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Constipation in Older People Pharmacological Management Issues

Michael C Woodward

ABSTRACT

Constipation is a common complaint amongst older people although they are often concerned about features of constipation other than bowel action frequency. A careful assessment should be made, including a history, examination and appropriate investigations. Non-pharmacological management often avoids the use of laxatives and includes adequate fibre, fluid and exercise.

The laxatives most appropriate for older people include stimulants such as senna, bulking agents and osmotic agents such as polyethylene glycol plus electrolytes or sorbitol. Short-term use is nearly always sufficient. Faecal impaction should be sought and managed before giving oral agents. Enemas and suppositories are usually appropriate for impaction and for excessive straining. Management of constipation with these measures will avoid long-term use and abuse of laxatives.

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INTRODUCTION

Constipation is not often regarded as a major therapeutic issue, but the use and abuse of laxatives by older people is highly prevalent. It is important for clinicians to have an understanding of the importance of constipation to older people, and of ways to improve laxative usage. This article will review the range of laxatives available, their efficacy and adverse effects, and practical issues in the correct use and withdrawal of laxatives. Readers are referred to reviews¹⁻⁴ for causes, assessment and complications of constipation.

PREVALENCE

Constipation is a common complaint amongst older people and a frequent concern for their healthcare providers in hospitals, long-term care settings, clinics and community practice. Patient self-report may overestimate the prevalence of constipation. For instance, a community study of 3000 people over the age of 65 found that 34% of women and 26% of men complained of being constipated,⁵ and a day hospital study reported that 55% complained of constipation.⁶ However, several studies have

shown no reduction in the frequency of bowel movements with normal ageing.⁶⁻¹¹ Among the elderly who do complain of constipation, 52–65% report bowel movements at least once daily, and only 2–7% describe moving their bowels on no more than two occasions per week.⁸⁻¹² Furthermore, laxative use in these subjects has been shown to be similar in individuals with and without infrequent bowel movements, making laxative dependence an unlikely explanation for the normal stool frequencies seen in community-dwelling elderly people with self-reported constipation.¹²

This overestimation of constipation in older people may result from differing definitions of constipation—older people are more likely to regard straining, passage of hard stools or a feeling of incomplete evacuation as due to constipation, but most definitions of constipation used in studies refer to bowel action frequencies. Additionally, older people may be overly concerned and more easily distressed by bowel action changes—a legacy of being brought up in an era where regular bowel actions were felt essential to good health, and any deviation led to a dose of castor oil or similar. Psychological distress has been shown to be associated with complaints about constipation in older people living at home.⁶

Laxative Use

Whatever the explanation, this concern with constipation is undoubtedly a major reason behind the high usage of laxatives in older people. Laxatives are the second most commonly acquired ‘over-the-counter’ medication by older people,¹³ with a third using them at least weekly.¹² But self medication is not the sole reason for extensive laxative use by older people—76% of hospitalised elderly patients and 74% of nursing home residents are prescribed at least one type of laxative.^{10-12,14} This high usage is not confined to those who consider themselves constipated—between a fifth and a third of regular laxative users do not consider themselves constipated,^{6,9} many taking laxatives in a misguided belief in the benefits of regular purgation.

ASSESSMENT

A full assessment is required when there is complaint of constipation, or laxatives are being used. A complete history should be taken including relevant details as outlined in Table 1, a physical examination performed and, on occasions, investigations arranged.^{3,4} At the very least, most patients should have abdominal palpation, a

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Table 1. Relevant details in the history

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- Past anorectal or bowel disease or surgery
 - Other illnesses
 - Diet and fluid intake
 - Mobility
 - Duration of episodes of constipation
 - Frequency of bowel actions
 - Character of stool (colour, volume, consistency)
 - Straining
 - Pain on defaecation
 - Faecal incontinence
 - Laxative use
 - Other medications (including non-prescribed medications)
-

rectal examination, and an abdominal X-ray. The purpose of this assessment is to exclude the reversible or more serious causes of constipation, which are included in Table 2. Many of these causes are more prevalent in older people, but age alone is not a cause of constipation. Constipation is associated with numerous complications (Table 3), so prompt assessment is appropriate.

