Constipation

Scottish Palliative Care Guidelines

Healthcare Improvement Scotland

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Introduction

Constipation is defecation that is unsatisfactory because of infrequent stools, difficult stool passage, or seemingly incomplete defecation. Stools are often hard and can be abnormally small or large. Constipation can cause unpleasant symptoms such as abdominal and rectal pain, distension, nausea and vomiting, and other negative effects on the patient's wellbeing. As well as the physical suffering, constipation can cause psychological distress and agitation in the terminally ill patient.

There are many reasons why patients with palliative care needs may develop constipation.

Constipation can be complex and may require specialist advice if standard treatment is not successful.

Assessment

A full assessment of the patient and their symptoms should be obtained looking at:

- normal and current bowel pattern (frequency, consistency, ease of passage, blood present, pain on passing stool)
- current and previous laxatives taken regularly (or as needed) and their effectiveness
- clinical features (may mimic bowel obstruction or intra-abdominal disease):
    - pain
    - nausea and vomiting, anorexia
    - flatulence, bloating, malaise
    - overflow diarrhoea
    - urinary retention

- possible causes of the constipation (clarify cause before starting treatment):
    - medication: opioids, antacids, diuretics, iron, 5HT3 antagonists, anticholinergics
    - secondary effects of illness (dehydration, immobility, poor diet, anorexia)
    - tumour in, or compressing, bowel wall
    - damage to lumbosacral spinal cord, cauda equina or pelvic nerves
    - hypercalcaemia
    - concurrent disease such as diabetes, hypothyroidism, diverticular disease, anal fissure, haemorrhoids, Parkinson's disease, hypokalaemia.

Abdominal and rectal or stomal examination is necessary, unless it would cause undue distress for the patient.

Management

The aim of management is to achieve regular comfortable defaecation without straining, rather than any particular frequency of bowel motion.

General advice

- Encourage a good oral fluid intake (2 litres per day if able) and review dietary intake.
- Ensure patient has privacy and access to toilet facilities.
- Encourage daily exercise according to ability.
- Address any reversible factors contributing to the constipation, including de-prescribing contributing medications where possible.
- Laxative doses should be titrated according to individual response.
- If current regimen is satisfactory and well tolerated, continue with this but review patient regularly and explain importance of preventing constipation.
- It is important to co-prescribe laxatives when commencing opioids – Refer to 'Choosing and Changing Opioids'
- Use oral laxatives in preference to alternative routes of administration.

Tables are best viewed in landscape mode on mobile devices

	Laxative Choice
1. Stimulant Laxative	• Senna tablets 15mg to 30mg, or bisacodyl tablets 5mg to 10mg at night. ○ If significant colic occurs, the stimulant should be discontinued, and surface wetting or osmotic used instead.
2. Add in Surface Wetting/Osmotic Laxative	• Macrogol (for example Laxido®) (caution in renal disease given potassium content)1 to 3 sachets daily. ○ If severe constipation, consider a higher dose for 3 days. • Docusate sodium 100mg twice daily is commonly added to senna but is unlikely to offer additional benefit over senna alone
3.Add Rectal Treatment **(if rectum loaded-** Do not give rectal treatment if rectum is ballooned and empty)	1. Start with glycerol suppository and bisacodyl suppository given at the same time, placing the bisacodyl suppository directly against the rectal mucosa 2. If no result but rectum remains loaded then progress to sodium citrate enema, and then a phosphate enema if no result 3. If very hard loading: arachis oil enema (except in those with nut allergy) overnight, followed by phosphate enema in the morning may be considered

Choice of laxative (see Further information - Laxative medicines information chart)

The options above may be equally effective

- Suggested laxative starting doses are provided; these should be titrated as appropriate depending on individual response.
- Patient preferences should be taken into consideration.
- For constipation in patients taking opioids resistant to standard management, refer to opioid induced constipation section.

Paraplegic or bedbound patient

- Adjust laxatives or loperamide to keep stool firm, but not hard.
- Commence regular rectal intervention (often referred to as a “bowel regimen”) every 1 to 3 days to avoid possible impaction resulting in faecal incontinence, anal fissures or both.

Opioid-induced constipation

- All opioids can cause constipation, but transdermal fentanyl is less constipating. If pain is stable and constipation isn't responding to standard treatments, consider rotation to fentanyl with specialist advice. Refer to Medicines information | Right Decisions
- Peripherally acting μ opioid receptor antagonists (PAMORAs) can relieve constipation but allow preservation of centrally mediated analgesia.
- Oral PAMORAs – such as naldemedine may be considered
- Contra-indicated in gastrointestinal (GI) obstruction or patients at risk of GI perforation
- Seek specialist palliative care advice if this is ineffective.

