CONSENSUS

Constipation in older people: A consensus statement

Anton Emmanuel1 | Francesco Mattace-Raso2 | Maria Cristina Neri3 | Karl-Uwe Petersen4 | Enrique Rey5 | June Rogers6

Summary

Background and Aims: Chronic constipation is a serious medical condition that affects 30%–40% of people over 60 years old. Although not normally life threatening, constipation reduces quality of life by the same extent as diabetes and osteoarthritis. There are currently no Europe-wide guidelines for treating constipation in older people, although there is some country-level guidance for the general population. We have evaluated the existing guidance and best clinical practice to improve the care of older people with constipation.

Method: European healthcare professionals working in gastroenterology, geriatrics, nursing and pharmacology discussed the treatment of constipation in older people and reviewed existing guidance on the treatment of constipation in the general population. This manuscript represents the consensus of all authors.

Discussion: Most general guidance for constipation treatment recommends increased dietary fibre, fluid intake and exercise; however, this is not always possible in older patients. Although a common first-line treatment, bulk-forming laxatives are unsuitable for older people because of an associated need to increase fluid intake, osmotic laxatives are likely to be the most suitable laxative type for older patients. Treatment is often hampered by reluctance to talk about bowel problems so healthcare providers should proactively identify older constipated patients who are self-medicating or not receiving treatment.

Conclusions: With certain modifications, general treatment guidelines can be applied to older people with constipation, although specific guidelines are still required for this age group. Awareness of constipation, its complications and treatment options need to be increased among healthcare providers, patients and carers.

1 INTRODUCTION

1.1 Background

The median prevalence of constipation is estimated to be 16% in adults overall and 33.5% in those aged 60–101 years,1 and yet the precise symptoms of constipation are ill defined.2 While patients associate constipation with both infrequent bowel movements and difficult to pass stools, physicians prioritise the former only when diagnosing constipation.3 It was these generally contrasting views that led to the development of the Rome Diagnostic Criteria, which have become the most widely used clinical definition of constipation.4,5 It is believed that the increased prevalence of constipation in older people is not caused by age-related physiological changes; a healthy older person is as likely to experience constipation as a young person.6,7 Reduced physical activity and polypharmacy are a major cause of constipation in older people.8–10 Unfortunately, it is not always possible to reduce the number of medications an older person receives nor is it always possible to increase their levels of physical activity; this highlights the importance of effective pharmaceutical intervention to treat constipation in older people. Chronic constipation is a particular problem in nursing home residents, where over 50% experience regular symptoms.11
Although constipation is not normally life threatening, its impact on quality of life of those suffering with the condition can be as great as the impact of other common chronic conditions like diabetes and osteoarthritis. An increased risk of psychological and social distress is also seen in people over 60 years who are playing a less active societal role. The seriousness of constipation and its high prevalence has the potential to place a considerable burden on healthcare resources; for example, in England between April 2013 and April 2014, there were 63,427 patients admitted to hospital with constipation and this accounted for 159,997 bed days. Given that the average cost of a single bed day (excluding treatment and procedure costs) is £303 (~€375) to the UK National Health Service, there is an undeniable economic case for identifying and treating constipated patients before they require hospital admission. A recent comparative survey suggests that prevalence of constipation is similar in France, Germany and Italy.

If constipation is not treated effectively, it can result in faecal impaction, which may require emergency hospitalisation. In England in 2014, 792 patients aged 60 years and over were admitted to hospital for manual evacuation of impacted faeces; this age group represented 68% of all adult admissions for this procedure. Mean hospital stay for patients with impaction was 7 days.

Appropriate management requires timely recognition of the symptoms and ensuring complete rectal emptying it is possible to reduce the frequency of faecal incontinence. Improperly diagnosed ‘overflow’ incontinence resulting from impaction can also be a key trigger of nursing home admission. The potential for confounded diagnosis leading to inappropriate measures and treatment failure (or even a deterioration) once more underlines the importance of an appropriate handling of chronic constipation in older people.

