Constipation in Older Adults

Quick Overview

- Docusate: ineffective for the treatment or prevention of constipation
- Bulk-forming agents (e.g. METAMUCIL):
  - Helpful for hard or difficult to pass stools
  - Likely ineffective for infrequent stools, severe pelvic floor dysfunction constipation, and medication-induced constipation
  - Individuals must be able to drink ≥250mL of water/juice with each dose
- Osmotic laxatives (e.g. LAX-A-DAY):
  - Helpful for infrequent bowel movements
  - Theoretically, may not help individuals who are dehydrated
  - Lactulose is not absorbed therefore likely safe in individuals with diabetes
- Stimulant laxatives (e.g. SENOKOT):
  - Helpful for opioid-induced constipation, neurogenic constipation (e.g. Parkinson’s disease) or infrequent bowel movements
- Fecal incontinence may be due to fecal impaction

Prevalence & Defining Constipation

- The prevalence of constipation increases with increasing age & differs between settings:
  - Community-dwelling:
    - ≥65 years of age: 26% for females, 16% for males
    - ≥84 years of age: 34% for females, 26% for males
  - Long-term case residents: as high as 80%
- Several definitions and tools are available for diagnosing constipation, but simply put, constipation is unsatisfactory defecation due to infrequent stools and/or difficult or incomplete evacuation. See next column for examples of definitions & tools.
- Constipation is symptom-based and subjective, as what is “normal” in terms of bowel movements varies among individuals.
- Healthcare providers often rely on the frequency of bowel movements to define constipation. Patients tend to use symptoms such as straining, hard stools and bloating.
- Straining is often the predominant symptom in older adults. It occurs in up to 65% of community-based individuals over the age of 65, and hard stools have been reported in approximately 40% of these individuals.

Types of Constipation

1) Primary (or idiopathic) Causes: further broken down into 3 subtypes
   a. Normal transit: accounts for ~60%
      - Normal defecation frequency, but stool is hard &/or difficult to pass
      - Management: lifestyle & long-term laxative(s) [AGA 2013 recommendation: strong, QE: moderate]
      - Fibre (30g/day) improves straining & stool frequency
   b. Slow transit: accounts for 15%
      - Infrequent bowel movements
      - Management: lifestyle & long-term laxative(s) [AGA 2013 recommendation: strong, QE: moderate]

Types of constipation continued on page 13-B

Definitions & Tools for Diagnosing Constipation

Rome III Diagnostic Criteria in Adults:
- When 25% of bowel movements are associated with at least 2 of the following symptoms, occurring in the previous 3 months with an onset of symptoms of at least 6 months:
  - Straining
  - Hard or lumpy stools
  - A sense of incomplete evacuation
  - A sense of anorectal obstruction
  - The need for manual maneuvers
  - Fewer than 3 defecations per week
  - Loose stools rarely present without the use of laxatives
- Insufficient criteria for irritable bowel syndrome (IBS-constipation often presents with recurrent abdominal pain &/or discomfort).

Canadian Association of Gastroenterology:
- Defines constipation as symptom-based, including a combination of fewer than three stools per week, stool form that is mostly hard or lumpy, and difficult stool passage (need to strain or incomplete evacuation) for more than six months (Level B).

The Bristol Stool Chart:
- A validated tool to correlate stool consistency with colonic transit time.
- Can be used with patients for assessment & monitoring.

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Separate hard lumps, like nuts (hard to pass)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
</tr>
</tbody>
</table>
Constipation in Older Adults continued

Types of Constipation continued

c. Pelvic floor dysfunction: accounts for ~25%
- The pelvic floor or external anal sphincter cannot relax. May occur with anal fissures or hemorrhoids.
- Management: pelvic floor retraining with biofeedback & relaxation training is recommended; AGA 2013 recommendation: strong, QE: high however, these interventions are usually not readily available. Suppositories or enemas may be preferred over oral laxatives alone in individuals with refractory pelvic floor dysfunction. AGA 2013 recommendation: weak, QE: low

2) Secondary Causes: constipation due to medications or diseases/conditions
- Medication-induced: when possible, decrease the dose, discontinue the drug or switch to another agent with a lower incidence of constipation (see next column)
- Disease/condition-induced: when possible, optimize disease management (e.g. blood glucose control in diabetics)

Constipation is often multifactorial, especially in the elderly. For example, an individual may have both pelvic floor dysfunction & slow transit, and be on medications, and have diseases or conditions that cause or exacerbate constipation.

