Cancer Care Ontario

Action Cancer Ontario

Symptom Management Pocket Guides:

BOWEL CARE

April 2012

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Assessment

- Obtaining a detailed history, including assessment of functional status and goals of care, is an important step in identifying etiologic factors and appropriate management strategies for constipation and diarrhea.
- Physical assessment should include vital signs, functional ability, hydration status, cognitive status, abdominal exam, rectal exam and neurological exam if a spinal cord or cauda equine lesion is suspected. Consider abdominal x-rays if bowel obstruction or severe stool loading of the colon is suspected.

Diagnosis

- Identifying the etiology of constipation and diarrhea is essential in determining the interventions required.

Non-Pharmacological Interventions

Constipation

Consider performance status, fluid intake, diet, physical activity and lifestyle when managing constipation.

General Education

- It is not necessary to have a bowel movement every day. As long as stools are soft and easy to pass, every two days is generally adequate.
- Avoid excessive straining.
- In absence of oral intake, the body continues to produce 1-2 ounces of stool per day.

PPS Stable, Transitional and End of Life (30-100%)

Fluid Intake

- Encourage intake of fluids throughout the day.
- Aim for fluid intake between 1500-2000 ml/day.
- For patients who are not able to drink large volumes, encourage sips throughout the day.
- Limit intake of caffeinated and alcoholic beverages, as they may promote dehydration

Physical Activity

- Physical activity should be tailored to the individual's physical ability, health condition and personal preference, to optimize adherence.
- Frequency, intensity and duration of exercise should be based on the patient's tolerance.
- For PPS 60% and above, walking is recommended (e.g., 15-20 minutes once or twice per day or 30-60 minutes daily, 3-5 times per week).
- For PPS 30-50% exercises such as low trunk rotation and single leg lifts, for up to 15 to 20 minutes per day, are encouraged, if able.

Personal Considerations

- Provide privacy during toileting.
- Attempts at defecating should be made 30 to 60 minutes following ingestion of a meal, to take advantage of the gastro-colic reflex.

PPS Stable and Transitional (40-100%)

Diet

- The following dietary recommendations are not applicable if bowel narrowing or obstruction is suspected.
- Dietary fibre intake should be gradually increased once the patient has a consistent fluid intake of at least 1500 ml per 24 hours.
- Aim for dietary fibre intake of at least 25 grams per day (choose 7-10 servings per day of whole fruits and vegetables, instead of juices, choose 6-8 servings of grain products per day, 100% whole grain breads and high fibre cereals, plant proteins daily as part of the 2-3 servings of meats and alternatives).
- Fruit laxative (125 ml pitted dates, 310 ml prune nectar, 125 ml figs, 200 ml raisins,125 ml pitted prunes).
- Consult with a dietitian for specific nutritional advice regarding fibre intake.

Personal Considerations

- Walking to the toilet, if possible, is recommended. If walking is difficult, use a bedside commode.
- Assuming the squat position on the toilet can facilitate the defecation process.
    - Sitting with feet on a stool may help with defecation.

PPS End of Life (10-30%)

- Raising the head of the bed may facilitate the defecation process.

- Simulate the squat position by placing the patient in the left-lateral decubitus position, bending the knees and moving the legs toward the abdomen.

PPS End of Life (10-20%)

- For patients with PPS 10-20%, consider the burdens and benefits of regular bowel care, using good clinical judgment when making recommendations.

Diarrhea

Consider performance status, diet, fluid intake, quality of life and lifestyle when managing diarrhea.

PPS Stable, Transitional and End of Life (30-100%)

Diet

- Eat small frequent meals.
- Limit consumption of caffeine, fried, greasy foods and foods high in lactose.
- Avoid sorbitol containing foods (e.g., sugar-free gum and sugar-free candy).
- Limit/avoid foods high in insoluble fiber (e.g., wheat bran, fruit skins and root vegetable skins, nuts and seeds, dark leafy greens and legumes such as dried peas).
- Include foods high in soluble fibre (barley, potatoes, bananas and applesauce).
- Avoid hyper-osmotic liquids (fruit drinks and sodas). Dilute fruit juices with water.

Fluid Intake

- Parenteral hydration may be required for severe diarrhea
- Provide fluids orally, if dehydration is not severe.
- An oral rehydration solution can be prepared by mixing 1/2 teaspoon salt and 6 level teaspoons sugar in 1 litre of tap water.

- Commercially available oral rehydration solutions containing appropriate amounts of sodium, potassium and glucose can be used.

PPS Stable, Transitional and End of Life (10-100%)
Quality of Life

- Persistent diarrhea can have severe effects on image, mood and relationships.
- Attention must be paid to understanding the emotional impact from the patient's perspective.
- Offer practical strategies to assist with coping: carefully plan all outings, carry a change of clothes, know the location of restrooms, use absorbent undergarments.

Life style

- Take steps to prevent skin excoriation:
  - Use mild soap, consider sitz bath.
  - Apply a skin barrier product.
- Hydrocolloid dressings may be used as a physical barrier to protect excoriated skin.