1.2 | The need for a consensus statement

Although several organisations have produced treatment guidelines that address chronic constipation in the general population, there are no guidelines that specifically describe how to manage the condition in older people. It was recognised by the consensus panel that the lack of clear advice on the best way to manage constipation in older people is a serious oversight, particularly in light of how frequently it occurs in this population and its potential to markedly impact on patient’s quality of life. To address the lack of guidance, this consensus statement was developed to evaluate the existing guidelines with respect to the unique challenges that older people face.

It was recognised that there is an urgent need to increase awareness of constipation both in terms of prevalence and impact as well as potential for treatment response. Patients and healthcare providers alike need to know the importance of early treatment to prevent the rare but serious complications. This consensus statement proposes methods that could be adopted to improve patient’s quality of life and reduce the economic burden of constipation.

What's Known
- Chronic constipation is a disorder that disproportionately affects older people; however, no clear pathophysiological reason for this has been identified.
- Untreated constipation can eventually lead to inpatient hospitalisation and increases the risk of impaction and faecal incontinence.
- Despite its high prevalence in older people, there are no treatment guidelines specific to this population at a national or European level.

What's New
- A panel of experienced healthcare professionals used their clinical expertise to evaluate the existing treatment guidelines for constipation and apply them to the treatment of constipation in older people.
- Based on existing guidance and their own clinical experience, the panel also proposed methods that will allow healthcare providers to identify patients with untreated constipation and enable treatment before they require admission to secondary care.

2 | METHODS

Six healthcare experts attended a face-to-face meeting in October 2015. A list of 12 candidates from across Europe was originally created and narrowed down to 6 based on availability to attend. Selection for inclusion on the panel was based on experience in gerontology and constipation in hospital, care home and community settings. The panel consisted of experts from five European countries (Germany, Italy, the Netherlands, Spain and the UK) and came from a variety of backgrounds (gastroenterology, nursing, geriatrics and pharmacology). Each member of the panel had significant clinical experience of treating older people with constipation. Several panel members also had a background in clinical research and guidance development. Before the meeting, attendees voted to determine the priority of discussion topics and an agenda was created. At the meeting, participants discussed, in structured form, their understanding of how constipation is addressed in their own country, their own experience of treating constipation and ways they thought that treatment could be improved. The day’s discussion was summarised in a comprehensive set of minutes and these were used to compile a list of consensus points, which were approved by the meeting participants. The group also provided their most relevant local treatment guidelines and these were evaluated along with guidelines from countries not represented in the meeting. This local guidance was supplemented with the group's consensus on best practice advice based on literature and experience. The minutes, consensus points and treatment guidance were then used to prepare this manuscript. All panel members were involved in the writing, review and approval of the manuscript.
3 | DISCUSSION

3.1 | Constipation is a serious problem for older people

There is a widely held belief among the public that constipation is related to lifestyle factors such as poor diet and lack of exercise\(^{31}\) and people often change their lifestyle before seeking drug treatment.\(^{15}\) However, there is little evidence to support lifestyle being the main cause of constipation, or indeed that behavioural change will alleviate symptoms.\(^{32}\) Increasing dietary fibre is often recommended. Although this approach can relieve symptoms in some people, in others it can make constipation worse and/or cause additional discomfort through bloating, flatulence or distension.\(^{32-34}\) Reduced physical activity is also implicated in constipation. However, it is generally considered to be only one of several causative factors in older people as simply increasing mobility does not provide relief from symptoms.\(^{32}\) Importantly, reduced physical activity in older people may be the result of poor mobility and frailty making it not possible for them to exercise.

3.2 | Review of existing guidance

Although there are no formal European-level guidelines for the treatment of constipation in older people, several countries have issued guidelines incorporating guidance that can be applied to older people and how the information pertains to older patients is summarised below. To facilitate understanding, the passages addressing older patients have been italicised.

