PURPOSE

To enable the comfortable passage of faeces minimising the need for rectal intervention and to provide evidence based nursing guidelines for the management of constipation.

PRINCIPLES

Constipation is a distressing and preventable symptom, often resulting in inpatient admission.

An understanding of the patient’s usual bowel habit is essential when planning treatment.

All patients on opioids MUST have prophylactic laxatives, regularly prescribed (not just prn/as needed).

A combination of stimulant and a softener is almost always required.

Laxative doses often need to be increased along with increased doses of opioids.

Successful management of constipation is the comfortable passage and feeling of complete evacuation 3. The ease of passage is more important than frequency.

The usual aim is for satisfactory bowel motion every 2-3 days – Bristol stool chart 4 or 5.

SCOPE

Medical and nursing staff managing the care of patients with palliative needs.

DEFINITION

Constipation is the passage of a small volume of faeces infrequently and with difficulty.

CAUSES

Causes of constipation are often multifactorial for example:
- Environment: privacy, reliance on others for assistance, easily accessible toilet
- Diminished food intake and a lack of fibre (with corresponding adequate fluid intake) in the diet
- Dehydration
- Poor mobility
- Drugs – opioids, anticholinergics (hyoscine, phenothiazines, tricyclic antidepressants, antacids, diuretics, iron)
- Anxiety, depression or impaired cognitive function
- The underlying illness (particularly if the disease affects the gastrointestinal tract)
- Concurrent disease – hypothyroidism, diabetes, hypokalaemia, diverticular disease, anal fissure or stenosis, hypercalcaemia
ASSESSMENT

Daily Assessment of Constipation:
- What is the usual pattern of defecation?
- When was the last bowel movement?
- What laxatives have been used?
- Have the laxatives been taken prn or regularly?
- Are the stools hard or soft?
- Is there any pain/mucous/blood on defecation?

Examination as Part of Assessment:
- MOUTH - to check for oral thrush, mucositis and dehydration
- ABDOMEN – inspect, palpate and listen for bowel sounds
- RECTUM – digital examination should be performed gently, avoid if the patient is neutropenic or has rectal bleeding
- INVESTIGATION - an abdominal x-ray can assess for faecal loading

Rectal Examination:
- Ensure the patient understands and consents to the procedure
- If possible lie the patient in the left lateral position with their knees drawn up
- Ensure the gloved finger is well lubricated
- Observe the perianal area for haemorrhoids, anal fissure and broken skin before proceeding
- Ensure the examination is performed gently, using one finger only
- Check content, whether the rectum is collapsed or ballooned and for bleeding or masses
- If you are unsure of your findings, please consult a colleague or medical staff
- In the case of a colostomy: if constipation is suspected gentle insertion of finger into the stoma will show if faeces is present, suppositories can be held in place with finger

NON-PHARMACOLOGICAL MANAGEMENT

- Provide privacy and dignity for patient and ensure easy access to toilet facilities
- Address where possible any reversible factors causing constipation (dehydration, hypercalcaemia, drug therapy)
- Encourage oral fluid intake
- Encourage patient choice of natural aperients e.g. prunes, kiwifruit
- Encourage mobilizing where possible
- Educate where required
- Record bowel evacuation daily
- Review bowel regime regularly
- Rectal intervention should only be considered as a last resort
- Treat associated symptoms i.e. nausea

PHARMACOLOGICAL MANAGEMENT

1. Softening agents
   - Docusatetablets 50mg, 120mg (Coloxyl)
   - Maximum dose 600mg/day PO usually as a BD dose
   - Limited use if prescribed alone, as stimulant is usually needed
2. Stimulant (contact) agents
   - Senna 7.5mg tablets (Senokot), start 7.5-15mg nocte, maximum 67.5mg (9 tabs)/24 hours, in divided doses
   - Bisacodyl 5mg tablets (Dulcolax), start 10-20mg nocte, maximum 20mg PO TDS

   Caution: Stimulants are unsuitable for patients with complete bowel obstruction as they increase peristalsis and may cause colic or perforation.

3. Combination softening and stimulant agents
   - Docusate 50mg & Senna 8mg tablets (Laxsol)
   - Start 1-2 tabs PO BD, maximum 8 tabs/day in divided doses (extrapolated from senna + docusate maximum doses)
   - Danthron with Poloxamer (Pinorax and Pinorax Forte)
     - Only for the prevention of constipation in the terminally ill
     - Contraindicated in faecal incontinence due to skin burns
       - Danthron 25mg with poloxamer 200mg per 5mL (Pinorax), start 7.5mL nocte, maximum 60mL (300mg danthron) daily
       - Danthron 75mg with poloxamer 1g per 5mL (Pinorax Forte), start 2.5mL nocte, maximum 20mL (300mg danthron) daily

   Caution: Stimulants are unsuitable for patients with complete bowel obstruction as they increase peristalsis and may cause colic or perforation.

