Management of Constipation Guideline

Causes of constipation

TUMOUR EFFECTS:	Bowel obstruction Neurological damage eg spinal cord compression Hypercalcaemia
DRUGS:	Opioids Anticholinergics eg Tricyclics, hyoscine Diuretics Iron
ADVANCED DISEASE:	Poor diet Poor fluid intake Immobility
OTHER PATHOLOGY:	Hypothyroidism Ano-rectal pathology

Management

HISTORY – including previous bowel habit

ABDOMINAL EXAMINATION **INCLUDING** RECTAL

RECORD bowel habit during admission, INCLUDING stool consistency

CONSIDER calcium and AXR

ANTICIPATE constipation with prophylactic laxatives if on constipating drugs

REMEMBER:

- Access to oral fluids (consider if the patient can reach and manage a glass)
- Access to toilet/commode
- Privacy
- Encourage activity, where possible
- Manage other symptoms (eg pain and vomiting)
- Increase laxative dose with increase in opioid dose
- Laxative dose may need to be reduced (or even stopped) if patient converted to fentanyl patch

Spinal Cord Compression

Patients with established spinal cord compression usually require regular rectal measures. A standard regime would be a regular oral stool softener (e.g. sodium docusate) together with an enema every 3 days. Oral laxatives with a significant stimulant effect (especially dantron) should be AVOIDED as there is an increased risk of faecal incontinence.

Laxative Classes

Remember: no laxative has a 'pure' effect; all laxatives have some characteristics of several classes. They are classified according to their **predominant** effect below:

1. Oral laxatives

	EXAMPLE	LATENCY	INDICATION
Bulking agents	Ispaghula husk (eg Fybogel) Methylcellulose (eg Celevac)	1-2 days	Mild constipation; patient able to drink well. **AVOID** in patients with advanced disease. Can cause bloating and flatulence.
Faecal softeners	Sodium docusate 100mg bd – 200 mg tds	1-3 days	Hard stool; Partial bowel obstruction and spinal cord compression – both require stool softening with limited stimulant effect
Stimulants	Senna 2-4 tablets nocte or bd Dantron (see combination drugs below)	6-12 hours	Infrequent defaecation; low risk of faecal incontinence. **AVOID** in patients with bowel obstruction
Osmotic agents	Polyethylene glycol (eg Movicol) 1-3 sachets daily (each in 125 mls of water) in divided doses. No more than 2 sachets in any 1 hour (faecal impaction 8 sachets daily dissolved in 1 litre of water).	4 hours – 2 days (dose dependant)	Any constipation; patient must be able to drink well. Licensed for faecal impaction as alternative to rectal measures. **NB** Lactulose is restricted to management of hepatic encephalopathy.
Combination drugs	Stimulant / softener combination e.g. co-danthramer (dantron + poloxamer '188') co-danthrusate (dantron + docusate)	6-12 hours	Patients with terminal diagnosis. **Dantron** - (including co-danthramer) must be avoided in patients with incontinence (either urinary or faecal) as it can cause skin burns. Can colour the urine red. Co-danthramer (2 caps ≡ 10ml suspension) Co-danthrusate (1 caps ≡ 10ml suspension) 15 ml co-danthramer susp ≡ 5ml strong co-danthramer suspension

2. Rectal

	EXAMPLE	LATENCY	INDICATION
Faecal softeners	Arachis oil enema	6-12 hours	Faecal impaction (usually in combination with a stimulant or osmotic rectal preparation). **Arachis oil enema** contains peanut oil and **MUST** be avoided in patients with peanut allergy.
Stimulants	Glycerin suppositories Bisacodyl suppositories	Minutes	Difficulty evacuating full rectum; stool soft.
Osmotic agents	Phosphates (eg Fleet enema) Sodium salts (eg Micralax enema)	Minutes	Faecal impaction (often used after arachis oil if stool very hard). Used on regular basis (every 2-3 days) for patients with neurological conditions such as spinal cord compression (often in combination with oral stool softener).

Modes of action

Bulking agents: increase faecal bulk → mechanical distension and peristalsis stimulated; hold water in stool. Adequate fluid intake important. Site of action – small and large bowel. Onset of action – 1 or more days.

Softeners: Docusate has detergent effect allowing water to permeate stool more effectively. Works in small & large bowel, takes 1-3 days to have effect. Arachis oil directly softens stool and retards colonic water absorption. This works in colon only and takes up to 12 hours for effect.

Stimulants: various classes of stimulants - anthraquinones include senna and dantron; bisacodyl; docusate (predominantly a faecal softener and may only be a stimulant in higher dose (above 600mg daily – R. Twycross) and castor oil. May work in slightly different ways. Overall, these drugs stimulate peristalsis (may have a direct action on mucosal muscle and/or stimulate myenteric plexus) and alter water and electrolyte secretion. Orally these work in 6-12 hours; senna and dantron are metabolised in colon to active form – ie only work here. Bisacodyl suppository works rapidly (up to 1 hour).

Osmotic agents: osmotically active particles draw water into intestinal lumen. Ionic agents (sodium, magnesium and phosphate salts) given orally for rapid bowel cleansing pre-procedures work in small and large bowel with rapid action (up to 3 hours) – degree of water secretion into bowel directly proportional to dose. These should be used with caution for pts with cardiac or renal insufficiency because can cause rapid alterations in fluid and electrolyte balance.

Movicol is formulated with electrolytes. This preparation limits water absorption from faecal matter in the colon and does not (unlike traditional osmotic agents) promote fluid shifts into the bowel. It has been labelled an 'iso-osmotic' laxative and is significantly less likely to alter fluid and electrolyte balance than the traditional ionic osmotic agents.