3.2.1 | United Kingdom

The UK’s National Institute for Health and Clinical Excellence (a public body that develops clinical guidelines) has issued separate clinical recommendations for the treatment of constipation in adults and children, but no guidelines have yet been issued for older people.\(^ {28}\) In the guidelines addressing constipation in adults, healthcare providers are recommended to inform patients of the importance of dietary fibre, fluid intake and exercise and to identify any medication that the patient may be taking that could cause constipation. Patients should be reminded that defecation should be unhurried and that they should attempt to defecate soon after waking or within 30 minutes of a meal. Particularly relevant to older patients is the recommendation that people with limited mobility should have sufficient access to carers such that they can quickly respond to the urge to defecate.

Where symptoms are refractory to these behavioural changes, the recommended first-choice laxative is a bulk-forming laxative; however, the guideline specifically notes that the necessary increase in fluid intake might make this unsuitable for older people. Osmotic laxatives are the recommended alternative to bulk-forming laxative with macrogol preferred over lactulose. In the event that stools continue to be difficult to pass despite being soft, the guidelines advise that a stimulant laxative should be administered with the osmotic laxative.

During the discussions that took place as part of the development of this consensus statement, it was noted that clinical experience in the UK suggests that sodium docusate is a good first-choice laxative for initial treatment of older people. In the event that sodium docusate is ineffective, an osmotic laxative should be used with macrogol as the first choice. It was also proposed that if stools are softened by laxative treatment but are still difficult to pass, a glycerine suppository, stimulant laxative or a microlax enema should be considered in that order of preference unless rectal administration is not acceptable for the patient or carer.

The guidelines also describe a detailed approach for the treatment of impaction. In the event that the impacted stool is hard, a high, escalating dose of oral macrogol should be used. An oral stimulant laxative is recommended when this approach is found to be ineffective, or if stools were soft to begin with. If an oral laxative treatment fails to resolve impaction, suppositories (bisacodyl for soft stools and glycerol with or without bisacodyl for hard stools) or a docusate or sodium citrate enema should be considered. If these first-choice enemas do not succeed, sodium phosphate or arachis oil enemas should be used. Clinical experience in the UK has found this approach to be suitable for older people.

3.2.2 | Germany

In Germany, a guideline on pathophysiology, diagnosis and treatment of chronic constipation in the general population was written based on a systematic literature search.\(^ {26}\) Participating experts were selected by the German Society of Neurogastroenterology and Motility and the German Society for Digestive and Metabolic Diseases in cooperation with four further medical societies.

The guideline suggests that frequently cited pathophysiological factors such as a low-fibre diet, insufficient fluid intake and lack of mobility may aggravate existing constipation, but have not been proven to cause constipation; therefore, measures to correct such deficiencies are of unclear benefit. Nonetheless, patients should be advised to increase dietary fibre, aim to drink 1.5–2 L of fluid per day, maintain a level of exercise appropriate for their age and avoid habitual voluntary stool restraint. If lifestyle changes and bulk-forming laxatives like psyllium prove insufficient or intolerable, further medical therapy should be considered.

The guideline recommends macrogol, bisacodyl and sodium picosulfate as first-choice treatments. The recommended second-line treatments are anthrachinones and sugars/sugar alcohols (lactulose, lactitol, sorbitol and, depending on the individual disposition, lactose). Further possibilities are combinations of the aforementioned measures, suppositories (eg, bisacodyl) and, as a temporary measure only, enemas. Salinic laxatives, such as magnesium hydroxide, are not recommended for chronic constipation because of possible adverse effects. Paraffin oil is not recommended because of the risk of lipid pneumonia secondary to microaspiration and disturbed absorption of lipid-soluble vitamins. Prucalopride is recommended for use only where lifestyle changes and conventional therapy have been unsatisfactory or intolerable. Where available, lubiprostone and linaclotide...
can be used to treat prucalopride-resistant constipation; the development of patient-specific treatment regimes is encouraged.

Opioid-induced constipation can be treated using opioid antagonists. Methylnaltrexone is mentioned in guidelines but it has the disadvantage of requiring subcutaneous administration. Further antagonists are alvimopan and oral naloxone. It should be noted that since the guideline was published, naloxegol, a pegylated naloxone derivative, has been approved.

