CONSTITUTION

1. PURPOSE

The management of constipation in pregnancy.

2. PROCEDURE

BACKGROUND

• Approximately 11% to 38% of women experience constipation during pregnancy, which is usually worse in the second trimester.1,2,3
• The cause of constipation usually multifactorial. In pregnancy it can be caused by the elevated progesterone levels causing smooth muscle relaxation, reduced motility and increased water absorption.1,2,3
• Straining to defecate can lead to damage of the pudendal nerve, impairing the supportive functioning of the pelvic floor muscles. This can be a contributing factor in development of utero-vaginal prolapse.4

CLINICAL HISTORY

• There is a wide variation in what each patient consider ‘normal’ bowel function.5
• Perform a medical history – diagnosis of constipation is made when there is an infrequent defecation (usually < 3 times/week) with stools that are hard and difficult to pass (need to strain or feeling of incomplete defecation).1,2,3,4,5
• Note any medical history that could lead to bowel symptoms, including use of laxatives, dietary habits, water consumption, physical activity, and use of medications such as iron supplements.1,6

Management Options: See below
STEP 1
Identify and, if possible, avoid causative drugs. ³

- A change in dosage regimen or formulation may alleviate constipation (e.g. CR Iron is claimed to have fewer GI adverse effects).³
- Examples of causative drugs: opioids, drug with anticholinergic effects, antacids containing aluminium or calcium, iron supplements, calcium supplements, verapamil.³,⁴

STEP 2
Identify and manage possible underlying causes ³

- E.g. chronic use of laxatives, dietary habits, lack of physical activity, dehydration, depression, neurological disorders (Parkinson’s disease, stroke), metabolic disturbances (diabetes mellitus, hypercalcaemia, hypothyroidism), malignancy, pelvic floor dysfunction, faecal impaction or obstruction, anal fissure.¹,³.

STEP 3

- Encourage mobility and adequate fluid intake (at least 2 litres per day).³,⁴,⁵,⁶
- Encourage adequate fibre intake (e.g. whole grains, rice, bran, beans, lentils, nuts, dried fruit, fresh fruit and vegetables.⁵ Introduce these foods gradually if the woman is not used to these foods as bloating and flatulence may occur otherwise.⁶
- Encourage responding to the urge to defecate immediately. ³,⁴,⁵,⁶

STEP 4
If the above strategies are insufficient, the addition of pharmacological treatment should be used for a short period of time where possible, until the patient has returned to regular and full bowel evacuation.³

Refer to Step-wise Choice of Pharmacological Treatment.
Step-wise Choice of Pharmacological Treatment

**FIRST Option: Bulk-forming laxatives**

- Do not use for acute relief of constipation as they can take several days to work fully.
- Do not use for opioid-induced constipation.
- Onset of action: 48-72 hours.
- Ensure adequate fluid intake.
- Introduce to diet slowly to prevent abdominal discomfort.
- Should not be taken immediately before going to bed.

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Available Products at KEMH</th>
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</table>
| Psyllium (preferred agent) | Metamucil® capsules  
Metamucil® oral powder |
| Ispaghula (preferred agent) | Fybogel® oral granules |
| Frangula bark, sterculia  
Note: Frangula bark is a stimulant laxative. May be used at recommended doses | Normacol Plus® oral granules |
| Wheat dextrin  
Note: no reference available regarding safety in pregnancy | Benefiber® oral powder |

**Second Option: Osmotic Laxatives**

- Not all Saline laxatives are safe in pregnancy, for example those containing magnesium salts.
- Ensure adequate fluid and fibre intake.

