

Management of Constipation in Palliative Care

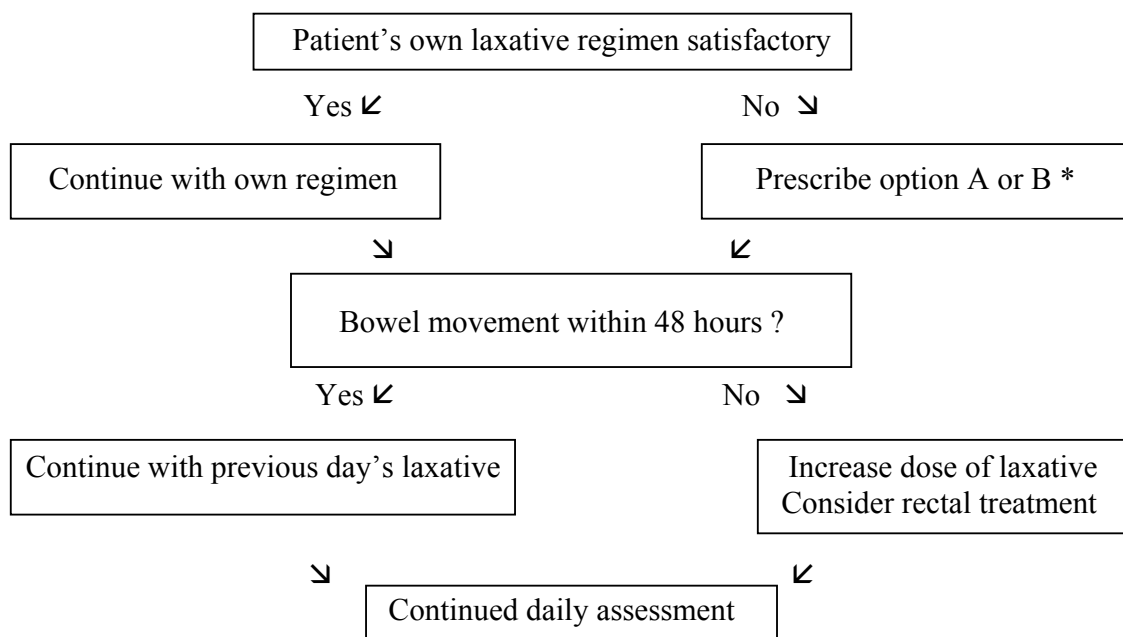
The aim of treatment is the comfortable passage of faeces without rectal treatment

- An understanding of the patient's normal, accepted bowel habit is essential when planning treatment
- All patients on opioids require a laxative, prescribed regularly (not prn)
- A combination of stimulant and softener is usually required
- Laxative doses often need to be increased along with increased doses of opioids

Daily assessment of constipation

Normal frequency of stool ?	Current frequency of stool ?
Stool consistency ?	Stool size/ volume ?
Is there blood or mucus in the stool ?	Ease of passage ?

Oral Treatment



* Option A	* Option B
Codanthramer 1-2 capsules once daily OR Codanthramer 5-10 ml once daily	Bisacodyl 5mg tablet once daily AND Docusate sodium 100mg capsule bd

Codanthramer is a combination laxative (stimulant/softener) which aids compliance, but it is only licensed for use in terminally ill patients (individual clinician needs to decide whether the patient has a limited prognosis)

Notes

- Titrate doses of laxatives according to response and before changing to an alternative laxative
- Consider using codanthramer strong when dose of codanthramer exceeds 2 capsules bd or 10ml bd
- Movicol may be used for severe constipation unresponsive to option A/B. Volume of 125 ml may be inappropriate for patients with a poor fluid intake.
- See laxative drug information chart for details of individual preparations

The following laxatives are NOT recommended for routine use

Senna tablets	Difficult to swallow
Docusate syrup	Pungent taste
Fybogel sachets	Inappropriate for patients with poor fluid intake and when opioids have reduced bowel motility
Lactulose	Associated with abdominal cramping and flatulence. Needs high fluid intake to work
Liquid paraffin	Associated with faecal leakage and, following the inhalation of paraffin, the potential development of a lipid pneumonia.

Rectal Treatment

Choice of rectal treatment depends on the result of a PR examination. If the rectum is ballooned and empty, use oral laxatives initially.

Soft loading	First line: bisacodyl 10mg suppository Second line: sodium citrate microenema (5ml)
Hard Loading	Glycerol 1g suppository Followed later, if necessary, by: Sodium citrate microenema (5ml) or a bisacodyl 10mg suppository
Very Hard Loading	Arachis oil enema overnight (avoid if patient has nut allergy) Followed later, if necessary, by: Phosphate enema

References

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3. Sykes N. A volunteer model for the comparison of laxatives in opioid related constipation Journal of Pain and Symptom Management 1996; 11 (6): 363-369
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Laxative Drug Information Chart

Oral Laxative	Starting Dose	Time of effect	Comments
Bisacodyl tablets	1-2 nocte	8-12 hours	<ul style="list-style-type: none"> Can cause abdominal cramping
Codanthramer capsules Codanthramer suspension Codanthramer strong capsules Codanthramer strong suspension	1-2 nocte 5-10ml nocte 2 nocte 5ml nocte	6-12 hours	<ul style="list-style-type: none"> Codanthramer may colour urine red Codanthramer to be avoided if incontinent of urine / faeces as red rash may develop on buttocks Codanthramer licensed for use in analgesic induced constipation in terminally ill patients
Docusate Sodium	100mg caps bd	24-36 hours	<ul style="list-style-type: none"> Predominantly softening action. Useful in subacute bowel obstruction
Rectal Laxative			
<i>(Soft loading)</i>			
Bisacodyl suppository	1 suppository prn	15-30 mins	<ul style="list-style-type: none"> Bisacodyl must come into contact with the bowel wall to be effective
Sodium Citrate Microenema	1 enema prn (5 mls)	15-30 mins	
<i>(Hard Loading)</i>			
Glycerol 4g suppository	1 prn	15-30 mins	<ul style="list-style-type: none"> Combined irritant and softener.
<i>(Very hard loading)</i>			
Arachis oil enema	1 prn	15-30 mins	<ul style="list-style-type: none"> Contains peanut oil, contraindicated in nut allergies.
Phosphate enema	1 prn	30 mins	<ul style="list-style-type: none"> Use with caution if haemorrhoids present may cause local irritation.

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