



Chronic & Refractory Constipation

An evidence-based clinical playbook and decision support tool for Australian primary care.

Synthesized from GESA, RACGP, and eTG frameworks.

A High-Volume Primary Care Challenge

Prevalence

14–20%

of Australian adults are affected, rising to ~25% in those aged ≥65. Women are disproportionately impacted (OR 2.2).

Clinical Volume

1.2 Million

annual general practice consultations in Australia are dedicated to chronic constipation.

Economic Burden

Top 20

Laxative use ranks among the top 20 Pharmaceutical Benefits Scheme (PBS) expenditure categories nationally.

Beyond discomfort, chronic constipation drastically reduces quality of life and drives immense healthcare utilization. The aetiology spans functional constipation (FC), opioid-induced (OIC), IBS-C, and secondary systemic causes.

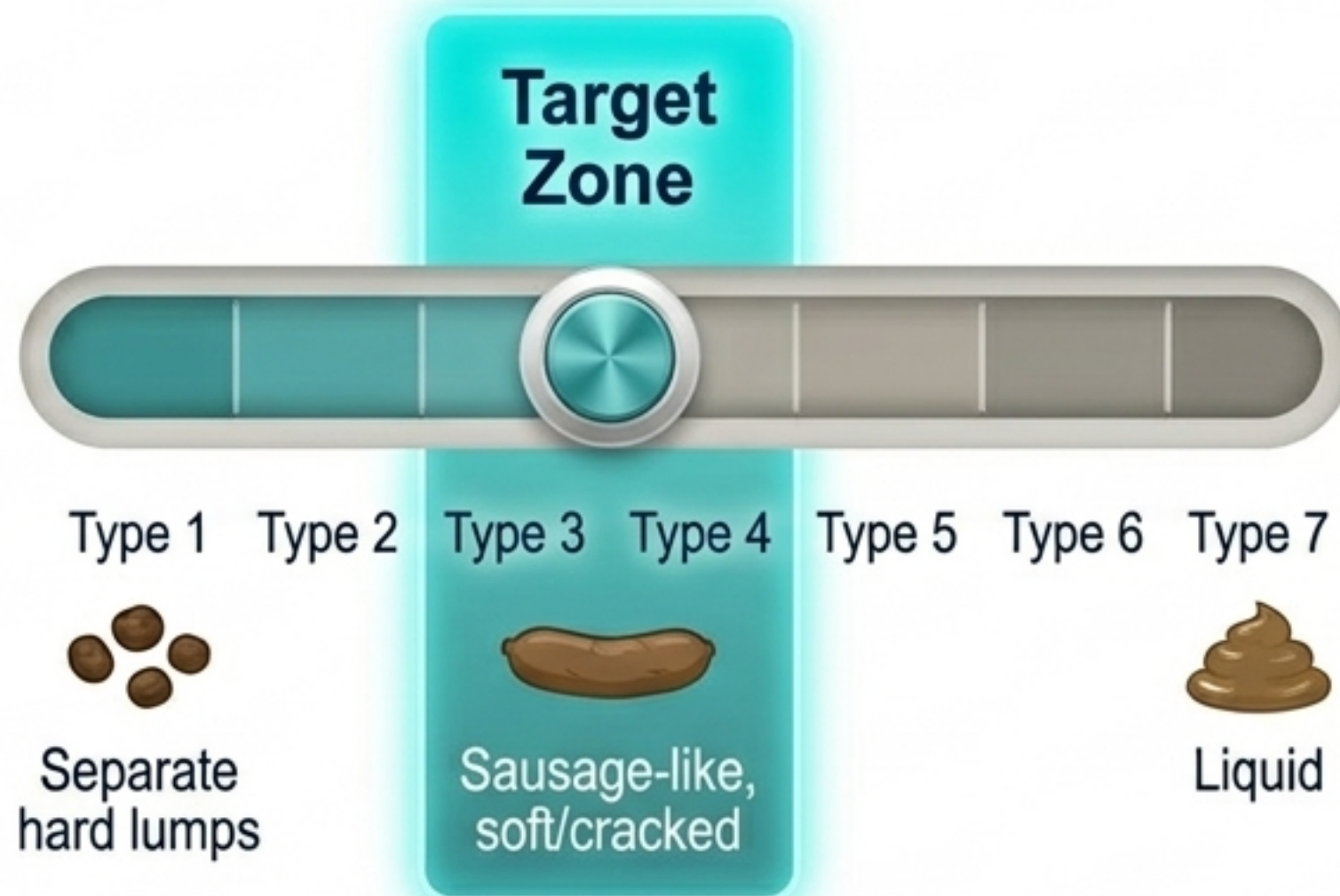
Diagnostic Frameworks & Treatment Targets

