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WHAT **YOU** NEED TO KNOW

MANAGING CONSTIPATION IN SENIORS

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EDUCATIONAL CAMPAIGN

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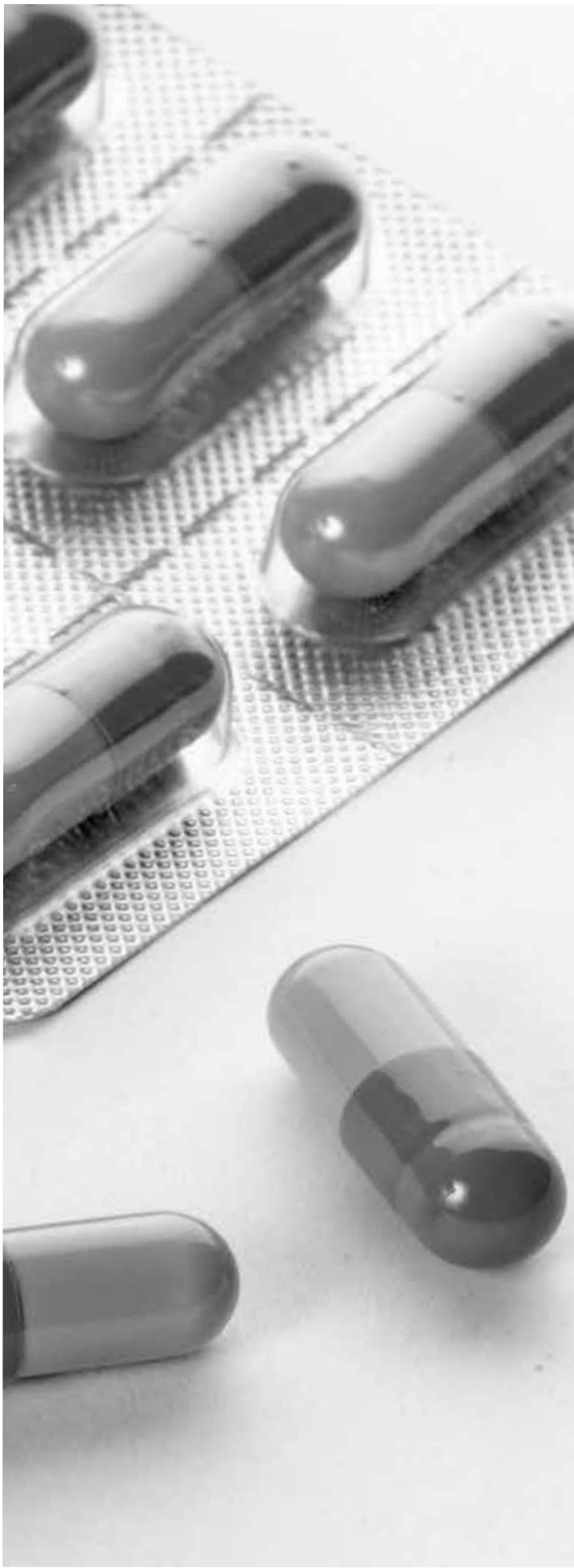
THE PREVALENCE OF CONSTIPATION IN OLDER ADULTS RANGES FROM TWENTY FOUR TO FIFTY PERCENT



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MANAGING CONSTIPATION IN SENIORS

Constipation is a disturbance in bowel habits, manifesting as one or more of the following symptoms: 1) difficulty passing stools, 2) incomplete passage of stools, and 3) reduced frequency of bowel movements (usually less than 3 times a week). It is a common health condition in the general population, but the elderly population is especially at risk. The prevalence of constipation in older adults ranges from 24 to 50%. It can usually be diagnosed based on symptoms and a physical examination. Chronic constipation can be primary (idiopathic) or secondary to medications/diseases. There are 3 types **of primary (idiopathic) constipation:**

1) Normal transit – is the most common type (approximately 60%) of idiopathic constipation. Defecation frequency is normal, but stool is hard/ difficult to pass.

2) Pelvic floor dysfunction (25%) – pelvic floor or external anal sphincter cannot relax. May occur with anal fissures or haemorrhoids.

3) Slow transit (15%) – is characterized by infrequent bowel movements.

A person can have both pelvic floor dysfunction and slow transit constipation at the same time.

