Constipation in palliative care

Introduction

Constipation is the passage of small, hard faeces infrequently or with difficulty, and less often than is normal for that individual. Constipation can cause unpleasant symptoms such as abdominal and rectal pain, distension, nausea and vomiting and other negative effects on the patient’s wellbeing. As well as the physical suffering, constipation can cause psychological distress and agitation in the terminally ill patient.

There are many reasons why palliative care patients may develop constipation and these are discussed below.

Constipation can be complex and may require specialist advice if the current treatment regime is not successful.

Assessment

A full assessment of the patient and their symptoms should be obtained looking at:

- normal and current bowel pattern (frequency, consistency, ease of passage, blood present, pain on passing stool)
- current and previous laxatives taken regularly (or as needed) and their effectiveness
- clinical features (may mimic bowel obstruction or intra-abdominal disease)
  - pain
  - nausea, vomiting, anorexia
  - flatulence, bloating, malaise
  - overflow diarrhoea
  - urinary retention
- possible causes of the constipation (clarify cause before starting treatment)
  - 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
  - concurrent disease such as diabetes, hypothyroidism, diverticular disease, anal fissure, haemorrhoids, Parkinson’s disease, hypokalaemia.

Abdominal and rectal or stomal examination is necessary, unless it would cause undue distress for the patient.

To exclude bowel obstruction and assess extent of faecal loading, an X-ray may be needed.
Management

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

General advice

- Encourage a good oral fluid intake (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.
- Address any reversible factors causing the constipation.
- Doses should be titrated according to individual response.
- If current regimen satisfactory and well tolerated, continue with this but review patient regularly and explain importance of preventing constipation.
- Use oral laxatives if possible in preference to alternative routes of administration.
- Rectal intervention may be needed for faecal impaction, for example if patient is immobile or bed bound.

Choice of laxative

The options below may be equally effective.

- Suggested starting doses are provided; these should be increased as appropriate depending upon individual response.
- Patient preferences should be taken into consideration.
- While separate softener and stimulant allows better titration, a combined preparation means less medication burden for the patient.
- Rectal treatment may be needed if rectum loaded or impacted.
- Do not give rectal treatment if rectum is ballooned and empty.

Option A (stimulant ± softener)

- Senna 2 to 4 tablets or bisacodyl 5 to 10mg, at bedtime.
- If stools become hard or colic supervenes add in softening agent, such as docusate sodium 100mg capsule, twice daily.

Option B (osmotic laxative)

- Macrogol (for example Laxido®) 1 to 3 sachets daily
  - if severe constipation, consider a higher dose for 3 days.

Rectal treatment

- Soft loading: bisacodyl suppository, sodium citrate or phosphate enema.
- Hard loading: glycerol suppository as lubricant or stimulant; then treat as above.
- Very hard loading: arachis oil enema overnight, followed by phosphate enema.

Paraplegic or bedbound patient

- Adjust laxatives or loperamide to keep stool firm, but not hard.
• Use rectal intervention every 1 to 3 days to avoid possible impaction resulting in faecal incontinence, anal fissures or both.

Practice Points

• The majority of palliative care patients on opioids need a regular oral laxative.
• If there is a clinical picture of obstruction with colic, stimulant laxatives should be avoided (see ‘Bowel obstruction in palliative care’ guideline).
• Review laxative regimen when opioid medication is commenced or dose is changed.
• Do not use an arachis oil enema if patient has nut allergy.
• Caution is needed with frail or nauseated patients who may not be able to tolerate the fluid volume needed along with Laxido®.
• Bulk-forming laxatives are not suitable if the patient has a poor fluid intake and reduced bowel motility.
• 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.
• Methylnaltrexone may be suitable for opioid induced constipation resistant to standard therapies, but this should be under specialist palliative care advice only.

Resources

Professional
• Palliative Care Drug Information online: [http://www.palliativedrugs.com/](http://www.palliativedrugs.com/)

Patient
• Patient leaflet: Managing constipation [http://www.nhsinform.co.uk/palliativecare/symptomcontrol/eatingproblems/constipation](http://www.nhsinform.co.uk/palliativecare/symptomcontrol/eatingproblems/constipation)

References


### Laxative drug information chart

<table>
<thead>
<tr>
<th>Oral laxative</th>
<th>Starting dose</th>
<th>Time to act</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisacodyl tablets 5mg</td>
<td>1 to 2 at night</td>
<td>6 to 12 hours</td>
<td>Can cause abdominal cramps.</td>
</tr>
<tr>
<td>Senna tablets</td>
<td>2 to 4 at night</td>
<td>8 to 12 hours</td>
<td>Tablets may be difficult to swallow. Can cause abdominal cramps.</td>
</tr>
<tr>
<td>Senna liquid</td>
<td>10 to 20ml at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Docusate sodium capsules 100mg</td>
<td>1 twice daily</td>
<td>24 to 36 hours</td>
<td>Mainly a softener. Liquid preparation not very palatable.</td>
</tr>
<tr>
<td>Macrogol (such as Laxido®)</td>
<td>1 to 3 sachets daily</td>
<td>1 to 3 days</td>
<td>Made up in 125ml of water per sachet. High dose (up to 8 sachets per day for 1 to 3 days in impaction). Available in half-strength sachets.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rectal preparations</th>
<th>Starting dose</th>
<th>Time to act</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisacodyl suppository 10mg</td>
<td>10mg</td>
<td>15 to 60 minutes</td>
<td>Must be in contact with bowel wall to be effective.</td>
</tr>
<tr>
<td>Sodium citrate microenema</td>
<td>1 to 2</td>
<td>30 to 60 minutes</td>
<td></td>
</tr>
<tr>
<td>Phosphate enema</td>
<td>1</td>
<td>15 to 30 minutes</td>
<td>Can cause local irritation. Warm to body temperature.</td>
</tr>
<tr>
<td>Glycerol suppository</td>
<td>1</td>
<td>15 to 30 minutes</td>
<td>Combined irritant and softener.</td>
</tr>
<tr>
<td>Arachis oil enema</td>
<td>1</td>
<td>15 to 60 minutes</td>
<td>Contains peanut oil; contraindicated in nut allergy. Warm to body temperature.</td>
</tr>
</tbody>
</table>