Constipation

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 patients with palliative care needs may develop constipation. 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 or 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. Consent for this must be obtained from 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 defaecation, rather than any particular frequency of bowel motion.

<table>
<thead>
<tr>
<th>Laxative choice</th>
<th>Dosage</th>
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<tbody>
<tr>
<td>Option A (stimulant ± softener)</td>
<td>• Senna tablets 15 to 30mg, or bisacodyl tablets 5 to 10mg, at bedtime.</td>
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<td></td>
<td>- If stools become hard add in softening agent such as docusate sodium 100mg capsule, twice daily.</td>
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<td></td>
<td>- If significant colic occurs, the stimulant should be discontinued and softener used instead.</td>
</tr>
<tr>
<td>Option B (osmotic laxative)</td>
<td>• Macrogol (for example Laxido®) 1 to 3 sachets daily.</td>
</tr>
<tr>
<td></td>
<td>- If severe constipation, consider a higher dose for 3 days.</td>
</tr>
<tr>
<td>If option A and B have been unsuccessful progress to Option C.</td>
<td></td>
</tr>
<tr>
<td>Option C (rectal treatment)</td>
<td>• Soft loading: bisacodyl suppository, sodium citrate or phosphate enema.</td>
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<tr>
<td></td>
<td>• Hard loading: glycerol suppository as lubricant or stimulant; then treat as above.</td>
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<tr>
<td></td>
<td>• Very hard loading: arachis oil enema (except in those with nut allergy) overnight, followed by phosphate enema.</td>
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</tbody>
</table>

Choice of laxative (refer to Appendix)
The options above may be equally effective.

- Suggested laxative starting doses are provided; these should be titrated as appropriate depending on individual response.
- Patient preferences should be taken into consideration.
- While separate softener and stimulant allows better titration, a combined preparation can reduce 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.
- For constipation resistant to standard management, refer to opioid induced constipation section.

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.
- Encourage daily exercise according to ability.
• Address any reversible factors contributing to the constipation.
• Laxative doses should be titrated according to individual response.
• If current regimen is 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.

**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.

**Opioid-induced constipation**

• Peripheral opioid antagonists can relieve constipation but allow preservation of centrally mediated analgesia. Methylnaltrexone* and naloxegol** should only be used for opioid-induced constipation and under specialist advice.
• Contra-indicated in gastrointestinal (GI) obstruction or patients at risk of GI perforation.

<table>
<thead>
<tr>
<th>Antagonist</th>
<th>Comments</th>
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</table>
| Methylnaltrexone*  | • Within NHS Scotland restricted to use in opioid-induced constipation in patients with advanced illness who have an insufficient response to alternative laxatives.  
• Subcutaneous injection dose according to weight of patient. |
| Naloxegol**        | • An antagonist of peripheral opioid receptors which is prescribed orally.  
• SMC approval for adults whose constipation has had inadequate response to laxative therapy.  
• 25mg tablet daily in the morning reduced to 12.5mg daily in moderate-severe renal impairment. Not recommended in severe hepatic impairment.  
• When naloxegol therapy is initiated, it is recommended that all currently used maintenance laxative therapy should be halted until clinical effect of naloxegol is determined. |

*Methylnaltrexone is accepted for restricted use within NHS Scotland for treatment of opioid-induced constipation in advanced illness patients who are receiving palliative care when response to usual laxative therapy has not been sufficient. It is restricted to use by physicians with expertise in palliative care.

**Naloxegol is accepted for use within NHSScotland for the treatment of opioid-induced constipation in adult patients who have had an inadequate response to laxative(s).
**Practice points**

- The majority of patients with palliative care needs on opioids need a regular oral laxative.
- Review laxative regimen when opioid medication is commenced or dose is changed. This includes increasing use of ‘as required’ opiate medication.
- 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).
- Do not use an arachis oil enema if patient has nut allergy.
- Caution is needed with frail or nauseated patients who may be unable 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.
- Manual evacuation, if absolutely necessary, requires consent and should never be attempted without analgesia and/or sedation.

**Resources**


**References**


# Appendix

## Laxative medicines 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>Bisacodyl and senna act in the large bowel and have little small intestine effect. Can cause abdominal cramps.</td>
</tr>
<tr>
<td>Senna tablets 7.5mg</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 7.5mg/5ml</td>
<td>10ml 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) – volume of liquid required may be difficult to tolerate. Available in half-strength sachets. Idrolax® preparation does not contain electrolytes.</td>
</tr>
<tr>
<td><strong>Peripheral opioid antagonists</strong></td>
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<tr>
<td>Methylnaloxone injection 12mg/0.6ml</td>
<td>Initial dose weight-related</td>
<td>30 to 60 minutes</td>
<td>For administration under specialist palliative care guidance only.</td>
</tr>
<tr>
<td>Naloxegol tablets 12.5mg, 25mg</td>
<td>25mg daily</td>
<td>6 hours average but can be</td>
<td>For administration under specialist palliative care guidance only. Reduce to 12.5mg in moderate to severe renal impairment.</td>
</tr>
</tbody>
</table>
Can cause cramps. Do not take tablet at a time when defaecation would be inconvenient. Contra-indicated if obstruction suspected or risk of bowel perforation.

<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>4g</td>
<td>15 to 30 minutes</td>
<td>Combined irritant and softener. Need to place adjacent to bowel wall.</td>
</tr>
<tr>
<td>Arachis oil enema</td>
<td>1</td>
<td>15 to 60 minutes</td>
<td>Contains peanut oil; contra-indicated in nut allergy. Warm to body temperature.</td>
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</tbody>
</table>