MANAGEMENT OF CONSTIPATION

PURPOSE

A regular bowel action without straining, generally every 1-3 days.

KEY POINTS

- Health professionals consider constipation as the passage of small, dry, hard stools, however patients may report
  - a reduction of stool frequency
  - straining to have their bowels open
  - the sensation of incomplete emptying
- Constipation may be accompanied by rectal and abdominal pain and nausea and vomiting.
- It is especially common in patients receiving opioid analgesia, but there are multiple contributing factors.
- Although laxatives are recommended, the prescription of laxatives remains based on practice guidelines rather than evidence based guidelines.
- Fibre containing laxatives are not recommended for opioid-induced constipation. Clinical observation supports that use of these agents is probably best avoided in women with gynaecological cancers.
- All agents must be reviewed regularly and continued or changed based upon the patient’s description of response.

POSSIBLE CAUSES

**Acute onset**

Intestinal obstruction – acute constipation may result from small or large bowel obstruction due to tumour involvement or adhesive adhesions. Suspect this if there is also no passage of flatus.

**More gradual onset**

- **Bowel disease** – hernia, rectocele, haemorrhoids, anal fissure, rectal prolapse, diverticular disease, colitis, irritable bowel syndrome.
- **Environmental** – lack of privacy, unfamiliar environment
- **Medications** – common contributors to constipation include opioid analgesics, anticholinergics, calcium channel antagonists, antacids, 5HT3 antagonists, diuretics, iron supplements, antidepressants, chemotherapeutic agents (especially carboplatin).
- **Metabolic and electrolyte disturbances** – hypokalaemia, hypercalcaemia
- **Medical disorders** – diabetes, hypothyroidism, depression
- **Neurological** – damage to spinal cord, cauda equine, pelvic plexus and autonomic nervous plexus.
- **Tumour related** – altered food intake, dehydration, reduced mobility and performance status.
TREATMENT OPTIONS

- Early surgical referral if bowel obstruction, bowel perforation or another surgical cause is suspected.
- Encourage mobility and ensure adequate hydration.
- Dietitian review.
- Correction of electrolyte imbalances.
- Ensure privacy and appropriate positioning for women who are opening their bowels.
- Discontinue or substitute medications which cause constipation.
- Laxatives

LAXATIVES COMMONLY USED IN PALLIATIVE CARE

Stool softening combined with stimulant laxatives
- Docusate and sennoside (2-4 tablets orally twice a day)

Stimulant laxatives
- Bisacodyl tablets (5mg orally twice a day)
- Bisacodyl suppositories (10mg suppository rectally daily)
- Sennoside tablets (15mg orally daily).

Osmotic laxatives
- Macrogel: (1-3 sachets daily; titrate to stool consistency)

Macrogel: sometimes referred to as “pseudo-osmotic” as it draws less fluid from the circulation provided that it is prepared in the correct volume of water (1 sachet in 120mL liquid). This is purportedly an advantage over those traditional osmotic laxatives that may exacerbate dehydration and electrolyte disturbances. Macrogel: effect on faeces passed may not be observed until 24-48 hours after administration, and this delayed effect must be considered when titrating the dose.

Stool softening laxatives
- Docusate (120 – 240mg orally twice a day)

Lubricant laxatives
- Liquid paraffin (30-60 mL orally twice a day)
- Glycerol suppository (1 daily)

FAECAL IMPACTION

- If rectal or colonic impaction is suspected, the use of rectal softeners may sometimes need to be combined with stimulant agents. Glycerol suppositories or oil enemas soften the stool and irritate the bowel which leads to increased peristaltic activity and stool movement. If the stool softens but peristalsis remains ineffective, seek specialist advice regarding high enemas.

- Manual removal of impacted faeces may be required to allow the laxatives to be effective. The administration of midazolam (2.5-5mg subcutaneously 10 minutes pre procedure) may make this more tolerable for the patient.

OPIOID-INDUCED CONSTIPATION

There are opioid receptors in the myenteric plexus of the bowel wall, thus administration of opioids for analgesia inevitably results in failure of the bowel to contract in response to distension by accumulating faeces.
Generally, the dose of laxative (including a stimulant laxative) needs to be titrated upwards whenever the opioid dose is increased.

Combination analgesics containing both a prolonged release formulation of oral oxycodone and oral naloxone are approved in Australia and are indicated for analgesic use in patients particularly at risk of opioid-induced constipation.

Severe opioid-induced constipation or faecal impaction in which the opioid is thought to be the principal underlying cause should be treated with a single dose methylnatrexone subcutaneous injection. A result is often seen within 30 minutes, with 70% of patients responding within 24 hours. Seek palliative care specialist advice before repeating the injection 24 hours later. Continuation of (and review of dose) of regular laxatives is mandatory when methylnatrexone has been used.

REFERENCES (STANDARDS)


National Standards – 1 Clinical Care
Legislation - Nil

Related Policies – *Palliative Care*
Other related documents – Nil

RESPONSIBILITY
Policy Sponsor: Palliative Care Consultants
Initial Endorsement: July 2009
Last Reviewed: March 2014
Last Amended: 
Review date: March 2017
Algorithm for the Management of Constipation

1. Constipation
   - History
   - Physical examination

2. Consider bowel obstruction
   - No
   - Yes
     - Urgent referral
       - To surgeon

3. Full rectum
   - PR
     - Hard
     - Glycerol suppository and PO laxative
     - soft
     - Bisacodyl suppository and PO laxative

4. Empty rectum
   - X-ray
     - Bowel obstruction
       - Yes
       - Refer to surgeon
     - No
       - Full colon
         - PO Laxative

5. No, reconsider diagnosis
   - Yes
     - PO Laxative