PALCARE
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THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

CONSTIPATION

INTRODUCTION

Constipation is the passage of small, hard faeces infrequently and with difficulty. Individuals vary in the importance they give to the different components of this definition and may introduce other factors, such as pain/discomfort when defecating, flatulence, bloating or a sensation of incomplete evacuation. A normal range of frequency of stools in an adult can be "three times a day to once every three days".

Causes of constipation in advanced disease:

- **Cancer related**
  - Bowel obstruction
  - Spinal cord compression/cauda equina syndrome
  - Hypercalcemia
  - Fluid loss - vomiting
  - Poor intake
  - Anorexia
- **Treatment related**
  - Medications - opioids, 5HT-3 antagonists, drugs with anti-cholinergic effects
- **Debility/ concurrent illness**
  - Elderly
  - Limited mobility
  - Depression
  - Hypothyroidism

ASSESSMENT

- Assessment must determine the underlying aetiology of constipation, effectiveness of treatment and impact on quality of life for the patient and their family ***(refer to the Guideline - Symptom Assessment)***
- Assessment must include frequency, consistency, changes in bowel pattern, discomfort, pain, sensation of complete/incomplete evacuation, environmental factors, medication history, need for use of laxatives and complications
- When assessing constipation, the nurse or physician should bear in mind that the experience of constipation is subjective and may vary from individual to individual. It is also important to assess the normal frequency of the passage of stools for each individual
- Abdomen and per rectal examination

- Laboratory investigations (as appropriate) - serum calcium, TSH
- X-ray abdomen (erect), to rule out intestinal obstruction and faecal impaction

MANAGEMENT

Goals of management

- Re-establish comfortable bowel habits to the satisfaction of the patient
- Relieve the pain and discomfort caused by constipation
- Restore a satisfactory level of independence in relation to bowel habits
- Consider the wishes of the patient and his/her family
- Prevent and treat related gastrointestinal symptoms such as nausea, vomiting, abdominal distension and abdominal pain
- Treat the reversible causes

Non-pharmacological measures:

- Advise physical exercise - if appropriate
- Improve dietary habits - e.g. encourage food intake, fluid intake, fibre intake (to the extent possible)
- Prompt response to the sensation of passing stools
- Privacy, comfort and easy access to toilet facilities (such as - use of a commode, hand rails in the patient's toilet to enhance independence, raised toilet seat for comfort, foot stool to support feet etc.)
- Restraining from straining
- Using the squatting position
- Placing forearm on thighs
- Curling upper body forward
- Drooping the head slightly forward
- Resting hands on thighs
- Relaxed breathing techniques

Pharmacological measures

- For patients with constipation and without colic, a stimulant laxative is preferred if the stools are normal or soft
- For patients who develop colic, discontinue stimulant laxatives and add, or increase, the stool softener
- The dose of laxatives should be individualised and titrated according to the response and need
- Per rectal measures are necessary, especially if the patient is immobile or bedbound
- Rectal treatment is to be avoided if the rectum is ballooned or empty

- When the patient presents with diarrhoea, always exclude constipation with overflow diarrhoea
- For patients with constipation of more than 2 days use rescue enemas or suppositories
- Only one rectal measure should be undertaken within 24 hours
- Withhold oral laxatives on those days when rescue enemas or suppositories are used
- In dying patients:
  - Relief of constipation should be kept in mind and rectal measures could be used to keep patient comfortable
  - Small dose of benzodiazepine could be used to relax the patient and sphincter and keep the patient comfortable during the procedure
  - Generous use of local anaesthetics is advisable
- In palliative care patients avoid bulk laxatives and osmotic laxatives

- **Laxatives - Starting doses**

  - Option A - Stimulant laxatives
    - Tab. Bisacodyl 10mg hsod
    - Tab. Senna 12mg hsod
    - Cap. Sodium Picosulphate 10 mg hsod

  - Option B - Softeners
    - Syr. Cremaffin 10-20ml hsod
      (Combination of Magnesium hydroxide and Liquid Paraffin)
    - Cap. Docusate Sodium 100mg bd

  - Option C - Combination of stimulant and softener
    - Combination of one of the Option A with one of the Option B
    - Syr. Cremaffin Plus 10ml hsod
      (Combination of Magnesium hydroxide, Liquid paraffin and Sodium Picosulphate)

- **Rectal Measures**
  - **Soft loaded stools**
    - Per rectal stimulant laxatives - Bisacodyl 10-20 mg suppository
    - Ensure that it is in contact with rectal mucosa
    - Onset of action - 15-60 minutes

  - **Impacted hard stools**
    - Very gentle manual digital evacuation with adequate lubrication may be needed if there are faecoliths

- Glycerol suppository - onset of action - 15-60 minutes
- Sodium phosphate enema - onset of action - 15 minutes

- **Impacted very hard stools**
  - Arachis oil enema (onset of action - 60 minutes) overnight followed by Sodium phosphate enema

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References

Larkin, P.J., Sykes, N.P., Centeno, C., Ellershaw, J.E., Elsner, F., Eugene, B., Gootjes, J.R.G., Nabal., M., Noquera, A., Ripamonti, C., Zucco, F., Zuurmond, W.W.A. The management of constipation in palliative care: clinical practice recommendations. *Palliative Medicine* (2008); 22: 796-807

Sykes, N. (2015). Constipation and diarrhoea. Oxford Textbook of Palliative Medicine (pp. 675-685)

Sykes, N., Ripamonti, C., Bruera, E., Gordon, D. (2006). Constipation, diarrhoea, and intestinal obstruction. ABC of Palliative Care (pp. 29-35)
Twycross, R. (2003). Symptom Management II. Introducing Palliative Care. (pp. 105-162)

Twycross, R., Wilcock, A., Howard, P. (2014). Drug monographs. Palliative Care Formulary 5. (pp. 37-112)