Your Symptoms Matter

# Prostate Cancer (EPIC patient questionnaire) Clinician Guides

**This toolkit includes five guides. Each guide provides clinical direction on the management of one symptom domain addressed in the Your Symptoms Matter, the Prostate Cancer (EPIC) patient questionnaire, including:**

- Urinary incontinence;
- Urinary irritation & Obstruction;
- Bowel function;
- Sexual function; and
- Hormonal symptoms/Vitality.

Although symptom management is often addressed with an interdisciplinary team, these guides are primarily aimed at allied health.

These guides are created to compliment your skills as a clinical practitioner. They will assist in providing education and encourage time for a clinical interaction. Should you need a specialized service, the guide also provides suggestions as to when this may be considered.

Patients who report experiencing any of the above symptoms may feel embarrassed and/or uncomfortable discussing them beyond the questionnaire. Understanding this will help providers communicate with and support patients who may have feelings of shame or emasculation in a sensitive manner. Sexual side effects and hormonal/vitality symptoms are particularly sensitive topics. The psychological distress of this can manifest in different ways (anger, substance abuse, depression, etc.), and awareness of this is critical to supporting to the patient, beyond biomedical treatment (i.e. PDE5 inhibitors). Emotional or psychological symptoms are often (though not always) a response to the physiological side effects and addressing these first is therefore recommended.

Given the sensitivity of symptoms addressed in the Your Symptoms Matter Prostate Cancer questionnaire, we would like to emphasize the importance of balancing patient preferences and wants with their needs as you provide care.

- Gauge symptom impact: Understanding the impact of symptoms and their importance to the patient is pivotal to management. In some cases patients may report a symptom, but the impact of the symptom or the bother of that symptom may be negligible. These patients may not feel a need or want to receive any degree of symptom management.
- Seek patient permission: Even if symptoms are bothersome, patients may not want to discuss further, especially for certain symptoms. It is important to seek permission before delving into assessment and management. Even if a patient declines discussion on a particular visit, the door has been opened for discussions on a subsequent visit.

As of March 2024, this Symptom Management Clinician Algorithm is IN REVIEW. This means that it is undergoing a review for currency and relevance. It is still appropriate for this document to be available while this updating process unfolds.

Your Symptoms Matter

# Prostate Cancer (EPIC questionnaire) Bowel Function

## Problems with bowel function following prostate cancer treatment can include

• Diarrhea (increase in liquidity and/or frequency of bowel movements) • Constipation • Bowel incontinence (the inability to control bowel movements) • Rectal pain or bleeding • Bowel urgency

During prostatectomy, damage to the rectum is rare, and bowel changes/symptoms seen in the first few weeks following surgery are likely a result of the body adjusting to increased space with loss of the prostate. However, radiation therapy can cause damage to the rectum and lead to the bowel symptoms.

## Step 1

**Check the patient's EPIC scores for questions 6a-d. If he reports these symptoms (below) to any degree (score of 1-4), proceed to Step 2.**

**Bowel urgency:**
Any indication of urgency of bowel movements (Q6a)

**Frequent stool i.e., diarrhea:**
Any indication of increased frequency of bowel movements (Q6b)

**Rectal bleeding:**
Any indication of bloody stools (Q6c)

**For Overall Bowel Habits:**
Any indication of problems with bowel habits (constipation, bowel incontinence) (Q6d)

**Rectal Pain:**
Any indication of rectal pain (Q6a)

## Step 2

**Conduct an initial assessment to evaluate the nature and severity of symptoms.**

### A. Take a clinical history.

Clinical history includes:
- Medical and medication history
- Bowel function (normal bowel pattern, frequency of stool, stool consistency, stool size/volume, ease of passage, presence of mucous, continence)
- Blood leakage in underwear: If blood present, quantify amount and colour (e.g. bright red blood per rectum indicated distal source, black/melena stools indicate proximal source)
- Diet and fluid intake (hydration)
- Physical dexterity and mobility
- Environmental factors (privacy, toilet accessibility)
- Functional ability (exercise patterns)

Use the OPQRSTUV Acronym (8) for questions to assess concerning patient symptoms.

Note: OPQRSTUV Acronym stands for Onset, Provoking/Palliating, Quality, Region/Radiation, Severity, Treatment, Understanding/impact on you, values.

