Constipation in Palliative Care - Adult

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• Department(s)	All departments
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• Used by which staff?	All clinical staff members that care for adult patients with palliative care needs
• Excluded	Child Health
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1. Purpose guideline

The purpose of this guideline is to manage constipation in people with palliative care needs.

Constipation is one of the most common problems in people with palliative care needs and can cause extreme suffering, both physical and psychological. Constipation is often preventable by correct prescribing at the appropriate time.

2. Guideline management principles and goals

- Thorough assessment and examination of the person including; rectal exam, medication, review and assessment for obstruction. Abdominal X-ray may be helpful.
- People can become agitated, confused and delirious because they are constipated.
- Review regularly aiming for a bowel motion every two to three days regardless of oral intake. Consider escalation of treatment if bowels not open for two days.
- Normal bowel movements are aided by adequate hydration, mobility, privacy and nutrition.
- Choice of natural aperients may be helpful and reduce medication need e.g. prunes, kiwifruit, Kiwi Crush, herbal products and juices – if accepted and tolerated.
- In the last days of life, it may not be appropriate to treat constipation.
- Laxatives should be prescribed at the time of prescribing opioids.
- Lactulose should not be used in people who have poor fluid intake and is often poorly tolerated in very ill patients. It is not the drug of first choice.
- Avoid oil enemas in people with a stoma as this effects adherence of appliances.
- Avoid phosphate-containing products in patients with end-stage renal failure.

Note: For intractable constipation not responding to suggestions in this guideline please contact the Hospital Palliative Care Team.

3. Process for treating constipation

Step	Description
1.	**Assessment** Frequency/consistency of bowel motions, change in pattern, abdominal pain, nausea, environmental factors, co-morbidities, medications etc.
2.	**Examination** Including rectal (PR) exam – more detail below.
3.	**Treat reversible causes where possible** • Drugs e.g. opioids, anticholinergics, ondansetron, cyclizine, chemotherapy, diuretics • Metabolic e.g. hypercalcemia, hypothyroidism, hypokalemia, diabetes • Neurological e.g. spinal cord/cauda equina compression, sacral plexopathy • Mechanical e.g. Intra/extra-luminal masses, adhesions, strictures, ascites • General e.g. low fibre/fluid intake, inactivity, weakness, depression, debility.
4.	Maximise oral laxatives (see below) and co-prescribe when starting opioids.