The Rome IV Diagnostic Gauge



Duration: ≥3 months with onset ≥6 months prior.

Bristol Stool Scale Slider



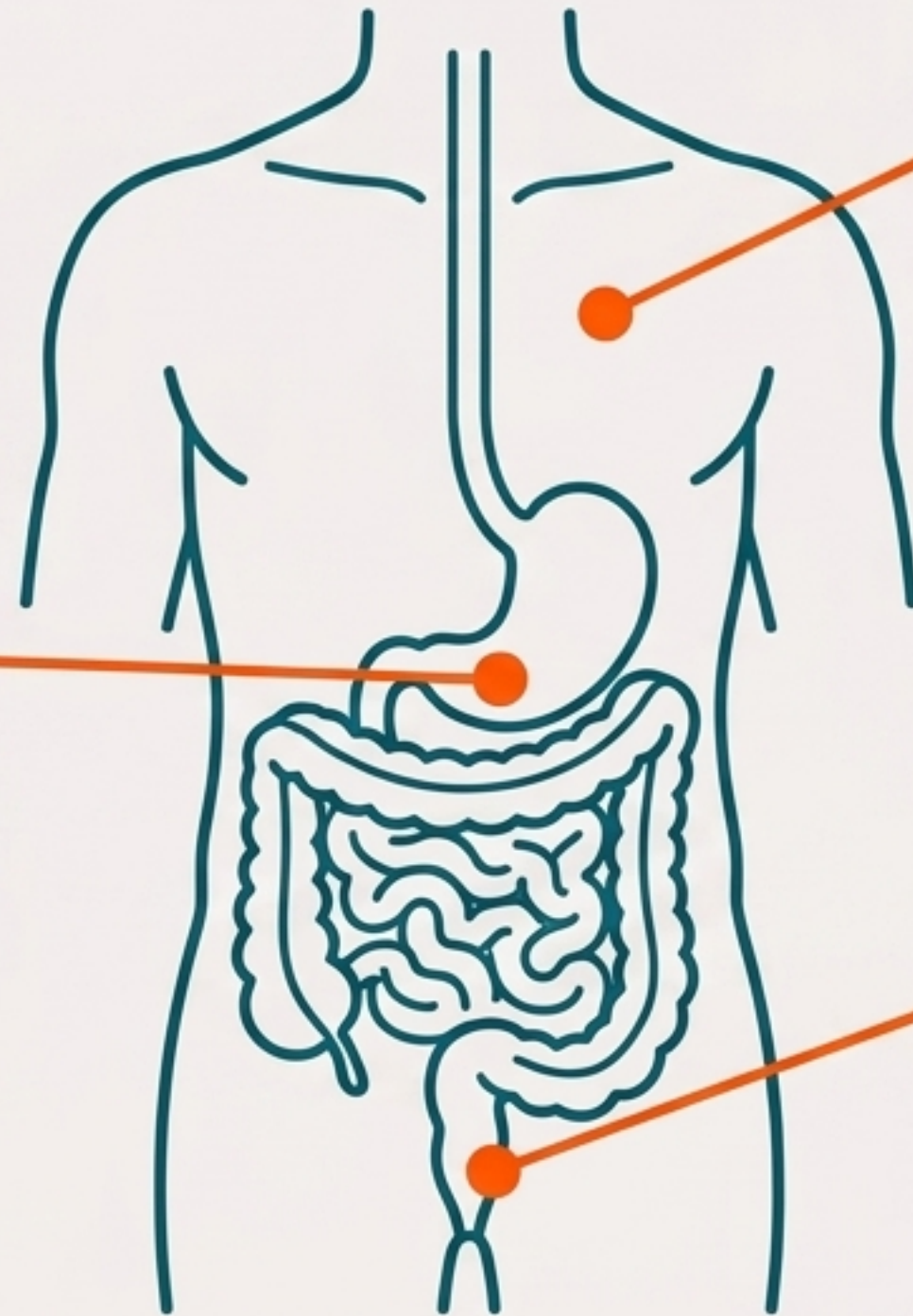
The Iatrogenic Culprits Matrix

Drug Class	Examples	GI Mechanism
Opioids	Codeine, oxycodone, tramadol	μ -receptor activation; reduced motility/secretion
Anticholinergics	Oxybutynin, amitriptyline	Reduced parasympathetic motility
Calcium-channel blockers	Verapamil, diltiazem	Smooth muscle relaxation
Supplements	Iron, Calcium carbonate	Direct irritant effect, altered motility
Serotonergic agents	SSRIs, ondansetron	5-HT ₃ antagonism; reduced GI motility



