Bowel Interest Group

PATIENT SELF-PRESENTS WITH CHRONIC CONSTIPATION

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If abnormal

Further investigations

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Not possible

MAKE A POSITIVE DIAGNOSIS and consider pathophysiology

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EDUCATION AND TAILORED LIFESTYLE ADVICE ▶

Adequate relief
Continue management and monitor as required

1ST AND 2ND LINE LAXATIVE PATHWAYS ▶ 6 months duration

3RD LINE THERAPY: Prokinetics ▶ 6 months duration

REFERRAL TO INTEGRATED CARE CONSTIPATION SERVICE ▶

REFERRAL TO SECONDARY CARE

BIG's Bowel Dysfunction Treatment Pyramid provides more information on secondary care referrals

▶ CLICK ON BOXES FOR ADDITIONAL INFORMATION

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General information ▶

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General Information

1. This is a consensus pathway
2. It is for adults only – not paediatrics or pregnancy
3. The reason for the pathway is to improve care and reduce costs associated with chronic constipation in the community. BIG's Cost of Constipation Report highlighted that the total cost for treating unplanned admissions due to constipation was £71 million in 2017/18.
4. Recognising that this is a large problem in primary care the guidance is structured pragmatically to allow quick and safe decision making. The first appointment may just cover history and examination. The pathway would then assist by standardising the lifestyle measures which have evidence to support them.
5. In functional patients there should be a clinical review after 1-3 months to confirm efficacy and decide on next steps.
6. Bowel management is similar in patients with functional and neurological causes. The difference is that the latter patients may find they progress through the pathway quicker.

- ▶ This pathway has been developed from the NICE CKS on constipation
- ▶ For further reading on points of escalation in treating chronic constipation read Dealing with Chronic Constipation, Information for General Practitioners an information pack developed by BIG.

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History

- **Suspect a diagnosis of faecal loading or impaction if there is history of:**
  - Hard, lumpy stools, which may be large and infrequent (for example passed every 7–10 days), or small and relatively frequent (for example passed every 2–3 days).
  - Having to use manual methods to extract faeces.
  - Overflow faecal incontinence, or loose stool.
- **Suspect a diagnosis of constipation if an adult presents with defecation which is:**
  - Unsatisfactory because of infrequent stools,
  - Difficulty passing stools,
  - Or a sensation of incomplete emptying.
- **Consider a diagnosis of constipation in the elderly if:**
  - There are non-specific symptoms, such as: Confusion or delirium, functional decline.
  - Nausea or loss of appetite.
  - Overflow diarrhoea.
  - Urinary retention.

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Alarm Features

- Age >50 years
- Short symptom history
- Unintentional weight loss
- Nocturnal symptoms
- Male sex
- Family history of bowel/ ovarian cancer
- Anaemia
- Rectal bleeding
- Recent antibiotic use
- Abdominal mass

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Physical exam

- **Assess for signs of weight loss and general nutritional status.**
- **Perform an abdominal examination to check for abdominal pain, distension, masses, or a palpable colon (suggesting retained faecal masses).**
- **Perform an internal rectal examination, checking for:**
  - Anal fissures, haemorrhoids, skin tags, rectal prolapse, rectocele, skin erythema or excoriation (may be a sign of faecal leakage).
  - Resting anal sphincter tone; rectal mass lesions and retained faecal masses, which may also be felt on external peri-anal palpation. Note: a faecal mass can be distinguished from a tumour or cyst, as firm pressure exerted by a finger will typically leave a palpable indentation in hard faeces.
  - Pelvic floor dysfunction (if appropriate) — while asking the person to 'bear down', there may be paradoxical contraction of the anal sphincter on straining.
  - Leakage of stool; rectal or anal pain.

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Pain present

If a patient who has no alarm features reports abdominal pain which is temporarily related to constipation symptoms the diagnosis of IBS should be considered.

NICE IBS guidance can be followed

▶ Irritable bowel syndrome in adults: diagnosis and management

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Constipation causing medication

Manage any underlying secondary cause of constipation, and advise the person to reduce or stop any drug treatment that may be causing or contributing to symptoms, if possible and appropriate.

