Managing constipation in older patients

First evaluate the cause(s) of constipation

Identify symptoms
- Infrequent stools
- Difficulty passing hard/lumpy stools
- A sensation of incomplete evacuation

Discuss lifestyle and consider medical history for possible causes (Figure 1)

Perform abdominal and rectal examinations in all older patients unless there is an obvious cause for constipation

Consider need for additional investigations e.g. full blood count and ferritin*, TSH, HbA\textsubscript{1c}, serum electrolytes, abdominal X-ray

A systematic approach is recommended to resolve symptoms based on potential cause(s)

Address reversible causes
- Review any medicine use and interactions
- Optimise the treatment of co-morbidities

Recommend lifestyle changes
- Encourage exercise, a caffeinated beverage and a high-fibre breakfast each morning
- Target: 20–30 g fibre and 1.5–2 L of fluid each day (not suitable for all patients)
- Give advice on an optimal toileting routine

Initiate laxatives if needed (Table 1)
- Lifestyle changes alone may not be enough
- Duration of use depends on patient response

Guidance for laxative use

Discuss goals + adverse effects

Apply a stepped approach
1. Begin with a single laxative
2. Increase dose if response is insufficient
3. Consider switching laxatives
4. Consider a combination

Faecal impaction becomes more likely with chronic constipation; see the full article for guidance on treating this patient group

Table 1. Laxatives for constipation in older patients

<table>
<thead>
<tr>
<th>Laxative class</th>
<th>Description</th>
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<tbody>
<tr>
<td>Osmotic</td>
<td>E.g. macrogols, lactulose (fully subsidised)</td>
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<tr>
<td>Bulk-forming</td>
<td>E.g. Psyllium husk powder (fully subsidised)</td>
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<tr>
<td>Stimulant</td>
<td>E.g. Bisacodyl, docusate sodium with sennoside B (fully subsidised)</td>
</tr>
<tr>
<td>Opioid-receptor antagonists</td>
<td>E.g. Methylnaltrexone (fully subsidised with Special Authority only in palliative care)</td>
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Figure 1. The causes of constipation can overlap

Colonic dysfunction
- Lifestyle e.g. dehydration, low-fibre diet, reduced mobility

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Primary causes
- Electrolyte imbalances
- Frailty
- Psychological factors e.g. depression

Secondary causes
- Underlying medical conditions e.g. diabetes, hypothyroidism, IBD, IBS

Colorectal cancer red flags
- Unintentional weight loss
- Blood in or with the stool
- An abdominal or rectal mass
- Iron deficiency anaemia
- Family history of bowel cancer or IBD

Avoid in older patients where possible: Epsom salts, mineral oil, soap enemas, phosphates, sodium citrate

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Further investigation and discussion with a gastroenterologist

Withdraw laxative(s) gradually
2–4 weeks after the patient begins producing soft, fully-formed stools 3x/week
- Withdraw one laxative at a time if taking multiple (stimulant laxatives first)
- Relapses can occur during withdrawal and should be treated by re-instating the dose

For detailed information on managing constipation in older patients, read the full article at: https://bpac.org.nz/2019/constipation.aspx.
For more information regarding specific laxatives and their associated adverse effects, refer to the New Zealand Formulary: https://nzf.org.nz.
HbA\textsubscript{1c}, glycaed haemoglobin; IBD, inflammatory bowel disease; IBS, irritable bowel syndrome; OTC, over the counter; TSH, thyroid stimulating hormone.