Management of Constipation in Palliative Patient

The aim of treatment is the comfortable passage of faeces without the need for rectal intervention

- An understanding of the patients normal bowel habit is essential when planning treatment
- All patients on opioids MUST have laxatives, regularly prescribed (not just prn)
- A combination of stimulant and a softener is almost always required
- Laxative doses often need to be increased along with increased doses of opioids

Constipation

Constipation is the passage of a small volume of faeces infrequently and with difficulty. Consider possible causes:

- General debility, low food and fluid intake
- Drug therapy eg: opioids (especially codeine), anticholinergics, ondansetron
- Spinal cord compression
- Hypercalcaemia, hypokalaemia
- Bowel obstruction
- Depression, fear of diarrhoea/incontinence, fear of bedpans

Daily Assessment of Constipation

When did the patient’s bowels last move?
Stool consistency? Stool size/volume?
Is there blood or mucus in stool? Ease of passage?
Faecal incontinence? Overflow?

** PLEASE DOCUMENT DAILY **

USE BRISTOL STOOL CHART
If you suspect the patient is constipated

- oral examination to check for oral thrush, mucositis and dehydration
- physical examination of abdomen and listen for bowel sounds
- a rectal examination should be performed gently, unless the patient is neutropenic or has rectal bleeding
- an abdominal X-Ray should be considered to assess for faecal loading

How to Perform Rectal Examination

- Ensure the patient understands and consents to the procedure
- If possible lie the patient in the left lateral position with their knees drawn up
- Ensure the gloved finger is well lubricated
- Observe the perianal area for haemorrhoids, rectal tears and broken skin before proceeding
- Ensure the examination is performed gently, using one finger only

  If rectum is empty and collapses – the rectal wall should be easily felt collapsed around the examining finger (this is usually an indication of a functioning bowel). No further treatment is required but continue to assess bowels daily.

  If rectum is empty and dilated – often feels ballooned on examination. This may indicate faeces high up in the bowel which is indicative of gross constipation. Be aware that fluid stool may actually be an indication of impaction with overflow

  Faeces in rectum – determine the consistency of the faeces and manage as per treatment section

  Tumour in the rectum – sometimes a mass in the rectum is not faeces. On examination the rectum feels lumpy or hard/irregular and the mass is immobile. Refer to medical staff and do not proceed with rectal laxatives or enemas.

- If you are unsure of your findings, please consult a colleague or medical staff
**Treatment Constipation**

See [Constipation Flowchart](#)

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### Oral Laxatives

**Bulk forming:** Dietary fibre acts by increasing and retaining the amount of fluid in the bowel, which leads to an increased faecal mass thus stimulating peristalsis and producing a bulkier and softer stool e.g. bran, Metamucil, fybogel

**Caution:** Unsuitable for elderly or debilitated patients as they need to drink extra fluids. Not normally used in Palliative patients.

### Contact Laxatives:

Softeners and stimulants. These act on the intestinal mucosa, promoting secreting fluid which softens the faeces and stimulates peristalsis.

Most work in the large bowel, except coloxyl, which acts in the small and large intestine. Expected time of action is 1-3 days

**Caution:** Stimulants are unsuitable for patients with complete bowel obstruction as they increase peristalsis and may cause colic or perforation

- Stimulants: senna, bisacodyl,
- Softener: coloxyl (docusate)

#### Commonly Used Regimens in Palliative Care

**Coloxyl and Senna™** 1-2 tablets bd (maximum 3 tablets tds)

If these are not effective then coloxyl™ and bisacodyl will be considered

**Danthron and Poloxamer**

(Conthram™, Conthram Forte™, Codalax™, Codalax Forte™)

**Dosing:** oral: opioid induced (prophylaxis and treatment):

- Susp 10-20ml once or twice a day
- Susp Forte 5-20ml once or twice a day

**Mechanism of action:** stimulates colonic activity via nerves in the intestinal mucosa (danthron) and increases fluid uptake by stools thus softening them (poloxamer).

