Palliative Care

Care Management Guidelines

Constipation

Department of Health and Human Services

Tasmania
Explore the possibilities

Constipation

Introduction

- This guideline outlines the symptomatic management of constipation in the palliative care setting.
- Whilst investigation and definitive active treatment of the underlying disease should always be considered and may be essential management, in-depth details are not provided here.

Key Principles

- "Prevention is better than cure".
- ALWAYS prescribe a laxative when commencing an opioid analgesic, including codeine-containing preparations. A combination of a faecal softener and bowel stimulant is the most appropriate and convenient laxative e.g. Coloxyl with Senna two tablets orally, once or twice daily.
- Careful assessment of bowel pattern is crucial e.g. the report of a bowel movement does not exclude constipation.
- In palliative care patients the treatment of constipation is different to that in healthy, active people.
- Even with poor oral intake the bowel produces its own 'bulk' and constipation can occur.
- Remember 'diarrhoea' can be overflow with constipation – abdominal X-ray is very helpful.
- Towards the end-of-life stage, active management of constipation may be unnecessarily intrusive and burdensome and can be curtailed (an exception may be the agitated patient with a full rectum).

Assessment

- Careful initial and repeated assessment, along with accurate documentation, of the patient's bowel pattern is essential for effective diagnosis and management of constipation.
  - Use of a standardised visual assessment tool such as the Bristol Stool Chart (see below) encourages a more detailed assessment of stool type and facilitates documentation of a patient's bowel pattern including the response to any interventions.
  - The response "I used my bowels this morning" does not exclude constipation and should not preclude more detailed questioning about the patient's bowel pattern.

Useful Questions When Assessing Constipation

Onset

- When/how did it begin?
- What was your usual bowel pattern?
- How much and how often? Before? Now?

Provoking/relieving

- What medication are you on?
- How is your appetite/food and fluid intake?
- What treatments/laxatives have you tried previously?
- What are you taking now?
- How effective are these?
- Do you get any side effects from these treatments/laxatives?

Quality

- What does it feel like?
- Is using your bowels painful?
- Is there a feeling of incomplete evacuation?
- What do the stools look like?
- Where do you most feel it? (abdomen? ano-rectal area?)

Severity

- How bad is the constipation (on a scale of 0 to 10 with 0 being none and 10 being worst possible)? Right now? At best? At worst? On average?
- How bothered are you by it?
- Are there any other symptoms that accompany the constipation e.g. anorexia, nausea, vomiting, abdominal pain, pain on defaecation, bloating?

Examination

- General examination: evidence of dehydration;
- Abdominal examination: for prominent faecal masses/other masses;
- Auscultate for bowel sounds;
- Inspection of anal area: look for haemorrhoids, anal fissure;
- Rectal examination: soft or hard faeces, empty rectum; and
- If a stoma is present then gently examine as for PR.

Investigation

- Plain abdominal X-ray can be useful if the cause of symptoms is in doubt, bowel obstruction is suspected, or to ascertain the degree/distribution of faecal loading.
- Check biochemistry (e.g. serum calcium, electrolytes, serum creatinine, Liver Function Tests, Thyroid Function Tests) if metabolic factors are suspected.

Management

Goals of Management

- Restoration of pre-illness bowel habit is often not achievable. The main goal is to prevent the consequences of constipation, or treat them if they have occurred. These consequences can be unpleasant and sometimes serious:
    - abdominal distension/pain;
    - anorexia, nausea and/or vomiting;
    - faecal 'overflow' incontinence;
    - haemorrhoids/anal fissure;
    - urinary retention/infection;
    - faecal impaction (progressing occasionally to bowel obstruction); and
    - agitated delirium.
- Identify and treat any reversible causes if appropriate.
- Proactive management with prophylactic laxatives in patients at high risk of constipation (e.g. commencing opioid).
- Education of patient and carers about the importance of close vigilance of bowel pattern, early intervention and ongoing management of constipation.
- Aggressive intervention to reverse severe constipation/faecal impaction and to prevent recurrence.

General, non-pharmacological measures

- Regular toileting especially after meals (gastrocolic reflex).
- Adequate privacy / proper positioning on toilet (? use of foot stool).
- Improve fluid/ fibre intake if possible.
- Encourage gentle increase in activity if appropriate.