NON-PHARMACOLOGICAL MANAGEMENT

Once constipation has been assessed, even if it is decided that the patient is not actually constipated, it is important to educate the person as to what constitutes normal bowel habit, correcting common misconceptions. Many patients are relieved to hear that between three bowel actions a week, and three a day, is normal, as is occasional straining and a variation in the amount and consistency of faeces passed. Toileting habits should be discussed, emphasising the need for sufficient time, comfort and privacy, particularly in institutional settings. Individuals should be encouraged to attempt defaecation half an hour following breakfast or other meals to take advantage of the gastrocolic reflex. Where straining is predominant, care should be given to treating haemorrhoids or other anorectal lesions, and where possible, elevating the legs whilst seated on the toilet so as to facilitate effective use of weakened abdominal and pelvic floor muscles—a moulded standing stool placed around the toilet is available for this.

The essentials of healthy bowel function should be attended to—these are adequate fluids, fibre and exercise. These approaches, described below, may take up to several weeks to be effective.

Fluids

Unless contraindicated, older people should be reminded to drink at least 6–8 glasses (1500 mL) of fluid daily. Increased fluid intake may be achieved through a jug of water being freely accessible beside the bed for institutionalised patients, and provision of soups, jellies and frozen ices. Fluid intake may need to be higher over summer and for those on diuretics who have a stable cardiovascular status.

Fibre

Whilst 15–20 g of fibre is adequate, many sources recommend 30–35 g per day. Dietary sources include bran, wholegrain breads, cereals, pasta and rice (especially brown rice), fruits, vegetables and legumes, and seeds and nuts. Fibre facilitates bowel actions by increasing faecal mass and reducing intestinal transit time. It also

Table 2. Causes of constipation in older people

Diet

- Reduced food intake
- Reduced fibre
- Reduced fluid

Limited mobility

- Illness
- Pain
- Sedentary lifestyle

Limited access to toilet

- Inconveniently located toilet
 - Uncomfortable toilet
 - Lack of privacy
 - A long journey
- (these all cause voluntary suppression of defaecation reflex)

Medications

- Opiates
- Anticholinergics
 - antispasmodics
 - antidepressants (tricyclics)
 - antipsychotics
 - antiparkinsonian medications
- Drugs that contain cations
 - iron
 - aluminium (antacids, sucralfate)
 - calcium (antacids, supplements)
- Neurally active agents
 - antihypertensives (some)
 - calcium channel blockers (some e.g. verapamil)
 - anticonvulsants
- Diuretics
- Anti-inflammatories
- Miscellaneous agents
 - octreotide
 - polystyrene resins
 - cholestyramine

Metabolic and endocrine causes

- Hypercalcaemia
- Hypokalaemia
- Hypothyroidism
- Porphyria

Gut lesions

- Irritable bowel syndrome
- Obstruction
 - carcinoma
 - volvulus
 - stricture
- Aganglionosis
 - primary (adult onset is rare)
 - acquired (may be due to laxatives)
- Diverticular disease (may be caused by constipation)

Anal lesions

- Painful lesions
- Fissures
- Haemorrhoids

Neurogenic causes

- Spinal cord lesions
- Multiple sclerosis
- Parkinson's disease
- Shy-Drager syndrome
- Stroke

Depression or isolation

- Direct effect of depression
- Increased preoccupation

States of confusion

- Dementia
 - Delirium
-

Table 3. Complications of constipation

Gastrointestinal
• Impaction
• Obstruction
• Megacolon
• Faecal incontinence
• Rectal distension
• Rectal prolapse
• Haemorrhoids
• Anorexia and vomiting
Urological
• Retention
• Incontinence
• Urinary infection
Cardiac and vascular
• Arrhythmias
• Vasovagal episodes
• Angina
• Pulmonary emboli
Other
• Delirium
• Laxative abuse
• Anxiety

provides a substrate for colonic bacteria, with the production of gases and short chain fatty acids that increase stool bulk. The increased bacterial numbers themselves contribute to stool bulk.

Fibre is not effective without adequate fluids, and is contraindicated in patients with faecal impaction or colonic dilatation. The salt content of processed breakfast

cereals varies widely (the more palatable are often the saltiest), so large amounts may be unsafe in patients with cardiac disease, renal impairment or hypertension.

Exercise

This may be as simple as a daily walk or even standing up for those who are otherwise bed-bound.¹⁵ Indeed, bed-bound people may benefit from being helped to the toilet or commode, rather than being offered a bed pan, and may also benefit from abdominal massage.

