Ontario Health
Cancer Care Ontario

Symptom Management Algorithm

Constipation

In Adults with Cancer

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.

About Constipation

Definition

- Constipation is the difficult passage of stools or less frequent than normal for the individual. It includes straining, a sensation of incomplete evacuation, and stool consistency that ranges from small, hard lumps to a large bulky mass. It may cause discomfort or pain

Risk Factors

- Common predisposing risk factors for constipation include: older age, reduced intake, immobility, advanced disease, and use of anticholinergic and/or opioid medications

Screening

ESAS-R+ (If Available)

- **Use this guideline for patients who screen positive on ESAS R+ for constipation**

Assessment

Constipation Assessment Acronym: OPQRSTUV

Ask the patient directly, whenever possible. Involve family and caregivers as appropriate, and as desired by the patient

Category	Assessment Questions
Onset	• When did it begin? How long does it last? How often does it occur? When was your last bowel movement?
Provoking/Palliating	• What brings it on? What makes it better? What makes it worse? What is your appetite like? How is your daily intake of food and fluids? How is your mobility? Do you need help to the bathroom/commode? When toileting, do you have enough privacy? Do you have pain or any other problems?
Quality	• What is your normal bowel pattern? Are your bowel movements (BM) less frequent than usual? What do the stools look like? Are they smaller or harder than usual? Do you have discomfort or strain when passing stool? Is there controllable urge or sensation, prior to BM? Are you able to empty you bowels completely when desired? Do you have stool leakage or incontinence?
Related Symptoms	• Not applicable
Severity	• How severe is this symptom? What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)? Right now? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
Treatment	• What medications and treatments are you currently using? Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? How effective are these? Do you have any side effects from the medications and treatments? What have you tried in the past? Do you have concerns about side effects or cost of treatments?
Understanding	• What do you believe is causing this symptom? How is it affecting you and/or your family or caregivers? What is most concerning to you? Do you get any other symptoms: pain, nausea/vomiting, loss of appetite, bloating, gas, blood or mucous in stools, headaches or agitation? Do you have any urinary problems? Do you have any previous trauma which may impact how we manage your bowel movements (e.g. rectal interventions may re-traumatize people with past abuse)? How can we make sure you feel safe and respected? Are you worried about incontinence?
Values	• What overall goals do we need to keep in mind as we manage this symptom? What is your acceptable level for this symptom scale of 0-10 (0 being none and 10 being the worst possible)? Are there any beliefs, views or feelings about this symptom that are important to you and your family or caregivers?

Additional Assessment

- Conduct a detailed history and physical examination, including a perineal inspection, and rectal or stomal exam. Review medications, medical/surgical conditions, psychosocial and physical environment. Differentiate fecal impaction with liquid stool bypass from diarrhea. Further investigations should be tailored to patient prognosis, goals of care, access to healthcare resources, and the potential benefits of a precise diagnosis

Diagnostics

- Blood tests are rarely needed but, depending on clinical presentation, CBC, electrolytes, calcium and thyroid function should be evaluated
- If obstruction is suspected, X-ray to determine if partial or complete, high or low. If severe stool loading of the colon is suspected in a constipated patient, a flat plate of the abdomen can be used to assess the amount and location of stool in the colon. This can help determine appropriate therapies

Intervention Considerations for All Patients

- Identifying the underlying etiology of constipation is essential in determining the interventions required
- When considering a management approach, always balance burden of a possible intervention against the likely benefit (e.g. does the intervention require transfer to another care setting?)
- It is not necessary to have a bowel movement every day, as long as there is a non-forced bowel movement every 1-2 days

Non-Pharmacological Interventions

The Palliative Performance Scale (PPS) is a reliable and valid tool for assessing a patient's functional status

PPS Stable, Transitional and End of Life (30-100%)	**PPS Stable and Transitional (40-100%)**	**PPS End of Life (10-30%)**