Pharmacological measures

First Line

- First line laxative treatment and dosage varies greatly from patient to patient, according to whether or not they are taking opioids and their history of laxative use.
- Generally a combination of stool softener and peristaltic stimulant are used.
- Recommended doses are:
    - Stool softener:
        - Coloxyl 1-2 x 120mg tablets po, nocté;

          or
        - Macrogol (Movicol) 1 - 2 sachets in 125 - 250mls of water orally, taken over 1 - 2 hours daily
    - Peristaltic Stimulant:
        - Senna 1 - 2 x 7.5mg tablets nocté;

          or
        - Bisacodyl 1 - 2 x 5mg tablets nocté
- Once constipation is resolved titrate dose to effect.

Note: *Modify medication regime if possible*

- Metoclopramide *metoclopramide* has a prokinetic effect on the bowel so can be a useful addition to treatment if nausea &/or vomiting are present.

Second Line:

- When there is no bowel action for three days consider a rectal examination (check if the patient is currently having chemotherapy due to the risk of neutropenia) and, if rectum is empty, plain abdominal X-ray.
- When there is no satisfactory bowel motion, or consequences of constipation persist.
- The choice of treatment will depend on the rectal examination result.

Note: *Rectal measures are usually for short-term use to relieve impaction, unless a neurological disorder necessitates regular suppositories/enemas to ensure adequate bowel emptying.*

Rectum Empty

- May be indicative of a higher impaction.
- Exclude obstruction (abdominal examination +/- abdominal X-ray)
  - Propulsive stimulant: bisacodyl (Durolax) suppositories 1 - 2 PR; repeat twice daily until good result. Bisacodyl suppositories need to be placed in contact with the rectal (or stomal) mucosa to be effective.

    or
  - Microlax enema 1 PR; repeat daily or even twice daily until good result.

    or
  - Movicol 8 sachets dissolved in 1 litre of water orally, taken over 2 - 4 hours.

    or
  - Senna milkshake = 2 - 3 teaspoons of senna granules dissolved + 20 - 30mls of Agarol + hot or cold milk shaken well.
- Once impaction has resolved, prevent recurrence with adequate doses of oral laxatives (colonic stimulant + stool softener).

Rectum Full – Hard Faeces

- Glycerine suppositories 1 - 2 PR to soften stools (placed into substance of stool) +/- bisacodyl (Durolax) suppositories 1 PR to stimulate rectum/bowel from above (placed in contact with rectal mucosa).
- Once resolved resume oral laxatives at appropriate dose(s).

  or
- Movicol 1 - 3 sachets in 500mls of water orally, taken over 1 - 2 hours daily; once resolved titrate dose to effect.
- Rarely, manual evacuation of hard stools is required under sedative cover (e.g. midazolam 5mg S/C or lorazepam 1mg S/L).

Rectum Full – Soft Faeces

- Senna 2 x 7.5mg tablets nocté, increasing to 15mg bd
- Bisacodyl – propulsive stimulant

  2 x 5mg tablets po nocté, increasing to 10mg bd

  (10-12 hour delay to onset)

  +/- Bisacodyl suppositories 1-2 PR until resolved

Note: *45 - 60 minutes delay to onset of action*

- If the patient is having difficulty expelling soft stool then add (or increase dose of) propulsive agent (senna or bisacodyl).

About Laxatives

- Contact laxatives (e.g. senna and bisacodyl) increase peristalsis so may cause some cramping abdominal pain in some patients.
- Docusate is primarily a faecal softener.
- Oral bulk-forming agents (e.g. Normacol, Agiofibe, Metamucil, Fybogel) require considerable fluid intake to be effective and are generally not suitable for palliative care patients: they may make the situation worse.
- Osmotic laxatives (e.g. lactulose) cause water retention in the bowel lumen; are broken down by bacteria in the colon causing increased peristalsis and therefore can cause abdominal discomfort/cramping and flatulence; sickly, sweet taste can be nauseating to some; not useful if patient's fluid intake is poor.
- Saline laxatives (e.g. sodium picosulfate/magnesium citrate ('Pico lax')) are frequently used as bowel prep; but can be useful in lower doses for a more gentle laxative effect if quick onset of action is required, without causing the purgative effect of the higher doses; onset of action is approximately 12 hours (compared with 1 - 3 days with docusate or lactulose); recent study suggests starting with 10mg (1 sachet) in 120mls daily and titrate according to response.
- Liquid paraffin(Agarol) acts as a faecal lubricant; it
  - can cause lipoid pneumonitis; avoid just prior to lying down; avoid if there is risk of aspiration (neurological disorder, severe Gastric Oesophageal Reflux Disorder (GORD), etc.
  - can impair absorption of fat-soluble vitamins (A,D,E & K) so avoid it at meal times.
- Macrogol or polyethylene glycol (Movicol) binds only orally taken fluids within the bowel, so does not lead to a net loss of fluid and electrolytes. It hydrates hardened stools, increases stool volume, dilates the bowel wall, and triggers the defaecation reflex. It is well tolerated and effective so may be a good choice for those who can take the required 125mls of fluid per sachet.