In addition, guidelines for the treatment of constipation in a palliative care setting have been published by the Leitliniengruppe Hessen (Hesse Guidelines Group) under the auspices of Kassenärztliche Vereinigung Hessen (Hesse Association of Statutory Health Insurance Physicians). Although based on experience and textbooks rather than published evidence, their merit is the special focus they take. Patients in palliative care often experience frailty, immobility, polypharmacy and decreased fibre and fluid intake. In many ways, this makes them comparable with older people from the point of view of constipation and its treatment. The guidelines recommend that the first stage of treatment should involve an increase in fibre, fluids and exercise. However, if these lifestyle changes are difficult to make because of a patient’s condition, therapeutic intervention is recommended. In the first instance, therapies based on macrogol with electrolytes are advised because they rarely cause bloating and they maintain electrolyte balance. In the event of a hardened stool, stimulant laxatives with the possible addition of lubricants should be used with manual removal considered a last resort. For patients who cannot swallow, rectal administration of bisacodyl or glycerol is recommended. Germany is clearly well served with treatment recommendations, although it emerged during discussions that they differ slightly from the developing consensus emerging from the meeting. As far as old people are addressed, treating physicians serving retirement and nursing homes are believed to prefer lactulose over osmotic laxatives (with electrolytes) or stimulant laxatives.

3.2.3 | Italy

The Italian Association of Hospital Gastroenterologists and the Italian Society of Colo-Rectal Surgery published an evidence-based consensus statement on the diagnosis and treatment of chronic constipation and obstructed defecation in adults. The authors found no evidence that constipation can be effectively treated by increasing physical exercise and improving defecation habits; increased fluid intake is recommended only if a patient is dehydrated. The guideline awards the highest grade of recommendation (Grade A) to macrogol, tegaserod and prucalopride. Psyllium, lactulose, lubiprostone and linaclotide receive a Grade B recommendation.

Experience from Italy suggests that treatment of older people with constipation should begin with a thorough review of the patient’s medications. If any constipation-causing medications are identified, the aim is to replace them with alternate therapies where possible. If this is not possible or fails to resolve the constipation, patients who are consuming less than 30 g of soluble fibre per day should aim to increase their intake to this level gradually. In addition, patients should be educated on recognising and responding to the urge to defecate and, to benefit most from the gastrocolic reflex, visits to the toilet should be routinely scheduled soon after waking and after meals. Elevating the feet with a foot stool and, if possible, abdominal and pelvic floor muscle-strengthening exercises may provide additional help with defecation.

It is generally considered that when patients fail to respond to fibre supplementation, osmotic laxatives such as macrogol should be used, with the dose titrated until a clinical response is achieved. Syrup-based formulations are particularly well tolerated by dysphagic patients. In patients with more refractory constipation, stimulant laxatives (bisacodyl, senna) and prokinetic agents (prucalopride 1 mg/dL) or secretagogue drugs (such as linaclotide, which improves intestinal transit and abdominal pain) should be used, if necessary in conjunction with osmotic laxatives. In patients with pelvic floor dysfunction, periodic hydrocolontherapy or once- or twice-weekly enemas are considered effective. Where patients have no cognitive impairment and demonstrate ano-rectal muscular integrity, biofeedback therapy can be effective in patients with pelvic floor dysfunction or faecal incontinence.

For residents of nursing homes (a location relevant to older patients), a daily stool diary should be maintained with a record of stool profile as described by the Bristol stool scale. It is important for the nurses who have daily contact with patients to co-ordinate their activities with attending physicians, especially in residents who are not able to report symptoms. Attention from a dietician may also be beneficial. Macrogol should be used as the first-line therapeutic intervention with dose titrated according to patient response. After 3 days without a bowel movement, a rectal exam should be conducted followed by a tap water enema. A combination of osmotic laxatives with stimulant or prokinetic laxatives (bisacodyl/senna or prucalopride) is also considered to be effective in nursing home residents suffering with constipation. A technical aid in the management of constipation that has been shown to have some effect in older people is an abdominal massage, which can increase the frequency of bowel movements and decrease discomfort in patients with constipation.