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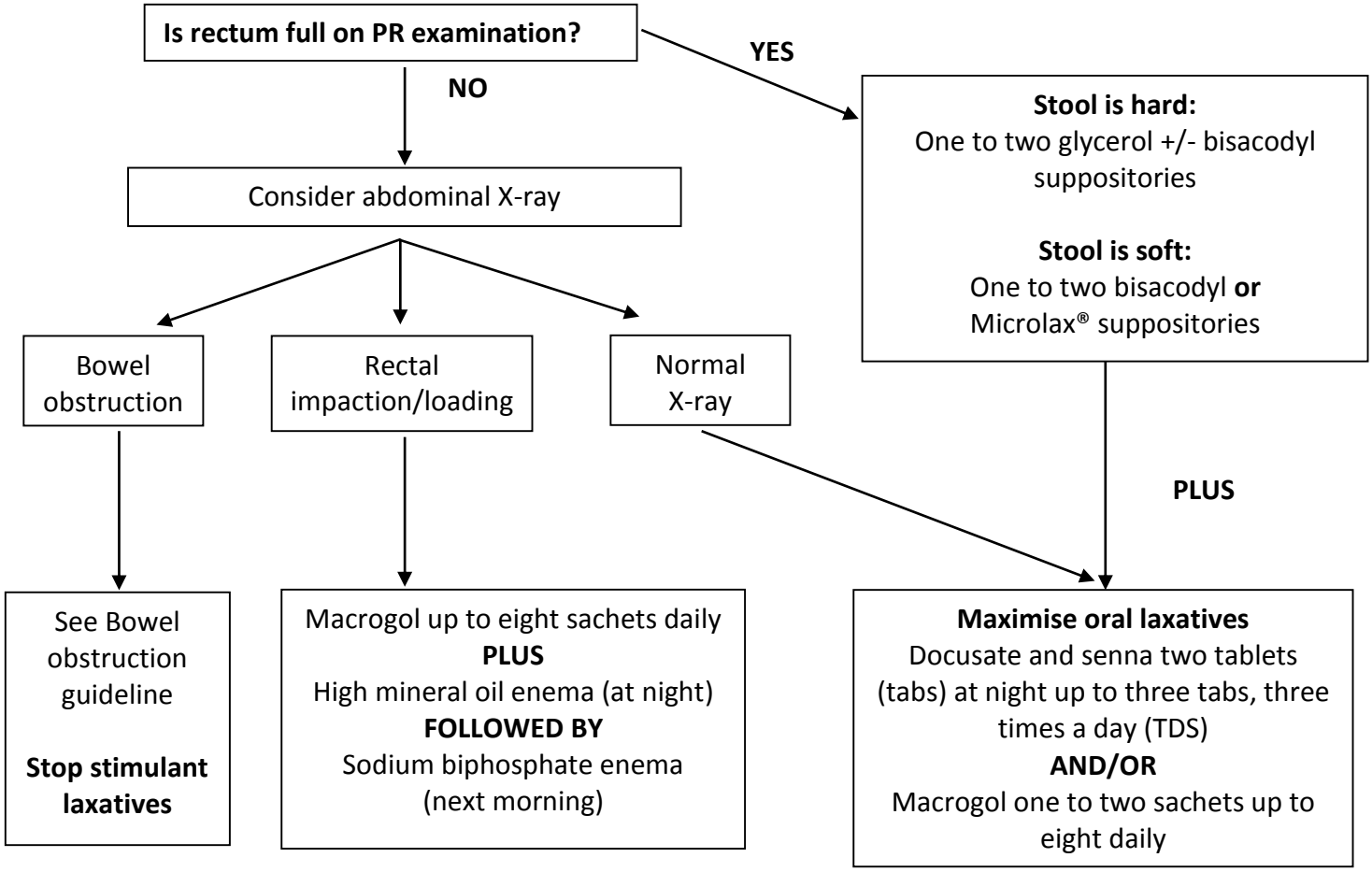
3.1 Flow chart to aid decision making



4. Contraindications

Rectal interventions may be contra-indicated under the flowing circumstances:

- Allergy to any of the ingredients
- Bowel obstruction (abdominal colic pain, no bowel sounds, no flatus)
- Acute Inflammatory Bowel Disease
- Severe abdominal pain associated with nausea and vomiting
- Neutropenia and thrombocytopenia
- Frail or near end of life – consider burden versus benefit
- Recent gastrointestinal or gynaecological surgery
- Recent radiotherapy to the lower pelvis unless medical consent given
- Malignancy of the perianal region/bowel.

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5. Specific information on laxatives

5.1 First Line: ORAL

Before moving to a second laxative, optimise the initial laxative by titration every one-two days according to response up to the maximum recommended or tolerable dose before changing to an alternative or adding in another agent. **Please note that these are not listed in order of preference.**

Medication	Treatment and starting dose	Time to act	Comments
Docusate (50 mg or 120 mg) (softener) **Trade name:** **Coloxyl®**	One to two tablets BD (can be titrated up to maximum three tablets TDS *Total daily dose – up to 480 mg*	1-3 days	As single agent, not laxative of choice for opioid-induced constipation Usually given in combination with senna
Docusate (softener) 50 mg and senna 8 mg(peristaltic stimulant) **Trade names:** **Laxsol®** **Coloxyl with Senna®**	Two tablets nocte (can be titrated up to maximum three tablets TDS)	8-12 hours	May cause abdominal cramps Avoid if signs of bowel obstruction Use docusate alone in resolving bowel obstruction
Sennoside B/Senna (7.5 mg) (peristaltic stimulant) **Trade name:** **Senokot®**	Two tablets daily (can be titrated up to maximum three tablets TDS) *Total daily dose – up to 80 mg*	8-12 hours	Can cause abdominal cramps
Bisacodyl (10 mg) (peristaltic stimulant) **Trade names:** **Dulcolax®** **Lax-tabs®**	One tablet nocte (can be titrated up to maximum six tabs)	6-12 hours	Can cause abdominal cramps. Avoid if signs of bowel obstruction
Macrogol – 3350 (13.12g) (osmotic laxative) **Trade names:** **Molaxole®** **Movicol®** **Lax-sachet®**	One sachet daily, mixed with 125 mL of water (can be increased to one sachet TDS)	1-2 days	For regular use, EACH sachet must be dissolved in 125 mL water or juice (i.e. 2 sachets = 250 mL water or juice)