Step-wise Approach to Managing Constipation

- Establish that the individual is suffering from constipation & identify the predominant symptom
  - Use the definitions and tools listed on page 13-A to help diagnose constipation.
  - Older individuals with impaired cognition or communication may present with non-specific symptoms (e.g. agitation, anorexia, or decline in function).

- Conduct a physician examination & rule out alarm features
  - Alarm features may indicate another condition (e.g. colon cancer).
  - The patient will require additional investigations if alarm features are present.

Alarm Features

- Age over 50 years with recent onset of symptoms
- Rectal bleeding
- Fever
- Significant weight loss
- Nocturnal symptoms
- Abnormal laboratory blood work (e.g. anemia or deficiency of iron)
- Strong family history (bowel cancer, inflammatory bowel disease, visceral myopathy or celiac disease)
- Palpable abdominal or rectal mass

- Identify and treat reversible causes
- Several diseases and conditions can cause or contribute to constipation.
- Optimize the management of these diseases, when possible, in an effort to lesson or resolve the constipation.

Diseases and Conditions that can Cause Constipation

- Cancer/Cancer related: colorectal cancer, dehydration, intestinal radiation, tumour compression of large intestine
- Endocrine: hormonal changes, hypothyroidism, diabetes, hyperparathyroidism
- Gastrointestinal disorders: diverticulosis, Hirschsprung’s disease, irritable bowel syndrome, mega colon, pelvic floor dysfunction, rectal prolapse, strictures
- Metabolic: hypercalcemia, hypocalcemia, hypomagnesemia, hypopituitarism, pan-hypopituitarism, uremia (urea in the blood)
- Neurologic: autonomic neuropathy, dementia, multiple sclerosis, muscular dystrophies, pain secondary to anal fissures or hemorrhoids, Parkinson’s disease, spinal cord lesions, stroke
- Psychological: anxiety, depression, eating disorders
- Other: older age, chronic kidney disease, systemic sclerosis, sexual abuse, lack of privacy or time

- Identify medications that may cause constipation. Balance the risk of constipation versus the benefit of the medication(s). If possible, decrease the dose, discontinue the medication or switch to another agent with a lower incidence of constipation.

Examples of Medications that can Cause Constipation*

- Analgesics: NSAIDs (e.g. ibuprofen), opioids (e.g. morphine; constipation occurs in 25-40% of non-cancer & up to 90% of cancer patients)
- Anticholinergics: antipsychotics (e.g. olanzapine), benztrtopine, oxybutynin (see 24-A)
- Anti-parkinson: amantadine, bromocriptine, pramipexole
- Anticonvulsants: gabapentin, phenytoin, pregabaline
- Antidepressants: tricyclic antidepressants (e.g. amitriptyline), paroxetine
- Antidiarrheals: diphenoxylate, loperamide
- Antiemetics: dimenhydrinate, ondansetron, prochlorperazine, promethazine, scopolamine
- Antihistamines: diphenhydramine, hydroxyzine
- Antihypertensives: β-adrenergic agonists (e.g. clonidine), β-blockers (e.g. metoprolol), calcium channel blockers (especially verapamil), diuretics
- Antispasmodics: dicyclomine
- Cation agents: aluminum, bismuth, barium, calcium, iron
- Chemotherapy: vincristine, cyclophosphamide
- Resins: cholestyramine, sodium polystyrene sulfonate

* This is not an exhaustive list.
### Constipation in Older Adults continued

**Medication-induced constipation continued**

- Numerous prescription and over-the-counter medications can cause or contribute to constipation.
- When reviewing an individual’s list of medications, remember that constipation is often multifactorial and the benefit of the medication may outweigh the risk of constipation.
- However, if possible, adjust the medications in an effort to reduce the risk of medication-induced constipation.
- To Discontinue or Adjust Examples:
  - Calcium should not be discontinued in individuals with osteoporosis (≤1200mg calcium per day from diet and/or supplements).
  - The benefit of opioid pain relief will often outweigh the risk of opioid-induced constipation in cancer patients. Use regular laxatives (see [RxFiles Management of Constipation](#) and [RxFiles Q&A Opioid-Induced Constipation](#)).
  - Discontinue amitriptyline when used as a sleep aid, especially when there is no history of depression. See Insomnia in Older Adults for alternatives (page 28A).
  - Switch verapamil to another antihypertensive when used for the treatment of hypertension.