3.2.4 | The Netherlands

Dutch guidelines, derived by a Delphi approach to sampling opinion and experience, have been issued by the Nederlands Huisartsen Genootschap (Dutch College of General Practitioners) for the treatment of constipation in the general population. The guidelines recommend lactulose or macrogol as first-line treatments and note that macrogol with electrolytes is as effective as macrogol without electrolytes. Macrogol with electrolytes is recommended for treating faecal impaction. If a patient does not tolerate a treatment—eg., they experience bloating or dislike the taste—the healthcare professional should select another treatment.

3.2.5 | Spain

Spanish guidelines for the treatment of constipation in the general population were developed using an evidence-based approach and
released in 2016.29 The guideline recommends that after drug-related or medical causes of constipation have been ruled out, patients should be encouraged to increase consumption of soluble fibre and fluids and take regular exercise. If this is not possible or is ineffective, osmotic laxatives are recommended as the first-line treatment with the guidelines noting the stronger evidence base for the use of macrogol over lactulose. Stimulant laxatives should be used as a recourse medication for non-responders. When laxatives fail to produce a satisfactory relief of symptoms, prucalopride is recommended as an alternative. A functional study by a gastroenterologist is required if none of these treatments are effective. Clinical experience in Spain indicates that these general guidelines would be suitable for the treatment of older patients.

3.2.6 France

In France, general treatment guidelines have been issued by the Société Française de Gastroentérologie (French Society of Gastroenterology).22 The authors took a systematic, evidence-based approach, which considered 722 different articles. The guidelines recommend that the first step of any treatment should be for healthcare professionals to remind patients of the importance of maintaining regular toilet habits and to establish that patients are allowing sufficient time for bowel movements and that they have enough privacy. The guidelines also cite a study in older people reporting that the use of a footstool while on the toilet improves stool movement through the anal canal. The guidelines do not find sufficient supporting evidence to recommend increased hydration and increased physical activity. A gradual increase in dietary fibre intake is suggested, although the guidelines mention that it may only have a modest impact.

The first-line therapeutic interventions recommended by the guidelines are osmotic laxatives (macrogol, lactulose or milk of magnesia) and bulk-forming laxatives (psyllium, ispaghula, sterculia gum and bran). No single laxative is identified as a first-choice treatment. Stool softeners are recommended as a second-line treatment, although the guidelines note the propensity of mineral oils to increase the risk of faecal incontinence and anal seepage, and the possibility that they may leech lipid-soluble vitamins A, D, E and K. The guidelines also mention that elderly patients may be at risk of complications caused by choking on orally administered oils. Stimulant laxatives are recommended for use only when other treatment options have failed; however, their usefulness in especially frail elderly patients is noted. For certain older patients or patients with neurological diseases suppositories and enemas are proposed.

3.2.7 Canada and USA

Although Canada and the USA are not represented on this panel, important messages can be derived from published consensus statements and guidelines. A Canadian consensus group was assembled to evaluate the literature and produced a statement on the treatment of constipation in the general population.21 The group concluded that there was insufficient evidence to support increased fluid intake or increased exercise to relieve constipation, although they supported the use of increased fibre intake. It is noted, however, that older patients may already have especially low fluid intake and that this should be increased. The findings of this literature-based exercise were similar to those of the Société Française de Gastroentérologie.22 Initially, it is recommended that patients are educated on bowel function followed by a gradual increase in dietary fibre. Should this be ineffective, osmotic laxatives are recommended followed by glycerine-based suppositories if necessary. A specific osmotic laxative is not recommended, although the guidelines note that milk of magnesia is cheaper than macrogol. However, the guidelines also highlight the gas-producing effect of lactulose and the fact that there have been no long-term studies of the effectiveness of lactulose or milk of magnesia.

