



fraserhealth

Better health.
Best in health care.

-
- Hospice Palliative Care Program
Symptom Guidelines

Bowel Care

Bowel Care

□ Rationale

This guideline is adapted for inter-professional primary care providers working in various settings in Fraser Health, British Columbia and the Fraser Valley Cancer Center and any other clinical practice setting in which a user may see the guidelines as applicable.

□ Scope

This guideline provides recommendations for the assessment and symptom management of adult patients (age 19 years and older) living with advanced life threatening illness and experiencing the symptom of constipation. This guideline does not address disease specific approaches in the management of constipation.

Bowel pattern changes cause distress in up to 18% of palliative care patients and rises to 80% or higher at the end of life.^(1, 2) Constipation is most frequent among patients treated with opioids – 40 to 50%.^(3, 4) It significantly impacts quality of life and may be a cause of restlessness.⁽⁵⁾ Constipation is more common in women and the elderly.⁽⁶⁾ Diarrhea is less common occurring in less than 10% of cancer patients.^(7, 8)

□ Definition of Terms

Constipation can be defined as “unduly infrequent and difficult evacuation of the bowels” that is “reduced frequency of bowel movements than is normal for the individual concerned, which may lead to pain and discomfort”.⁽⁹⁾

Ingestion induced **constipation** results from inadequate intake of fluids and/or fiber or intake of constipating foods (cheese or milk) or by drugs.^(1, 4) Other forms of **constipation** are; hypotonic – caused by a decreased rate of water absorption and muscular tone, dyschezia (or habit) - caused by ignoring the urge to defecate, chronic hypertonic – caused by excess colonic muscular activity secondary to hyper segmentation and prominent creasing of feces (rather than propulsion) and fecal impaction (obstruction).⁽¹⁾

Diarrhea is defined as 3 or more loose, watery stools per day.^(1, 8)

□ Standard of Care

1. Assessment
2. Diagnosis
3. Education
4. Treatment: Nonpharmacological
5. Treatment: Pharmacological

Recommendation 1 Assessment of Constipation and Diarrhea

Ongoing comprehensive assessment is the foundation of effective management of constipation, including interview, physical assessment (abdomen/bowel sounds/skin), medication review, medical and surgical review (x-ray of the abdomen may be indicated where obstruction is suspected), psychosocial review, review of physical environment and appropriate diagnostics (see Table 1). Assessment must determine the cause, effectiveness and impact on quality of life for the patient and their family.^(2, 7, 9-11) Complete a bowel assessment and consistently reevaluate.^(1, 12) An excellent resource for guidance on interview questions for Constipation⁽¹³⁾ and Diarrhea⁽¹⁴⁾ can be found on the BC Cancer Agency website.

Table 1: Constipation / Diarrhea Assessment using Acronym O, P, Q, R, S, T, U and V

| | |
|--|--|
| O Onset | When did it begin? How long does it last? How often does it occur? |
| P Provoking / Palliating | What brings it on? What makes it better? What makes it worse? What has your diet been like – solids and fluids? What makes the stools softer/harder/watery, more/less frequent? |
| Q Quality | What does it feel like? Can you describe it? What have the stools looked like? |
| R Region / Radiation | Where is it? Does it spread anywhere? |
| S Severity | What is the intensity of this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Right Now? At Best? At Worst? On Average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom? For example, pain, nausea/vomiting, bloating, loss of appetite? |
| T Treatment | What medications and treatments are you currently using? How effective are these? Do you have any side effects from the medications and treatments? What medications and treatments have you used in the past? |
| U Understanding / Impact on You | What do you believe is causing this symptom? How is this symptom affecting you and / or your family? |
| V Values | What is your goal for this symptom? What is your comfort goal/acceptable level for this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Are there any other views or feelings about this symptom that are important to you or your family? |

* Physical Assessment (as appropriate for symptom)

Recommendation 2 **Diagnosis**

Identifying the underlying etiology of constipation and diarrhea is essential in determining the interventions required (see *Tables 2 and 3*).^(6, 10, 11)