### B. Conduct a physical examination.

- Examine the abdomen, checking for signs of distension, abdominal masses, pain/tenderness
- Ensure patient is hemodynamically stable, checking for signs of anemia/excessive blood loss (check posturals if blood loss is high)
- Assess for signs of dehydration (tachycardia, dry mouth, poor skin turgor, low blood pressure)
- For rectal bleeding: Conduct a digital rectal examination

### C. Ask patients to complete a diet and stool diary.

Patients unable to provide accurate stool and diet information should fill out a stool diary with information on: frequency of bowel movements, duration, time of day, stool type, incontinence, food intake. Diary duration is typically 3-7 days.
- Documents baseline symptom levels so treatment treatment impact can be assessed.

# Step 3

**Use the history to understand the underlying cause(s) of the symptoms.**

**Are the symptoms treatment-related?**

Radiotherapy can cause bowel symptoms when the small bowel, large bowel or rectum receives radiation doses high enough to cause inflammation. Surgery rarely causes bowel symptoms other than during short-term post-op recovery. For patients who have not had radiotherapy, bowel symptoms are likely due to other causes such as medical problems (e.g., hemorrhoids, irritable bowel, diverticular disease) or medication side-effects.

**Are the symptoms due to small bowel inflammation?**

The small bowel is commonly exposed to radiation when the pelvic nodes are treated (e.g., high-risk prostate cancer, some cases of bladder cancer). Small bowel inflammation is called "enteritis". Common symptoms include cramps, diarrhea, loose or watery bowel movements, bloating, or loss of appetite. (See step 4, diarrhea)

**Are the symptoms due to rectal inflammation?**

Rectal inflammation is called "proctitis". Virtually all men who receive radiation will have at least some proctitis. Common symptoms include a sense of bowel urgency, a feeling that bowel emptying is incomplete, bright-red bleeding, or mucous on the toilet paper. Sometimes patients refer to this as "diarrhea", but a careful history will clarify if the problem relates to small bowel, rectum, or both. (See Step 4, bowel urgency and rectal bleeding).

# Step 4

**Consider the following conservative (behavioral or lifestyle) interventions as first-line treatment.**

### For Bowel Urgency:

- Consider non-specific anti-diarrhea agents
- Restrict foods that make bowels fast, soft and gassy (peeled fruits, vegetables, insoluble dietary fibre, spicy foods, caffeine, alcohol)
- Ingest psyllium

### For Diarrhea:

- Consider non-specific anti-diarrhea agents
- Eat small, frequent meals
- Limit caffeine, fried, greasy foods and foods high in lactose
- Avoid sorbitol-containing foods (sugar- free gum or candy)
- Avoid hyper-osmotic liquids (fruit drinks and sodas)

### For Rectal Bleeding:

- Consider CBC
- Consider hydrocortisone containing suppositories
- Consider topical 5-ASA
- Consider suggesting sitz baths. If it continues to worsen, consider glaxal cream.

### For Overall Bowel Habits:

**(1) Constipation:**

- Consider osmotic laxatives
- Encourage regular fluid intake
- Increase fibre intake (psyllium), in relation to fluid intake
- Improve toileting habits (empty bowel on a schedule e.g., first thing in the morning, 30-60 minutes after a meal; assume a squatting position)
- Limit caffeine and alcohol

**(2) Incontinence:**

- Improve toileting habits
- Limit caffeine
- Limit dietary fibre
- Pelvic floor muscle training
- Ingest psyllium

**(3) Bowel Urgency:**

- Consider management strategies for Bowel Urgency (column to far left)

# Step 5

**If patients are refractory to these measures, consult a gastroenterologist.**

# Annotated Reference List

**Step 2:**
**Conduct an initial assessment to evaluate the nature and severity of symptoms.**

**a. Take a clinical history**
3: Recommendation 1 (p.624)
5: Assessment (p.12)
6: Assessment (p. 2-3)
7: Recommendations for diagnostic assessment (p. 2-3)
8: Tables 2 & 3 (p. 2-3)

**b. Conduct a physical examination**
2: Physical Examination (p. 1588)
3: Recommendation 3 (p.625)
5: Physical Examination (p.14)
7: Recommendations for diagnostic assessment (p. 2-3)
8: Physical Assessment (p.3)

**c. Ask patients to complete a diet and stool diary**
1: Recommendations 1.3.2
2: Supportive Measures (p. 1594)
7: Recommendations for diagnostic assessment (p. 8)