Opioid-Induced Constipation (OIC) affects up to 80% of patients on long-term opioids. Co-prescribe a **stimulant + osmotic laxative** proactively. Standard laxatives often fail due to peripheral μ -receptor mechanisms.

Alarm Features Mandating Urgent Investigation



Systemic / Global

- Unintentional weight loss (>5% in 6 mo)
- Iron-deficiency anaemia
- New-onset in age ≥ 50

Abdominal

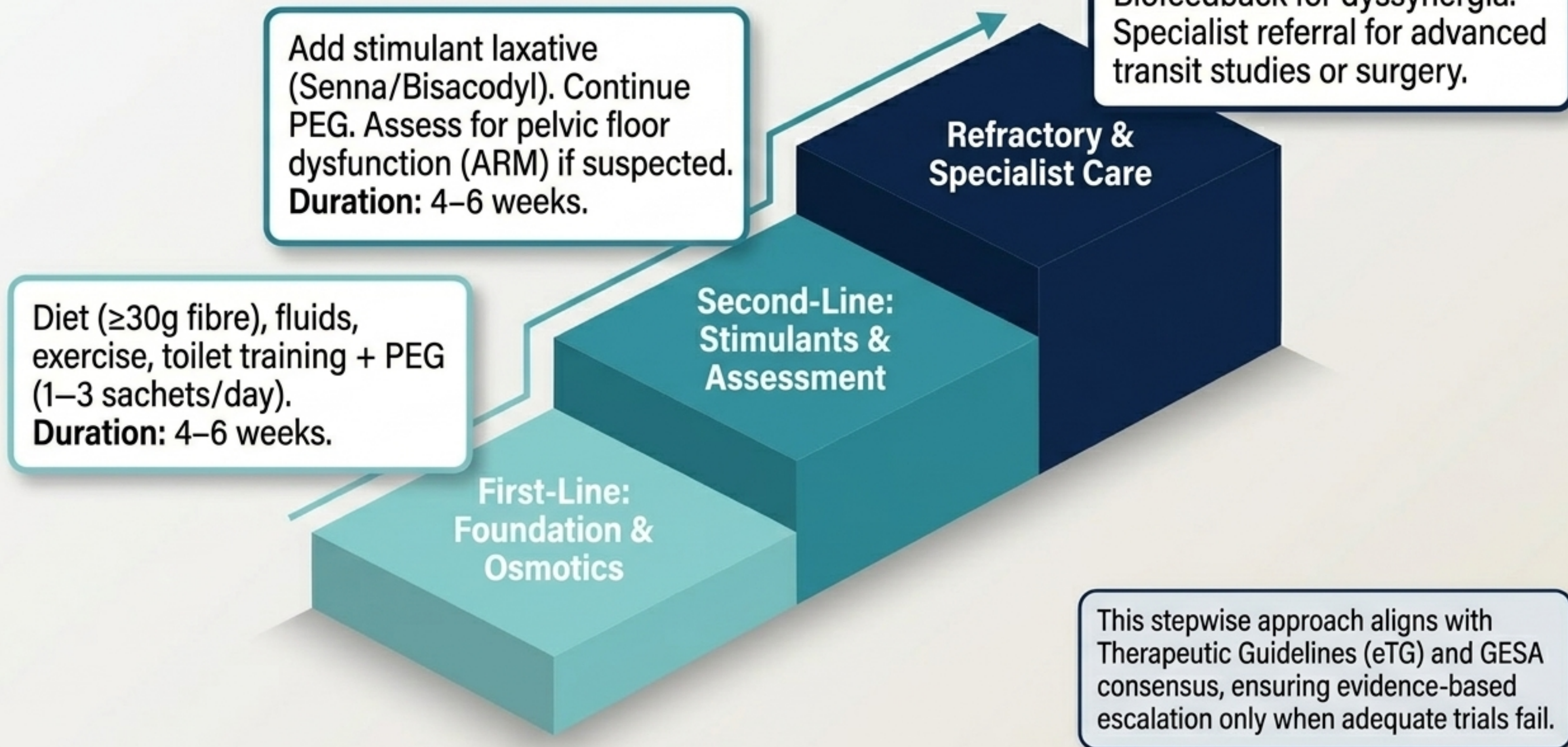
- Progressive worsening
- Palpable abdominal mass
- Symptoms of obstruction (vomiting, colicky pain, distension)