Table 2: Constipation in Advanced Cancer Patients^(1, 6, 7, 13)

| | |
|---------------------------------|--|
| Structural abnormalities | GI Obstruction Pelvic tumour mass Radiation fibrosis Painful anorectal conditions (anal fissure, hemorrhoids, perianal abscess) |
| Drugs | Opioids Drugs with anticholinergic action - anticholinergics, antispasmodics, antidepressants, phenothiazines, haloperidol, antacids Antiemetics – 5HT ₃ antagonists Diuretics Anticonvulsants Iron Antihypertensives Chemotherapy agents –vinca alkaloids |
| Metabolic disturbances | Dehydration Hyperglycemia Hypokalemia or Hypercalcemia Uremia Hypothyroidism |
| Neurological disorders | Cerebral tumours Spinal cord involvement/compression Sacral nerve infiltration Autonomic failure |
| General | Advanced age Inactivity Depression Sedation Decreased intake Low fiber diet Poor fluid intake Physical or social impediments |

Recommendation 2 Diagnosis continued...

Table 3: Causes of Diarrhea in Advanced Disease^(1, 6, 7, 14)

| | |
|---------------------------|---|
| Obstruction | Malignant tumour Fecal impaction Opioid bowel syndrome |
| Drugs | Laxatives Antacids Antibiotics Chemotherapy agents – 5-flourouracil, mitomycin NSAID – diclofenac, indomethacin Iron preparations Disaccharide containing elixirs |
| Malabsorption | Pancreatic carcinoma or insufficiency Gastrectomy Ileal resection Colectomy |
| Tumour | Cancer of the colon or rectum Pancreatic islet cell tumour Carcinoid tumour |
| Radiation | Abdominal or pelvic radiation with or without chemotherapy (RT induced enteritis) |
| Concurrent disease | Diabetes mellitus Hyperthyroidism Inflammatory bowel syndrome – Crohn’s Irritable bowel syndrome – Colitis Gastrointestinal infection – C. Difficile |
| Diet | Bran Fruit Hot spices Alcohol |

Constipation can be multifactorial in nature.^(10, 15, 16)

Recommendation 3 Education

- Even in the absence of oral intake, the body continues to produce 1 to 2 ounces of stool per day.⁽¹⁷⁾
- It is not necessary to have a bowel movement every day. As long as stools are soft and easy to pass, every 2 to 3 days is acceptable.⁽¹²⁾
- “Normal” bowel movements vary from person to person.⁽¹³⁾
- If appetite is small, try to incorporate nutritious liquids such as milkshakes, cream soups, fruit juice.⁽¹³⁾

Recommendation 4 Treatment: Nonpharmacological

Constipation:

- Incorporate constipation prevention strategies for as long as possible and appropriate, including: fluid intake, dietary fiber (only for those with adequate fluid and mobility), fruit (prunes) and other natural agents, appropriate toileting, and physical activity. ^(1, 3, 7, 11, 15, 18, 19) A fruit laxative can be made with prunes, dates, figs and raisins. ^(10, 12)
- Attempts at defecating should be made 30 to 60 minutes following ingestion of a meal to take advantage of the gastro colic reflex. ^(1, 10, 11)
- Bowel action should be initiated when it is “normal and convenient” for the patient in a sitting position. This can be facilitated by using; raised toilet seats, commodes and ensure adequate pain control for movement and comfort. ^(1, 10)
- Provide privacy during toileting. ^(1, 3, 10, 11, 15, 19, 20)
- Avoid excessive straining (this can complicate some medical conditions). ^(1, 10)
- Encourage activity. ⁽¹³⁾

Diarrhea:

- For most patients with diarrhea decreasing fiber intake is helpful, however if there is excessive liquid in the bowel an absorbent can be helpful (crackers). If over stimulation of the bowel is suspected reducing intake to sips of fluid for 24 to 48 hours can be helpful. ^(1, 8)
- Limit consumption of high fiber foods, large meals, fatty foods, caffeine ⁽¹⁴⁾ and dairy products. ⁽⁶⁾
- Maintain hydration and electrolytes as appropriate (particularly in cases of severe diarrhea). ^(1, 14) Ringers lactate is the preferred solution for parenteral hydration. ⁽²¹⁾ Rehydration can also be done orally, if the dehydration is not severe, with the WHO rehydration fluid (2 gm salt plus 50 gm sugar to 1 litre of water). ^(8, 21)
- A single liquid or loose stool usually does not require intervention. ⁽¹⁾
- Good hygiene and application of hydrocolloid dressings ⁽²¹⁾ or barrier cream will help prevent excoriation with diarrhea. ^(1, 8) If already inflamed or excoriated use a corticosteroid cream for 1 to 2 days. ⁽⁸⁾
- Persisting diarrhea can have severe effects on image, mood and relationships, which will need support. ⁽²¹⁾

