information Service of the Pharmacy Department, Repatriation General Hospital, Daw Park, South Australia. The RGH Pharmacy E-Bulletin is distributed in electronic format on a weekly basis, and aims to present concise, factual information on issues of current interest in therapeutics, drug safety and cost-effective use of medications.

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Constipation (part one)

Constipation is not easily defined because there is wide inter-individual variation in normal bowel habit (the normal frequency of bowel motions may vary from three times per day to twice per week), but the term implies a diminished frequency of bowel motions and/or the passage of small hard stools. Causes of constipation are many, and in an individual, may be multifactorial. Causes of constipation include: inadequate fibre intake, dehydration, immobility reduced muscle tone in small/large bowel, pregnancy, carcinoma, dementia, depression, hypercalcaemia and drugs.

Drugs that are known to induce constipation include:

- opioid analgesics
- iron supplements
- antipsychotics
- anticholinergic agents
- aluminium- and/or calcium containing antacids
- calcium-channel blockers especially verapamil
- gabapentin & pregabalin

Note that in a scenario where someone is taking iron supplements +/- laxatives, this may mask anaemia and constipation as symptoms of GI tract malignancy.

To treat constipation in adults, start with increased dietary fibre, fluid and exercise - this is probably the most important step for an ambulatory person. If these approaches are not successful, it is appropriate to use drug therapy – the suggested order would be:

- 1) Bulk-forming agents – useful for mild constipation
- 2) Hyperosmotic laxatives
- 3) Stool softeners - no evidence that these are effective for constipation in adults when used alone
- 4) Stimulant laxatives

For the elderly, constipation is best monitored by symptoms of straining and pain or discomfort rather than frequency, because of the variation in perceived 'normal' bowel pattern in this age group. Osmotic and stimulant laxatives are likely to be required for a bedbound patient. Overflow diarrhoea should be a consideration when diarrhoea starts in a residential care patient who has been constipated until recently.

If faecal impaction is confirmed then enemas or suppositories may be necessary to clear the rectum of stool. Large doses of an osmotic laxative such as Movicol® are also used. Once the bowels have been emptied, regular laxatives must be used to prevent recurrence.

In palliative care patients a combination of stool softener and stimulant laxative is the best choice. Osmotic laxatives can be added as a second line agent. Stimulant laxatives are essential when taking regular opioids. For patients with spinal injury, a regimen of regular bowel evacuation is necessary, along with adequate fluid and fibre intake. Alternate day suppositories (e.g. bisacodyl) or enemas (sodium phosphates) can be given regularly. Opioid-induced constipation requires the use of a stimulant laxative, and most of the evidence is for senna (alone). Laxatives should be prescribed prophylactically whenever opioids are used; even a few as-needed doses can cause constipation.

This E-Bulletin is based on work by Jenny Casanova, Senior Clinical Pharmacist, RGH

FOR FURTHER INFORMATION CONTACT THE PHARMACY DEPARTMENT ON 82751763 or email: chris.alderman@health.sa.gov.au
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