Anorectal

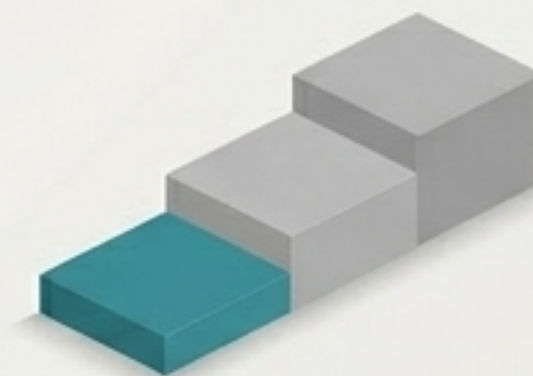
- Rectal bleeding (non-haemorrhoidal)
- Palpable rectal mass on DRE
- Acute change in bowel habit in older adults (≥ 65 years)

Presence of ANY alarm feature requires prompt investigation—typically colonoscopy—before attributing symptoms to a functional aetiology.

The Stepped Escalation Pathway



Step 1: Lifestyle Modification & First-Line Osmotics



Fibre



≥30 g/day

Mixed soluble/insoluble, whole grains, psyllium.

Hydration



≥1.5–2 L/day

Non-caffeinated fluids.

Activity



≥150 mins/week

Moderate physical activity.

Toilet Habit



15-30 mins post-meals

Utilize gastrocolic reflex, use a footstool.

Prescription Card

Polyethylene Glycol (PEG) 3350 (Movicol[®], Osmolax[®]) – Iso-osmotic, non-absorbable.

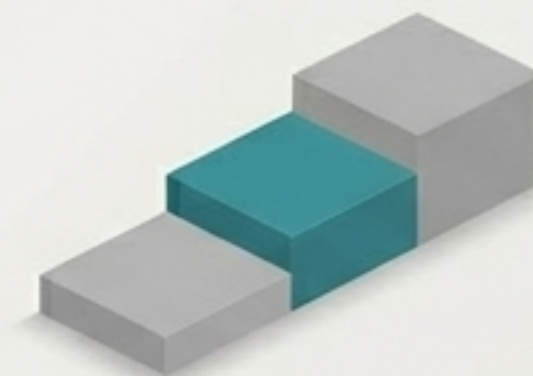
Dose: Start 1 sachet daily, titrate by ½–1 sachet every 2–3 days until Bristol 3–4 achieved. Max 3 sachets.

Notes: Efficacy review at 4-6 weeks. Safe for long-term use.