4. Osmotic agents
   - Movicol is also an osmotic laxative but is preferable to lactulose in the palliative patient.
     - Macrogol solution (Movicol/Lax sachets) Powder sachet reconstituted with 125mL water: dose 1–3 sachets per day as regular laxative - not recommend for on-going management of constipation as contact laxatives will generally achieve the same result.
   - Lactulose – 15mL OD

   Caution: Lactulose is associated with abdominal cramps, bloating and nausea.

5. Rectal agents (see section Rectal Treatment below)
   - Suppositories
     - Softening and mild stimulant: Glycerol 3.6g: dose 2 PR/day
     - Stimulant: bisacodyl 10mg: dose 2 PR/day

   Caution: Stimulants are unsuitable for patients with complete bowel obstruction as they increase peristalsis and may cause colic or perforation.

   - Enemas
     - Osmotic
       - Sodium Citrate & Sodium Lauryl Sulphoacetate (Microlax)
       - Sodium Acid Phosphate (Fleet Phosphate)
     - Oil retention (softener)
       - Fleet mineral oil

For faecal Impaction:
8 sachets of Movicol/Lax sachets (see above) each in 125mL of water to make up to 1 litre and to be taken with 6 hours, review former laxative dose and up titrate if needed following faecal dis-impaction.
### Rectal Intervention:

<table>
<thead>
<tr>
<th>Rectal Examination</th>
<th>Stool present</th>
<th>Treatment</th>
<th>Important notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If rectum is empty and collapses</strong> – the rectal wall should be easily felt collapsed around the examining finger (this is usually an indication of a functioning bowel).</td>
<td>Nil</td>
<td>No further treatment is required, but continue to assess bowels daily</td>
<td>This may indicate faeces high up in the bowel which is indicative of gross constipation. Be aware that fluid stool may actually be an indication of impaction with overflow.</td>
</tr>
<tr>
<td><strong>If rectum is empty and dilated</strong> – often feels ballooned on examination.</td>
<td>Nil</td>
<td>Continue oral stimulant laxatives</td>
<td></td>
</tr>
<tr>
<td><strong>Faeces in rectum</strong> – determine the consistency of the faeces</td>
<td>Soft stool</td>
<td>1 X bisocodyl suppository or Microlax enema</td>
<td>Do not insert a medicated suppository (dulcolax) into faecal mass as its effect will be minimal, (blunt end first) – must have contact with rectal wall 3</td>
</tr>
<tr>
<td></td>
<td>Firm/Hard stool</td>
<td>1st - 1 X bisocodyl and 1 X Glycerol suppository / Microlax enema</td>
<td>Lubricant suppositories (glycerol) should if possible be inserted into the faecal mass in order to dissolve and soften the faeces</td>
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<tr>
<td></td>
<td></td>
<td>2nd - Phosphate enema*</td>
<td>Enemas should be administered at room temperature. These should not be used more than once or twice as they can lead to electrolyte imbalance</td>
</tr>
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<td></td>
<td>Hard stool</td>
<td>Oil retention enema overnight followed by phosphate enema in morning</td>
<td>Use gravity and not force to administer an enema. Forcing can result in bowel spasm, leakage or shock.</td>
</tr>
<tr>
<td><strong>Tumour in the rectum</strong> – sometimes a mass in the rectum is not faeces. On examination the rectum feels lumpy or hard/irregular and the mass is immobile.</td>
<td>N/A</td>
<td>Refer to medical staff and do not proceed with rectal laxatives or enemas</td>
<td></td>
</tr>
<tr>
<td><strong>Spinal Cord Compression/neurological condition</strong></td>
<td>Aim for firm stools</td>
<td>Rectal intervention three times a week to prevent undignified episodes of faecal incontinence alongside daily laxative regimen</td>
<td>Individualise regime</td>
</tr>
</tbody>
</table>
RELATED DOCUMENTS

HBDHB/EAC/IPUPPM/8186 Bowel Management Guidelines for the Critically Ill Patient
Bristol Stool Chart

REFERENCES


KEYWORDS

Constipation
Cranford
Hospice
Palliative

For further information please contact the Specialist Palliative Care Service.
Appendix 1

**Bristol Stool Chart**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
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</tbody>
</table>