LAXATIVES

Where non-pharmacological therapy has failed, laxatives may be needed. Whilst a large range of oral laxatives, suppositories and enemas are available, there have been relatively few new medications developed in recent years. Those available can be categorised as shown in Table 4. The mechanism, efficacy and adverse effects of the drugs in these classes vary widely and warrant further discussion.

Bulking Agents

Some of these are extracted from natural sources such as seeds, bark and gum, and some are synthetic compounds such as methylcellulose. These agents work similarly to dietary fibre, itself a bulking agent. They may have additional actions—psyllium, for instance, also lowers cholesterol. As with dietary fibre, they must be taken with adequate fluid.

Adverse effects also shared with dietary fibre include bloating and flatulence which may discourage the older patient from continuing with them. However, these

Table 4. Examples of oral laxatives and enemas and suppositories

Type	Products	Time to onset
Oral agents		
Bulking agents	• Psyllium (Agiofibe*, Agiolax*, Metamucil*, Mucilax, Nucolox)	2-3 days
	• Ispaghula (Fybogel, Agiofibe*, Agiolax*, Metamucil*)	2-3 days
	• Methylcellulose (Cellulone)	2-3 days
	• Sterculia (Granocol*, Normacol Plus*, Normafibe)	2-3 days
Stool softeners	• Docusate Sodium (Coloxyl tablets, Sennesoft*)	1-3 days
Stimulants and secretagogues	• Senna (Agiolax*, Bekunis Senna Tablets, Coloxyl with Senna*, Laxettes with Senna, Sennesoft*, Senokot)	8-12 hours
	• Phenolphthalein (Figsen laxative tablets, Laxettes)	6-12 hours
	• Bisacodyl (Bisalax, Durolox)	6 hours
	• Frangula (Granocol*, Normacol Plus*)	2-3 days
Osmotic laxatives	• Lactulose (Actilax, Duphalac, Lac-Dol)	24-48 hours
	• Sorbitol (Sorbilax)	6-12 hours
	• Polyethylene glycol plus electrolytes (Colonlytely, Glycoprep, Golytely, Movicol)	6-12 hours
	• Magnesium sulphate (Epsom Salts)	1-3 hours
	• Soda buffered saline laxative mixture (Kwikprep, Fleet)	6-12 hours
	• Sodium picosulphate (Picolax*)	6-12 hours
Lubricants	• Paraffin liquid (Parachoc, Agarol)	6-12 hours
Prokinetic drugs	• Colchicine (Colgout)	4-6 hours
	• Misoprostol (Cytotec)	4-6 hours
	• Cisapride (Prepulsid)	6-12 hours
Enemas and suppositories	• Docusate and bisacodyl (Coloxyl Suppositories)	minutes
	• Bisacodyl (Durolox, Fleet)	minutes
	• Glycerol (Glycerin Suppositories, Glycerol Suppositories)	minutes
	• Sorbitol and sodium salts (Fleet Micro-Enema, Microlax)	minutes
	• Soap and water	minutes
	• Phosphate (Fleet Ready-to-Use Enema, Travard Phosphate Enema)	minutes

* combination products

symptoms tend to resolve in the second week of treatment,¹⁶ so the patient should be encouraged to persist. Temporarily reducing the dose may also be helpful. Bulk laxatives do not cause malabsorption of iron (unlike unprocessed bran), fat-soluble vitamins or digoxin.^{17,18}

The actual fibre content of the recommended daily dose of agents varies widely, from 1.6–12.1 g,¹⁹ so care should be taken to recommend an adequate dose: this should be around 10 g of fibre a day, along with dietary fibre. In addition, preparations can vary in electrolyte and sugar content e.g. regular and orange-flavoured Metamucil contain different amounts of sucrose, which needs to be considered in diabetic people.

The efficacy of bulking agents and fibre has, surprisingly, not been well established. Studies have shown that whilst these agents increase stool output and reduce intestinal transit time in people with normal colonic function, a meta-analysis of these studies showed that this effect is reduced in patients with constipation, who do not achieve a return to normal stool output or transit time.²⁰

In nursing homes, addition of dietary fibre has been shown to decrease laxative use.²¹ Despite these conflicting results, bulking agents remain a preferred laxative for older people but may need to be combined with, or substituted by, other agents if found ineffective.

