PALLIATIVE CARE TIPS

Issue # 3 Constipation In Advanced Disease

Original Contributor: Paul Walker, MD.
Revised (September 27, 2012): Yoko Tarumi, MD. Palliative Care Program, Royal Alexandra Hospital
Re-issued (October 2012): Yoko Tarumi, MD. Palliative Care Program, Royal Alexandra Hospital

Significance: Constipation can cause extreme suffering and symptoms; however it is often under-recognized and not routinely assessed.

Definition: Constipation can be defined as unsatisfactory defecation with infrequent stool. The Rome III criteria help to define functional constipation when two or more of following conditions are met:
1) stool frequency less than 3 per week 2) difficulty in stool passage with straining 3) lumpy or hard stools 4) sensations of incomplete evacuations 5) anorectal blockage 6) may require manual maneuvers.

Common presentations: Altered bowel habits and decreased volume of stool irrespective of oral intake, as well as abdominal pain and nausea are common. Fecal emesis, anorexia, restlessness, urinary retention or anxiety may occur.. An overflow diarrhea (liquidified stool leakage past impacted feces with or without using laxatives) is not uncommon.

Approach:
Prevention and routine assessment are essential:

1. Consider a bowel routine utilizing oral laxatives such as sennosides, docusates, dulcolax, polyethylene glycol (peg 3350, *not* GoLytely), lactulose, mineral oil (Lansoyl®) especially when patient is on opioids.
2. Monitor hydration status including oral, IV and HDC fluids and medications such as diuretics.
3. Monitor bowels movements following the Rome III criteria (noted above).
4. Increasing oral fluids, adding a high fibre diet and encouraging exercise have limited effect in patients with advanced and progressive disease. Regular toileting and privacy should be ensured.

If constipation is suspected:

1. Perform a digital rectal examination to assess for retained stool or fecal impaction and an abdominal exam with history to rule out bowel obstruction.
2. A plain supine abdominal flat plate x-ray can assess for degree of constipation. The x-ray is then viewed in four quadrants representing the ascending, transverse, descending and rectosigmoid colon segments. The amount of stool is scored from 0-3. A 0 score is no stool present with 3 being complete stool impaction. The total score denominator is 12. A score >7 requires aggressive bowel care.
3. Reassess medications that may contribute to constipation such as pysillium products (Metamucil®) especially with decreased oral fluid intake; 5HT3 antagonists (ondansetron); medications associated with anticholinergic effects (TCA's, phenothiazines, antispasmodics); iron supplements (ferrous sulfate); calcium supplements; and antacids.
4. Assess and consider treating hypercalcemia of malignancy (Tips #)
5. Assess and manage uncontrolled symptom such as severe pain with activities or uncontrolled breathlessness at rest or breathlessness on exertions may contribute to one's ability to defecate.
6. Structural disorders such as intra or extraluminal bowel lesions, postoperative adhesions, or patients with colostomies are at risk of developing constipation or partial/total obstruction of bowel. If stool is not passed on a regular basis (once to several times a day), further investigation is warranted. Hypothyroidism, neurological, cognitive factors may influence on bowel habits. Cancer therapy such as vinca alkaloids often causes constipation.

Treatment of symptomatic constipation:

1. Proximal fecal retention without bowel obstruction: If able to tolerate, initiate oral laxatives. For opioid induced constipation consider methylnaltrexone (Relistor) 8 mg subcutaneously (BW< 75 kg) or 12 mg (BW >75 kg) subcutaneously every two days may be considered.
2. Distal fecal retention without bowel obstruction: Perform digital rectal evacuation, Consider dulcolax suppository, a high (utilizes a rectal tube) Fleet enema and initiatiate oral laxatives. For significant constipation administer high mineral oil retention enema to soften and ease passing of hard stool followed by soap suds cleansing enema 8 hours afterward. Methylnaltrexone (Relistor) may also be considered.