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Medication	Treatment and starting dose	Time to act	Comments
Macrogol is also used for faecal loading on AXR with rectal treatment as below	Can be used to treat faecal loading: Eight sachets in 1 litre of water consumed over 6 hours for a maximum of three days (the solution is stable for up to 6 hours)		
Lactulose (osmotic laxative) **Trade names:** **Laevolac®**	*Not recommended in palliative care except in people with hepatic encephalopathy*	Up to 2 days	Avoid in people with decreased oral intake Can cause abdominal cramps and flatulence Nausea (can be reduced by administration with water, fruit juice, or with meals)
Psyllium husk powder (peristaltic stimulant) **Trade names:** **Bonvit®** **Konsyl-D®** **Mucilax®** **Metamucil®**	*Not recommended in palliative care due to high fluid intake required*	2-3 days	Can cause abdominal cramps Avoid if signs of bowel obstruction Fibre and bulk-forming laxatives do not usually help constipation in patients taking opioids or who have reduced oral intake

Source: Table adapted from Mercy Hospice Constipation Guidelines (April, 2020).

5.2 Second Line: RECTAL

Continue usual oral laxative treatment in people having rectal intervention.

	Treatment and starting dose	Dose	Time to act	Comments
Hard faeces in rectum	Glycerol suppository 3.6g **Trade Name:** **Glycerol (PSM) suppository** Bisacodyl suppository **Trade names:** **Dulcolax®** **Lax-suppositories®**	3.6g daily	15-60 mins	Encourages water penetration of the faecal mass resulting in stool softening

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	Treatment and starting dose	Dose	Time to act	Comments
	Then: treat as for soft faeces in rectum			
Soft faeces in rectum	Bisacodyl 10mg two suppositories **Trade names:** **Dulcolax®** **Lax-suppositories®** Sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL (combination softening and stimulant mini enema) **Trade Names:** **Microlax® enema** **Micolette® enema** Phosphate sodium dibasic 59.3 mg/mL + phosphate sodium monobasic 161 mg/ml enema (osmotic effect) **Trade name:** **Fleet phosphate enema**	20mg daily	15-60 mins 5-30 mins 1-10 mins	Must be in contact with bowel wall to be effective May stimulate colonic activity via nerves in the intestinal mucosa and increased fluid uptake by stools thus softening them Prolonged use may cause electrolyte imbalance.
Faecal loading on abdominal X-ray	1. **High mineral oil enema** (paraffin liquid 100% 1g/mL) at night to soften **Followed by** 2. **High Fleet phosphate enema** next morning	120 mL daily	2-15 minutes 1-10 minutes	Softens surface of stool, has lubricant effect Stimulates bowel

Source: Table adapted from Mercy Hospice Constipation Guidelines (April, 2020).

5.3 High mineral oil retention enema administration

Previously available as the proprietary brand – Fleet Mineral Oil enema – but now discontinued, high mineral oil retention enema used in Auckland DHB now refers to the use of at least 120 mL of 100% liquid paraffin rectally (K. Zhao, personal communication, November 19, 2020) . This can be ordered from Pharmacy. It does not contain peanut oil and is latex free.