Consultation and Advice

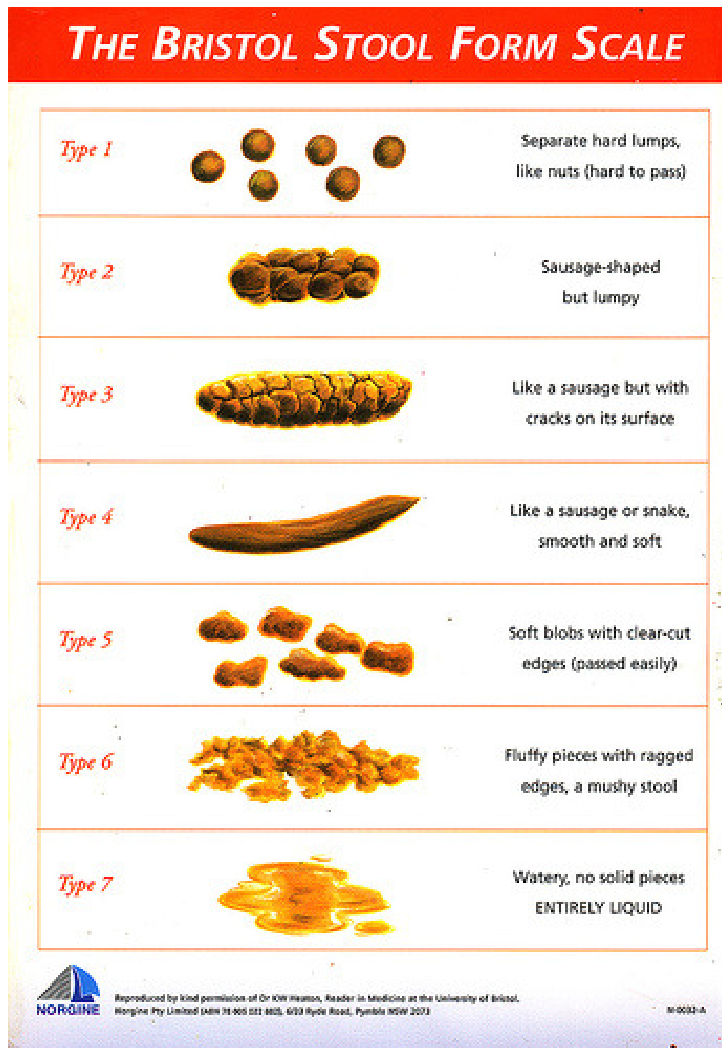
Consider seeking advice if:

- Complications are present: obstruction, nausea and vomiting, overflow incontinence.
- Failure to respond to second line intervention.
- Severe opioid induced constipation.
- Impaction high or low, especially when initial rectal intervention has failed.

Definitions

- Constipation is the difficult or unduly infrequent passage of faeces.
- It is a common and frequently troublesome symptom in patients with advanced illness.
- Often multiple causative factors are present:
  - reduced food (including fibre) and fluid intake;

- reduced mobility;
- reduced abdominal and pelvic muscle power;
- constipating drugs (e.g. opioids, drugs with anticholinergic action, 5HT3 antagonist anti-emetics, iron);
- reduced rectal/anal tone and sensation (neurological impairment); or
- metabolic disorders (e.g. hypercalcaemia, hypokalaemia, hypothyroidism, diabetic autonomic neuropathy).



Revision history and planned frequency

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