- **Recommend lifestyle changes for individuals with deficiencies such as low fibre, low fluid intake, inactivity & when interventions are safe.**

  There is limited evidence that lifestyle changes resolve constipation, but it is universally accepted as a 1st line approach.

  - **Physical Activity:** enhances quality of life in older adults, but studies were unable to show an improvement in bowel movements. Pelvic tilts, trunk rotation and leg lifts are activities recommended for bedridden individuals.
  - **Fluid Intake:** studies have shown that low fluid intake has been associated with constipation in LTC residents, but not in other settings (e.g. community, hospital). Increasing fluid intake can be recommended for individuals with low intake or who are on bulk-forming agents or osmotic laxatives, providing there are no fluid restrictions (e.g. heart or kidney failure). There is little guidance on how much fluid should be consumed. Total fluid intake should include all fluids – i.e. from all beverages (not just water) & from food (e.g. fruits, vegetables). Limit caffeinated & alcoholic beverages that have a diuretic effect. Older adults with urinary incontinence may avoid drinking fluids; optimizing the management of urinary incontinence can help alleviate concerns. Apple, pear & prune juice contains sorbitol & may help constipated individuals.
  - **Dietary Fibre:** studies that assessed dietary fibre in the elderly report mixed results and were of low quality. Soluble fibre (e.g. psyllium) has better evidence than insoluble fibre (e.g. bran) and is preferred. Dietary fibre should be titrated gradually (e.g. increase by 5g per week) to minimize gastrointestinal side effects (e.g. flatulence, bloating), up to 20-30g per day. Prunes have been shown to increase stool frequency & consistency, compared to psyllium. Some long-term care homes use dried fruits spreads (e.g. FRUITRITE 2g fibre/25g).

- **Daily Regimented Bowel Routine:** recommended for older adults suffering from constipation. For example, within 1 hour of waking do mild physical activity (e.g. walking, swimming, yoga, Thai Chi), have a hot beverage (preferably caffeinated), a fibre cereal & encourage regular toileting, regardless of urge. End the day with a fibre supplement.

  - **Initiate or alter laxative therapy and monitor efficacy & safety.**

    There are no studies assessing a step-wise approach for the management of constipation. The following information is based on guidelines, available data & clinical practice.

- **Bulk-Forming Agents**
  - Generally recommended as 1st line, unless contraindications/safety concerns exist.
  - May not treat or prevent slow-transit, severe pelvic floor dysfunction, or medication induced constipation.
  - **Efficacy:**
    - Improves stool frequency (conflicting evidence for stool consistency & transit time) [ACG 2014 recommendation: strong, QI: low](#).
    - NNT=2 (i.e. need to treat 2 people with fibre for 1 person to benefit)
    - Similar efficacy to lactulose, better than dietary fibre.
    - Beneficial for straining, incomplete evacuation & normal transit constipation.
  - **Safety:** AVOID if fluid restriction, dehydration, dysphagia & esophageal strictures.
    - Must be taken with ≥250mL of water/juice to prevent fecal impaction & esophageal obstruction.
  - **Onset of Action:** 12 to 72 hours
  - **Examples of Bulk-forming Agents:** multiple products/formulations available. Refer to dosing instructions on package. Titrate slowly to minimize transient, dose-dependent flatulence & bloating.
    - Psyllium [Metamucil](#) 3.4 to 6.8g daily to TID (maximum: 30g/day) - most efficacy/safety data
    - Inulin [Renfibre, Metamucil Simply Clear](#) powder 3 to 5g daily to TID
    - Calcium polyacrylate [Prepekt](#) 2 caplets daily to QID
      - Similar efficacy to psyllium
      - Less risk of flatulence & bloating compared to the other bulk-forming agents