OIC

- **If the person has opioid-induced constipation:**
  - Do not prescribe bulk-forming laxatives.
  - Offer an osmotic laxative and a stimulant laxative (or docusate is an alternative which also has stool-softening properties).
- **Bulk-forming laxatives are not recommended as their mode of action is to distend the colon and stimulate peristalsis, but opioids prevent the colon responding with propulsive action. This may cause abdominal colic and rarely bowel obstruction.**
- **Osmotic laxatives retain fluid in the stool making defecation easier, and docusate also has stool-softening properties.**
- **Stimulant laxatives overcome the reduced peristalsis caused by opioid medication.**

Modify if possible

Manage any underlying secondary cause of constipation and advise the person to reduce or stop any drug treatment that may be causing or contributing to symptoms, if possible and appropriate.

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Make a positive diagnosis and consider pathophysiology

- Give the information regarding diagnosis in a positive and emphatic way.
- Explain that there is no organic disease, but there is a "real" problem with the way the bowel works, specifically related to altered physiology of the bowel
- Use the patient's symptoms to decide on whether problems are related to transit, evacuation difficulty or a combination

Transit problem

The symptoms of infrequent urge and hard stools raise the probability of slow transit.

▶ See Bristol stool form types 1 and 2

Evacuation problem

The sensation of incomplete emptying, needing to strain, or requiring digital manoeuvres to defecate raise the probability of an evacuation problem.

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Education and tailored lifestyle advice

- **Eating a healthy, balanced diet and having regular meals:**
  - The person's diet should contain whole grains, fruits (and their juices) high in sorbitol, and vegetables.
  - Fruits that have a high sorbitol content include apples, apricots, grapes (and raisins), peaches, pears, plums (and prunes), raspberries, and strawberries.
  - Fibre intake should be increased gradually (to minimize flatulence and bloating) — adults should aim to consume 30 g of fibre per day. There is evidence to support specific fibre types namely wheat germ, flax and linseeds.
  - Advise the person that the beneficial effects of increasing dietary fibre may take several weeks.
- **Public Health England's booklet ▶ The Eatwell Guide has patient information on eating a healthy, balanced diet.**
- **Drinking an adequate fluid intake, especially if there is a risk of dehydration. The Association of UK Dietitians has a useful ▶ Food Fact Sheet on Fluid.**
- **Increasing activity and exercise levels, if needed.**
- **Helpful toileting routines:**
  - Advise on a regular, unhurried toilet routine, giving time to ensure that defecation is complete.
  - Advise on responding immediately to the sensation of needing to defecate.
  - Ensure that people with limited mobility have appropriate help to access the toilet and adequate privacy.
  - Ensure the person has access to supported seating if they are unsteady on the toilet.
- **Some patients find abdominal massage beneficial to increasing stool output. The massage technique is best taught by a HCP.**

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1st and 2nd line laxative pathways

- If the person has ongoing symptoms despite changes to lifestyle, offer drug treatment with oral laxatives using a stepped approach. Adjust the dose, choice, and combination of laxatives used, depending on the person's symptoms, the desired speed of symptom relief, the response to treatment, and their personal preference.

- Offer initial treatment with a bulk-forming laxative such as ispaghula. Note: it is important for the person to drink an adequate fluid intake.

- If stools remain hard or difficult to pass, add or switch to an osmotic laxative, such as a macrogol.

- If a macrogol is ineffective or not tolerated, offer treatment with lactulose second-line.

- If stools are soft but difficult to pass or there is a sensation of inadequate emptying, add a stimulant laxative.

- Although there are no clinical trials there is a logic to using suppositories in patients who have difficulty with rectal evacuation.

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3rd line therapies: Prokinetics

- Consider the use of drug treatment with prucalopride if at least two laxatives from different classes have been tried at the highest tolerated recommended doses for at least 6 months, and failed to relieve symptoms, where other treatment (such as suppositories, enemas, rectal irrigation and/or manual disimpaction) is being considered.

- NICE guidance allows prucalopride to be prescribed by doctors experienced in treating constipation. This can be a GPs, or there may be local pathways to shared care with the hospital.

  ▶ Prucalopride for the treatment of chronic constipation in women

- The prokinetic prucalopride (a selective, high-affinity, serotonin [5HT4] receptor agonist) stimulates gastrointestinal motility. Offer a prescription for 4 weeks and if there is no symptom response

- The prokinetic prucalopride is only for patients with functional constipation

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Referral to Integrated Care Constipation Service

Here are four examples of constipation services found across the country. In the UK there are services which can support patients with constipation and provide other bowel care. These services can provide treatment options for constipation such as transanal irrigation, nerve stimulation and biofeedback.

1. HEALTHY BOWEL CLINIC

The Healthy Bowel Clinic was set up in 2003 as part of Aintree University Hospital Trust, it is a unique specialist clinic that treats patients presenting with functional bowel problems (constipation, faecal incontinence and obstructed defecation) in an outpatient setting. Patients referred into the service are directed straight to The Healthy Bowel Clinic and the majority will never see a medic. The service is run solely by Physiotherapists

The clinic utilises the MDT approach and includes Gastroenterologists, Colorectal Consultants, Specialist Physiotherapists, Specialist Nurses, Physiologists, Radiographers and a Cognitive Behavioural Therapist. They routinely see over 150 patients per week.

The clinic can refer for appropriate tests (Transit Marker studies, Defecating Proctograms, Anorectal physiology and various blood tests). They independently interpret results and decide on appropriate treatment/management. When conservative management is not successful, patients are discussed in the MDT and/or seen in the fortnightly Consultant led Pelvic floor clinic.

Patients continue their care under the direction of the Healthy Bowel Clinicians until their management is stabilised or symptoms resolve.

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Referral to Integrated Care Constipation Service - *continued*

2. UCLH COMMUNITY GI NURSE SERVICE

A Band 8 nurse provides care and treatment for patients in close collaboration with the secondary care gastroenterology clinical team. The nurse acts as a catalyst for shaping services and liaising with the provider multidisciplinary team to manage people with GI conditions such as Community and hospital dietetic services

Responsibilities of the GI nurse include assessment of patient conditions through all stages of the condition, being the first point of contact for information and signposting, to provide clinical monitoring and medicine management.

3. NURSE-LED BLADDER & BOWEL CLINICS

In Manchester the Nurse-Led Bladder & Bowel Clinics assess and treat patients at several different Health centres. They support the community nurses who provide home continence assessments for patients unable to attend clinic due to poor health and immobility.

They have great relationships with the community nurses, learning disability nurses, falls teams, consultants and GP's with an overall aim to prevent emergency admissions, to improve bladder and bowel care and quality of life. They operate an in-house Continence prescribing service and have dedicated telephone support lines for patients for advice and support and to prevent their continence problems deteriorating.

They run several Bladder & Bowel education sessions, one is the Bowel Care study day, which is for qualified nursing and medical staff or band 4 assistant practitioners who regularly perform bowel care procedures in their current role.

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Referral to Integrated Care Constipation Service - *continued*

4. BOWEL MANAGEMENT CLINICAL NURSE SPECIALIST

Kings College Hospital have a Bowel Management Clinical Nurse Specialist (CNS). This post seeks to reduce ED admissions as a result of constipation and subsequent bed day utilisation by 50% and provide specialist care and follow up to these patients.

They are creating a new Constipation Pathway, linking with multiple other medical specialities, but working particularly closely with Emergency Medicine, care of the Elderly and General Surgery. The CNS will be collecting data on medical history, medications, aetiology of constipation, inpatient episodes/bed days and patient-related outcomes. They also plan to investigate the psychological impact of constipation.

Once this pathway has been set up, they hope to be able to streamline patient care, instituting appropriate treatment at an earlier timepoint (e.g. medications, dietary factors and transanal irrigation). They work closely with the Specialist GI dietician and GI Psychologist to create a holistic approach to all bio-psycho-social aspects of constipation.

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