Follow the steps below to administer a high mineral oil retention enema:

Step	Action
1.	Explain the procedure, obtain consent and identify any allergies or contraindications.
2.	Gather supplies, draw up 120 mL of liquid paraffin into two x 60ml BD catheter syringes.
3.	Hand wash and place an incontinence sheet underneath the patient.
4.	Attach soft size 14-18 Foley indwelling catheter onto BD catheter syringe.

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Step	Action
5.	Put KY jelly on gauze swab and lubricate end of Foley catheter.
6.	Insert Foley catheter into anal canal until the Foley catheter is unable to be inserted any further (this may be up to 30 cm) or if the patient complains of discomfort. **Do not force the Foley catheter tip into rectum as this can cause injury.**
7.	If possible, ask the person turn towards left side (lateral recumbent position) with their knees and hips flexed for fluid to go further into the colon.
8.	Slowly insert the BD catheter syringe (containing 60 mL of liquid paraffin) into the Foley catheter, kink Foley catheter (to prevent backflow).
9.	Remove first BD catheter syringe and repeat this step with second BD catheter syringe (containing 60 mL of liquid paraffin).
10.	Slowly remove the catheter and ensure foot of bed is elevated by 45° for as long as possible, preferably overnight.
11.	Check that a phosphate enema is prescribed for the next morning.

5.4 Opioid antagonists - only with Palliative care specialist advice

Methylnaltrexone (Relistor®) is a peripheral acting opioid receptor antagonist. It can be considered under specialist guidance for people who have opioid-induced constipation resistant to other laxative management (see Associated documents).

5.5 Bowel management in paralysed or spinal cord compression patients

- Refer to the guideline: Bowel & nutrition management in acute spinal cord injuries (see Associated documents).
- People with spinal cord or cauda equina compression have compromised bowel function - a lack of awareness of the need to pass stool and lack of voluntary effort to assist with bowel emptying.
- These patients should be maintained on a stimulant oral laxative regimen and have regular rectal intervention every second or third day.

5.6 Manual removal of stool

- Manual removal of stool should be considered only in patients with clinical or X-ray suggestion of impacted stool, who have not responded to appropriate oral and rectal intervention and who are distressed by their constipation.
- Manual removal of stool is a distressing intervention for the patient and should be carried out with adequate prior analgesia and sedation in an inpatient setting (not appropriate for community setting). Use of SC Midazolam may be indicated for its sedative and amnesic effect.

6. Ongoing assessment

- Document bowel function daily (including volume of stool, colour of stool, type of stool as per Bristol Stool Chart, ease of passage, any faecal incontinence).
- Review effectiveness of management plan and modifying appropriately (responsibility of both nursing and medical staff).

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7. Supporting evidence

- Mercy Hospice constipation guidelines (5th review). April 2020.
- New Zealand Formulary [accessed 2020 May 01]; Available from: https://nzf.org.nz/nzf_70665
- Palliative Care Formulary (PCF6). 2017 [accessed 2020 May 01]; Available from: https://www.medicinescomplete.com/#/content/palliative/rectal-products-for-constipation?hspl=constipation
- Scottish Palliative Care Guidelines [accessed 2020 May 01}: Available from: https://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/Constipation.aspx
- Cancer Care Ontario. (April 2012). Symptom Management Guide-to-Practice: Bowel Care. Available from: www.cancercareontario.ca

8. Associated documents

Auckland DHB policies and guidelines

- Spinal Injuries – Acute: Bowel & Nutrition Management
- Management of Malignant Bowel Obstruction in Palliative Care
- Medications – Prescribing
- Medications – Administration
- Medications – Allergies & adverse drug reactions (ADRs) identification, documentation & recording
- Methylnaltrexone guideline

Other

Bristol stool chart

Clinical forms

- CR5504: Bowel motion chart
- CR5775: Bowel chart older people's health

Patient information and resources

- Combating Constipation. Available from:
- https://adhb.hanz.health.nz/site/Anaesthesia/Acute Pain/Combating Constipation Booklet.pdf
- Health Navigator (May 2020). Palliative care and constipation. Available from: www.healthnavigator.org.nz/health-a-z/p/palliative-care/palliative-care-constipation/

9. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

10. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.