**Step 4:**
**Suggest conservative (behavioral or lifestyle) interventions as first-line treatment.**

**Bowel Urgency**
- Non-specific anti-diarrhea agents
  Expert Opinion
- Restrict foods
  3: Recommendation 1, Medical Management (p. 626)
  7: Recommendations for nonsurgical treatments (p. 9)
- Limit caffeine
  2: Recommendations (p. 1596)
- Limit caffeine
  2: Recommendations (p. 1596)
- Ingest psyllium
  Expert Opinion

**Diarrhea**
- Non-specific anti-diarrhea agents
  Expert Opinion
- Small, frequent meals
  8: Non-pharmacological treatment for diarrhea, Diet (p. 5)
- Limit caffeine and restrict select foods
  2: Recommendations (p. 1596)
  3: Recommendation 1, Medical Management (p. 626)
  8: Non-pharmacological treatment for diarrhea, Diet (p. 5)
- Avoid sorbitol-containing foods
  8: Non-pharmacological treatment for diarrhea, Diet (p. 5)
- Avoid hyper-osmotic liquids
  8: Non-pharmacological treatment for diarrhea, Diet (p. 5)

**Rectal bleeding**
- Hydrocortisone rectal foam
  Expert Opinion
- Topical 5-ASA
  Expert Opinion

**Overall Bowel Habits / Constipation:**
- Consider osmotic laxatives
  Expert Opinion
- Increased fluid intake
  1: Recommendations 1.3.2
  5: Lifestyle Factors (p. 22)
  8: Non-pharmacological treatment for constipation, Fluid Intake (p. 5)
- Dietary fibre (psyllium)
  5: Lifestyle Factors (p. 18)
  8: Non-pharmacological treatment for constipation, Diet (p. 6)
  Expert Opinion
- Improve toileting habits
  5: Toileting Habits (p.16)
  8: Non-pharmacological treatment for constipation, Personal Considerations (p. 6)
- Limit caffeine/alcohol
  8: Non-pharmacological treatment for constipation, Fluid Intake (p. 5)
- Increased fluid intake
  1: Recommendations 1.3.2
  5: Lifestyle Factors (p. 22)
  8: Non-pharmacological treatment for constipation, Fluid Intake (p. 5)

**Bowel Incontinence:**
- Improve toileting habits
  1: Recommendations 1.3.4
  2: Supportive Measures, Recommendation (p. 1592)
  3: Recommendation 1, Medical Management (p. 626)
- Limit caffeine
  2: Supportive Measures (p. 1595)
  3: Recommendation 1, Medical Management (p. 626)
- Limit dietary fibre
  2: Supportive Measures (p. 1595)
- Pelvic floor muscle training
  7: Recommendations for nonsurgical treatments (p. 9)
- Ingest psyllium
  Expert Opinion

# References


**1.** National Clinical Guideline Centre for Acute and Chronic Conditions. Fecal incontinence in adults: management. London (UK): National Institute for Health and Care Excellence (NICE); 2007 Jun. (Clinical guideline; no. 49).

**2.** Rao, SCS & American College of Gastroenterology Practice Parameters Committee. Diagnosis and management of fecal incontinence: Practice Guidelines. E. Ann Gormley, Deborah J. Lightner, Kathryn L. Am J Gastroenterol. 2004 Aug; 99(8): 1585-604.

**3.** Paquette IM, Varma GM, Kaiser AM, Steele SR, Rafferty JF & the Clinical Practice Guidelines Committee of the American Society of Colon and Rectal Surgeons). The American Society of Colon and Rectal Surgeons' Clinical Practice Guideline for the Treatment of Fecal Incontinence. Diseases of the Colon & Rectum. 2015; 58: 7.

**4.** St. Richard's Hospice & the Clinical Guidelines Committee. Clinical Care Guidelines: Constipation Guidelines. Updated Dec 2010. 17 p.

**5.** Folden SL, Backer JH, Gilbride JA, Maynard F, Pires M, Stevens K & Jones K.. Practice Guidelines: For the management of constipation in adults. Rehabilitation Nursing Foundation; 2002. 51 p.

**6.** Nottingham City Hospital / Queen's Medical Centre ' Rushcliffe PCT. Guidelines for Bowel Management (NHCT Version): Nursing Practice Guidelines. 2006.

**7.** Walk A, Bharucha AE, Cosman BC & Whitenhead WE. ACG Clinical Guideline: Management of Benign Anorectal Disorders. Am J Gastroenterol advance online publication, 15 July 2014.

**8.** CCO. CCO's Symptom Management Pocket Guides-to-Practice: Bowel Care. April 2012.