Management of Constipation

Palliative Care Module – Day 4

Your Experiences…

Are you a bowel Nurse ?

How often do you encounter constipation in others?

Is constipation assessed and managed well in your area?

How confident do you feel in assessing and managing constipation?

Definition of Constipation

- The passage of small, hard faeces infrequently or with difficulty, and less often than is normal for the individual
- Constipation can cause unpleasant symptoms such as abdominal and rectal pain, distension, nausea and vomiting
- Can have negative effects on the patients wellbeing
- As well as the physical suffering constipation can cause psychological distress and agitation in the last days or short weeks of life

Recognised causes

- Lack of Fibre
- Not drink enough
- Inactivity
- Dietary changes
- Stress, anxiety & depression

Assessment

- As with every symptom assessment is the key
- Identify normal bowel pattern
- Current or previous treatment
- Effectiveness of any treatment
- Clinical features
    - Is there pain
    - Nausea, vomiting, anorexia
    - Flatulence, bloating, malaise
    - Overflow diarrhoea
    - Urinary retention

Possible causes of constipation

- medication: opioids, antacids, diuretics, iron, 5HT3 antagonists
- secondary effects of illness (dehydration, immobility, poor diet, anorexia)
- tumour in, or compressing, bowel wall
- damage to lumbosacral spinal cord, cauda equina or pelvic nerves
- Hypercalcaemia , hypokalaemia, hypomagnesaemia
- concurrent disease such as diabetes, hypothyroidism, diverticular disease, anal fissure, haemorrhoids, Parkinson's disease

Abdominal examination may help identify adbo pain, faecal loading , ascities.

Rectal or stomal examination can be useful to identify hard stools or masses.

Consider whether examinations would cause undue stress for the patient.

Management & General Advice

The aim of management is to achieve comfortable defaecation, rather than any particular frequency of bowel motion.

- Encourage a good oral fluid intake (1.5- 2 litres per day if able) and review dietary intake.
- Ensure patient has privacy and access to toilet facilities. A foot stool to elevate knees may help.
- Encourage daily exercise according to ability.
- Address any reversible factors contributing to the constipation (eg deprescribe contributing medications)
- Do not delay treatment whilst waiting for the results of investigations such as blood tests.
- Laxative doses should be titrated according to individual response.
- If current regimen is satisfactory and well tolerated continue, but review patient regularly and explain importance of preventing constipation.
- Use oral laxatives if possible in preference to alternative routes of administration
- Co-prescribe laxatives when commencing opioids

Laxative Choice	
First line: **Stimulant laxative**	• Senna tablets 15 mg to 30 mg, or bisacodyl tablets 5 mg to 10 mg at night. ◦ If significant colic occurs, the stimulant should be discontinued, and a surface-wetting or osmotic laxative used instead.
Second line: **Add in surface-wetting/osmotic laxative**	• Macrogol (for example Laxido®) (with caution in patients with renal disease given the potassium content) 1 to 3 sachets daily. ◦ If severe constipation, consider a higher dose for 3 days. • Docusate sodium 100 mg to 200 mg twice daily. Docusate sodium can be used in isolation, however, docusate sodium may not provide additional benefit when combined with senna treatment.
Third line: **Add rectal treatment if the rectum is loaded** (do not give rectal treatment if the rectum is ballooned and empty)	1st. Start with a glycerol suppository and bisacodyl suppository given at the same time, placing the bisacodyl suppository directly against the rectal mucosa 2nd. If no result but the rectum remains loaded then progress to a sodium citrate enema, and then a phosphate enema if no result 3rd. If very hard loading an arachis oil enema (except in those with nut allergy) overnight, followed by a phosphate enema in the morning, may be considered

Choice of Laxative

- Patient preferences should be taken into consideration.
- Suggested laxative starting doses are provided . These should be titrated as appropriate depending on individual response.
- For constipation in patients taking opioids that is resistant to standard management, refer to opioid induced constipation guidance

Other Considerations

- Paraplegic or bedbound patient
- Opioid-induced constipation
- Bowel Obstruction


THE BRISTOL
STOOL TART
1
2
3
4
5
6
7

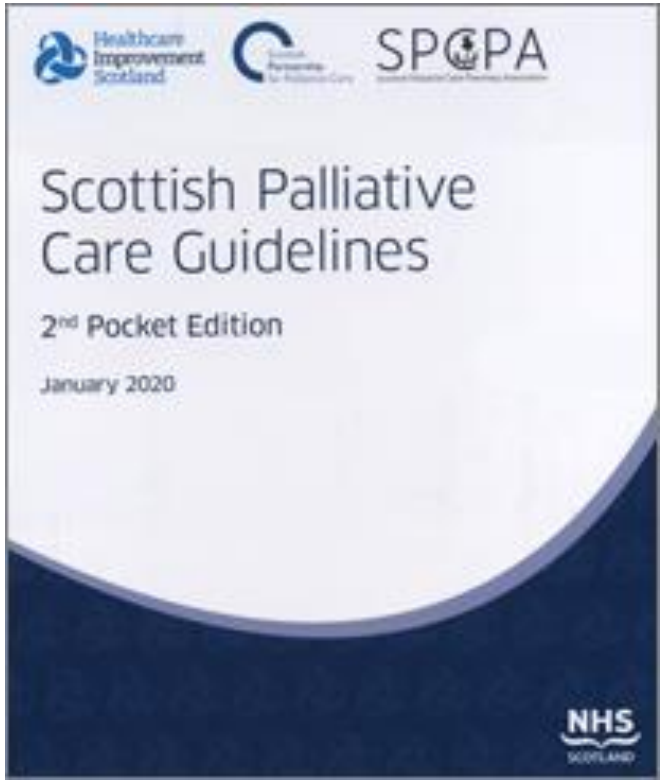

The Bristol Stool Tart


1
2
3
4
5
6
7

Practice Points

- Majority of palliative care patients on opioids need a regular oral laxative.
- Always review laxative regimen when opioid medication is commenced or dose is changed. This includes increasing use of ‘as required’ opiates
- Caution is needed with frail or nauseated patients who may be unable to tolerate the fluid volume needed for macrogol laxative ((laxido) to be effective
- Bulk-forming laxatives are not suitable if the patient has a poor fluid intake and reduced bowel motility (eg Fybogel)
- Lactulose is not effective without a high fluid intake; it can cause flatulence and abdominal cramps in some patients.
- If laxative therapy fails, seek specialist palliative care advice for alternative options.
- Manual evacuation, if absolutely necessary, requires consent and should never be attempted without analgesia and/or sedation.
- If there is a clinical picture of obstruction with colic, peripheral opioid antagonists are contra-indicated and stimulant laxatives should be avoided (refer to Bowel Obstruction guideline).

Remember …
Think Scottish Palliative Care Guidelines…



Constipation | Right Decisions