Part 2: Pain and Symptom Management

Constipation

Effective Date: February 22, 2017

Key Recommendations

• Prevent constipation by ordering a bowel protocol when regular opioid medication is prescribed.

Assessment

1. Understand the patient's bowel habits, both current and when previously well (e.g., frequency of bowel movements (BMs), stool size, consistency, and ease of evacuation). Consider using the bowel performance scale available at: http://www.bccancer.bc.ca/family-oncology-network-site/Documents/BPSConstipationScale.pdf
2. The goal is to restore a patient's normal BM frequency, consistency, and ease of passage.
3. For lower performance status patients (e.g., reduced food intake and activity), lower BM frequency is acceptable as long as there is no associated discomfort.

Management

1. There are many etiologies (e.g., reduced food/fluid/mobility and adverse effects of medications).
2. Exclude impaction when a patient presents already constipated. Abdominal x-ray can be useful when physical examination is inconclusive.
3. Minimize/avoid rectal interventions (enemas, suppositories, manual evacuation), except in crisis management. Note that rectal interventions are contraindicated when there is potential for serious infection (neutropenia) or bleeding (thrombocytopenia), or when there is rectal/anal disease.
4. When risk factors are ongoing, as they are in most cancer patients, suggest laxatives regularly versus prn. Adjust dose individually. Laxatives are most effective when taken via escalating dose according to response, termed “bowel protocol”.
5. Sennosides (e.g., Senokot®) are the first choice of laxative for prevention and treatment. Patients with irritable bowel syndrome may experience painful cramps with stimulant laxatives and often prefer osmotic laxatives such as lactulose or polyethylene glycol (PEG). There is weak evidence that lactulose and sennosides are equally effective; however lactulose can taste unpleasant and cause bloating.
6. If rectal measures are required, generally a stimulant suppository is tried first, then an enema as the next option.
7. The BC Palliative Care Drug Plan covers laxatives written on a prescription for eligible patients.
8. For patients with opioid-induced constipation, after a trial of first-line recommended stimulant laxatives and osmotic laxatives, methylnaltrexone (or nalaxegol) may be helpful. Cancer, GI malignancy, GI ulcer, Ogilvie's syndrome and concomitant use of certain medications (e.g., NSAIDs, steroids and bevacizumab) may increase the risk of GI perforation in patients receiving methylnaltrexone. [Health Canada MedEffect Notice: http://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2010/14087a-eng.php]

1 BCGuidelines.ca: Palliative Care for the Patient with Incurable Cancer or Advanced Disease Part 2: Pain and Symptom Management – Constipation (2017)
Constipation Management Algorithm

Hyperlinks indicate additional information available in guideline sections above:
A = Assessment
M = Management

Assessment (A1)
- Normal bowel habit
- Current bowel performance (A3)
  - Stool frequency
  - Stool consistency
  - Ease of evacuation

Obstructed bowel?
- Yes
  - Manage according to FPON guideline, Medical Management of Malignant Bowel Obstruction

Constipation?
- Yes
  - TREATMENT needed (M2)
  - 1. Rectum empty; OR
  - 2. Contraindications to rectal intervention:
    - neutropenia (WBC <0.5) OR
    - thrombocytopenia (Plt <20)

  - Rectal Measures (M3)
    - Manual disimpaction (if indicated)
    - Glycerin supp
    - Bisacodyl supp
    - Microlax enema
    - Fleet enema*
    - Warm water enema
    - Oil enema

  - Sennosides-based Protocol (M4+5)
    - Escalating doses until satisfactory BM
    - Maximum senna dose 36 mg tid
    - Add rectal measures at any time if indicated and no contraindications (M3)

  - Opioid-induced (M9)
    - Consider switching to less constipating opioid (e.g., fentanyl)

  - Add or switch to osmotic laxative

  - Consider methylnaltrexone (or naloxegol)

Palliative Care Consult

*Contraindicated in patients with renal failure.

PREVENTION needed
- Irritable bowel syndrome?
  - No
    - Osmotic Laxative (M4+5)
      - Lactulose or sorbitol
      - Polyethylene glycol
      - Escalating doses until satisfactory BM

  - Yes
    - Sennosides-based Protocol (M4+5)
      - Escalating doses until satisfactory BM
      - Maximum senna dose 36 mg tid
      - Add rectal measures at any time if indicated and no contraindications (M3)

Assess cause
- No success
  - Hypomobility (e.g., ascites, autonomic neuropathy, abdominal cancer)

  - Consider prokinetic agent (e.g., domperidone, metoclopramide)

  - Add or switch to osmotic laxative

  - No success

BCGuidelines.ca: Palliative Care for the Patient with Incurable Cancer or Advanced Disease Part 2: Pain and Symptom Management – Constipation (2017) 2
References


Abbreviations

AEs  adverse effects
BM  bowel movement
GI  gastrointestinal
NSAIDs  non-steroidal anti-inflammatory drugs
PEG  polyethylene glycol

Appendices

Appendix A – Medications Used in Palliative Care for Constipation
Appendix A: Medications Used in Palliative Care for Constipation

Tailor dose to each patient; those who are elderly, cachectic, debilitated or with renal or hepatic dysfunction may require reduced dosages; consult most current product monograph for this information:  http://www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index-eng.php

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<tr>
<td><strong>Generic Name</strong></td>
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<tr>
<td>bisacodyl</td>
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**Available Dosage Forms**

- **Tabs:** 5 mg
- **Supp:** 10 mg
- **Oral syrup:** 8.8 mg per 5 mL
- **Powder:** 2.65 g
- **Syrup:** 70% 15 to 45 mL
- **Micro-enema:** 5 mL
- **Enema:** 22 g per 100 mL
- **Injection:** 12 mg per 0.6 mL
- **Tabs:** 12.5, 25 mg

**Standard Adult Dose**

- 5 to 10 mg PO x 1 dose
- 10 mg PR x 1 dose
- 2 tabs PO at bedtime to 3 tabs tid
- 10 mL PO at bedtime to 15 mL tid
- 1 supp PR x 1 dose
- 17 grams in 250 mL fluid
- 5 mL PR x 1 to 2 doses
- 120 mL PR x 1 dose
- 120 mL PR x 1 dose
- 8 to 12 mg SC every 2 days
- 25 mg PO once daily

**Drug Plan Coverage**

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**Approx. cost per 30 days**

- $1 (G)
- $0.51 (G) per supp
- $3–20 (G)
- $14–72 per 30 days
- $0.25 (G) per supp
- $7–28 (G) per 30 days
- $20–25 per 30 days
- $10–136 (G) per 30 days
- $1.80 per micro-enema
- $6 per enema
- $8 per enema
- $616 per 30 days
- $193 per 30 days

**Abbreviations:**

- **G** generics
- **LCA** subject to Low Cost Alternative Program
- **PO** by mouth
- **PR** per rectum
- **SC** subcutaneous
- **Supp** suppositories (rectal)
- **tabs** tablet

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