- **Osmotic Laxatives**
  - Generally considered as 2nd line agents, & are added to bulk-forming agents if required.
  - Beneficial in individuals whose primary symptom is infrequent bowel movements.
  - Osmotic laxatives draw fluid into the intestine. Theoretically, these agents may not be effective in dehydrated individuals.
  - **Examples of Osmotic Laxatives:**
    - Polyethylene Glycol (PEG 3350) [Lax-A-Day, Restoralax](#) 17g daily
      - Superior to lactulose for stool frequency, stool consistency & abdominal pain
      - NNT=3 (i.e. need to treat 3 people with PEG 3350 for 1 to benefit)
      - Onset of action: 48 to 96 hours
      - Odourless & tasteless, therefore may be preferred over lactulose (very sweet).
      - Need to be able to drink 250mL of fluid with each dose.
Examples of Osmotic Laxatives continued

- **Lactulose** 15 to 30mL daily to TID
  - Improves stool frequency, NNT=4 (i.e. need to treat 4 people for 1 to benefit)
  - Onset of action: 24 to 48 hours
  - Lactulose is a sugar but it is not absorbed; therefore it is likely safe in individuals with diabetes. However, to err on the side of caution, monitor for signs & symptoms of hyperglycemia if used in this population.
  - To mask the sweet taste, dilute lactulose in water, juice, milk or desserts.

- **Sorbitol** less sweet than lactulose, therefore less nausea
  - Sorbitol 70% solution 15 to 30mL po daily to BID (onset of action: 24 to 48 hours)
  - Sorbitol 25 to 30% solution 120mL as PR (onset of action: 5 to 15 minutes)

- **Glycerin** 1 adult suppository PR daily PRN (onset of action: 15 to 60 minutes)
  - Less effective if stool is dry & hard
  - Moisten suppository in lukewarm water prior to insertion. Retain suppository in rectum for 15 to 30 minutes. The suppository does not have to melt in order to produce a bowel movement (i.e. may see a formed suppository in stool).

**Stimulants**

- Generally considered as a 3rd line agent for chronic constipation, or 1st line for opioid-induced constipation. May provide benefit in neurogenic or slow transit constipation.

- Stimulant laxatives are usually provided as needed; however, some individuals may require scheduled therapy (e.g. opioid-induced constipation).

- Majority of efficacy data is based on bisacodyl, as it has been studied more than senna:
  - Effective for chronic constipation
  - NNT=3 (i.e. need to treat 3 people with a stimulant laxative for 1 to benefit)
  - Senna + bulk-forming agent was more effective than lactulose in older adults (mean age 83 years), however lactulose therapy was better tolerated.

- Long-term efficacy & safety unknown (studies were of short duration).

- Tolerance may occur in individuals with slow transit constipation, but it is rare.

**Examples of Stimulant Laxatives:**

- **Bisacodyl** DULCOLAX 5 to 10mg po HS or 10mg suppository PR daily PRN (max 30mg/day)
  - Stronger stimulant than sennosides
  - Onset of action: tablet 6 to 12 hours, suppository 15 to 60 minutes
  - Tablets are enteric coated. Do not crush, chew or break.
  - Space bisacodyl tablets & milk, antacids, H2-blockers (e.g. ranitidine) & proton-pump inhibitors (e.g. omeprazole) by 1 hour. These decrease the acidity in the stomach & therefore can cause early disintegration of the enteric coated tablets, resulting in gastrointestinal irritation.

- **Sennosides** SENOKOT, SENOKOT-S 17.2 to 34.4mg or 10 to 15mL HS (max 4 tablets/15mL BID)
  - SENOKOT-S contains sennosides 8.6mg and docusate sodium 50mg
  - Onset of action: 6 to 12 hours
  - May discoulour urine and/or feces yellow-brown or red-violet
  - Often found in herbal products, cleanses & teas

### Medications with a Unique Mechanism of Action

- These agents are relatively new, and have only been tested against placebo in clinical trials. As such, the exact role is unknown. Reserve use for individuals who continue to suffer from constipation despite optimal management of the above.

- Refer to the RxFiles Management of Constipation for more information:
  - **Methylnaltrexone** NNT=3, versus placebo
    - Indication: adjunct for opioid-induced constipation in palliative care patients
  - **Prucalopride** NNT=5, versus placebo
    - Indication: for chronic constipation in females who have failed other laxatives
  - **Linacotide** NNT=6, versus placebo
    - Indication: treatment of chronic idiopathic constipation or IBS-constipation

### Monitoring

- **Chronic Constipation**: ideally, an individual should have regular bowel movement patterns after 1 month of therapy

- **Opioid-Induced Constipation**: goal is to have a bowel movement at least every 3 days

- Bloating and cramping due to constipation should resolve after a full bowel movement

### Long-Term Laxative Use

- Chronic laxative use may result in intermittent malabsorption, dehydration, fecal incontinence or electrolyte imbalances in susceptible individuals.

