Constipation is one of the most common gastrointestinal problems experienced by the general population, with an estimated UK prevalence of 52 per cent. Despite this, constipation is often both misdiagnosed and under-treated both in children and adults. This paper will look at the issues and suggest specific management strategies for addressing constipation in both the general adult population and these apparently vulnerable groups.

Key words:
Constipation
Management
Community

Management of constipation in the community

Constipation is one of the most common gastrointestinal problems experienced by the general population; a study undertaken to identify laxative usage within the UK population in patients diagnosed by their General Practitioner (GP) as having constipation, estimated a UK prevalence of up to 52 per cent. Despite the high prevalence, constipation is often both misdiagnosed and under-treated. Particular groups of the population appear to be particularly vulnerable, such as children, women, the older person and those undergoing palliative care.

Definition of constipation
Various definitions of constipation exist, with the Rome III criteria being considered as the best consensus statement. According to the criteria, the individual needs to have had 2 or more of the following symptoms present for at least 3 months:

- straining
- lumpy or hard stools
- sensation of incomplete evacuation
- Sensation of ano-rectal obstruction manual manoeuvres to facilitate evacuation
- less than 3 bowel movements per week

However, it appears that few clinicians apply the criteria in their own clinical practice. A study by Mihaylov et al which studied laxative usage, found that a major issue in identifying patients with constipation was the differing definitions used by patients, nurses and GPs. The nurses in the study defined constipation from both a patient perspective and symptom descriptions; doctors defined constipation from a patient perspective, but also focused on ‘text book’ definitions including reduced frequency of defecation and other related clinic symptoms. The patients defined constipation in terms of changes in routine and frequency. In addition, approach to treatment differed between the nurses and GPs, with the nurses looking more holistically at management and including dietary, fluid and lifestyle advice, while many GPs merely prescribed laxatives. The paper concluded that there was little shared understanding between professionals and patients with little consensus regarding optimum management strategies.

Constipation is considered to be the result of slow gut transit or dysfunctional evacuation. In slow gut transit, the stool moves very slowly through the colon which results in large, hard stools which are difficult to pass. As one of the functions of the colon is to reabsorb water from the stools, the longer the stools stay in the colon, the more water is drawn out. In dysfunctional evacuation, although there may be a normal stool transit time, it is unable to be expelled from the rectum. Acute constipation is more often associated with organic disease. It is important to determine whether the patient has a history or signs and symptoms of a neurological, endocrine, or metabolic disorder. These include abdominal pain, nausea, cramping, vomiting, weight loss, any blood in the stool, rectal bleeding, rectal pain, and fever.

In order to ensure good treatment outcomes, it is important that treatment addresses the particular underlying problem.

Assessment of constipation
Clarification of what the patient means by ‘constipation’ is important, as many individuals feel constipated because they are not opening their bowels on a daily basis, even if they are passing stools regularly with no apparent problem. The Bristol Stool Chart (Figure 1) should be used to determine the nature of the bowel movements (size, consistency, frequency), and the duration of the constipation noted. Assessment of dietary fibre intake, level of physical activity, and use of medications, including over-the-counter (for example, laxatives) is also required. The patient’s perspective and concerns should be elicited, and a careful psychosocial...
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history should be obtained; signs of depression or anxiety should be noted as these are known contributory factors. In adults, a rectal examination and palpation should be undertaken to detect the presence of masses, anal and perianal fissures, inflammation, or the presence of hard stool. This should only be undertaken by an appropriately qualified practitioner. In children, digital rectal examination (DRE) purely to establish if constipation is present is not recommended. If an underlying abnormality is suspected, particularly in infants under the age of 1 year, then urgent referral to a health care professional competent in both carrying out DRE and interpreting the findings is recommended. As constipation is known to also affect the activity of the bladder it is important that any assessment also includes a review of the lower urinary tract.

**Management**

Figure 2 gives an overview of suggested generic treatment and laxative options for adults presenting with constipation. Diet and lifestyle advice is the first-line option, and recent studies have also suggested that the use of probiotics, in both children and adults, has been found to be beneficial in the management of constipation.

Patients should be provided with advice and information which includes an explanation and aetiology of constipation and an overview of treatment options. A range of booklets for both patients and health care professionals are available from PromoCon and the NHS Choices website.

Patients should be advised not to ignore any spontaneous urge to defecate and to adopt the correct toilet position with the knees slightly higher than the hips, with feet supported on a step if necessary. Utilising the gastro-colic reflex, particularly in the morning or after meals, should be encouraged. For those with a very sedentary lifestyle, particularly the elderly, increasing physical activity may be helpful in stimulating bowel movements. However, in younger active individuals with chronic constipation results of increasing exercise have been variable.