Fluid, Fibre[*]*, Mobility*
• Encourage hydration, fibre intake and mobility, as tolerated
• Minimize caffeine and alcohol intake
• Encourage natural laxatives[**], as tolerated
Physical Activity
• Encourage patients to perform physical activity, as tolerated
• Consult with a physiotherapist or occupational therapist for advice regarding mobility, positioning or other modalities
Personal Considerations
• Provide privacy during toileting
	Diet
	The following dietary recommendations are not applicable if bowel obstruction is suspected:
	• Counsel patients on adequate fibre intake for prevention and management
	• Counsel patients on adequate fluid intake for management, as part of wider multicomponent program
	• Consult with dietitian for specific nutritional advice regarding fibre intake and fibre supplements, including psyllium fibre
	  ○ psyllium fibre supplementation is not indicated for persons who are bed-bound or for the older adult population in long-term care settings
	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
		• 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%)
		
		• Consider the burdens and benefits of regular bowel care, using good clinical judgment when making recommendations

Pharmacological Interventions

- The recommendations below are based on low level evidence and consensus due to limited available research
- Consider etiology of constipation, patient's preferences, patient's recent bowel function and response to previous treatments to guide appropriate selection and sequence of pharmacologic treatments
- Ask the patient about usage of non-traditional or alternative therapies for bowel management. If these are being used then consider potential drug interactions and toxicities
- In general, oral measures are preferred and reduce need for rectal interventions
- First, second, and third line recommendations can be combined

First Line Agents	Second Line Agents	Third Line Agents
• Stimulant and/or osmotic laxative with a goal of one non-forced bowel movement every 1 to 2 days: ○ Oral colonic stimulant (sennosides or bisacodyl) AND/OR ○ Oral colonic osmotic (lactulose or polyethylene glycol)	• If impaction is observed, glycerine suppositories (with or without mineral oil retention enema) may be administered or manual disimpaction performed ○ Suppositories (glycerin or bisacodyl) OR ○ Enemas (phosphate enema) • Magnesium citrate saline laxatives or magnesium oxide saline laxatives may be a systemic option to soften stool *Fecal Impaction* • If no perforation or bleed suspected, manage with disimpaction (usually digital fragmentation and extraction of the stool), followed by the implementation of a maintenance bowel regimen to prevent recurrence • For proximal fecal impaction in the absence of complete bowel obstruction, lavage with PEG solutions containing electrolytes may help to soften or wash out stool *Colostomy Patients* • 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* • Oral laxatives may be needed to move stool to the rectum • Schedule a rectal exam every 1-2 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	• Picosulfate sodium-magnesium oxide-citric acid OR • Methylnaltrexone (if the patient is taking regular opioids), see below *Methylnaltrexone for Opioid-Induced Constipation (OIC)* • Consider for patients that had not responded to at least two different classes of standard laxative therapy. The oral formulation can be expensive, and is not covered by the Ontario Drug Benefit program ○ Begin with oral dose of 450mg once a day • Subcutaneous (SQ) formulation: ○ 8mg or 12mg based on weight (< or > than 62kg) ○ Dose adjustments required for renal and/or hepatic impairment ○ A single dose of SQ is often effective at relieving OIC within 4 hours • Methylnaltrexone should not be used in patients with postoperative ileus or mechanical bowel obstruction • Caution should be taken in using psyllium fibre concurrently with opioids *Peripherally acting mu-opioid receptor antagonists (PAMORAs)* • PAMORAs should always be considered in patients with opioid-induced constipation

*For more guidance, visit: Canada's Food Guide, and Health Link BC: Fibre and Your Health
**For more natural laxative guidance visit the Canadian Cancer Society's Constipation page