- The risk of myenteric plexus or smooth muscle damage due to stimulants is rare, and it is unclear if the damage is due to constipation or laxative use.

### Fecal Impaction

- Fecal impaction is the inability to pass an accumulation of hard stool.

- It may result from untreated or chronic constipation, or an intestinal blockage (e.g. a tumour pressing/growing into the lumen of the intestine or inadequate fluid intake with bulk-forming agents).

- Fecal impaction can lead to fecal incontinence & a bowel obstruction, which in severe cases may result in bowel perforation.

- Symptoms include: constipation, rectal &/or abdominal pain, anorexia, vomiting, urinary &/or fecal incontinence.

- **Management**: fecal mass must be removed before preventative or maintenance measures are implemented.
  - **Manual Disimpaction** use 2% lidocaine gel to anesthetize & lubricate the rectum/anus.
  - **Enemas** daily for up to 3 days (e.g. tap water 500-800mL PR, FLEET MINERAL OIL 120mL PR). Onset: 5 to 15 minutes.
  - If the stool is located higher up in the intestine & manual disimpaction and enemas are ineffective, try **PEG 3350** (e.g. with electrolytes 2L po x 1 to 2 days or 1L po x 3 days).
  - A combination of the above, along with laxatives (oral &/or suppositories), may be required.
  - **AVOID**: soapsuds enemas due to colonic mucosa irritation & bulk-forming laxatives.
## Constipation in Older Adults: STOPP & Beers Criteria

### Medications used to treat constipation & their precautions

<table>
<thead>
<tr>
<th>Drug or Drug Class</th>
<th>Clinical Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LAXATIVES</strong></td>
<td></td>
</tr>
<tr>
<td>Docusate calcium</td>
<td>For the TREATMENT OR PREVENTION OF CONSTIPATION</td>
</tr>
<tr>
<td>Magnesium or sodium-based laxatives</td>
<td>In RENAL OR CARDIAC IMPAIRMENT</td>
</tr>
<tr>
<td>Magnesium hydroxide</td>
<td></td>
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<tr>
<td>Sodium phosphate oral solution</td>
<td></td>
</tr>
<tr>
<td><strong>Mineral Oil, given orally</strong></td>
<td>≥65 YEARS OF AGE</td>
</tr>
</tbody>
</table>

### Medications used for indications other than constipation, that may cause/worsen constipation

<table>
<thead>
<tr>
<th>Drug or Drug Class</th>
<th>Clinical Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTICHOLINGERICS &amp; ANTISPASMODICS</strong></td>
<td></td>
</tr>
<tr>
<td>See Anticholinergics: Reference List of Drugs with Anticholinergic Effects in section 24</td>
<td></td>
</tr>
<tr>
<td><strong>ANTIDEPRESSANTS</strong></td>
<td></td>
</tr>
<tr>
<td>Selective Serotonin Re-uptake Inhibitors (SSRIs)</td>
<td></td>
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<tr>
<td>Paroxetine</td>
<td></td>
</tr>
<tr>
<td>Tertiary Tricyclic Antidepressants (TCAs)</td>
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<tr>
<td>Amitriptyline</td>
<td></td>
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<tr>
<td>Clomipramine</td>
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<tr>
<td>Doxepin &gt;6 mg/day</td>
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<tr>
<td>Imipramine</td>
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<tr>
<td>Trimipramine</td>
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</tbody>
</table>

### STOPP Beers Criteria

**QE** = Quality of Evidence  
**SR** = Strength of Recommendation

- Insufficient evidence to support its use.  
  Unlikely to be effective.  
  Anecdotally, may help to prevent straining in individuals with recent rectal surgery or myocardial infarction, unstable angina or anorectal disorders.  
  Often given as a combination product with sennosides (i.e. SENOKOT-S). The addition of docusate to sennosides may not provide benefit, but also likely not to cause harm.