Should these approaches fail, DO NOT escalate injectable PAMORAs. This should only be used for opioid-induced under specialist palliative care advice. **(see Further information - PAMORAs)**

Practice points

- The majority of patients with palliative care requirements on opioids add link to choosing and changing opioids need a regular oral laxative.
- Review laxative regimen when opioid medication is commenced, or dose is changed. This includes increasing use of ‘as required’ opiate medication.
- Caution is needed with frail or nauseated patients who may be unable to tolerate the fluid volume needed along with macrogol laxative.
- Bulk-forming laxatives are not suitable if the patient has a poor fluid intake and reduced bowel motility.
- Lactulose may be considered in hepatic encephalopathy. However, as a laxative, it is not effective without a high fluid intake; it can cause flatulence and abdominal cramps in some patients.
- If laxative therapy fails, seek specialist palliative care advice for alternative options.
- Manual evacuation, if absolutely necessary, requires consent and should never be attempted without analgesia and/or sedation.
- Because constipation in advanced disease is generally multifactorial in origin, peripheral opioid antagonists will augment rather than replace laxatives.

Resources

- CADTH. Routine bowel care for patients in long-term or palliative care: guidelines. 2015 [cited 2018 Oct 02]; Available from: https://www.cadth.ca/sites/default/files/pdf/htis/dec-2015/RB0940%20Bowel%20Care%20in%20LTC%20Final.pdf
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- National Institute for Health and Clinical Excellence (NICE). Palliative care – constipation. Clinical Knowledge Summary 2024. Available from https://cks.nice.org.uk/topics/palliative-care-constipation/

Further information

Laxative medicines information chart

Tables are best viewed in landscape mode on mobile devices

Laxative	Starting Dose	Time to act	Comments
Osmotic laxatives			
Lactulose Refer to End Stage Liver Disease	15ml twice daily	2–3 days	Palatable — although some find it sickly sweet. Adequate fluid intake is recommended. If used alone in opioid-induced constipation, it often needs to be given in large doses that cause bloating and colic
Macrogols (e.g. Laxido®) (caution in renal disease given potassium content)	1-3 sachets daily	2–3 days	Some people find it difficult to drink the prescribed volume of macrogol (125ml per sachet). Licensed for use in faecal impaction (up to 8 sachets per day for max 3 days). Available in half-strength sachets.
Surface-wetting laxatives			
Docusate sodium	100mg twice daily	12–72 hours	Probably acts both as a softening agent and a stimulant. May be a useful alternative for people who find it hard to increase their fluid intake sufficiently to use a macragol. Tablets available and syrup is unpalatable.
Stimulant laxatives			
Senna	15mg at night	8–12 hours	Licensed only for short-term use. Tablets can be hard to swallow and syrup is available.
Bisacodyl	5-10mg at night	6–12 hours	No syrup available. Licensed only for short-term use

Sodium picosulfate	5-10mg at night	6–12 hours	Licensed only for short-term use. Syrup is palatable. May be trialled by senna ineffective or not palatable.
Rectal laxatives			
Glycerol suppositories (lubricating and weak stimulant)	4g	15–30 minutes	Can be used for hard or soft stools. Licensed for occasional use only. Suppositories must be placed alongside the bowel wall so that body heat causes them to dissolve and distribute around the rectum. Suppositories should be moistened before use to aid insertion
Bisacodyl suppositories (stimulant)	10mg	15 minutes to 3 hours	Avoid if large, hard stools, as no softening effect. Use for soft stools
Sodium citrate microenema (osmotic)	1-2	5–15 minutes	Smaller volume (5 mL) than a phosphate enema (130 mL). Useful to remove hard, impacted stools. Correct administration important to prevent damage to rectal mucosa. Licensed for occasional use only
Phosphate enema (osmotic/stimulant)	1	15-30 minutes	Useful to remove hard, impacted stools. Correct administration important to prevent damage to rectal mucosa. Licensed for occasional use only. Use of phosphate enemas can cause hypocalcaemia and hyperphosphataemia in ill patients or in renal impairment. They can also produce rectal gangrene in ill patients with a history of haemorrhoids

Arachis oil enema (softener)	1	Retention enema — used overnight and warmed before use	Useful for hard, impacted stools. Should not be used in people with peanut allergy. Licensed for occasional use only

PAMORAs

Antagonist	Comments
Naldemedine	• Oral preparation • Naldemedine is accepted for use within the NHS Scotland for the treatment of opioid-induced constipation (OIC) in adult patients who have previously been treated with a laxative • Initiate with caution in patients over 75years of age • No evidence for benefit if morphine oral equivalent dose is greater than 400mg per day • No evidence for benefit if being treated with partial μ opioid agonists such as buprenorphine
Naloxegol	• Oral preparation • Naloxegol is accepted for use within NHSScotland for the treatment of opioid-induced constipation in adult patients who have had an inadequate response to laxative(s) ○ 25mg tablet daily in the morning reduced to 12.5mg daily in moderate-severe renal impairment. Not recommended in severe hepatic impairment. • When naloxegol therapy is initiated, it is recommended that all currently used maintenance laxative therapy should be halted until clinical effect of naloxegol is determined.
Methylnaltrexone	• Subcutaneous injection

	• Methylnaltrexone is accepted for **restricted use** within NHS Scotland for treatment of opioid-induced constipation in advanced illness patients who are receiving palliative care when response to usual laxative therapy has not been sufficient. **It is restricted to use by physicians with expertise in palliative care**.
	  ○ Subcutaneous injection dose according to weight of patient.
	  ○ Contra-indicated in severe renal/hepatic failure
	  ○ Subcutaneous injection dose according to weight of patient.
	
	• Contra-indicated in severe renal/hepatic failure

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