Pharmacological Interventions

Oral

Drug	Type	Action	Formulations	Doses	Latency	Notes	ODB coverage
Bisacodyl	• Colonic stimulant	• Stimulates colonic motility • Reduces water and electrolyte absorption in colon	• 5mg tablet	• 5-15mg every night at bedtime • Increase up to 15mg three times a day	• 6-12 hours	• PPS 30-100%	• Yes
Cascara sagrada bark	• Colonic stimulant	• Stimulates colonic motility	• Various capsule sizes	• 300-1000mg a day	• 6-12 hours	• PPS 30-100% • Natural health product	• No
Lactulose	• Colonic osmotic, predominantly softening • Secondarily stimulant	• Disaccharide metabolized by bacteria in colon to produce osmotic effect • Secondary peristalsis	• 667mg/mL syrup	• 15mL a day to 60mL three times a day	• 1-3 days	• PPS 30-100% • Non absorbable sugar	• Yes
Magnesium salts (sulphate; hydroxide; citrate)	• Osmotic, predominantly softening	• Osmotic effect • Secondary peristalsis	• Sulphate: 99g/100g powder • Hydroxide: 80 mg/mL suspension • Citrate: 50mg/mL liquid	• Sulphate: 10-30g in 240mL liquid a day • Hydroxide:15-60mL a day to twice a day • Citrate: 75-150mL a day	• 1-3 hours	• PPS 30-100% • Do not use if renal insufficiency, heart block or myasthenia gravis is present • May affect absorption of other medications; space by at least 2 hours	• No
Picosulfate sodium-magnesium oxide-citric acid	• Colonic stimulant and osmotic	• Stimulates colonic peristalsis; osmotic	• 10mg & 3.5g & 12g in each sachet	• 1 sachet in 250mL water 1-2 times a day until good effect	• 3-6 hours or less	• PPS 30-100% • Not for use as a regular laxative • · Do not use in renal insufficiency	• Yes
Polyethylene glycol (PEG)	• Colonic osmotic, predominantly softening • Secondarily stimulant	• Osmotic effect in colon • Secondary peristalsis	• PEG 3350 • PEG with electrolytes	• 17-34g powder in 125-250mL non-carbonated fluid 1-3 times a day	• 1-3 days	• PPS 30-100% • Do not use PEG with electrolytes in renal insufficiency	• No
Psyllium	• Bulk forming	• Normalizes stool volume	• 0.3-0.6g per g of powder; regular and sugar-free • 525, 550mg capsule	• 3.4g daily to three times a day		• PPS 30-100% • Do not use if food and fluid intake is poor	• Yes, oral powder only
Sennosides	• Colonic stimulant	• Stimulates myenteric plexus • Reduces water and electrolyte absorption in colon	• 8.6mg tablet; • 1.7mg/mL syrup	• 1-4 tablets or 5-20mL every night at bedtime • Increase up to 4 tablets or 20mL twice a day	• 6-12 hours	• PPS 30-100%	• Yes
Sorbitol	• Colonic osmotic, predominantly softening • Secondarily stimulant	• Osmotic effect in colon • Secondary peristalsis	• 70% solution		• 1-3 days	• PPS 30-100%	• No

Rectal or Stomal

Drug	Type	Action	Formulations	Doses	Latency	Notes	ODB coverage
Bisacodyl suppository	• Peristalsis stimulating	• Evacuates stool from rectum	• 5, 10mg	• 10mg every 3 days, as needed	• 15-60 min	• PPS 20-100% • Avoid if neutropenic	• Yes, 10mg only
Glycerin suppository	• Osmotic, predominantly softening	• Softens stool in rectum	• Adult suppository • Pediatric suppository	• Once a day, as needed	• 15-60 min	• PPS 20-100% • Avoid if neutropenic	• No
Large volume enema (tap water or saline)	• Colonic dilation, stimulation • Lubrication	• Evacuates stool from descending colon	• Tap water • Normal saline solution	• 750-1000mL	• 10-15 min	• PPS 30-100% • Avoid if neutropenic	• N/A
Oil retention enema	• Softening and lubricating	• Softens hard stool	• Mineral oil	• 150-200mL	• 30-60 min	• PPS 30-100% • Avoid if neutropenic	• N/A
Phosphate (sodium bisphosphate, sodium phosphate) enema	• Osmotic and peristalsis stimulating	• Evacuates stools from rectum and sigmoid colon	• 160mg & 60mg/mL Rectal Solution	• Every 3 days, as needed	• 15-60 min	• PPS 20-100% • Avoid if neutropenic • Avoid in renal insufficiency	• Yes

Disclaimer

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