Secondary constipation can be the first manifestation of metabolic (diabetes mellitus, hypothyroidism, hypercalcemia, heavy metal intoxication), neurologic, or obstructive intestinal disease. More often, it occurs as a side effect of commonly used drugs. Opioid- induced constipation is common among those who suffer from chronic or cancer-related pain.

WHAT ARE THE RISK FACTORS?

In addition to age, female gender, sedentary lifestyle, low education and income, high number of concurrent medications, comorbid illnesses and nursing home residence are also risk factors for chronic constipation. Ignoring the urge to defecate habituates the rectum to the stimulus of the fecal mass, and contributes to a weaker signal for defecation over time.

WHAT ARE THE SIGNS AND SYMPTOMS?

Some patients mistakenly believe that a daily bowel movement is necessary and that anything less means they are constipated. In fact, the average number of bowel movements for adults and children 3 years old and above varies from 3 daily to 1 every 3 days. Top three most bothersome symptoms of constipation are straining, hard/small stools and bloating. Amongst others are incomplete rectal emptying, infrequent defection, nausea and rectal bleeding. In older adults, constipation may be associated with fecal impaction and overflow fecal incontinence, leading to stercoral ulceration, bleeding and anemia. Additional investigations to rule out other causes (e.g. colon cancer) are required if any of the following alarm symptoms are present: over 50 years of age with new onset of symptoms, blood in stools, significant weight loss, fever and anemia.

HOW IS IT TREATED?

The goal of treatment is to eliminate the symptoms of constipation and return frequency and consistency of stool to previous normal. If constipation is secondary to disease/medications, treating or correcting the secondary cause should be the first step of treatment.

Non-pharmacological treatment: Lifestyle modifications, for example: consuming a high-fibre diet, practicing regular private toilet routine and increasing exercise, are to be considered first in both treatment and prevention of chronic constipation. A daily fibre intake of 20-25g is generally recommended but is rarely achieved by most. 10g a day is often sufficient as a daily minimum goal. Biofeedback and relaxation training to improve coordination of relaxation and pushing during defecation has been used in the treatment of constipation caused by pelvic floor dysfunction, but further well-designed trials are necessary to confirm effectiveness.

Pharmacological treatment:
Laxative use in older adults should be individualized based on the resident's history, comorbidities, drug interactions and side effects. There are 4 basic groups of laxatives: bulk-forming, emollient, osmotic and stimulant.

Bulk-forming laxatives (e.g. psyllium and wheat dextrin) are recommended as first-line in residents who do not respond to non- pharmacological interventions. They increase stool volume and are considered the safest agents for long-term use. 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. A trial of osmotic laxatives (e.g. PEG 3350 and lactulose) should be considered in those not responding to bulk-forming laxatives. They 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 and bisacodyl) are efficacious, but chronic use should be avoided as the long-term safety in the elderly is not known. Electrolyte imbalances and dehydration are associated with continuous daily use. They remain the laxatives of choice for opioid-induced constipation.

Stool softeners (emollients) and suppositories have limited clinical efficacy. 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. Evidence is insufficient to support the safety and effectiveness in using probiotics, natural health products and homeopathy for treatment of constipation.

Other drug classes include μ-opioid receptor antagonists (e.g., methylnaltrexone, naloxegol), prokinetic agents (e.g., domperidone, erythromycin, prucalopride) and guanylate cyclase C-agonists (e.g., linaclotide). The decision to use these agents is based on ethiology of constipation, tolerability, and affordability. μ-opioid receptor antagonists may play a role in opioid-induced constipation without impairing analgesic effects of opioids, but data is lacking among older adults.

SOURCES

1. Bowles-Jordan J. Constipation (Chapter 31), Therapeutic Choices for Minor Ailments, 1st edition. Canadian Pharmacists Association. Toronto, ON. 2013. **2.** Rao, S. S. (2018, May 21). Constipation in the Older Adult (N. J. Talley, Ed.). Retrieved August 3, 2018, from https://www-uptodate-com.myaccess.library.utoronto.ca/contents/constipation-in-the-older-adult. **3.** Kosar, L., & Schuster, B. (Eds.). (n.d.). Management of Constipation. In RxFiles (pp. 60-61). Saskatoon Health Region (SHR). **4.** Routine Bowel Care for Patients in Long-Term or Palliative Care: Guidelines. (2015, December 7). Retrieved August 3, 2018, from https://www.cadth.ca/sites/default/files/pdf/htis/dec-2015/RB0940 Bowel Care in LTC Final.pdf

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