Northamptonshire Healthcare
NHS Foundation Trust

MMG034 Management of Constipation within Specialist Palliative Care

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Why we need this Guideline

Constipation is defecation that is unsatisfactory because of infrequent stools, difficult stool passage or seemingly incomplete defecation. Stools are often dry and hard.[1] Constipation is a common problem in the palliative care population and is often caused by multiple factors for example underlying disease, poor mobility, change in diet and fluid intake and drugs especially opioids. Thorough assessment of constipation is important as it can compound other symptoms e.g. pain and vomiting, cause psychological distress and has social consequences.[2] There have also been case reports of more serious implications such as colonic perforation.[3]

Constipation is characterised by prolonged gastrointestinal transit time that allows more water absorption from the faeces making them harder to pass and disordered rectal evacuation leading to the need to strain when defecating.[2]

What the Guideline is trying to do

The aim of this guidance is to aid clinical decision making when assessing and managing constipation within specialist palliative care.

Which stakeholders have been involved in the creation of this Guideline

Palliative Care Team

Medicines Management Committee

Key duties

The Medicines Management Committee

Will approve and review these guidelines.

Ward Managers

Will ensure that all staff are aware of the guideline, have received appropriate training in identification of patients with constipation and are able to deliver appropriate care.

Doctors

Will identify patients with constipation and prescribe according to the guideline.

Nursing Staff

Will ensure that patients at the end of life receive appropriate care of their diabetes in line with this guideline.

Guidance for specialist palliative care setting

History and Examination

1- Enquire about the patient's bowel habits. In particular how often does the patient open their bowels, what is the consistency of the stool and how has this changed since their diagnosis or commencement of recent medications especially opioids? When did they last open their bowels? Enquire about previous laxative use. Any associated symptoms such as pain, vomiting or bleeding? Enquire how the patient mobilises to the toilet. Do they need to wait for assistance from carers and enquire about other factors such as height/comfort of toilet seat, privacy and dignity. Note the medications they are taking that could be contributing to

constipation e.g. opioids and antimuscarinics. Please document this on SystmOne. Please note currently the template on SystmOne requires the constipation box to be ticked before an entry can be made, describing the severity of the symptom.

2- Examine the patient. Is the abdomen distended or tender? Can faecal masses be palpated? Can altered bowel sounds be heard on auscultation? Consider a rectal examination if bowels have not been open for more than 3 days.

3- Investigations are not usually routinely required however it may be important to rule out contributing factors such as hypercalcaemia, hypothyroidism and bowel obstruction.

Management

Please also see the attached constipation flow chart – Appendix 1

Where possible and not contraindicated, patients should be encouraged to increase their fluid and nutritional intake and to optimise their mobility.

Ensure privacy and comfort to allow normal defecation.

The aims of drug management are to restore the amount of water in the faeces and to improve rectal evacuation by improving faecal consistency and promoting peristalsis. There are two broad classes of laxatives:

- faecal softeners
- bowel stimulants

However, softeners increase faecal mass and thereby also promote peristalsis and stimulants reduce water absorption from the faeces and therefore also have a softening action.[2]

There is a lack of randomised controlled trial evidence to recommend one laxative over another, but the cause of the constipation, how the laxatives work and cost should be considered.[2,4]

Special considerations:

Constipation in patients with advanced cancer and Opioid induced constipation

Opioids cause constipation by increasing ring contractions, decreasing propulsive intestinal activity and by enhancing the resorption of fluid and electrolytes. Some strong opioids are less constipating than morphine e.g. fentanyl, buprenorphine and methadone.[2] Bulk forming laxatives are not recommended as they act to distend the colon and stimulate peristalsis but opioids prevent this propulsive action.[1] Rectal interventions such be avoided if possible in patients who are thrombocytopenic or neutropenic due to the risk of bleeding and infection.[2]

1- When an opioid is commenced prescribe senna 15mg orally at night if not constipated and 15mg twice a day if constipated

2- If no response after 24 – 48 hours increase by increments of 7.5mg every 24 - 48 hours up to a dose of 30mg three times a day.

3- If there is no bowel action after 3 days consider giving a suppository e.g. bisocodyl 10mg and glycerol 4gram, or a microenema

4- If the maximal dose of the laxative is ineffective or the patient is unable to tolerate it, halve the dose and add in macrogols e.g. Movicol/Laxido 1 sachet daily or lactulose 15mls once or twice dailyand titrate according to response.

5- If a patient is admitted taking a laxative e.g. sodium picosulfate titrate this up to the maximum dose before switching and consider intervention with suppositories.

If response to laxatives is insufficient despite titration and there are no colic symptoms consider adding a prokinetic agent such as metoclopramide, domperidone or erythromycin 250 - 500mg four times a day (off license use).

Bowel obstruction

Investigations may be required to ascertain whether the patient has developed partial or full bowel obstruction and surgical intervention may be required. If this is not possible and the patient is in partial obstruction, or the obstruction is being exacerbated by constipation then laxative therapy may still be appropriate and will need to be titrated according to need and symptoms. Docusate may be considered as it is a faecal softener, a surface wetting agent given orally and has a relatively weak effect on GI transit time. Starting dose is 100mg twice a day and can be increased to 200mg three times a day[2]. Rectal intervention may also be required.

End stage liver failure/hepatic encephalopathy

Lactulose is the laxative of choice in patients with end stage liver failure at risk of developing hepatic encephalopathy. Lactulose is an osmotic laxative and draws fluid into the large intestine. It is fermented by colonic bacteria to organic acids which stimulate the large intestine. The low pH reduces the proliferation of ammonia-producing organisms, reduces the absorption of ammonium ions and other nitrogenous compounds. The aim is to produce 2 - 3 soft bowel movements a day. Patients may need between 15 - 50ml three times a day.[2]

Cord compression / paraplegia and tetraplegia

The following is a guide but it is important to remember that a pattern may emerge with certain interventions and that needs to be tailored to the preference of the patient.