Recommendation 5 Treatment: Pharmacological

Constipation:

- Constipation is a common side effect of all opioids.^(1, 12)
- Patients often stop opioid therapy because of opioid induced constipation.⁽²²⁾
- Opioid induced constipation is much easier to **prevent** than treat.⁽²³⁾
- Opioids cause decreased motility (by suppression of intestinal peristalsis) and increased water and electrolyte re-absorption in the small intestine and colon.^(1,4) Transdermal fentanyl⁽⁴⁾ and methadone^(16, 20) have been shown to produce less constipation. Consider opioid rotation for severe refractory constipation.^(16, 20)
- Tolerance will not develop to the constipating effects of opioids.^(15, 23)
- The constipating effect of opioids are not dose dependant.⁽²⁴⁾
- Laxatives are available under the *Palliative Benefit Program* but require a prescription.
- Consider patient preferences when determining bowel regime.⁽¹⁸⁾
- In randomized clinical trial comparing senna to lactulose – senna was preferred secondary to a favorable toxicity profile and cost advantage.⁽²⁵⁾ The sweet taste of lactulose can cause problems with compliance.⁽⁷⁾ Sorbitol has been found to be less nauseating.⁽⁶⁾
- Start laxatives on a regular basis for all patients taking opioids^(1, 12, 17, 19, 24) (*see Appendix A*).
- Based on the bowel pattern, time since last bowel movement and bowel medication previously being used, determine the level of the bowel protocol for medications.⁽¹²⁾
- Use a step wise approach, titrate the laxatives^(1, 12, 16, 24) according to the bowel protocol to ensure regular bowel movements. Aim for soft formed stool at least once every 2 to 3 days.⁽¹²⁾
- Three days without a bowel movement requires intervention.^(1, 12)
- The continued use of docusate in the palliative care setting is based on inadequate experimental evidence.^(22, 26)
- Rectal laxative should never accompany an inadequate prescription of oral laxative.⁽⁷⁾
- Avoid use of bulk forming agents (fiber) in patients with poor oral fluid intake. The patient must be able to tolerate 1.5 to 2 litres of fluid per day.^(1, 3, 11) This makes bulk forming agents a poor choice in cancer patients.⁽⁷⁾ They may worsen with an incipient obstruction.⁽⁷⁾

Recommendation 5 Treatment: Pharmacological continued...

- Osmotic laxatives should be accompanied by an increase in fluid intake.⁽⁷⁾
- Metoclopramide inhibits dopamine centrally and peripherally, therefore increasing peristalsis in the digestive tract as well as combating nausea and vomiting.⁽³⁾ Metoclopramide 10 to 20 mg PO q6h.⁽¹⁰⁾
- There is some evidence to support the use of polyethylene glycol as a laxative for opioid induced constipation.⁽²²⁾ Polyethylene glycol 10 to 30 g PO daily to b.i.d. or 60 to 240 g for evacuation.⁽¹⁾

| Oral laxatives: | Type | Action |
|------------------------------|--|---|
| Sodium docusate | Predominantly softening - surfactant | Detergent, increase water penetration |
| Lactulose | Predominantly softening – osmotic laxative | Retain water in small gut |
| Sorbitol | Predominantly softening – osmotic cathartic | Retain water in small gut |
| Methyl cellulose | Predominantly softening – bulk forming agent | Normalize stool volume |
| Magnesium sulphate | Predominantly softening – saline laxative | Retain water and strong purgative action |
| Polyethylene glycol | Predominantly softening – osmotic cathartic | Increases fluid and purgative action |
| Sennosides | Peristalsis stimulating - anthracenes | Reduces water and electrolyte absorption and purgative action |
| Bisacodyl | Peristalsis stimulating - polyphenolic | Reduces water and electrolyte absorption and purgative action |
| Rectal laxatives: | Type | Action |
| Bisacodyl suppository | Peristalsis stimulating - polyphenolic | Evacuates stools from rectum or stoma: for colonic inertia |
| Glycerin suppository | Predominantly softening - osmotic laxative | Softens stools in rectum or stoma |
| Phosphate enema | Peristalsis stimulating – saline laxative | Evacuates stools from lower bowel |
| Oil enema | Predominantly softening – lubricant laxative | Softens hard impacted stool |

