

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

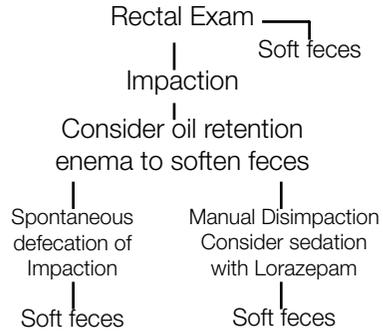
- Softeners
Surfactants like docusate (Colase)
- Osmotic
Lactulose
Sorbitol
- Bulking agents
Metamucil (usually not appropriate at EOL)
- Saline laxative
Magnesium citrates or Milk of Magnesia (MOM)

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



Algorithm for Treatment

Soft feces

Base choice of treatment on:

- Patient preference
- Urgency for bowel movement
 - Oral Bisacodyl or Magnesium Citrate
↓
Rectal vault empty
 - Fleets Enema or Bisacodyl Suppository
↓
Rectal vault empty

Algorithm for Treatment

Rectal vault empty

Bisacodyl 2–4 QD
May add MOM 30 cc QD

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|---|--|
| Goal:
Bowel movement every 48 hours
↓
Increased risk of impaction if interval between bowel movements > 48 hours | Address Environment:
<i>Privacy</i>
<i>Gastrocolic reflex</i>
<i>Assistance with feeding and hydration</i>
<i>Access to toilet</i>
<i>Maximize activity</i> |
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Constipation

Selected Readings

Overview

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