Tenesmus Management Tips for Healthcare Professionals

Guiding Principles: Rectal tenesmus is a distressing symptom in patients with advanced cancer and challenging to treat.

Step 1. Top underlying treatable causes and diagnosis:

- **Definition:** Tenesmus can be defined as the persistent and usually painful sensation of rectal fullness/incomplete evacuation. Tenesmus results in a sensation of needing to defecate multiple times a day, adversely impacting on quality of life. Often due to an infiltrating cancer, tenesmus can be accompanied by painful smooth muscle cramping or neuropathic pain.
- Can be mistaken as diarrhea or constipation
- Rule out non-malignant causes e.g. inflammatory bowel disease, treatment side effects (e.g. radiation proctitis), constipation

Step 2a. Non-pharmacological management:

- Treat underlying malignancy when possible; may include radiotherapy (but usually not immediately effective for symptom control)
- Optimize dietary interventions to minimize diarrhea and/or constipation

Step 2b. Pharmacological options (limited evidence):

- Optimize analgesics including opioids
- Belladonna and Opium suppositories (65 mg – 15 mg) rectal, daily-bid prn (Max: 4 doses/day; ***contraindicated in severe renal impairment***)
    - If Belladonna and Opium suppositories are unavailable locally, compounding pharmacies can provide an alternative suppository: 7.5 mg morphine and 15 mg belladonna
- Buscopan 10 mg q6h po prn (Caution: increased side effects in ***elderly***)
- Consider hydrocortisone (e.g. radiation proctitis) or lidocaine 2% gel rectal enema
- Limited evidence supporting use of adjuvants such as calcium channel blockers (Caution: associated ***cardiovascular toxicities***)
    - Nifedipine 5 mg po bid-tid (can titrate up to 20 mg bid-tid)
    - Diltiazem 30 mg po q6h (if effective, can be transitioned to Diltiazem ER 120 mg po daily)

Step 3. When to refer to other specialists:

- Ongoing difficult to control pain despite above treatment
- Oncology: To ensure maximal oncologic treatment of local disease
- Palliative: If concomitant other symptoms and/or moderate to high opioid doses
- Anesthetic/Pain Service: For interventional and/or injections and/or neuraxial analgesia
- Spinal surgery: Lumbar Sympathectomy
- GI: Endoscopic Laser Therapy (ELT) [potential for serious complications]

NOTE: Guidelines do not replace individualized care and clinical expertise.

References:

1. Laoire A, Fettes L et Murtagh F EM, A systematic review of the effectiveness of palliative interventions to treat rectal tenesmus, Palliative Medicine, 2017 31(10): 975-81.
2. Radiation Oncology Management Decisions ed. 2, Philadelphia, USA, ed. KS Clifford Chao, Lippincott Williams and Wilkins, 2002. p. 720-1.
3. The Pallium Palliative Pocketbook: a peer-reviewed, referenced resource. 2nd Cdn ed. Ottawa, Canada: Pallium Canada; 2016.

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