

DSH PSYCHOTROPIC MEDICATION

Operational Procedures

Appendix -- Management of Medication-induced Constipation

NOTE: Directive statements and procedures described in this chapter are informational and advisory in nature.

I. Background:

- a. Clozapine-treated patients are at significant risk for ileus primarily due to its potent anticholinergic properties.(1) **While the average colonic transit time in adults is 24 hours, for clozapine-treated patients not on laxatives the median CTT is over 4 times longer (110 hours).**(2) Even with use of maximal doses of each of the 3 common classes of laxatives (docusate; osmotic; stimulant) the median CTT remains elevated at 62 hours.(2)
- b. Other anticholinergic medications, especially in cases of anticholinergic polypharmacy may produce adverse effects similar to clozapine.
- c. Patients prescribed **glucagon-like peptide 1 receptor agonists (GLP1-RA) or GLP1-RA and glucose-dependent insulintropic polypeptide (GIP)** may experience constipation particularly when combined with other constipating medications, such as clozapine.(3) GLP1-RA and GLP1-RA/GIP drugs can cause gastroparesis, a measurable delay in gastric emptying with clinical symptoms of nausea, vomiting, early satiety, postprandial fullness, bloating, and abdominal discomfort. (4)
 - i. In patients taking clozapine, other anticholinergic medications, opioids, and other constipating medications, ensure constipation is adequately controlled before the addition of a GLP1-RA or GLP1-RA/GIP.
- d. **Opioid-induced constipation (OIC) is common in patients receiving** certain medications to treat opioid use disorder (e.g., methadone and buprenorphine).(5) In the GI tract, opioids act on motor neurons and secretory neurons to increase transit time and decrease luminal secretions resulting in a hard, dry stool. Opioid-induced dysfunction of the anal sphincter impairs elimination of stool. (6) Although buprenorphine is a partial agonist at the mu opioid receptor, **the rate of constipation is similar between buprenorphine and methadone** (60.2% vs 65.2%, respectively).(7)
- e. Patients prescribed multiple medications with the side effects of constipation and/or gastroparesis should be monitored closely.

Below are evidence-based recommendations for managing medication-induced constipation:

II. A. Nonpharmacological Interventions [6-9]

Encourage physical activity. Being sedentary promotes constipation. Daily moderate exercise, e.g. walking for 20 minutes, has shown the greatest benefit.
Encourage adequate fluid intake. Remind patients on GLP1-RA or GLP1-RA/GIP medications to drink fluids as these medications decrease thirst. Dehydration increases water resorption from the bowel, thereby hardening stool further. This is especially important during hot summer months.
Encourage intake of fruits and vegetables, as adequate dietary fiber promotes bowel regularity.
Encourage patients to report any substantial changes in bowel habits, stool consistency or color, blood in the stool, or development of straining, incomplete evacuation, or hard stools. <u>Recommend patients describe stool using the Bristol Stool Chart.</u> (12) However, patient report of symptoms is often unreliable.
Monitor usage of as needed (PRN) medications for constipation, a proxy measure of whether constipation is adequately controlled.

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II. B. Minimize Medication Related Causes of Constipation [10-15]

a.	Where feasible, minimize or <u>discontinue anticholinergic medications</u> , as they prolong transit time, promote drying of stool, and increase risks of constipation, fecal impaction, or bowel obstruction. This includes antiparkinsonians (e.g. benztropine, diphenhydramine, trihexyphenidyl), and non-psychiatric medications (e.g. oxybutynin, tolterodine, darifenacin, solifenacin, trospium and glycopyrrolate). Importantly, hydroxyzine is not included as it is not anticholinergic. <u>The use of anticholinergic agents with clozapine doubles the ileus risk.</u>
b.	DO NOT USE bulk laxatives (psyllium or polycarbophil). When slowed colonic transit times are present, bulk laxatives may add to constipation problems, and increase risk of fecal impaction and bowel obstruction.
c.	Iron: If the patient is not iron deficient or suffering from iron-deficiency anemia, avoid use of iron supplements as they promote constipation. When iron-deficiency anemia resolves, consider discontinuation of iron or reducing iron supplement frequency e.g., every other day. In those with anemia, consider holding iron during the initial 4-6 weeks of clozapine, methadone, or buprenorphine initiation, and then add back slowly with careful monitoring of bowel habits.
d.	Opioids: When feasible, opioids used to treat pain, (e.g. hydrocodone, etc.) should be stopped prior to clozapine initiation as these agents are profoundly constipating. Patients treated with agonist medications for opioid use disorder (methadone, buprenorphine) should be continued on the dose that is effective in maintaining abstinence from illicit opioids. These patients require enhanced bowel monitoring when treated with clozapine or another anticholinergic medication.
e.	Other medications associated with constipation include antiepileptics, diuretics, calcium channel blockers, cholinolytics, and serotonin antagonists (e.g. antiemetics). The effects of these agents are not as great as for anticholinergics, iron or opioids, but removal or modifying medications where possible may lessen the severity of constipation.