Stool Softeners

Docusate sodium acts as a surfactant, lowering stool surface tension to allow water to penetrate and soften the stool. It stimulates cyclic AMP to increase the secretion of water, sodium and chloride into the gut. It also causes mucosal irritation with release of histamine and 5-hydroxytryptamine²² and desquamation of gut epithelial cells.²³ It has no effect on colonic motility.²⁴

Adverse effects of docusate include melanosis coli and, through altering intestinal mucosal permeability, increased absorption of some medications including other laxatives such as mineral oil and phenolphthalein.

At least six randomised trials have examined the efficacy of docusate for prophylaxis and treatment of constipation.^{25–30} None provides convincing evidence of a beneficial effect despite doses of up to 300 mg daily, but most show non-significant trends towards increased stool frequency and reduced frequency of hard stools. The extensive use of docusate, especially in institutional settings,² does not seem warranted on this evidence base. It may be more useful when confined to patients who strain excessively, or where straining should be prevented (e.g. crescendo angina or painful haemorrhoids). The usual dose is 50–120 mg a day.

Stimulants and Secretagogues

Senna, an anthracine glycoside manufactured from the dried leaflets or legumes of *Cassia acutifolia* or *C. angustifolia*, is hydrolysed by colonic bacteria into free absorbable anthraquinones, which alter electrolyte transport and increase intraluminal fluids, thus generating propulsive activity.^{31,32} The overall effect is to increase peristalsis in the distal colon and to stimulate a mass peristalsis, followed shortly by evacuation of softened stool.³³

Senna generally induces evacuation 8–12 hours after administration but frail elderly patients have slower response times³⁴ and may require up to 10 weeks of daily

use before achieving a regular bowel habit.³⁵ Bedtime use reduces the risk of nocturnal faecal incontinence. The usual dose is 1–2 tablets (7.5–15 mg) or 1–2 teaspoons daily.

Phenolphthalein acts similarly to cholera enterotoxin, increasing intestinal water and electrolyte content. Approximately 15% is absorbed and undergoes enterohepatic circulation, prolonging its duration of action.

Bisacodyl is structurally related to phenolphthalein and has mechanisms of action similar to free anthraquinones.^{33,36} There is also a suppository form of bisacodyl that has minimal systemic absorption³⁷ and is most useful for older people who strain to defaecate. Daily use may result in a sensation of rectal burning so administration three times a week is recommended.³⁸ Castor oil is also a stimulant laxative but is now rarely used.

Adverse effects of stimulant laxatives may include malabsorption of fats, protein, calcium and potassium. However, administration of high doses of senna to patients over the age of 80 for 6 months did not cause any significant losses of protein or potassium.³⁹ Oral bisacodyl is more likely to cause electrolyte disturbances than senna.³¹ All stimulant laxatives can cause dose-dependent cramping and diarrhoea. Cathartic colon is said to be another adverse effect of stimulant laxatives and is suspected when increasing laxative doses are required, but it is ill defined and based largely on a 1968 study⁴⁰ in mice using unspecified doses of senna. The damage to the myenteric plexus seen in that study has not been replicated in subsequent studies in men,^{41,42} and similar changes have been found in patients with diabetes and Crohn's disease without prior laxative use.⁴³ The present evidence suggests that cathartic colon is an unusual complication arising from the heavy ingestion of stimulant laxatives for many years, which, as one case report illustrates may be reversed following cessation of laxative use.⁴⁴

Melanosis coli is a histological finding that is also associated with the consumption of stimulant laxatives, but not however with symptoms of constipation nor prolonged transit time.

Phenolphthalein and castor oil are associated with a high risk of malabsorption and dehydration and are not recommended for older people.

Demonstration of the efficacy of stimulants and secretagogues suffers the same problems that plague many trials of laxatives in older people—poorly defined end points, small numbers of patients and the frequent use of combination laxatives, precluding a conclusion on which agent was effective. Indeed, a recent review of randomised trials of laxatives in four classes (bulking, stimulant, stool softeners and osmotic) concluded that there were only non-significant trends in favour of treatments over placebo when the end points were number of bowel actions per week.⁴⁵ In a randomised double-blind cross-over study of 77 institutionalised elderly patients, a senna-fibre combination was found to be significantly more effective than lactulose.⁴⁶

Osmotic Laxatives

Osmotic Agents

Hyperosmolar laxatives include the non-absorbable disaccharides lactulose and sorbitol. They pass unchanged into the colon to be metabolised by colonic bacteria into lactic, acetic and formic acids, with the liberation of car-

bon dioxide. These low molecular weight organic acids osmotically increase intraluminal fluid and lower stool pH.

