MANAGEMENT OF CONSTIPATION

AND BOWEL OBSTRUCTION

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Lets Play ….

Constipation Consequences !!!

I will ask you a series of questions

After each question, write down your answer

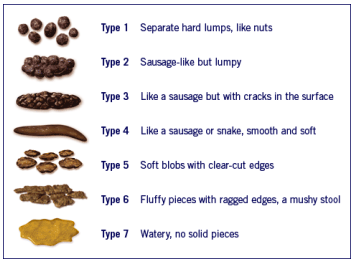
Fold over the paper to cover your answer as pass the paper to your left

And continue …

- (1) How would you define constipation ?
- (2) How long can food residue stay in your colon for ?
- (3) Give three symptoms of constipation.
- (4) Give three causes of constipation

- (5) Give an example of a question you might use when assessing a patients' bowel pattern
- (6) What % of people experience constipation
- (7) What would be your top 3 tips to a patient experiencing constipation ?

(8) When did you last have your bowels opened ?



Definition

The difficult passage of hard formed faeces or the feeling of not completely emptying their bowel

An estimated 2 – 20% of people eating a westernised diet experience constipation.

This increases to for patients at end of life
From 32 – 87%

International classification of constipation

A diagnosis of constipation needs to include any two of the following :-

- Straining during at least 25% of defaecations
- Lumpy or hard stools in at least 25 % of defaecations
- Sensation of incomplete evacuation for at least 25% of defecations
- Sensation of ano – rectal obstruction or blockage for at least 25% of defaecations
- Manual removal of stool in at least 25 % of defaecations
- Less than 3 defaecations per week
- Loose stools are rarely present without laxative use
- Insufficient criteria to diagnose irritable bowel syndrome

The function of the colon - some facts

STORAGE
- The colon stores unabsorbed food residue and within 72 hours – 70% is excreted
- The remaining 30% can stay in the colon for up to a week

ABSORPTION
- Sodium, water, chloride, some vitamins, some drugs

SECRETION
- Mucous is secreted to lubricate to stool

SYNTHESIS
- A small amount of vitamin is produced

ELIMINATION
- Is through peristaltic movement, sensory nerve endings detect the presence of the faecal matter and gives the sensation of fullness.
- We are able to detect if it is wind, loose or normal stool and release or contract our muscles accordingly

What is a normal bowel action ?

Bowel frequency of a healthy individual is from
One to three times a day
to
three times a week
This is different for everyone and dependent on health, diet and gender.

Normal stool output is 200g per day

Symptoms

- Stomach ache and cramps
- Feeling bloated
- Feeling nauseous
- Vomiting / reflux
- Loss of appetite
- Generally feeling unwell / malaise
- Soiling of underwear
- Headaches
- Generalised pain
- Lack of energy
- Being irritable, angry or unhappy
- Foul-smelling wind and stools
- Halitosis
- Coated tongue
- Incontinence / urinary retention
- Rectal discomfort
- Anxiety / embarrassment
- Reports of diarrhoea (overflow)

CAUSES - Generic

- Not eating enough fibre, such as fruit, vegetables and cereals
- Unbalanced diet
- Change in your routine / lifestyle, such as a change in your eating habits, holiday, new environment
- Limited privacy when using the toilet, i.e. communal toilet area, bedpan, commode
- Ignoring the urge to pass stools
- Lack of exercise
- Immobility
- Not drinking enough fluids
- Being underweight or overweight
- Anxiety or depression
- Lack of nursing or social care
- Distance to the toilet
- Embarrassment / fear
- Medication

Causes - Medication

- Antidepressants
- Antiepileptics (medicine to treat epilepsy)
- Antipsychotics (medicine to treat schizophrenia and other mental health conditions)
- Calcium supplements
- Diuretics (water tablets)
- Iron supplements
- Some chemotherapy
- Pain killers