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<tr>
<th>Active Ingredient</th>
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<th>Onset of Action</th>
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</thead>
<tbody>
<tr>
<td>Lactulose (preferred agent)</td>
<td>Actilax oral liquid</td>
<td>24-72 hours</td>
</tr>
<tr>
<td>Sorbitol</td>
<td>Sorbilax oral liquid</td>
<td>24-72 hours</td>
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</tbody>
</table>
| Macrogol laxatives  
Note:  
- limited data available in pregnancy, should only be considered on doctors advice, occasional doses appears safe | Movicol oral powder | 1-4 days |
| Saline laxatives  
Note:  
- Microlax® brand is safe to use in pregnancy.  
- May cause electrolyte disturbances. | Microlax® Rectal Enema | 2-30 minutes |
| Glycerol  
Note: useful if stool is present in lower rectum | Petrus® Rectal Suppository | 5-30 minutes |
Third Option: Stool Softeners

- Ensure adequate fluid and fibre intake ³,4,5,6
- There is limited evidence of efficacy when used as monotherapy ¹,3

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<th>Onset of Action</th>
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<tbody>
<tr>
<td>Docusate</td>
<td>Coloxyl® tablets</td>
<td>24-72 hours³</td>
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<tr>
<td>Liquid Paraffin</td>
<td>Note:</td>
<td></td>
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<tr>
<td></td>
<td>- Do not give dose immediately before lying down to avoid aspiration³</td>
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<tr>
<td></td>
<td>- Avoid chronic use as maternal absorption of food, fat-soluble vitamins, and some oral medicines may be impaired¹⁰</td>
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<tr>
<td></td>
<td>Agarol® Vanilla oral liquid</td>
<td>24-72 hours³</td>
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<td></td>
<td>Parachoc® oral liquid</td>
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<tr>
<td>Poloxamer</td>
<td>Coloxyl® oral liquid drops</td>
<td>24-72 hours³</td>
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Final Option: Stimulant Laxatives

- Stimulant laxatives are usually reserved for severe constipation or if unresponsive to other laxatives mentioned in previous sections.³
- Stimulant laxatives are used if colon motility is poor (e.g. from opioids).³
- Stimulant laxatives are category A in pregnancy and do not cause congenital abnormalities, however should be avoided except for occasional doses. ³,5,10
- Stimulant laxatives should not be given to women with a history of preterm labour without medical consultation.
- Stimulant laxatives are contraindicated where there is an intestinal obstruction, acute abdominal conditions, and inflammatory bowel conditions.³
- Ensure adequate fluid and fibre intake ³,4,5,6
- Castor oil should be avoided as it may induce premature labour.
- Stimulant laxatives are usually given at night.³

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<tr>
<td>Senna</td>
<td>Senokot® oral tablets</td>
<td>6-12 hours³</td>
</tr>
<tr>
<td>Note: High doses or prolonged use may cause inadvertent uterine stimulation especially in cases of threatened premature labour ¹⁰</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senna combined with Docusate</td>
<td>Coloxyl with Senna® oral tablets</td>
<td>6-12 hours³</td>
</tr>
<tr>
<td>Note: High doses or prolonged use may cause inadvertent uterine stimulation especially in cases of threatened premature labour ¹⁰</td>
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</tr>
<tr>
<td>Bisacodyl</td>
<td>Bisalax® oral tablets</td>
<td>6-12 hours (^3)</td>
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</tr>
<tr>
<td>Bisacodyl</td>
<td>Petrus® rectal suppositories</td>
<td>5-60 minutes (^3)</td>
</tr>
<tr>
<td>Sodium picosulfate</td>
<td>Note: use only when no other alternatives are available</td>
<td>Unavailable</td>
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**ADDITIONAL INFORMATION**

While a stepwise approach as outlined above is preferred, treatment approach should be individualised to each woman. Acute constipation usually benefits from aperients with a quick onset of action such as suppositories or osmotic laxatives, whilst for chronic constipation; a bulk forming laxative may be useful.

**REFERENCES (STANDARDS)**


National Standards – 1 Clinical Practice; 4 Medication Safety Legislation - Nil

Related Policies – *Minor Symptoms and Disorders of Pregnancy*

Other related documents – Nil

**RESPONSIBILITY**

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<tr>
<th>Policy Sponsor</th>
<th>Chief Pharmacist KEMH</th>
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Access the current version from the WNHS website

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