III. Treatment Protocol [16-19, 4]

	Stepwise Treatment Intervention
Step 1	Add one osmotic laxative, e.g. polyethylene glycol 17 gms qam or lactulose 30 ml BID. Polyethylene glycol 3350 (Miralax®) is generally superior to lactulose. (Lactulose is reserved for the treatment of hyperammonemia.) (see first line agents quality of evidence below)
Step 2	If step 1 isn't adequate to alleviate constipation, then add one stimulant laxative. Options include bisacodyl starting at 5 mg qhs (max 30 mg per day) or sennosides starting at 17.2 mg qhs (max 34.4 mg BID). If the patient is taking an opioid, then skip to step 3. (see first line agents quality of evidence below)
Step 3	If steps 1-2 fail to adequately control constipation, the next step depends on the etiology of the constipation: Clozapine Patients: Add one secretagogue (see Table 1). If the secretory laxative is effective, it may be possible to taper off the stimulant laxative first and then the osmotic laxative. GLP1-RA or GLP1-RA/GIP patients: Add one intestinal prokinetic drug (see Table 2) If the intestinal prokinetic drug is effective, it may be possible to taper off the stimulant laxative first, followed by the osmotic laxative. OIC Patients: Add one peripherally acting mu opioid receptor antagonist (see Table 2). If the peripherally acting opioid antagonist is effective, it may be possible to taper off other laxatives.
Step 4	If steps 1-3 fail to adequately control constipation, step 4 involves the addition of drug with an alternative mechanism of action: Clozapine Patients: Add intestinal prokinetic drug. It can be used concomitantly with secretagogues which have alternative mechanisms of action. If the prokinetic laxative is effective, it may be possible to taper off the secretagogue, then stimulant laxative, and finally the osmotic laxative. GLP1-RA or GLP1-RA/GIP Patients: Add secretagogue. If the secretagogue laxative is effective, it may be possible to taper off the intestinal prokinetic, then stimulant laxative, and finally the osmotic laxative. OIC Patients: If step 3 fails to diminish constipation entirely, add one secretagogue (see Table 1). If the secretagogue in combination with the peripherally acting opioid antagonist is effective, it may be possible to taper off other laxatives.

First-line agents for treating clozapine-induced constipation, dosing, and evidence.

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ACG = American College of Gastroenterology. Adapted from Meyer and Stahl 2019

Drug	Mechanism of Action	Starting dose	Max dose	Comments
Polyethylene glycol 3350 (PEG-3350)	Osmotic laxative	17 g QD	17 g BID	- Strong ACG recommendation - High quality of evidence
Lactulose	Osmotic laxative	30 ml QD	30 ml BID	- Strong ACG recommendation - Low quality of evidence
Bisacodyl	Stimulant laxative	5 mg QHS	15 mg BID	- Strong ACG recommendation - Moderate quality of evidence
Sennosides	Stimulant laxative	8.6 mg QD	17.2 mg BID	- Absence of controlled data

**Docusate sodium has questionable efficacy in the treatment of constipation.(24, 25)*

Table 1. Basic Info on Intestinal Secretagogues* [20-25]

Name	Mechanism	Starting Dose	Max Dose	Comments
Lubiprostone (Amitiza®)	Prostaglandin E1 analog	8 mcg BID	24 mcg BID	Give with food and water. Adverse effects can include nausea, abdominal pain, distention, diarrhea, dehydration, and rectal bleeding.
Linaclotide (Linzess®)	Guanylate cyclase-C agonist	145 mcg qD	290 mcg qD	Give > 30 min before 1st meal. Adverse effects can include diarrhea, dehydration, hypokalemia, and rectal bleeding.
Plecanatide (Trulance®)	Guanylate cyclase-C agonist	3 mg qD	3 mg qD	Adverse effects can include diarrhea, dehydration, hypokalemia, and rectal bleeding.

*None of these agents exhibit any drug-drug interactions. The proprietary secretory laxatives cost about \$400 per month of treatment; however, lubiprostone has become less expensive because it is generically available.

Table 2. Basic Info on Intestinal Prokinetic Drug

Name	Mechanism	Starting Dose	Max Dose	Comments
Prucalopride* (Motegrity®)	5-HT ₄ agonist, stimulates peristalsis	2 mg qD	2 mg qD	Adverse effects can include headache, abdominal pain, nausea, diarrhea, abdominal distention, dizziness. Monitor for worsening depressive symptoms or emergence of suicidal thoughts/behavior.

*FDA approved for constipation, may have benefit for gastroparesis and is generically available.

Table 3. Basic Info on Peripherally Acting Mu Opioid Receptor Antagonists [19, 26]**

Name	Mechanism	Starting Dose	Max Dose	Comments
Naloxegol (Movantik®)	Peripherally acting mu opioid receptor antagonist	25 mg qD (12.5 mg qD if creat clearance < 60 ml/min)	25 mg qD	Give at least one hour before 1st meal or 2 hours after meal. Contraindicated in patients taking strong CYP 3A4 inhibitors (e.g. clarithromycin, ketoconazole) Drug interactions: Avoid use with strong CYP 3A4 inducers (e.g. phenytoin). Avoid use with moderate CYP P450 3A4 inhibitors (e.g. diltiazem, erythromycin, verapamil). If concurrent use cannot be avoided, reduce naloxegol dose to 12.5 mg daily.
Naldemedine (Symproic®)	Peripherally acting mu opioid receptor antagonist	0.2 mg qD	0.2 mg qD	Give with or without food Avoid use in patients with severe hepatic impairment (Child-Pugh Class C) Drug Interactions: Avoid use with strong CYP 3A4 inducers. Moderate or strong CYP 3A4 inhibitors and P-glycoprotein inhibitors may increase naldemedine exposure.

** Contraindicated in known or suspected GI obstruction. Avoid concomitant use with other opioid antagonists. Adverse effects can include GI perforation, severe or persistent diarrhea, abdominal pain, and opioid withdrawal. Naldemedine and naloxegol cost about \$400 per month of treatment, naloxegol generic versions expected in 2026. Methylnaltrexone, a third agent, was not listed here due to its cost of >\$2000/month. Note that these medications do not effectively cross the blood-brain barrier and do not interfere with opioid agonist or partial agonists used for pain treatment or medication assisted treatment of opioid substance use disorder.

References

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