- **↑** Risk of electrolyte disturbances in susceptible individuals  
  Safer alternatives available

- Potential for aspiration & adverse effects  
  Safer alternatives available

- **↑** risk of exacerbating constipation  
  Avoid unless no other alternatives

- **↑** risk of exacerbating constipation  
  Avoid unless other alternatives unsuitable

- **↑** risk of severe constipation  
  SSRI: select a SSRI other than paroxetine  
  TCA:  
  - secondary TCAs (i.e. nortriptyline & desipramine) have somewhat less anticholinergic properties  
  - **the safety profile of low-dose doxepin (≤6 mg/day) is comparable to that of placebo**  
  - Adverse effects are dose dependent

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For more detailed medication information, see the RxFiles Drug Comparison Charts
<table>
<thead>
<tr>
<th>Drug or Drug Class</th>
<th>When a Medication Could be Problematic for Older Adults</th>
<th>Clinical Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1ST GENERATION ANTIHISTAMINES</strong>&lt;br&gt;(As single agent/combo product or over the counter products)</td>
<td></td>
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</tr>
<tr>
<td>Brompheniramine</td>
<td>Not listed</td>
<td>• ↑ risk of exacerbating constipation</td>
</tr>
<tr>
<td>Chlorpheniramine</td>
<td>Not listed</td>
<td>• Avoid unless no other alternatives</td>
</tr>
<tr>
<td>Clemastine</td>
<td>Not listed</td>
<td></td>
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<tr>
<td>Cyproheptadine</td>
<td>Not listed</td>
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<tr>
<td>Dexampheniramine</td>
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<tr>
<td>Dimenhydrinate</td>
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<tr>
<td>Doxylamine</td>
<td>Not listed</td>
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<tr>
<td>Promethazine</td>
<td>Not listed</td>
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<tr>
<td>Triprolidine</td>
<td>Not listed</td>
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<tr>
<td><strong>ANTIMUSCULARINICS FOR URINARY INCONTINENCE</strong>&lt;br&gt;(Consult the RxFiles Drug Comparison Charts)</td>
<td></td>
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<tr>
<td>Darifenacin</td>
<td>Not listed</td>
<td>• ↑ risk of exacerbating constipation</td>
</tr>
<tr>
<td>Fesoterodine</td>
<td>Not listed</td>
<td>• Avoid unless no other alternatives</td>
</tr>
</tbody>
</table>
| Flavoxate | Not listed | • May switch to an agent with a lower incidence of constipation, if needed. Approximate incidences:
| Oxybutynin | Not listed | o Darifenacin 7.5mg daily: 15%, 15mg daily: 21%
| | | o Fesoterodine 4mg daily: 4%, 8mg daily: 6%
| | | o Oxybutynin IR: 15%, XL: 9%, topical gel: 1%
| | | o Solifenacin 5mg daily: 5%, 10mg daily: 13%
| | | o Tolterodine 1mg BID: 6%, 4mg daily (IR & ER): ~6%
| | | o Trospium 20mg BID: 10% |
| **NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS (CCB)**<br>(Consult the RxFiles Drug Comparison Charts) | | |
| Diltiazem | Not listed | • ↑ risk of exacerbating constipation |
| Verapamil | Not listed | • Avoid unless no other alternatives |
| **OPIOIDS**<br>(Consult the RxFiles Drug Comparison Charts) | | |
| Buprenorphine | Not listed | • ↑ risk of severe constipation |
| Codeine | Not listed | • All opioids can cause constipation |
| Fentanyl | Not listed | • Regular laxative therapy to be prescribed when starting an opioid (e.g. SENO-2 to 4 tablets po HS). See RxFiles Q&A: Opioid-Induced Constipation for more information. |
| HYDROmorphine | Not listed | | |
| Methadone | Not listed | | |

*Denotes a combination product

**STOPP & Beers Criteria**

**QE** = Quality of Evidence

**SR** = Strength of Recommendation
14) Canadian Agency for Drugs and Technologies in Health (CADTH). Rapid Response Report: Dioctyl Sulfosuccinate or Docusate (Calcium or Sodium) for the Prevention or Management of Constipation: A Review of the Clinical Effectiveness. June 2014.
18) Lewis SJ, Heaton KW. Stool form scale as a useful guide to intestinal transit time. Scand J Gastroenterol. 1997 Sep;32(9):920-4. (Bristol Stool Chart)