- Latency of action of docusate sodium is one to three days.⁽⁷⁾
- Latency of action of lactulose and sorbitol is one to two⁽⁶⁾ and up to three days.⁽⁷⁾
- Latency of action of peristalsis stimulating laxatives is 6 to 12 hours.⁽⁷⁾
- Enemas may need to be repeated to clear the bowel of hard impacted stool.⁽⁷⁾
- Latency of action of suppositories and enemas is 15 to 60 minutes.⁽⁶⁾

Recommendation 5 Treatment: Pharmacological continued...**Diarrhea:**

Diarrhea can be caused by over use of laxatives or can be a side effect of radiation, chemotherapy or surgical treatments.^(1, 8, 21)

Symptomatic relief is generally achieved with non-specific antidiarrheal agents – loperamide PO up to 16 mg daily⁽⁸⁾ or codeine 10 to 60 mg PO q4h.⁽⁷⁾ Unlike constipation, where multiple drugs are used simultaneously, a single drug should be used for diarrhea and care should be taken to avoid sub-therapeutic doses.⁽⁷⁾

Metronidazole is recommended for C. Difficile diarrhea⁽⁶⁾ metronidazole 500 mg PO t.i.d.⁽⁸⁾

Octreotide is an effective therapy for severe refractory diarrhea.⁽²¹⁾ Octreotide 300 to 600 mcg per day S.C.⁽²¹⁾

Revision page 11: May 15, 2018

Kya Milne, Project Leader – Fraser Health Authority Palliative Care Program
Barbara McLeod – Fraser Health Clinical Nurse Specialist Palliative Care
Dr. Neil Hilliard – Fraser Health Medical Director Palliative Care (2014 – 2017)
Dr. Charlie Chen – Fraser Health Medical Director Palliative Care (2017 – present)
Dr. Grace Park – Fraser Health Medical Director Home Health
Lisa Zetes-Zanatta – Executive Director

Approved by: Palliative Care Quality & Operations Committee Meeting (PCQOC), September 13, 2018

Approved by: Palliative Care Clinical Practice Council, September 24, 2018

□ References

Information was compiled using the CINAHL, Medline (1996 to April 2006) and Cochrane DSR, ACP Journal Club, DARE and CCTR databases, limiting to reviews/systematic reviews, clinical trials, case studies and guidelines/protocols using constipation/diarrhea terms in conjunction with palliative/hospice/end of life/dying. Palliative care textbooks mentioned in generated articles were hand searched. Articles not written in English were excluded.