The Master Laxative Formulary

Agent	Class / Mechanism	Standard Adult Dose	PBS Status	Key Cautions
PEG 3350 (Movicol, Osmolax)	Osmotic	1-3 sachets daily	General Benefit	Caution with electrolyte formulations in severe renal impairment
Psyllium (Metamucil)	Bulk-forming	3.5g 1-3 times daily	OTC	Choking risk <6yrs, requires adequate fluid intake
Lactulose (Actilax)	Osmotic	15-30mL once/twice daily	General Benefit	Bloating, flatulence, avoid in renal impairment
Senna (Senokot)	Stimulant	15-60mg nocte	General Benefit	May cause cramping
Bisacodyl (Dulcolax)	Stimulant	10mg PO or PR nocte	General Benefit	Do not crush/chew oral tablets
Linaclootide (Constella)	GC-C agonist	290µg daily	Authority Required	Diarrhoea (16-20%), contraindicated in obstruction
Prucalopride (Resotrans)	5-HT4 agonist	2mg daily	Authority Required	Headache/nausea, caution in severe cardiac disease

Step 2: Stimulants & Scheduled Adjuncts



Senna



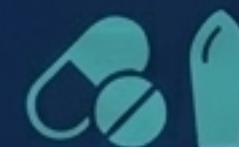
Class: Stimulant (anthraquinone).

Dose: 15–60 mg at night.

Use: Rescue therapy or scheduled adjunct.

Status: PBS General Benefit.

Bisacodyl



Class: Stimulant (diphenylmethane).

Dose: 10 mg orally at night OR 10 mg suppository (rapid effect 30-60 min).

Status: PBS General Benefit.



Myth: Chronic stimulant laxative use causes anatomical colonic damage (cathartic colon).

Fact: Current evidence robustly supports their safety for long-term adjunctive use at standard doses when osmotics alone fail.

Step 3: Secretagogues & Prokinetics



Linaclootide (Constella[®])

- **Mechanism:** Guanylate cyclase-C agonist → increased fluid secretion & transit.
- **Dose:** 290 µg daily, 30 mins before first meal.
- **Caution:** Diarrhoea is the most common side effect (16–20%). **Contraindicated in mechanical obstruction.**

PBS: Authority Required
(Refractory ≥3 months)



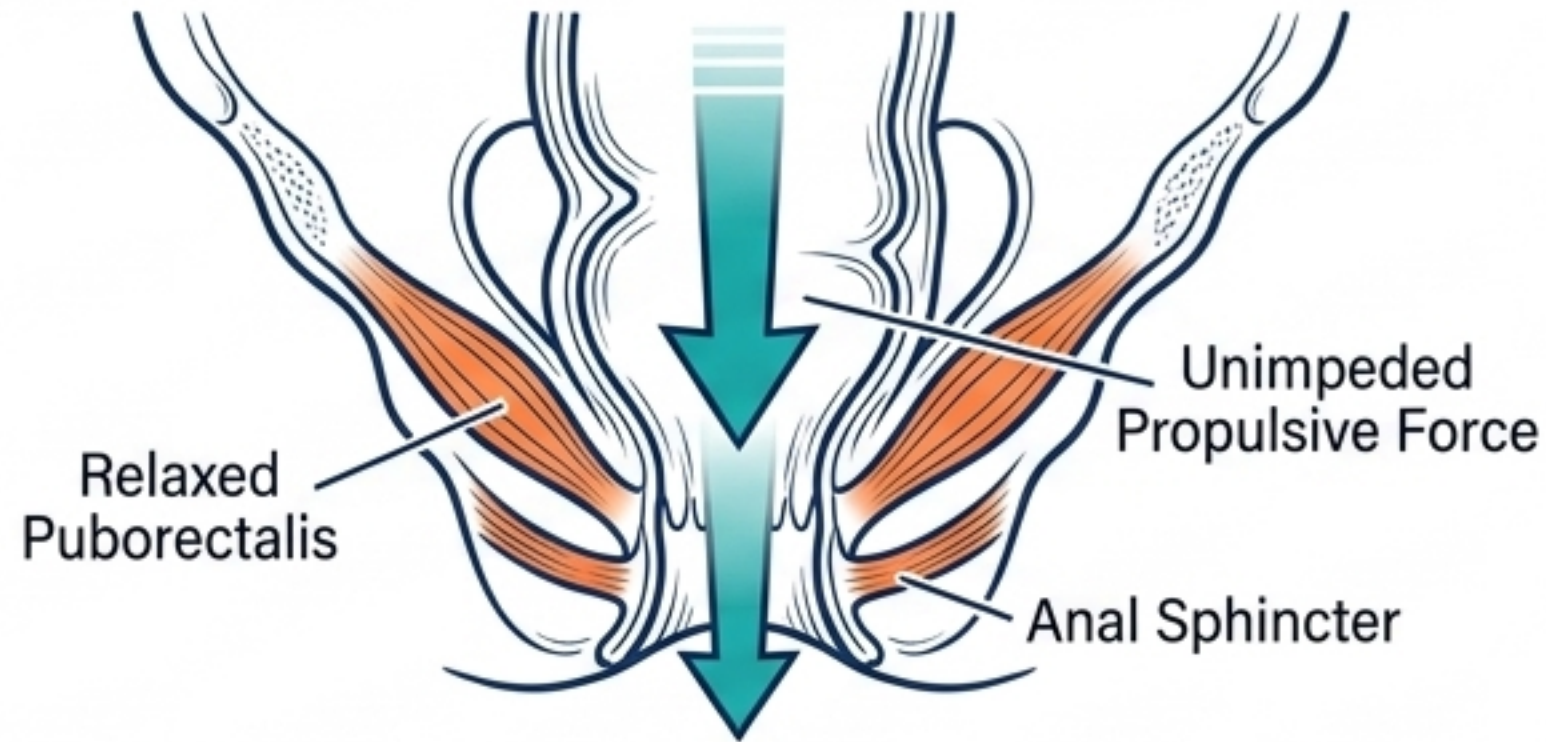
Prucalopride (Resotrans[®])