Causes – medical conditions

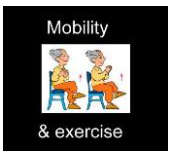
- Diabetes
- Hypercalcaemia, (↑calcium in the bloodstream
- Underactive thyroid
- Muscular dystrophy
- Multiple sclerosis
- Parkinson's disease
- Pregnancy / menstrual cycle
- Spinal cord injury
- Anal fissure, a small tear of the skin just inside the anus
- Inflammatory bowel disease
- Irritable bowel syndrome (IBS)
- Colon or rectal cancer
- Haemorrhoids
- Dehydration

Assessment

What is normal for the patient ? – frequency, amount, timing
When was last bowel movement ?
What was amount, consistency, colour ?
Any blood ?
Any abdominal discomfort ie cramp, N&V, increased flatulence, rectal fullness
Laxative history
Other measures to relieve constipation
Medication history
Dietary history

Prevention and Management

Always be …..



Evaluation

- Assessment
- Listen to patient
- Abdominal examination
- Rectal examination
- Assessment tool
  - Bristol Stool Chart

Management with laxatives

Drug Treatment

- Lack of good evidence
- Limited data on efficacy & safety of laxatives in palliative care
- Generally a combination of a softener & a stimulant laxative is recommended

General Principles

- The aim of laxative therapy is to promote comfortable defaecation not any particular frequency of bowel action.
- The dose should be titrated against the response.
- In opioid induced constipation, laxative therapy should be regular not intermittent.
- A combination of stimulant and softener is usually required

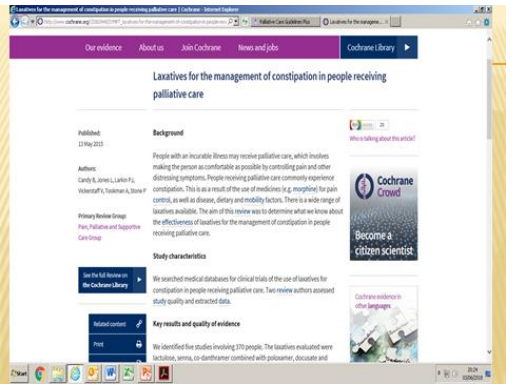
Laxatives

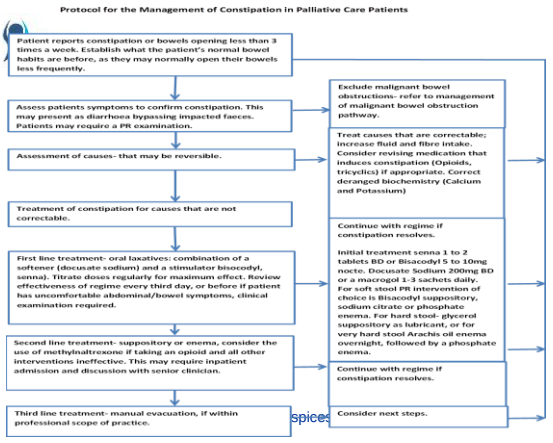
Osmotic Laxatives	Lactulose Magnesium sulphate
Macrogols	Polyethlene glycol
Surfactant Laxatives	Docusate Poloxamer
Stimulant Laxatives	Senna Bisacodyl Danthron
Peripheral Opioid Antagonists	Methylnaltrexone, Naloxogel

Non Laxatives

- Prokinetics (Metoclopramide)
- Rectal measures
- Complementary therapy
- Increased fluid intake, dietary changes

- Soft stools in a lax rectum can be evacuated by a stimulant such as bisacodyl suppositories, which must come into direct contact with the mucous membrane of the rectum if they are to be effective.
- Hard stools can be softened with glycerin suppositories, which must be inserted directly into the faeces and allowed to dissolve, thereby softening the faecal mass.
- Lubricant enemas such as arachis oil can be given overnight as retention enemas to soften very hard stools high in the rectum or higher up, before administration of a stimulant phosphate enema the next morning.