**Onset:** oral 6 - 12 hours

Only for elderly and terminally ill when other laxatives have failed (due to association of danthron with tumours in rats)

### Osmotic Laxatives:

**Lactulose:** These non-absorbable sugars exert an osmotic influence causing water retention in the lumen. Expected time of action is 1-3 days

**Caution:** Can cause dehydration in patients with poor oral intake. Can cause cramping and nausea so generally **not suitable** for palliative patients
Movicol is also an osmotic laxative but is preferable to lactulose in the palliative patient. It contains macrogol and electrolytes and exerts an osmotic action in the gut, which induces a laxative effect. Macrogol increases the stool volume, which triggers colon motility via neuromuscular pathways. Expected time of action is 1-3 days.

Commonly Used Regimens in Palliative Care

Severe Constipation: The dose is 1 sachet daily. This may be increased to 2-3 sachets daily, if required. We do not recommend this for ongoing management of constipation as contact laxatives will generally achieve the same result without excessive cost to the patient.

Faecal Impaction: 8 sachets daily, consumed within 6 hours. A course of treatment for faecal impaction does not normally exceed 3 days and other laxatives should be ceased while this treatment is being used.

Saline Laxatives: eg: Magnesium Sulphate - draws fluid in to the bowel which results in softening of the stool and stimulation of peristalsis with rapid bowel evacuation usually within 1-6 hours.

Caution: Should not be given to elderly or debilitated patients as fluid intake needs to be increased and prolonged use will result in electrolyte imbalance.

Rarely used in palliative care and if needed the patient may require intravenous fluids while it is being used.

Rectal Intervention:

- When oral laxatives have not produced a bowel motion or when rapid relief from rectal loading is required, suppositories or enemas may be appropriate.
- Suppositories are more easily retained by palliative care patients so should be used as first line before enemas.
- When inserting suppositories or enemas have patient lie in left lateral position (Addison, 2000)
- Push suppositories about 4cm in to the rectum
- Do not insert a medicated suppository (dulcolax) into faecal mass as its effect will be minimal. Lubricant suppositories (glycerol) should if possible be inserted into the faecal mass in order to dissolve and soften the faeces
- Enemas should be administered at room temperature
- Use gravity and not force to administer an enema. Forcing can result in bowel spasm, leakage or shock
The following table outlines the use of such suppositories and enemas.

<table>
<thead>
<tr>
<th>Laxative</th>
<th>Starting Dose</th>
<th>Time of effect</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Soft faecal loading)</em></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Stimulant suppository</td>
<td>1 suppository prn</td>
<td>15-30 minutes</td>
<td>Must be inserted <strong>blunt end first</strong> (Mallett, 2000) and be in contact with the bowel wall to be effective</td>
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<tr>
<td>Bisacodyl</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><em>(Hard faecal loading)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lubricant suppository</td>
<td>1 suppository prn</td>
<td>15-30 minutes</td>
<td>Combined irritant and softener</td>
</tr>
<tr>
<td>Glycerol 4g</td>
<td></td>
<td></td>
<td>Can be inserted <strong>pointed end first</strong> (Cambell, 1993) to facilitate insertion into faeces</td>
</tr>
<tr>
<td><em>(Very Hard faecal loading)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retention Enema</td>
<td>1 prn</td>
<td>15-30 minutes</td>
<td>Contains peanut oil, contraindicated in nut allergies</td>
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<tr>
<td>Arachis Oil</td>
<td></td>
<td></td>
<td>If retaining for any length of time slightly raise the end of the bed to assist retention</td>
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<tr>
<td>Evacuant Enema</td>
<td>1 prn</td>
<td>30 minutes</td>
<td>These should not be used more than once or twice as they can lead to electrolyte imbalance</td>
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<tr>
<td>Phosphate</td>
<td></td>
<td></td>
<td>Use with caution if haemorrhoids present as they may cause local irritation</td>
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References: