

WHAT YOU NEED  
TO KNOW

## MANAGING CONSTIPATION IN SENIORS

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# UNDERSTANDING CONSTIPATION

Constipation is a disturbance in bowel habits characterized by:

- *Difficulty passing stools*
- *Incomplete passage of stools*
- *Reduced frequency of bowel movements (usually less than 3 times a week)*

The prevalence of constipation in older adults ranges from 24 to 50%.

## PHARMACOLOGICAL TREATMENT – A Focus on Laxatives

The basic groups of laxatives include:

- **Bulk-forming laxatives** (e.g. psyllium, wheat dextrin) - recommended 1st line in patients who do not respond to non-pharmacological interventions. They should be administered with 250ml of water/juice to prevent fecal impaction, therefore are not suitable if the resident is dehydrated or fluid restricted.
- **Osmotic laxatives** (e.g. PEG 3350, lactulose) help retain water within the intestines; the increased pressure in the lumen wall induces gastric motility. PEG is superior to lactulose in terms of effectiveness and palatability.
- **Stimulant laxatives** (e.g. senna, bisacodyl) work by irritating the intestines. They are efficacious, but chronic use should be avoided as the long-term safety in the elderly is not known. They remain the laxatives of choice for opioid-induced constipation.
- **Stool softeners** (e.g. Colace) work by drawing fat and water into the stool, however they have limited clinical efficacy.
- **Lubricant laxatives** (e.g. mineral oil) – lubricate the stool.

Enemas should only be used to prevent fecal impaction in residents with several days of constipation. Sodium phosphate (Fleet) enema is not recommended to be used in patients > 70 years of age due to its association with complications including hypotension and volume depletion, electrolyte imbalances, renal failure and EKG changes.

REFERENCES ON REVERSE SIDE.

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