- **Mechanism:** Selective 5-HT₄ receptor agonist (prokinetic).
- **Dose:** 2 mg daily (1 mg if eGFR 15–30).
- **Caution:** Headache/nausea common. **Caution in severe cardiac disease (QT prolongation).**

PBS: Authority Required
(Women with refractory constipation)

The Mechanical Barrier: Pelvic Floor Dyssynergia

Normal Defaecation



Wide, open angle allows stool to pass easily.

Dyssynergic Defaecation



Sharp, closed angle impedes stool passage.

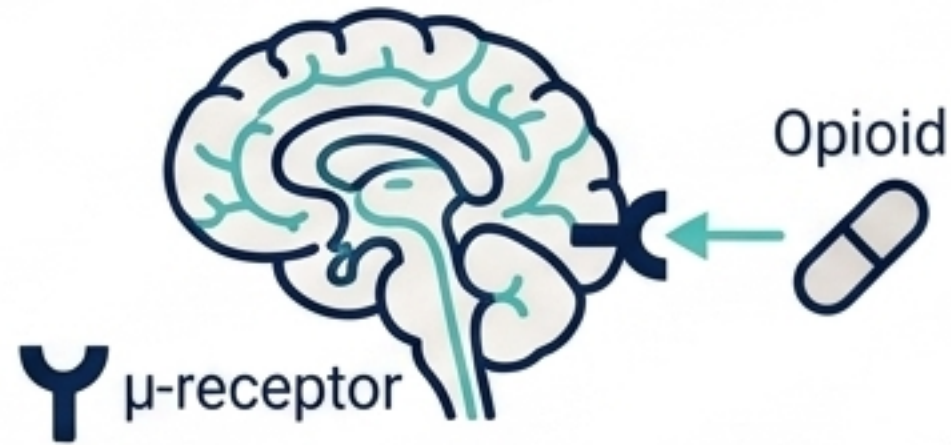
Clinical Clues

Suspect if: excessive straining, incomplete evacuation sensation, need for manual splinting, normal stool frequency but difficult evacuation.