PPS End of Life (10-20%)
Exercise good clinical judgment regarding the burden and benefits of parenteral fluids for the individual patient

Pharmacological Treatments

- Ask patient whether using non-traditional or alternative therapies for bowel management.
- Consider the etiology of constipation or diarrhea before initiating any pharmacological treatment.

Constipation

Consider the patient's preferences and previous experiences with bowel management when determining a bowel regimen.

Consider the patient's recent bowel function and response to previous treatments to guide appropriate selection and sequence of pharmacological treatments.

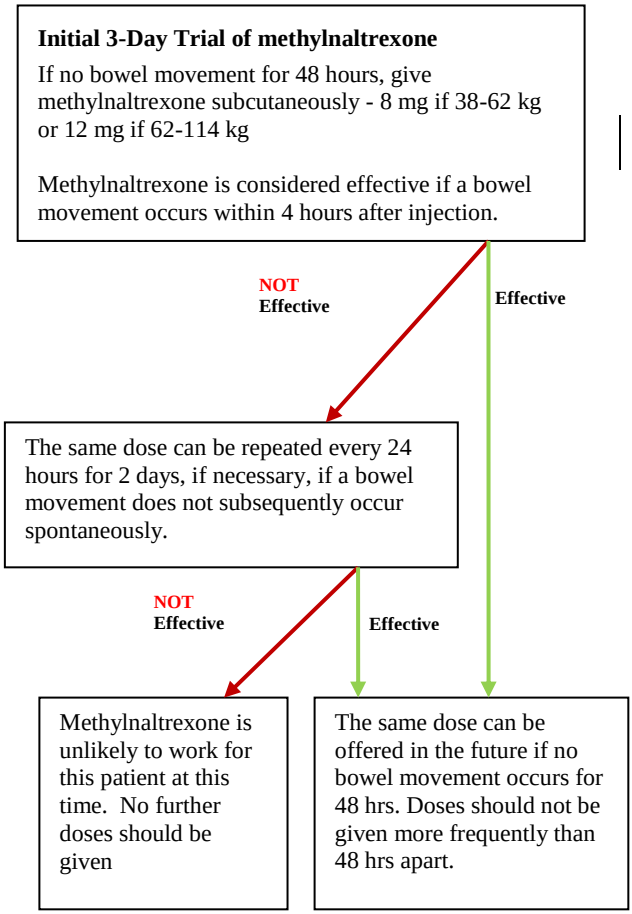
Recommended first line agents
• Oral colonic stimulant (sennosides or bisacodyl) and/or • Oral colonic osmotic (lactulose or polyethylene glycol)
Recommended second line agents
• Suppositories (glycerin or bisacodyl) or • Enemas (phosphate enema)
Recommended third line (rescue) agents
• Picosulfate sodium-magnesium oxide-citric acid or • Methylnaltrexone (if the patient is taking regular opioids)

Fecal Impaction

- If stool is impacted in the rectum, use a glycerin suppository to soften the stool, followed 1 hour later by digital disimpaction, if necessary (after pretreatment with analgesic and sedative), and/or a phosphate enema.
- If stool is higher in the left colon, use an oil retention enema, followed by a large volume enema at least 1 hour later.

Constipation Management in Special Circumstances

Opioid-induced constipation is much easier to prevent than to treat. Start a first line oral laxative on a regular basis for all patients taking opioids.


Initial 3-Day Trial of methylnaltrexone
If no bowel movement for 48 hours, give methylnaltrexone subcutaneously - 8 mg if 38-62 kg or 12 mg if 62-114 kg
Methylnaltrexone is considered effective if a bowel movement occurs within 4 hours after injection.
NOT Effective
Effective
The same dose can be repeated every 24 hours for 2 days, if necessary, if a bowel movement does not subsequently occur spontaneously.
NOT Effective
Effective
Methylnaltrexone is unlikely to work for this patient at this time. No further doses should be given
The same dose can be offered in the future if no bowel movement occurs for 48 hrs. Doses should not be given more frequently than 48 hrs apart.

Patients with a Colostomy

- Use the same approach to bowel care as for the patient without a colostomy.
  A patient with a very proximal colostomy may not benefit from colonic laxatives.
- There is no role for suppositories since they cannot be retained in a colostomy.
- Enemas may be useful for patients with a descending or sigmoid colostomy.

Paraplegic Patients

- A patient with paraplegia is unable to voluntarily evacuate the rectum.
- Passage of stool spontaneously may represent overflow only.
- As for patients without paraplegia, oral laxatives may be needed to move stool to the rectum, but the paraplegic patient needs help to empty the rectum.
  - Schedule a rectal exam daily or every 2 days, depending on the patient's preference, followed, if necessary, by assistance emptying the rectum using one or more of the following:
    - suppository
    - enema
    - digital emptying
- Develop an effective, regular protocol that is acceptable to the patient.

Table 1 and 2 below offer additional information on oral and rectal laxatives available in Canada.

