Constipation

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Definition

Constipation is the irregular, difficult passage of small, hard faeces. Bowel habit varies widely between individuals and consequently what is considered to be constipation by a patient will depend on their previous experience.

Introduction

As over 99% of British populace defaecate at least three times per week, a frequency of fewer than this is often taken as an objective indication of constipation. Constipation is common in advanced cancer & about 50% of cancer patients presenting at hospices complain of constipation. Diminished food and fibre intake, lack of exercise and drugs are all causal factors. Because of the patient's physical limitations, fatigue and associated anorexia, laxatives are generally the foundation of treatment.

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Causes

Often multi-factorial but consider the following:

Drugs

- Opioids
- Drugs with anticholinergic effects, e.g. hyoscine, tricyclic antidepressants
- Diuretics
- Anticonvulsants
- Iron
- Chemotherapy

Direct effects of tumour

- Narrowing of gut lumen.
- Spinal cord or pelvic plexus damage.
- Hypercalcaemia.

Secondary effects of disease

- Inadequate food intake.
- Inactivity.
- Low fibre diet.
- Debilitation.
- Dehydration.
- Inadequate toilet facilities. Lack of privacy.

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Assessment

History must make clear what is happening in terms of stool frequency, difficulty of defaecation and an assessment of the patient's previous experience. Consider:

- Changes in bowel habits
- Diet and fluid intake
- Drug history e.g. opioids
- Precipitating/relieving factors
- Stool characteristics (loose, formed, or hard pellet)
- Abdominal examination
- Rectal examination if there has not been a satisfactory evacuation. This is important to avoid missing the diagnosis of constipation or confusing constipation with malignant obstruction

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Management

- Maintain good general symptom control, enabling the patient to potentially be mobile and to eat as well as possible.
- High fibre foods will not treat severe constipation and are unpalatable to ill patients
- Consider ordering commode
- Ensure privacy for defaecation
- Anticipate the need for laxatives and use appropriately

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Management of opioid induced constipation

- All opioids constipate to varying degrees. As a general rule, all patients prescribed morphine should also be prescribed a laxative. About 1/3 of patients also need rectal measures, either because of failed oral treatment due to advanced disease e.g. spinal cord compression
- Encourage fluids
- Consider changing opioid for an alternative less constipating one e.g. fentanyl
- Palpate for faecal masses in the line of the colon
- Rectal examination if the bowels have not been open for >3days or if the patient report discomfort
- When an opioid is prescribed, prescribe either senna or co-danthrusate 1capsule nocte **prophylactically**
- If already constipated, consider prescribing co-danthrusate 2 capsules nocte or senna tablets e.g. 2 nocte & lactulose 10-20ml b.d.
- Adjust the dose every few days according to results
- If the patient has difficulty swallowing tablets/capsules or prefers a liquid preparation, use co-danthrusate suspension (5ml = 1 capsule) or senna liquid
- Movicol is a useful alternative if patient is able to tolerate drinking a reasonable amount of water (125ml per sachet)
- If > 3 days since last bowel action consider movicol sachets (up to 8/24 hrs for faecal impaction), suppositories e.g. bisacodyl 10mgs or a micro-enema
- If these are ineffective, administer a phosphate enema and possibly repeat the next day
- **Caution if bowel obstruction present** .Sodium docusate is licensed for use in partial

obstruction. Twycross et al (2002)

- ***For specialist advice please contact Macmillan team or Continence Advisor***

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References

- Twycross, R, Wilcock, A, Charlesworth, S & Dickman, A (2002) Palliative Care Formulary 2 nd Edition. Radcliffe Medical Press: Oxon