Diagnostic & Treatment Path

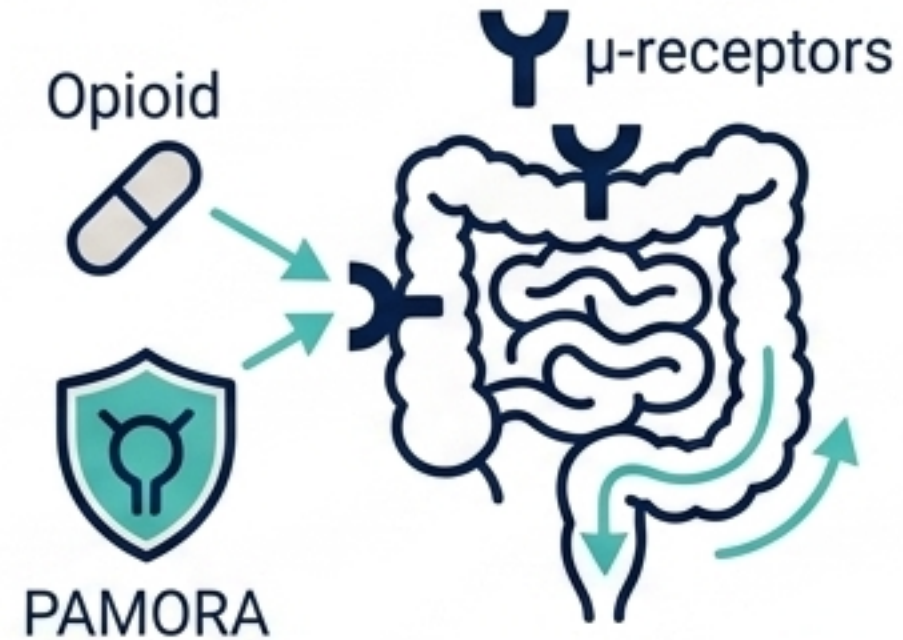
Gold standard diagnosis = Anorectal Manometry (ARM).
First-line treatment = Biofeedback therapy (60-80% improvement via specialized physio).

Opioid-Induced Constipation (OIC) & PAMORAs



Central = Pain Relief

Blood-Brain Barrier



Peripheral Blockade = Restores Motility

Naloxegol (Moventig®)

Oral PAMORA

Dose: 25 mg daily (empty stomach).
PBS Authority Required.

Methylnaltrexone (Relistor®)

Injectable PAMORA

Dose: 8-12 mg SC every other day.
Used in palliative care when oral fails.

⚠ WARNING: Do not use if mechanical GI obstruction is suspected. **Contraindicated with methadone.**

The Investigative Toolkit

Tier 3: Specialist Only

- Anorectal Manometry (ARM) for dyssynergia.
- MRI Defaecography for anatomical abnormalities.
- Wireless Motility Capsule (SmartPill).

Tier 2: Available Modalities

- Colonoscopy (Alarm features, age $\geq 45-50$).
- Colonic Transit Study (Differentiates slow transit from outlet obstruction; $>80\%$ retention on day 5 = slow transit).

Tier 1: Essential (Primary Care)

- Digital Rectal Examination (DRE) - Assess tone, impaction, paradoxical contraction.
- Bloods: FBC/Iron studies (exclude anaemia), TFTs (hypothyroidism), Calcium/Glucose/eGFR.

Special Populations Cheat Sheet

	Pregnancy	Paediatrics	Elderly	Renal Impairment	Hepatic Impairment
1st Line Choice	PEG (safe all trimesters)	PEG (0.4–0.8 g/kg/day, PIPES)	Electrolyte-free PEG (Osmolax)	Electrolyte-free PEG	PEG + Lactulose (for encephalopathy)
Alternative / Add-on	Lactulose	Senna / Bisacodyl	Review polypharmacy, watch Valsalva	N/A	N/A
Strictly Avoid (Orange Text)	Prucalopride, Linaclotide	Psyllium (<6yrs choking), Mineral oil	Routine phosphate enemas if frail	Magnesium laxatives, Sodium phosphate enemas	Lactulose overload causing dehydration

Aboriginal & Torres Strait Islander Health Considerations

Barrier

Diet & Food Security: Low fibre diets linked to remote fresh food access.



Solution

Support community programs (Good Food Bags), integrate native bush foods, liberalize PBS laxative prescribing.

Barrier

Access & Geography: Specialist motility clinics concentrated in urban hubs.

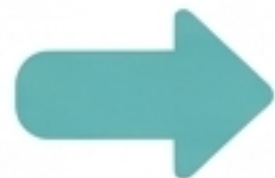


Solution

Utilize Telehealth (MBS 99200), Section 100 (S100) PBS pathways for sustained medication supply.

Barrier

Cultural Safety: Embarrassment/stigma discussing bowel habits.

