Alberta Health Services

Palliative Care Tip – Issue#3:
CONSTIPATION IN ADVANCED ILLNESS / Revised May 23, 2018

Significance:
Constipation can be a source of discomfort and suffering yet it is often under-recognized and under-investigated. Reported prevalence ranged from 32% to 87% depending on different palliative care settings. **Abdominal pain and nausea are commonly associated. 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.**

Definition:
Constipation can be defined as unsatisfactory defecation with infrequent stool. The Rome IIII criteria helps to define functional constipation when there is two or more of following conditions in the past 3-6 months :1) stool frequency less than 3 per week 2) difficulty in stool passage with straining in more than 25% of defecations 3) lumpy or hard stools in more than 25% of defecations 4) sensations of incomplete evacuations in more than 25% of defecations 5) anorectal blockage in more than 25% of defecations 6) may require manual maneuvers in more than 25% of defecations.

Approach:
Prevention and routine assessment are essential:
1. Consider a bowel routine utilizing oral laxatives such as polyethylene glycol (peg 3350), sennosides, lactulose, especially when opioids are concurrently administered
2. Monitor hydration status including oral, IV and HDC fluids and medications such as diuretics
3. Monitor bowels movements following the Rome IIII criteria (noted above)
4. Regular toileting and ensuring privacy
5. In the context of advanced, progressive diseases with established constipation, following are not recommended: increasing oral fluids, adding high fiber diets, encouraging exercise and use of stool softeners

When constipation is suspected:
1. Perform a history, abdominal exam with digital rectal examination when appropriate to assess for retained stool or fecal impaction. Rule out bowel obstruction. Assess for other causes: Structural disorders such as intra or extraluminal bowel lesions, or postoperative adhesions. Cancer therapy such as Vinca alkaloids, hypothyroidism, neurological disorders, hypercalcemia (Tips # 7) and cognitive impairment are among the factors that may influence bowel habits.
2. Reassess medications that may contribute to constipation such as psyllium products (Metamucil®) especially with decreased oral fluid intake; 5HT3 antagonists (ondansetron); medications with anticholinergic effects (TCA's, phenothiazines, antispasmodics); iron supplements (ferrous sulfate); calcium supplements; and antacids.
3. A plain supine abdominal flat plate x-ray can be requested to view four quadrants representing the ascending, transverse, descending and rectosigmoid colon segments. The amount of stool is scored from 0-3 in each quadrant. A score of 0 in one quadrant= no stool and score of 3 = complete stool impaction. The total score is 12. A score >7/12 requires aggressive bowel care.
4. Manage uncontrolled symptom such as pain and breathlessness. These symptoms and their treatments may contribute to constipation.

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Treatment of symptomatic constipation:

1. Proximal fecal retention without bowel obstruction: Initiate oral laxatives if able to tolerate.
2. Distal fecal retention without bowel obstruction: Consider Dulcolax suppository, a high (utilizes a rectal tube) Fleet enema followed by 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.
3. Opioid induced constipation: In case of ineffectiveness of the above measures (minimum of 4 days of consistent trials), may consider naloxegol (Movantik®) 25 mg orally or 12.5 mg if not tolerated once daily. For those who are unable to tolerate oral medications, methylnaltrexone (Relistor®) 8 mg subcutaneously (BW< 75 kg) or 12 mg (BW >75 kg) subcutaneously every two days (dose adjustment required in renal failure). Naloxegol and methylnaltrexone are contraindicated in bowel obstruction. Please be aware that these prescriptions may not be covered by the drug plan for the community patients. Please consult the local pharmacy for actual cost that may become burden to patient and family.