The American Gastroenterological Association has also published a set of guidelines for the treatment of constipation in the general population.27 In common with several other guidelines, they recommend increased fibre as the initial treatment. As a first-line treatment, they recommend an inexpensive osmotic agent with milk of magnesia and macrogols given as examples.

3.3 Precis of national guidance documents

3.3.1 Awareness of constipation

The perception that chronic constipation is not in itself a treatable medical condition leads to under-reporting and this is compounded by the fact that many older people consider bowel health a private matter and find it difficult to discuss.6 Consequently, many patients resort to self-medication and therefore do not benefit from the expertise of healthcare professionals.9,38

To circumvent the self-imposed social stigma associated with constipation, the authors recommend that healthcare providers should proactively identify patients with constipation who are not receiving appropriate treatment. In older patients, this could be addressed by asking few short questions at routine health visits that would allow healthcare providers to determine if any treatment is required. The questions could be as simple as “are you happy with your bowels?”, “how long do you spend on the toilet?”, “do you ever need to strain on the toilet?”, “how frequent are your bowel movements?” and “do you use any medication for your bowel?”. Alternatively, questions that are more general could be asked such as “do you have any problems with your bowels?” or “do bowel symptoms prevent your enjoyment of any part of life?”. Introducing patients to the Bristol stool scale may also assist in the discovery of undiagnosed constipation. Where a healthcare provider thinks that a patient might be constipated, they can ask further questions and decide on an appropriate intervention.

To encourage patients who self-medicate to seek professional advice, a partnership with pharmacists would be useful. For example, when a patient buys an over-the-counter constipation treatment, the pharmacist should ask a simple question such as “how long have you been using this?”. If the answer is longer than 3 months, the pharmacist should recommend an alternative treatment or encourage the patient to seek further advice from a healthcare provider.
One final group of older people with constipation who may prove difficult to identify are older people with communication difficulties. In the opinion of the authors, stool diaries and digital rectal examination could be used with the goal of identifying constipation before patients require treatment for impaction. As discussed above, preventing impaction is likely to reduce the occurrence of faecal incontinence; this is important on many levels because it can have a substantial negative impact on the dignity of patients and increases the workload of nursing home staff.

To better emphasise the need for proactive identification of patients suffering with constipation, the economic aspects of constipation need to be thoroughly considered. Only through the collection and reporting of robust patient outcome data will it be possible to encourage general practitioners to think in terms of long-term secondary care costs instead of short-term prescribing costs. To date, there has been almost no research into the secondary care costs of untreated constipation, although a report by the company Coloplast determined that constipation cost UK hospitals £145 million (£179 million) in 2014/15.

Some research has reported on the estimated economic value of macrogol over lactulose, but the research only considers the basic costs of the treatments and does not evaluate the cost of secondary care that can arise from complications.  

### 3.3.2 Drug therapy

Osmotic laxatives are considered to be the most effective treatment in the general population and this is reflected by their recommendation as a first-choice laxative in general treatment guidelines in Germany, the Netherlands, Spain, France, Canada and the USA. In the panel’s view, this preference also suits elderly patients. In contrast, the UK’s National Institute of Clinical Excellence guidelines recommend bulk-forming laxatives over osmotic laxatives, although they note that the increased fluid intake required by patients receiving bulk-forming laxatives may make them unsuitable for older people.

Several clinical trials have demonstrated the effectiveness of osmotic laxatives in this population. For example, lactulose has been shown to reduce constipation-associated symptoms in older people and the clinical effectiveness of macrogol with electrolytes has been demonstrated in older people with Parkinson’s disease.

The relative effectiveness of lactulose and macrogol in the general population was recently evaluated in a Cochrane review. The review considered data from ten clinical trials and concluded that, overall, macrogol increased stool frequency and improved stool form. As well as the clearer efficacy of macrogol over lactulose, there are also reports of bloating and flatulence when lactulose is metabolised by gut flora—something that impacts on treatment tolerability and patient’s quality of life.