1. Carter B, Black F, Downing GM. Bowel Care - Constipation and Diarrhea. In: Downing GM, Wainwright W, editors. *Medical Care of the Dying*. Victoria, B.C. Canada: Victoria Hospice Society Learning Centre for Palliative Care; 2006. p. 341-62.
2. McMillan SC. Presence and severity of constipation in hospice patients with advanced cancer. *American Journal of Hospice and Palliative Care*. 2002 November/December 2002;19(6):426-30.
3. Tamayo AC, Diaz-Zuluaga PA. Management of opioid-induced bowel dysfunction in cancer patients. *Support Care Cancer*. 2004 June 19;12:613-8.
4. Choi YS, Billings A. Opioid Antagonists: A Review of Their Role in Palliative Care, Focusing on Use in Opioid-Related Constipation. *Journal of Pain and Symptom Management*. 2002 July 2002;24(1):71-90.
5. Goodman ML, Low J, Wilkinson S. Constipation Management in Palliative Care: A Survey of Practices in the United Kingdom. *Journal of Pain & Symptom Management*. 2005 March 2005;29(3):238-44.
6. Sykes NP. An investigation of the ability of oral naloxone to correct opioid-related constipation in patients with an advanced cancer. *Palliative Medicine*. 1996;10:135-44.
7. Fallon M, O'Neill B. ABC of palliative care: Constipation and diarrhoea. *British Medical Journal*. 1997 November 15;315:1293-6.
8. Waller A, Caroline NL. Diarrhea. *Handbook of Palliative Care in Cancer*. 2nd ed. Boston, MA; 2000. p. 223-9.
9. Goodman ML, Wilkinson S. Laxatives for the management of constipation in palliative care patients. *The Cochrane Database of Systematic Reviews*. 2006;1.
10. Paolini CA. Symptoms Management at the End of Life. *The Journal of the American Osteopathic Association*. 2001 October 2001;101(10):609 - 15.
11. Beckwith C. Evidence Based Symptom Control in Palliative Care: Constipation in Palliative Care Patients. *Evidence Based Symptom Control in Palliative Care: Systematic Reviews and Validated Clinical Practice Guidelines for 15 Common Problems in Patients with Life Limiting Disease*. 2000;8(1):47-57.
12. British Columbia Cancer Agency. Suggestions for dealing with constipation - draft Management of Constipation - draft. British Columbia Cancer Agency; 2006.
13. BC Cancer Agency Professional Practice Nursing. Telephone Consultation Protocol: Constipation. [cited 2006 August 2006]; Protocol]. Available from: <http://www.bccancer.bc.ca/HPI/Nursing/References/TelConsultProtocols/Constipation.htm>
14. BC Cancer Agency Professional Practice Nursing. Telephone Consultation Protocol: Diarrhea. [cited 2006 August 2006]; Protocol]. Available from: <http://www.bccancer.bc.ca/HPI/Nursing/References/TelConsultProtocols/Diarrhea.htm>
15. Esper P, Heidrich D. Symptom Clusters in Advanced Illness. *Seminars in Oncology Nursing*. 2005 February 2005;21(1):20 - 8.
16. Mancini IL, Hanson J, Neumann CM, Bruera E. Opioid Type and Other Clinical Predictors of Laxative Dose in Advanced Cancer Patients: A Retrospective Study. *Journal of Palliative Medicine*. 2000;3(1):49-56.
17. Capital Health Regional Palliative Care Program. Bowel Care Protocol for Palliative Care Patients. 2003 March 20, 2003 [cited 2006 April 2006]; Protocol]. Available from: <http://www.palliative.org/pc/clinicalinfo/Clinical%20Practice%20Guidelines/PDF%20files/Bowel%20Care%20in%20Palliative%20Care.pdf>

18. Cadd A, et al. Assessment and documentation of bowel care management in palliative care: incorporating patient preferences into the care regimen. *Journal of Clinical Nursing*. 2000;9:228-35.
19. Waller A, Caroline NL. Constipation. *Handbook of Palliative Care in Cancer*. 2nd ed. Boston, MA: Butterworth-Heinemann; 2000. p. 197-206.
20. Dean M, Harris JD, Regnard C, Hockley J. Constipation. *Symptom Relief in Palliative Care*. Oxford, United Kingdom: Radcliffe Publishing; 2006. p. 75-9.
21. Dean M, Harris JD, Regnard C, Hockley J. Diarrhea. *Symptom Relief in Palliative Care*. Oxford, United Kingdom: Radcliffe Publishing; 2006. p. 81-4.
22. Wirz S, Klaschik E. Management of constipation in palliative care patients undergoing opioid therapy: Is polyethylene glycol an option? *American Journal of Hospice and Palliative Medicine*. 2005 October 2005;22(5):375-81.
23. Ross DD, Alexander CS. Management of Common Symptoms in Terminally Ill Patients: Part II Constipation, Delirium and Dyspnea. *American Family Physician*. 2001 September 15, 2001;64(6):1019 - 26.
24. Daeninck P, Crawford G. Constipation. In: MacDonald N, Oneschuk D, Hagen N, Doyle D, editors. *Palliative Medicine - A case based manual* 2nd ed. New York: Oxford University Press Inc.; 2005. p. 201-11.
25. Agra Y, Sacristan A, Gonzalez M, Ferrari M, Portugues A, Calvo MJ. Efficacy of senna versus lactulose in terminal cancer patients treated with opioids. *Journal of Pain & Symptom Management*. 1998 Jan;15(1):1-7.
26. Hurdon V, Viola R, Schroder C. How Useful is Docusate in Patients at Risk for Constipation? A Systematic Review of the Evidence in the Chronically Ill. *Journal of Pain & Symptom Management*. 2000 February 2000;19(2):130-6.