Table 1. Oral Laxatives

Oral	Type	Formulations	Doses	Latency
Bisacodyl	Colonic stimulant	5 mg tablet	5-15 mg qhs; increase up to 15 mg tid	6-12 hours
Lactulose	Colonic osmotic, predominantly softening, secondarily stimulant	667 mg/ml syrup	15 ml daily to 60 ml tid	1-3 days
Picosulfate sodium-magnesium oxide-citric acid	Colonic stimulant and osmotic	10 mg - 3.5 gm - 12 gm in each sachet	1 sachet in 250 ml water 1-2 times daily until good effect	3-6 hours or less
Polyethylene glycol (PEG)	Colonic osmotic, predominantly softening, secondarily stimulant	PEG 3350; PEG with electrolytes	17-34 gm powder in 125-250 ml non-carbonated fluid 1-3 times daily	1-3 days
Sennosides	Colonic stimulant	8.6 mg tablet; 1.7 mg/ml syrup	1-4 tablets or 5-20 ml qhs; increase up to 4 tablets or 20 ml bid	6-12 hours

Notes: bid = twice daily; gm = grams; mg = milligrams; ml = milliliter; qhs = every night at bedtime; tid = three times a day.

Table 2. Rectal Laxatives

Rectal or Stomal	Type	Formulations	Doses	Latency
Bisacodyl suppository	Peristalsis stimulating	5, 10 mg	10 mg every 3 days prn	15-60 minutes
Glycerin suppository	Osmotic - predominantly softening	Adult suppository Pediatric suppository	One daily prn	15-60 minutes
Large volume enema (tap water or saline)	Colonic dilation and stimulation; lubrication	Tap water Normal saline solution	750-1000 ml	10-15 minutes
Oil retention enema	Softening and lubricating	Mineral oil	150-200 ml	30-60 minutes
Phosphate enema	Osmotic and peristalsis stimulating	Sodium and potassium phosphate solution in pre-packed bottles	Every 3 days prn	15-60 minutes

Notes: mg = milligrams; ml = milliliters; prn = as required;

Diarrhea

A single liquid or loose stool usually does not require intervention.

A single drug should be used for diarrhea and care should be taken to avoid sub-therapeutic doses.

- Loperamide (2 mg tablets; 2 mg/15 ml solution) is the preferred first-line anti-diarrheal agent:
  - Initially, use 2 mg orally after each loose bowel movement, up to 16 mg per day.

- For chronic diarrhea, a regular bid dose can be used, based on the 24-hour dose found to be effective, plus 2 mg after each loose bowel movement, up to 32 mg per day total.

OR

- Diphenoxylate/atropine (2.5/0.025 mg tablets)
  - 1-2 tablets orally as needed, up to 4 times per day (maximum 20 mg diphenoxylate per day)
  - Titrate dose down once diarrhea control achieved, to determine the maintenance dose.
- Opioids – consider if the patient is not currently on an opioid for other indications.
- Metronidazole 500 mg orally tid for 2 weeks for Clostridium difficile diarrhea.
- Octreotide 50-600 mcg per day subcutaneously (dosed bid or tid) can be considered for severe, refractory diarrhea.In cases of severe diarrhea, parenteral rehydration may be required.
- If the perianal skin is already inflamed or excoriated, use a topical corticosteroid cream for 1 to 2 days.

Edmonton Symptom Assessment System (ESAS)

Alberta Health Services | Covenant Health

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

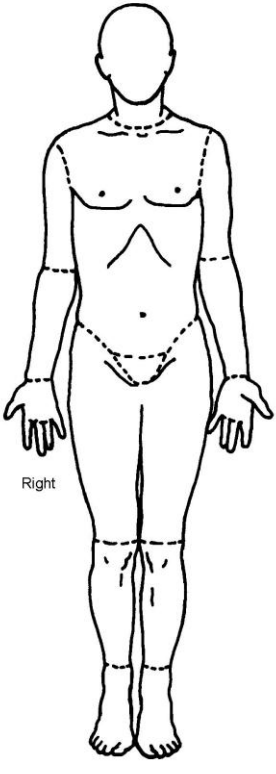
Patient's Name _____

Date _____ Time _____

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

Please mark on these pictures where it is you hurt.



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1) Fraser Health. Hospice palliative care program symptom guidelines: Bowel Care [Internet]. Surrey, BC: Fraser Health Website; 2006. Website: http://www.fraserhealth.ca/media/04FHSymptomGuidelinesBowelCare.pdf

2) Oncology Nursing Society. Putting Evidence Into Practice: Evidence-Based Interventions to Prevent, Manage, and Treat Chemotherapy- and Radiotherapy-Induced Diarrhea. Clinical Journal of Oncology Nursing 2009;13(3):336-341. Link to ONS PEP Diarrhea Quick View Resource: http://www.ons.org/Research/PEP/Diarrhea.

3) Registered Nurses' Association of Ontario. Prevention of Constipation in the Older Adult Population. (Revised). Toronto, Canada: Registered Nurses' Association of Ontario; 2005. Website: http://www.rnao.org/Page.asp?PageID=924&ContentID=809

4) National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology Palliative Care. V.2.2011. Website: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

For full references and more information please refer to CCO's Symptom Management Guide-to-Practice document.