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ELDER CARE

A Resource for Interprofessional Providers

Outpatient Management of Constipation in Older Adults

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Constipation is common in older adults. Up to 28% of individuals over age 65 experience constipation, and it is the reason for more than 2.5 million office visits to primary providers each year in the US.

Although constipation is common in older adults, it should not be considered normal. When evaluating patients who have constipation, clinicians should seek to identify reversible causes with the goal of improving quality of life and avoiding complications that include risk for fecal impaction and incontinence, hemorrhoids, anal fissure, organ prolapse, and bowel obstruction.

Diagnostic Criteria

Patients and clinicians often have different ideas about what is normal when it comes to bowel movements. To help define and diagnose constipation, the American Gastroenterological Association (AGA) refers to otherwise uncomplicated constipation as "functional" constipation and recommends using the Rome III criteria for diagnosis.

The Rome III criteria specify that the first symptoms of constipation should have begun at least 6 months previously and that two of the following must be present for at least 3 months: (a) fewer than three defecations per week or any of the following during at least 25% of defecations: (b) lumpy or hard stools, (c) a sensation of incomplete evacuation, (d) a sensation of anorectal obstruction/ blockage, or (e) the need for manual maneuvers, like digital stimulation. In addition, loose stools should rarely be present and the patient should not meet criteria for irritable bowel syndrome (IBS). A key difference between constipation and IBS is that IBS involves pain relieved by defecation, while constipation by itself is not painful.

History and Physical

Constipation in older adults almost always involves multiple contributing causes (Table 1), all of which should be considered during the evaluation. The history should include questions about medical conditions, medications, prior surgeries, and pelvic floor trauma. Questions should also specifically ask about "red flags," such as acute onset, weight loss, rectal bleeding, and a personal or family history of colorectal cancer, any of which might indicate malignancy as the cause of constipation.

Table 1. Factors That Can Cause or Contribute to Constipation

Medical Conditions	Medications
Anorectal pathology (fissures, strictures, prolapse, hemorrhoids)	Antacids
Cerebrovascular disease	Anticholinergics
Colon Masses/strictures	Antidepressants
Dementia	Antihistamines
Depression	Antipsychotics
Diabetes mellitus	Calcium Channel Blockers
Hypercalcemia	Calcium supplements
Hyperparathyroidism	Diuretics causing dehydration
Hypothyroidism	Iron supplements
Inflammatory bowel disease	Opiates
Multiple sclerosis	**Lifestyle**
Parkinson's disease	Immobility
Spinal cord injury/tumors	Lack of privacy
	Low-fiber diet
	Not responding to urge to defecate
	Poor fluid intake

Additional Testing

The AGA recommends performing a complete blood count, thyroid function tests, and a basic metabolic panel. Colonoscopy should be performed if there is concern about cancer or if the patient is due for routine colon cancer screening. Other tests, such as colonic transit testing, anorectal manometry, and balloon expulsion testing, should only be done when patients fail a therapeutic trial of laxatives and increased dietary fiber.

TIPS FOR DEALING WITH CONSTIPATION IN OLDER ADULTS

- Use the Rome III criteria to diagnose constipation.
- Identify medical conditions, medication side effects, and lifestyle issues as potentially reversible causes of constipation.
- Recommend non-pharmacological approaches including timing of bowel movements in the morning and after meals, increased physical activity, and increased dietary fiber.
- Recommend medications for treatment of constipation only if the response to non-pharmacological approaches has been inadequate.

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Non-Pharmacological Treatment

Medical conditions that may be contributing to constipation should be treated and controlled. Constipating medications should be discontinued whenever possible or changed to agents with similar action but less potential for constipation.

Counsel patients to respond to the urge to defecate when it occurs and to develop a schedule for bowel movements. The bowels are most active in the morning and 30-60 minutes after meals, so patients should be taught to take advantage of these times to use the bathroom. Institutionalized patients should be given enough time and privacy to have bowel movements. Valsalva should be avoided in cardiac patients as it can result in bradycardia and death.

Although increasing mobility is effective for preventing constipation, there is no evidence that it is effective once constipation develops. Similarly, there is no evidence to support fluid status as a factor contributing to constipation. Increasing fluid intake in older adults, many of whom have a delicate fluid balance at baseline, should be avoided.

Dietary fiber, however, is effective and intake should be increased. The increase should occur slowly (over the course of a few weeks) to the goal intake of 25-35 grams daily. Increasing too quickly can result in bloating and flatulence.

Pharmacologic Treatment

There is no good evidence to guide drug treatment of constipation in older adults. Medications are, however, considered appropriate to use when the response to non-pharmacological treatment has been inadequate.

To decrease adverse effects, the choice of laxative should be made with the patient's comorbidities in mind. Table 2 describes available laxatives and gives guidance on how to choose an appropriate agent. Enemas and suppositories should only be used to treat acute constipation. Patients taking laxatives should ensure good fluid intake to avoid dehydration. Those requiring opioids should receive prophylactic bowel regimens to prevent constipation. Lubiprostone, promoted for treating constipation in the general population, has not been studied in older adults

New evidence supports the use of probiotics to prevent constipation in hospitalized patients, but more research is needed before this can be considered standard care. Biofeedback is only effective when treating constipation caused by anorectal dysfunction and is not appropriate for patients with cognitive impairment. Surgery, such as subtotal or total colectomy for treatment of colonic inertia, should only be considered for severe recalcitrant cases.

Table 2. Selecting Laxatives for Constipation in Older Adults

Type of Laxative	Examples	Key Side Effects	What to Consider
Bulk Laxatives	Psyllium Methylcellulose	Bloating, flatulence, impaction above strictures	Can decrease absorption of some medications, including warfarin, aspirin, digoxin
Emollient Laxatives (Stool softeners)	Docusate Sodium Docusate Calcium	Fecal soiling	Not recommended for chronic treatment
Osmotic Laxatives	Polyethylene Glycol	Bloating, flatulence, pulmonary edema	Avoid in patients at risk for aspiration
	Lactulose, Sorbitol	Bloating, flatulence	Recommend for patients in nursing homes
	Magnesium Sulfate Magnesium Citrate	Watery stools, urgency, magnesium toxicity, hyperkalemia	Avoid in patients with renal insufficiency
Stimulant Laxatives	Bisacodyl, Senna	Cramping, gastric and rectal irritation, melanosis coli	Recommended only for short-term use; avoid in patients with bowel obstruction

References and Resources

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