### 4 CONCLUSIONS

The bowel health of older people has the potential to have a marked impact on their overall quality of life; unfortunately, it is something that many people are uncomfortable discussing. For this reason, constipation often goes untreated, which increases the risk of impaction and incontinence. This consensus statement underlines how the healthcare community is here failing older people. It draws attention to the social and economic importance of effective constipation treatment and includes suggestions for healthcare providers to identify patients who are unsuccessfully self-medicating or not seeking treatment. It provides treatment guidance for older people, which is derived from general evidence-based treatment guidelines that have been produced by respected national authorities. The authors hope that this work will serve as a ‘call to action’ to those working with older people to develop guidelines, especially where they do not already exist, that address the challenges posed by the condition.

### 4.1 Consensus statements

Figure 1 shows a simple treatment flowchart that summarises the panel’s recommendations for treatment of constipation in elderly patients. These recommendations take the discussed local guidelines into account; while they are in agreement for the most part, they emphasise the special circumstances of constipation in this age group. The panel also decided to describe specific treatment scenarios with particular relevance to the elderly people in separate flows, rather than integrating them in the main chart.

For emphasis and further detail, written consensus statements are given below, with reference to local guidelines and published reviews, and, where appropriate, to the panel’s experience.

- Need to increase awareness of constipation, both in terms of the prevalence and patient impact as well as the potential for treatment response.
- Lifestyle modification rarely alleviates symptoms of chronic constipation, and is rarely feasible in the elderly people, where enhanced fluid intake may collide with cardiac disease and increased mobility with frailty (panel experience).
- Defecation should be unhurried and patients should attempt to defecate soon after waking or within 30 minutes of a meal.
- Increased fibre consumption may improve symptoms in some patients, but can cause additional discomfort through bloating or flatulence.
- Osmotic laxatives (macrogol) are usually first-choice; macrogol is preferred over stimulant laxatives (mostly because of the latter lacking studies in the older people) and lactulose citation.
- The panel agreed that their general experience conformed with the NICE position that an alternative to soften the stool is sodium docusate (initial measure) and that if stools are soft but difficult to pass, the alternatives are as follows: (i) a glycerine suppository, (ii) a stimulant laxative or (iii) a microlax enema.
- In laxative-refractory patients, prucalopride is indicated, which has been successfully studied in elderly patients. Lubiprostone is an alternative, but not widely available and still awaiting robust trials in the elderly people, which is also true of linaclotide.
The panel agreed that their experience suggested that in faecal impaction the stools must be softened, with titrated macrogol if stools are hard, and supplemented with a stimulant laxative once softened. If rectal evacuation remains difficult, a stimulant suppository is first-line over an osmotic enema.24,28

In opioid-induced constipation, a peripherally acting \( \mu \)-receptor opioid antagonist such as naloxegol should be considered early enough, taking into account that the benefit of conventional measures is limited in a large number of patients, with particular relevance to the elderly patients.53

### 4.2 Potential benefits of the consensus statement

The principal aim of this consensus exercise was to evaluate the current guidance on the treatment of constipation, comment on its applicability to older people and devise advice that may improve patient care and reduce the likelihood of patients requiring expensive secondary care for complications such as faecal impaction. In short, people need to know that they can be happy with their bowels with the help of healthcare professionals. It is anticipated that patients who receive guidance that successfully manages their symptoms will be encouraged to seek treatment for similar problems in the future and thus experience long-term improved bowel health.

**DISCLOSURES**

Anton Emmanuel has provided consultancy services to Allergan, Almirall, Coloplast, Hollister, Norgine, Shionogi, Shire, Takeda and Wellspect. Karl-Uwe Petersen has acted as an expert adviser to and received honoraria from Hexal, Norgine and Novartis. Enrique Rey has received research funds from Norgine, Almirall and Allergan.

**AUTHOR CONTRIBUTIONS**

AE, FMR, MCN, KUP, ER and JR attended the consensus meeting and contributed to writing and critical review of the manuscript. JR chaired the meeting.

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