Lactulose has been shown to be more effective than placebo in elderly patients.⁴⁷ A well designed trial has shown lactulose and sorbitol to be equally efficacious in treating severe constipation in ambulatory elderly people⁴⁸ but, as described above, lactulose has been shown to be less effective than a senna-fibre combination.⁴⁶

Lactulose is considerably more expensive than sorbitol and, as it is equally efficacious, sorbitol is preferred at a dose of 20–30 mL up to four times a day. However, the long-term safety data available for lactulose are not yet available for sorbitol.

Polyethylene glycol is a potent hyperosmolar laxative that moves a large amount of fluid into the lumen. It is an effective bowel cleaning agent⁴⁹ and is also effective in the treatment of faecal impaction.^{50,51}

Large volume polyethylene glycol (up to 3000 mL) is used mainly as a bowel preparation but can, in extreme cases, be used for constipation. Polyethylene glycol with electrolytes is recommended for faecal impaction and is probably also effective for chronic constipation, at a dose of up to 8 sachets per day, each mixed with 125 mL of water. The usual dose is 1–3 sachets per day.

Saline Laxatives

Magnesium salts osmotically draw fluid into the small bowel lumen, inducing mixing actions and contractions of the colonic wall. Magnesium hydroxide also stimulates the release of cholecystokinin, which shortens transit through the colon as well as small intestine. Because of their adverse effects, magnesium salts are not recommended for the treatment of constipation in older people. There is one published study on the benefits of saline laxatives in elderly people.⁵²

Oral phosphate works similarly but appears to be more potent. It can be used for severe constipation but there is little published data on its effectiveness.

Adverse Effects

All osmotic laxatives can cause excessive fluid and electrolyte shifts, and have been associated with hypotension, collapse and death. Additionally, magnesium salts and oral phosphate can be absorbed, causing hypermagnesaemia and hyperphosphataemia. Hyperosmolar laxatives promote bacterial overgrowth which can cause flatulence and colic but rarely to the degree of affecting compliance. The long-term safety of lactulose has been demonstrated in elderly users.^{53,54} Polyethylene glycol can be associated with hyponatraemia and hypokalaemia but this is less likely when it is combined with electrolytes.⁵⁵

Lubricants

Paraffin liquid lubricates faeces and is particularly useful when straining is a major problem, which probably explains its continued popularity amongst older people. However, it has been associated with a wide range of adverse effects including lipoid pneumonia from aspiration, granulomatous hepatitis from systemic absorption, deficiencies in the fat soluble vitamins A, D, E and K, and pruritus ani and faecal incontinence from anal leakage of the oily stool. As aspiration is more likely in older patients with dysphagia or oesophageal motility disorders, paraffin should be particularly avoided by these

patients, but its use in all elderly people is not recommended due to its overall adverse effect profile.

Prokinetic Agents

Colchicine works by increasing intestinal motility and increasing prostaglandin secretion. It may also cause some malabsorption, contributing to its laxative efficacy. However, it can cause renal failure so should not be used as a first-line agent, and should only be used in the recommended dose of 0.5 mg three times daily.

Cisapride directly increases gastrointestinal motor activity, as does misoprostol, a synthetic prostaglandin E₁ analogue. Both are systemically active and have been shown to be effective in single studies.^{56,57} Cisapride has recently been associated with cardiac arrhythmias so should only be considered as a laxative where all other measures have failed. The recommended doses are 15–40 mg daily for cisapride and up to 1200 mg a day for misoprostol. These drugs should only be used short term in patients refractory to more standard approaches.

Enemas and Suppositories

Enemas induce evacuation as a response to colonic distension as well as by plain lavage. Enemas given three times a day to nursing home residents did not increase their baseline slow intestinal transit times.⁵⁸ The multiple active components of some small volume enemas also irritate the rectal mucosa and cause release of electrolytes and water, further increasing rectal distension. Paraffin and glycerol suppositories soften and lubricate faeces.