An increased fluid intake may be of benefit for those individuals, particularly the elderly, whose daily intake of fluid is less than recommended volumes (approximately 2 litres per day). However, the effect of fluid intake on chronic constipation has been controversial with little apparent evidence that increasing fluid has any benefit. It is generally accepted that fibre is known to increase stool weight and shorten gut transit time with a recommended dose of 20-30g per day. However, the role of fibre in constipation management has been debated, with some suggestion that increased fibre is not always helpful, particularly for those individuals who have associated symptoms such as abdominal distension and pain. It is important therefore that any increase in fibre intake is done slowly.

For individuals whose constipation remains unresolved despite these measures, consideration should be given to the use of laxatives or referral to a specialist service.

**Constipation in childhood**

The National Institute for Health and Clinical Excellence provides clear recommendations regarding the assessment and treatment of constipation in children and young people, with specific key priorities for implementation. Laxatives should be instigated as first line treatment, with Movicol® Paediatric Plain being the laxative of choice. Diet and lifestyle changes should also be addressed, but should not be seen as a stand alone first line treatment in any but mild-acute cases.

The key issue with infants and children is to commence laxatives early, at a dose that produces regular soft formed stools and to continue with laxative treatment for at least 6 months if necessary to reduce the risk of relapse.

**Constipation in women**

Constipation appears to be more common in women for number of reasons, including pregnancy and childbirth. NICE has recently approved a

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Figure 1: Bristol Stool Chart. A

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Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Separate hard lumps, like nuts (hard to pass)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
</tr>
</tbody>
</table>

Figure 1: Bristol Stool Chart.
new treatment modality, prucalopride (Resolor®, Movetis) as an option for women with unresolved chronic constipation in whom standard treatment (the use of two laxatives from different classes at the highest tolerated recommended dose, for at least 6 months) has failed to provide adequate relief.

Prucalopride is not a laxative; it belongs to a group of medicines which enhance gut motility (prokinetics) and is a selective 5-HT4 receptor agonist. It works in a similar way to serotonin (5HT) which influences motility, visceral perception and recreation in the gut. Mucosal stimulation from food normally stimulates the release of serotonin. The serotonin attaches to 5-HT4 receptors in the gut wall and stimulates the receptors, resulting in coordinated contraction and relaxation of the smooth muscle of the gut—the peristaltic reflex. Prucalopride mimics serotonin and attaches to and stimulates the same 5-HT4 receptors, thereby increasing peristalsis resulting in increased stool frequency and consistency.

If prucalopride is not effective after 4 weeks, the woman should be reviewed and the benefit of continuing treatment...
considered. Prucalopride can be used in combination with laxatives if necessary. NICE also states that prucalopride should only be prescribed by a clinician with experience of treating constipation and who has carefully reviewed the woman’s treatment history.

**Constipation in pregnancy**

Constipation is reported to be second only to nausea as the most common gastrointestinal complaint in pregnancy, resulting from physiological and anatomical changes in the gastrointestinal tract. It is estimated that between 11 and 38 per cent of women who are pregnant experience problems with constipation.

It is suggested that dietary and lifestyle changes should always be tried first and if these fail to resolve the constipation, then the use of bulk forming laxatives such as Fybogel®, or an osmotic laxative such as Movicol®, should be tried. The majority of laxatives are poorly absorbed into the blood stream, so if a stimulant laxative is required, senna could be considered.

**Constipation in the older person**

Constipation is said to affect up to 50 per cent of older adults in the community and 74 per cent of those living in nursing homes. Within the elderly population, constipation is more likely to have a multi-factorial aetiology including: lifestyle and dietary issues; disease co-morbidities, and side effects of poly-pharmacy. As a result, there often needs to be a multi-factorial treatment approach to take into account all the contributory factors.

**Constipation in palliative care**

Constipation is one of the major side effects of opiate use in palliative care and can result in increased discomfort and distress for the patient. Currently, methylnaltrexone (Relistor®) is the only peripherally acting opioid-receptor antagonist that is licensed for the treatment of opioid-induced constipation in palliative care patients when other laxatives have failed to resolve the constipation. It has been found to be effective in resolving constipation in about 50 per cent of cases.

Methylnaltrexone binds to the same receptors as opioid analgesics such as morphine, but it acts as an antagonist, blocking the effects of those analgesics, specifically the constipating effects on the gastrointestinal tract. Furthermore, as methylnaltrexone cannot cross the blood–brain barrier, it does not reverse the pain-killing properties of opioid agonists or cause withdrawal symptoms, which are obviously of great benefit to the patient.

**Discussion**

Constipation is one of the most common gastrointestinal conditions found in the community. The delivery of patient-centred care which aims to individualise the treatment of constipation to the individual, will help not only improve treatment outcomes but also potentially shorten treatment time and reduce the risk of complications developing. For those individuals whose constipation fails to respond to community intervention then referral on for further investigation and treatment should be instigated.

**References**


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**Correction**

Ousey K, Atkinson R, Fleming et al. (2013) Academia and clinical practice - working together successfully to develop skin integrity knowledge and Skills. 27: 1: 15-17. An author was listed as Rose Atkinson. This should read Ross Atkinson. The editor would like to apologise to Mr Atkinson for this error.