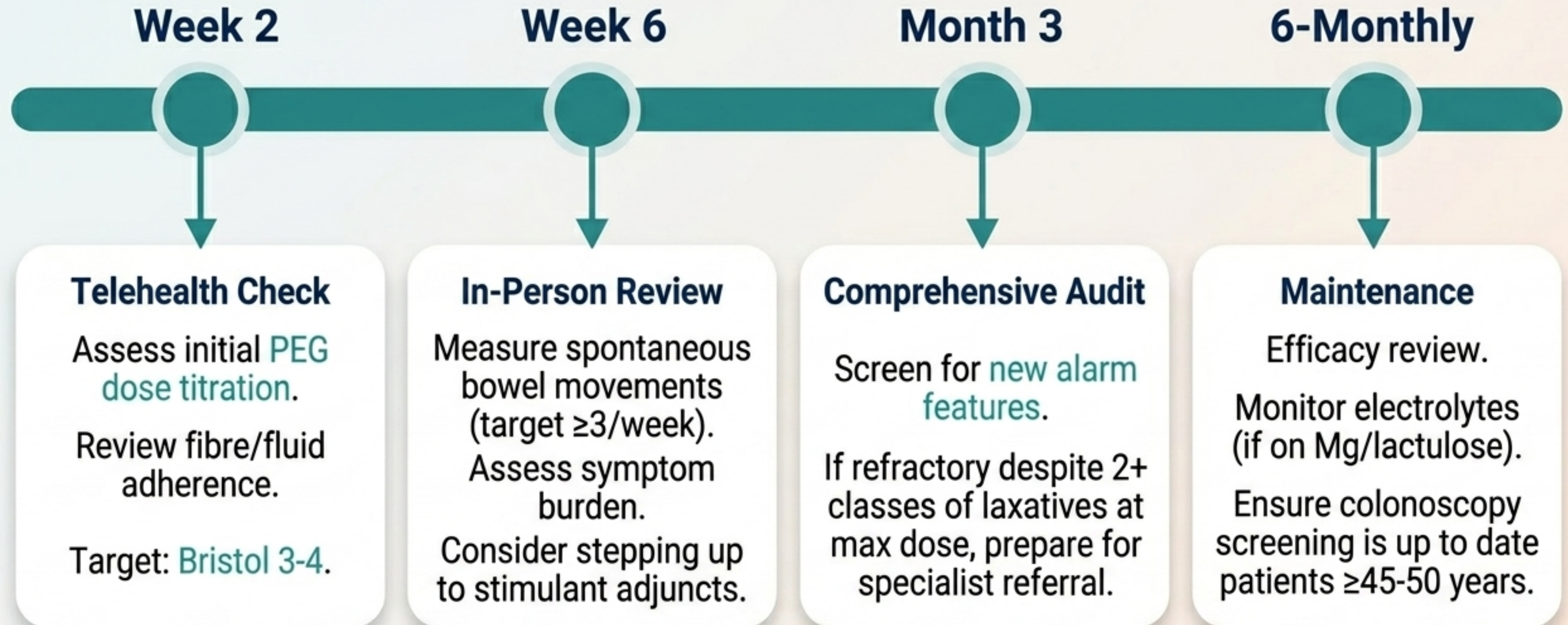


Solution

Engage Aboriginal Health Workers/Practitioners (AHWPs) as core team members; use plain-language.

ALARM SCREENING ALERT: Lower FOBT participation (~25%) necessitates aggressive investigation of alarm features due to later-stage presentation patterns.

Clinical Monitoring & Reassessment Timeline



Referral Triggers & Specialist Pathways

Standard Gastroenterology Referral

Refractory symptoms despite ≥ 3 months of optimized Step 1 & 2 therapy.

Age $\geq 45-50$ without colonoscopy in the past 5 years.

Suspected **dyssynergia** requiring **Anorectal Manometry**.

Requirement for **Authority PBS** initiation of secretagogues/prokinetics.

Urgent/Same-Day Assessment

Suspected **obstruction** (colicky pain, absolute constipation, absent sounds).

Acute onset with **alarm features** (bleeding, mass) in older adults.

Faecal impaction failing oral disimpaction in the community.

Multidisciplinary Care



Physiotherapists:
Pelvic floor biofeedback.



Dietitians:
Complex food insecurity or strictures.



Palliative Care:
Complex Opioid-Induced Constipation.