Phosphate and soap enemas have been associated with rectal mucosal damage and even rectal necrosis,^{59,60} and all enemas, especially if used frequently and if used before manual disimpaction, can risk perforation of the rectum.⁶¹ Enemas have also been associated with fluid and electrolyte disturbances—phosphate enemas, for instance, can cause hyperphosphataemia.⁶² Paraffin and glycerol suppositories can cause faecal leakage and pruritus ani.

There is little published evidence on the effectiveness of enemas and suppositories, but clinical experience does suggest they can be effective. They are most appropriate for faecal impaction (after manual disimpaction, if needed) and for patients who strain to defaecate. The commonest reason for their failure is probably inadequate administration.

PRACTICAL APPROACH TO MANAGEMENT

Prevention

For patients who are concerned about the possibility of constipation reassurance may be all that is required. The non-pharmacological approaches, discussed above, should be emphasised. However, when constipation is highly likely to occur (for example, in a patient who will be having abdominal surgery or who will be treated with narcotic analgesics) it may be justifiable to prescribe a short course of a laxative—for instance an osmotic agent or senna.

Impaction

Faecal impaction must be excluded in all more severely or chronically constipated people by both a rectal examination and an abdominal X-ray. Impaction should be dealt with before fibre or oral laxatives are used. Suppos-

itories or enemas may be sufficient, but manual disimpaction is sometimes required first. This is very uncomfortable and may need to be carried out over a day rather than on one occasion. A local gel anaesthetic should be used liberally and sometimes a general anaesthetic is required. After manual disimpaction, or if this is not required, management is as for severe acute constipation (below).

Acute Constipation

After impaction has been excluded, a short course of an oral agent is appropriate (e.g. senna) in conjunction with the non-pharmacological approaches. Fibre and bulking agents should only be used if the bowel is not dilated—an abdominal X-ray can be helpful. For patients who fail to respond, sorbitol or polyethylene glycol with electrolytes can be used in increasing doses, to the recommended maximum, if necessary. If straining is a major symptom, a suppository or enema can be used. Some would recommend docusate for these patients, despite the lack of convincing evidence of efficacy.

If the patient remains constipated, especially if ongoing impaction is confirmed by an abdominal X-ray, a repeat search for more serious causes of constipation should be made.

Chronic Constipation

For these patients, an underlying cause should be sought. Bowel dilation is more common so an abdominal X-ray should be performed before using bulking agents. The colon should be emptied and this may require frequent enemas or higher doses of oral agents such as sorbitol or polyethylene glycol with electrolytes. Once the colon is empty and not dilated (an abdominal X-ray will confirm this) non-pharmacological approaches should be instituted. Bowel retraining with appropriate use of enemas can be helpful—many continence clinics can assist here. These patients are often long-term laxative abusers and this should be addressed (see below), although success may be limited.

Laxative Abuse

Management of this can be very difficult. The patient should be educated about normal bowel function and the other non-pharmacological approaches instituted. If the patient is unwilling to completely cease all laxatives, attempts should be made to change them to safer agents such as sorbitol, lactulose or senna, and then to progressively wean them (for example, reduce from daily to second daily). A good therapeutic relationship is important. Again, bowel retraining may be helpful, under expert supervision.

Residents of Long-Term Care Facilities

The first principles of non-pharmacological management pertain, but may need to be modified (e.g. simply standing rather than exercise). Fibre and bulking agents should be avoided until an abdominal X-ray shows no colonic dilation. Faecal impaction should also be sought and treated first. Oral agents, enemas and suppositories, if necessary, should be used for short courses only. As soon as possible, dietary fibre should be increased.

Faecal Incontinence

This is commonly due to faecal impaction, so there should

be a high index of suspicion that this is present. If in doubt, the patient should be treated as if impacted.

Cost Containment

Most laxatives are relatively cheap—partly because there are several competing brands or generics, and most are available over the counter. Dietary fibre is nearly always cheaper than bulking agents. Sorbitol is cheaper than lactulose and as effective. Polyethylene glycol with electrolytes is relatively expensive but may be very effective for more severe constipation or faecal impaction.

CONCLUSION

Constipation is a common clinical issue and should certainly be taken seriously. Most elderly people improve with advice about normal bowel function, and recommendations about fibre, fluid and exercise. Older people will enjoy a better quality of life, wherever they are resident, if they are satisfied with their bowel function. This is nearly always achievable.

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