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Bowel Obstruction

Definition

- Is due to mechanical obstruction (partial or complete) of the bowel lumen and / or peristaltic failure
- Occurs most commonly with patients with Ca Bowel (10 – 28%) and Ca Ovary (20 – 30%)
- Poor prognosis with mean survival 1- 6 months
- Can be complex and need acute / specialist advice from palliative care, oncologists and surgeons

Signs and symptoms

- Constipation
- Intermittent nausea, often relieved by vomiting undigested food
- Worsening nausea and / or faeculant vomiting
- Continuous abdominal pain due to tumour and/ or nerve infiltration
- Colic, altered bowel sounds
- Abdominal distension and early satiety
- Faecal incontinence
- Patient may be anxious / frightened

Clinical Assessment

- Clinical history
  Including cancer diagnosis other health concerns, medication, bowel history, radiotherapy and chemotherapy history
- Clinical examination
  rectal examination, abdominal xray, abdominal examination with palpation and auscultation, surgical history, hernias

Consider if surgery or other clinical interventions may be helpful

- Drainage of ascites
- Stenting
- Venting gastrostomy
- IV / SC fluids
- NGT
- Surgery if single site obstruction and patient is fit enough

Non medical management

- Frequent mouth care
- Access to vomit bowl and tissues
- Biotene / artificial saliva for dry mouth
- Iced fluids, ice lollies
- Complementary therapies
- Distraction
- Heat pad

Pharmacological Management

Review medications
Ie non essential drugs
Alternative routes for other medications

SC anti emetics
CSCI medications

Bowel obstruction WITHOUT Colic

Peristaltic Failure
May be due to autonomic neuropathy or intra abdominal cancer
Partial Obstruction and reduced bowel sounds
AIM is to increase / stimulate gut motility

STOP medication that reduces peristalsis ie cyclizine, 5HT3 antagonists, amitriptyline, hyoscine

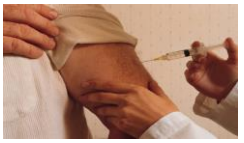
USE prokinetic antiemetic
Metoclopramide via CSCI 30 – 120mg / 24 hours.
Laxative therapy
Switch oral analgesia to SC equivalent or transdermal patch

Mechanical Obstruction

- Laxatives macrogel / docusate, but avoid stimulant laxatives
- SC dexamethasone (6 -16mg) SC daily may help to reverse partial obstruction and reduce oedema / swelling
- NOTE if patient begins to experience COLIC, prokinetic drug must stop and switch to Hyoscine Butylbromide (Buscopan) Range 40 – 120mg / 24 hours via CSCI
- If vomits are volumatic (emptying vomits) Hyoscine Butylbromide may help reduce volume due anticholinergic and antisecretory effect, also helps colic
- Octreotide may also be added into CSCI medication (250 – 1000 micrograms over 24 Hours

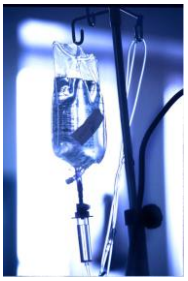
Advantages / Disadvantages of using stat medication vs syringe driver delivery

- Quick effect between 20 – 30 minutes.
- Likelihood of delay if in community
- May only have a 4 - 6 hour effect.
- Regular injections – not a preference for most people



- Stable blood plasma levels
- Increased patient comfort Potential for better overall symptom management

Intravenous Infusion ???



- If symptoms remain uncontrolled by other means
- May need to be considered
- Severe dehydration
- Correct electrolyte imbalance

Nasogastric Tube ???

- Is an option
- Often avoided in palliative care
- May improve wellbeing and quality of life for some patients
- Can be insitu until patient is approaching death

Resources

- Dickman, A (2012).Drugs in Palliative Care. OUP. 2nd Edition
- https://cks.nice.org.uk/palliative-care-nausea-and-vomiting accessed 1/11/17
- Palliative Care Adult Network Guidelines http://book.pallcare.info/ (on Hospice desktop as Pallicalc)
- http://www.palliativecareguidelines.scot.nhs.uk/