1.3 Constipation

Key Points

1. Assess all patients at Life's End for constipation. Evaluate for obstipation after 48 hours without a bowel movement.

   Over half of patients at Life's End suffer from constipation. Inquire about bowel habits (frequency, consistency, and previous habits), other symptoms (nausea/vomiting, abdominal pain, distention, anorexia, and diet), and attempted interventions. Obstipation is such severe constipation and impaction that there is a functional bowel obstruction.

2. Determine the cause of constipation by rectal digital exam, abdominal exam, and neurological exam. Radiographic and laboratory studies may be helpful.

   Rectal exam: Evaluate for impaction, hemorrhoids, or other problems. Abdominal exam: Evaluate for bladder distention, hernias, and masses.

3. Asthenia (fatigue) can play a role in constipation at Life's End by disrupting the normal gastrocolic reflex and limiting activity and privacy.

   Support bowel routine. Assist patient to be up. Assist to the toilet when urge occurs. Serve hot beverages. Assure as much privacy as possible.

4. Differential diagnosis should consider medication side effects, concurrent diseases, and environmental factors.

5. Physicians should treat constipation rather than withholding opioids that may be contributory.

6. Large-bowel stimulants and interventions to support bowel routine are key to managing constipation in the palliative-care setting.

   Over 80% of palliative patients, and nearly all on opioids, require laxative therapy. Use Bisacodyl (Dulcolax) 1–4 tablets a day or Senna 2–8 tablets a day. Senna can be much more expensive—be guided by patient preference.

Constipation

The Palliative Response

Overview of Constipation

- Definition

  The infrequent passage of small hard feces
- Prevalence at Life's End

  Over half of palliative care patients report constipation as a troubling symptom
- Intervention

  >80% of patients at Life's End need laxatives

  Nearly all patients on opioids need laxatives

Assess Constipation in All Palliative Patients

- Bowel Habits

  Frequency and consistency

  Previous bowel habits
- Other Symptoms

  Nausea/vomiting

  Abdominal pain, distention, anorexia
- Interventions

  What has been tried and what helps?

Assess for Impaction

- General Rule

  Evaluate for constipation and impaction after 48 hours with no bowel movement
- Obstipation

  Functional bowel obstruction from severe constipation and impaction

Asthenia (Fatigue) as Contributor

- Disruption of normal gastrocolic reflex

  Gastrocolic reflex produces urge to defecate usually within an hour after breakfast and lunch

  Urge will resolve in 10–15 minutes if suppressed

  Reflex may disappear if suppressed for several days
- Limited activity

  Often cannot walk to the bathroom
- Limited privacy

  Prevents or deters use of bedside commode/bedpan

Support Bowel Routine

- Assist patient with being up
- Hot beverage if known to be helpful
- Assist patient to toilet when urge occurs
- Assure as much privacy as possible

Rectal Digital Exam

- Tumor
- Constipation
- Impaction
- Local fissures
- Hemorrhoids
- Ulcers

Abdominal Exam

- Bladder distention
- Urinary retention
- Obstruction
- Hernias
- Masses

  Tumor

  Impacted stool

Additional Evaluation

- Neurological exam

  Impending cord compression
- Consider flat plate and upright X-rays

  High impaction

  Bowel obstruction

  Gastric outlet obstruction
- Lab evaluation

  Hypercalcemia

  Hypokalemia

Differential Diagnosis
Medication Review

- Opioids
- Medications with anticholinergic effects
- Diuretics
- Iron
- Anticonvulsants and anti-hypertensives
- Vincristine and platinols
- Antacids with calcium and aluminum
- Ondanstron

Continuation of Opioids

- Treat constipation rather than withdrawing opioids
- Never stop opioids as response to constipation if patient requires opioids for relief of pain or other distressing symptoms

Differential Diagnosis
Concurrent Diseases

- Diabetes
- Hypothyroidism
- Hyperparathyroidism
- Hypokalemia and hypomagnesemia
- Hernia
- Diverticular disease
- Anal fissures and stenosis
- Hemorrhoids

Differential Diagnosis

Environmental Factors

- Decreased food intake
- Dehydration
- Weakness and inactivity
- Confusion
- Depression
- Structural barriers to bathroom or toilet

Laxative Treatments

- Softeners
  Surfactants like docusate (Colase)
- Osmotic
  Lactulose
  Sorbitol
- Bulking agents
  Metamucil (usually not appropriate at EOL)
- Saline laxative
  Magnesium citrates or Milk of Magnesia (MOM)

Large Bowel Stimulant

Constipation must be managed in the palliative-care setting

- Bisacodyl (Dulcolax) 1–4 tablets a day
- Senna 2–8 tablets a day
  Can be much more expensive than bisacodyl
  Be guided by patient preference

Algorithm for Treatment

Rectal Exam — Soft feces

↓

Impaction

↓

Consider oil retention enema to soften feces

↓

Spontaneous defecation of Impaction → Soft feces

Manual Disimpaction Consider sedation with Lorazepam → Soft feces

Algorithm for Treatment

Soft feces

↓

Base choice of treatment on:

- Patient preference
- Urgency for bowel movement

↓

Oral Biscodyl or Magnesium Citrate → Rectal vault empty

Fleets Enema or Biscodyl Suppository → Rectal vault empty

Algorithm for Treatment

Rectal vault empty

↓

Bisocodyl 2–4 QD
May add MOM 30 cc QD

Goal:
Bowel movement every 48 hours

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Increased risk of impaction if interval between bowel movements > 48 hours

Address Environment:
Privacy
Gastrocolec reflex
Assistance with feeding and hydration
Access to toilet
Maximize activity

Selected Readings

Overview

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