Bowel Care

Hospice Palliative Care Program • Symptom Guidelines

Pre-Printed Orders for

BOWEL CARE FOR PALLIATIVE CARE (Adult Clients)

- Complete Bowel Assessment (i.e., Symptom Assessment Acronym: O, P, Q, R, S, T, U, V and Physical Assessment).
- Determine Level at which to start based on bowel pattern, time since last bowel movement (BM) and previous bowel medication use. Document chosen starting Level on Hospice Palliative Flowsheet.

| INDICATIONS | CONTRAINDICATIONS |
|--|--|
| To prevent and manage opioid-induced constipation in adult Palliative Care clients. | Do not use this pre-printed order for patients with: <ul style="list-style-type: none"> • Ileostomy • Diarrhea • Impaction, if present, clear impaction prior to initiating protocol. • Potential for low platelets / WBC e.g., client receiving chemotherapy or with leukemia – consult Oncologist re safety of rectal measures • Rectal tumor(s). <p>If in doubt, contact the client's Physician or Nurse Practitioner (NP)</p> |
| LEVEL I – PREVENTION | • sennosides 12 to 36 mg PO daily at bedtime |
| LEVEL II – PREVENTION | <ul style="list-style-type: none"> • sennosides 24 to 36 mg PO BID at breakfast and bedtime <u>AND</u> • lactulose 15 mL PO BID at breakfast and <u>supper</u>time <p>** If lactulose is not tolerated, consider polyethylene glycol 3350 (RESTORALAX EQUIV) 17 g PO daily. Polyethylene glycol 3350 is <u>not covered</u> by the BC Palliative Care Drug Plan.</p> |
| <p>**If no BM after 3 days of Level I or II Prevention, perform abdominal and/ or rectal assessment and implement Level III: Constipation Management. After sufficient results, return to previous Prevention Level but increase dose of sennosides to ensure adequate bowel management. If no BM or insufficient results at Level III, proceed to Level IV: Constipation Management.</p> | |
| LEVEL 3 – CONSTIPATION MANAGEMENT | Continue sennosides and lactulose – <u>PLUS</u> : select a), b) or c) below: <ol style="list-style-type: none"> If <u>soft stool</u> in rectum <ul style="list-style-type: none"> • glycerin suppository rectally, given alone or immediately before • bisACODYL suppository 10 mg rectally. If not effective within 1 hour, • give sodium citrate enema 5 mL (MICROLAX enema EQUIV) or • SODIUM phosphate enema 130 mL (FLEET enema EQUIV) rectally If <u>hard or impacted stool</u> in rectum <ul style="list-style-type: none"> • mineral oil enema 130 mL rectally. If not effective within 1 hour, • give sodium citrate enema 5 mL (MICROLAX enema EQUIV) or • SODIUM phosphate enema 130 mL (FLEET enema EQUIV) rectally. Disimpact if indicated If <u>no stool</u> in rectum <ul style="list-style-type: none"> • If normal bowel sounds, give sodium citrate enema 5 mL (MICROLAX enema EQUIV) rectally or SODIUM phosphate enema 130 mL (FLEET enema EQUIV) rectally. • If abnormal bowel sounds, CALL physician/NP/Palliative Care Consult Team for further direction. |
| LEVEL 4 – CONSTIPATION MANAGEMENT | Nursing Assessment including thorough abdominal assessment. May repeat Level III or consult with Physician/NP/Palliative Care Consult Team. |

OUTCOME: Maintain BM **at least every 3 days** or as per client's normal bowel pattern.

| | | | |
|--------------------|------|----------------------|-------------------------------------|
| Date (DD/MMM/YYYY) | Time | Prescriber Signature | Printed Name <u>and</u> College ID# |
|--------------------|------|----------------------|-------------------------------------|