In theory if the spinal cord lesion is above T12/L1 the cauda equina will be intact leading to a spastic GI tract with preserved sacral reflex and should respond to rectal intervention. If the lesion is below T12/L1 with the cauda equina involved this will cause a flaccid GI tract and may require digital evacuation of the rectum. The aim of treatment is to produce a comfortable, controlled evacuation every 1 - 3 days with the faeces being neither too soft nor hard.

1- If patients are also taking constipating drugs e.g. opioids commence an oral stimulant laxative e.g. senna 15mg twice a day or bisacodyl 5-10mg twice a day

2- Initially if rectum is impacted, empty it digitally. Then develop a routine of inserting glycerol, or bisocodyl, or microenemas every 1 to 3 days. A hot drink after about an hour may stimulate a gastrocolonic reflex. Digital stimulation may be required to completely empty the rectum. Position may need to be adjusted e.g. lying in lateral position or hoisted onto a commode.

Motor Neurone Disease (MND) and other neurodegenerative diseases

MND does not directly affect the GI tract, however it indirectly affects bowel function due to weak abdominal muscles, immobility and altered diet and fluid intake. Patients may well benefit from stimulant laxatives and/or rectal intervention as above.

Specific laxatives

Docusate Sodium is-classified as a stimulant laxative, although it is principally an emulsifying and wetting agent with relatively little effect on GI transit. Not usually recommended as the sole laxative except in patients with partial bowel obstruction.

Lactulose is an osmotic laxative that deposits a large volume of fluid into the large intestine.

Senna is a naturally occurring plant derivative anthranoid requiring hydrolysation by colonic microflora and acts locally in large bowel directly enhancing motility. It is taken orally.

Bisacodyl is a prokinetic laxative acting locally in large bowel directly stimulating the nerve endings in the colonic mucosa thereby enhancing motility, reducing transit time and increasing water content of stool. It can be taken orally or rectally in form of suppositories.

Movicol/Laxido are oral macrogols, an inert polymer of ethylene glycol which is non-absorbable and non-metabolised in the gastrointestinal tract and sequesters fluid in the bowel by forming hydrogen bonds with water resulting in high osmotic pressure. It acts as a softening and bulk forming agent due to water retention in the bowel. It is licenced for faecal impaction – up to 8 sachets in 1 litre of water over 6 hours.

Sodium picosulfhate is hydrolysed by colonic microflora and acts locally in large bowel directly enhancing motility, reducing transit time and increasing water content of stool. It is taken orally.

Glycerol is an osmotic laxative given rectally by suppository.

Micro-enemas These are osmotic enemas that contain sodium citrate and sodium lauryl sulfoacetate with several excipients including glycerol and sorbitol.

Phosphate enema increases intestinal water secretion and stimulates peristalsis. Try to avoid use as can sometimes cause water and electrolyte disturbances especially in >65 age group and when co-morbidities present.

Prucalopride is only recommended for chronic constipation in women. See NICE guidance for more details[1]

Lubiprostone is only recommended for chronic idiopathic constipation in adults. See NICE guidance for more details.[1]

Methylnatrexone is a peripherally acting opioid antagonist that can be considered if optimal use of other laxatives has been unsuccessful. It is marketed for opioid induced constipation and is available as a SC injection. Between 1/3 and 1/2 patients given methylnatrexone have a bowel movement within 4 hours without loss of analgesia or opioid withdrawal. Dosing is dependent on weight and renal function. It is contraindicated in bowel obstruction. Additional use of other laxatives may still be required.

- Weight between 38-61kg and eGFR> 30ml/min commence 8mg on alternate days
- Weight between 62-114kg eGFR>30ml/min commence 12mg on alternate days

For weight and renal function outside these ranges consult the BNF or PCF.

Naloxegol is an oral peripherally acting mu-opioid receptor anatagonist for the treatment of opioid induced constipation. It has been NICE approved for patient with and without cancer; however the studies included mainly non-cancer patients. Many patients required additional laxatives

- 12.5-25mg once daily.

In patients with moderate to severe renal impairment commence at 12.5mg.

Caution with CYP3A4 inhibitors, patients taking methadone and those at risk of increased gastrointestinal perforation. Contraindicated in bowel obstruction.[5]

Training requirements associated with this Guideline

There is no mandatory training associated with this Guideline.

How this Guideline will be monitored for compliance and effectiveness

There is no monitoring associated with this guideline.

Equality considerations

See MMP001 Control of Medicines Policy.

Reference Guide

1. https://cks.nice.uk/constipation (revised October 2015) Accessed 4/1/2017
2. Tywcross R, Wilcock A, Howard P. Palliative Care Formulary 5. 2014.
3. Davies A, Webber K Stercoral perforation of the colon: a potentially fatal complication of opiod induced constipation. *Journal of Pain and Symptom Management. 2/8/15.*
4. Candy B, Jones L, Larkin PJ, Vickerstaff V, Tookman A, Stone P. Laxatives for the management of constipation in people receiving palliative care. Cochrane Database of Systematic Reviews 2015 Issue 5
5. NICE (2015) TA345: Naloxegol for treating opioid-induced constipation
6. BNF 72 September 2016-March 2017

Document control details

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1	11.7.17	11.07.17	31.07.19	New guidance

Appendix 1 – Flowchart for Constipation within Specialist Palliative Care