Guidelines for the Control of Constipation in Adult Patients With Cancer

Adapted and reprinted with permission of NHS Fife (part of the NHS [National Health Service] Scotland) from the work of its Area Drug and Therapeutics Committee.

http://www.show.scot.nhs.uk/fifeadtc/

Constipation has been defined as a decrease in normal frequency of the passage of formed stools and is characterized by stools that are hard and often difficult to pass.[1] In clinical practice, this definition can be somewhat imprecise since individual patterns of "normal" bowel elimination can vary substantially. In a large study of bowel function that included 1,055 persons, 99% reported bowel movements in the range of 3 per day to 3 per week.[2]

Kallman[3] noted three categories of dysfunction are generally reported by patients who complain of constipation: (1) defecation is less than in the past, (2) the amount of stool is less than normal, and (3) bowel movements are either painful or difficult. Characteristics that indicate constipation are noted in Table 1 on page 4. An acceptable definition of constipation for clinical practice would be the following: *a decrease in the frequency of passage of formed stools and characterized by stools that are hard and difficult to pass*.

The following can be considered as possible causes of constipation:

- General debility
- Metabolic upset (eg, hypercalcemia/hypothyroid)
- Spinal cord compression
- Low food and fluid intake
- Drug therapy

An understanding of the patient's normal accepted bowel habit is essential when planning treatment. Such as assessment considers the following characteristics:

- Normal and current frequency of stool
- Stool size, volume, and consistency
- The presence of blood or mucus in the stool
- Nausea, vomiting, colic
- Ease of passage

Constipation in cancer patients needs to be treated along with the other symptoms and side effects of the disease. Patients should have an abdominal and rectal examination. Abdominal x-ray could be considered to differentiate between constipation and abdominal obstruction. A guideline for prophylaxis or treatment of constipation developed by the Fife Area Drug and Therapeutics Committee of the National Health Service of Scotland is shown at the right.

For patients receiving opioid analgesics:

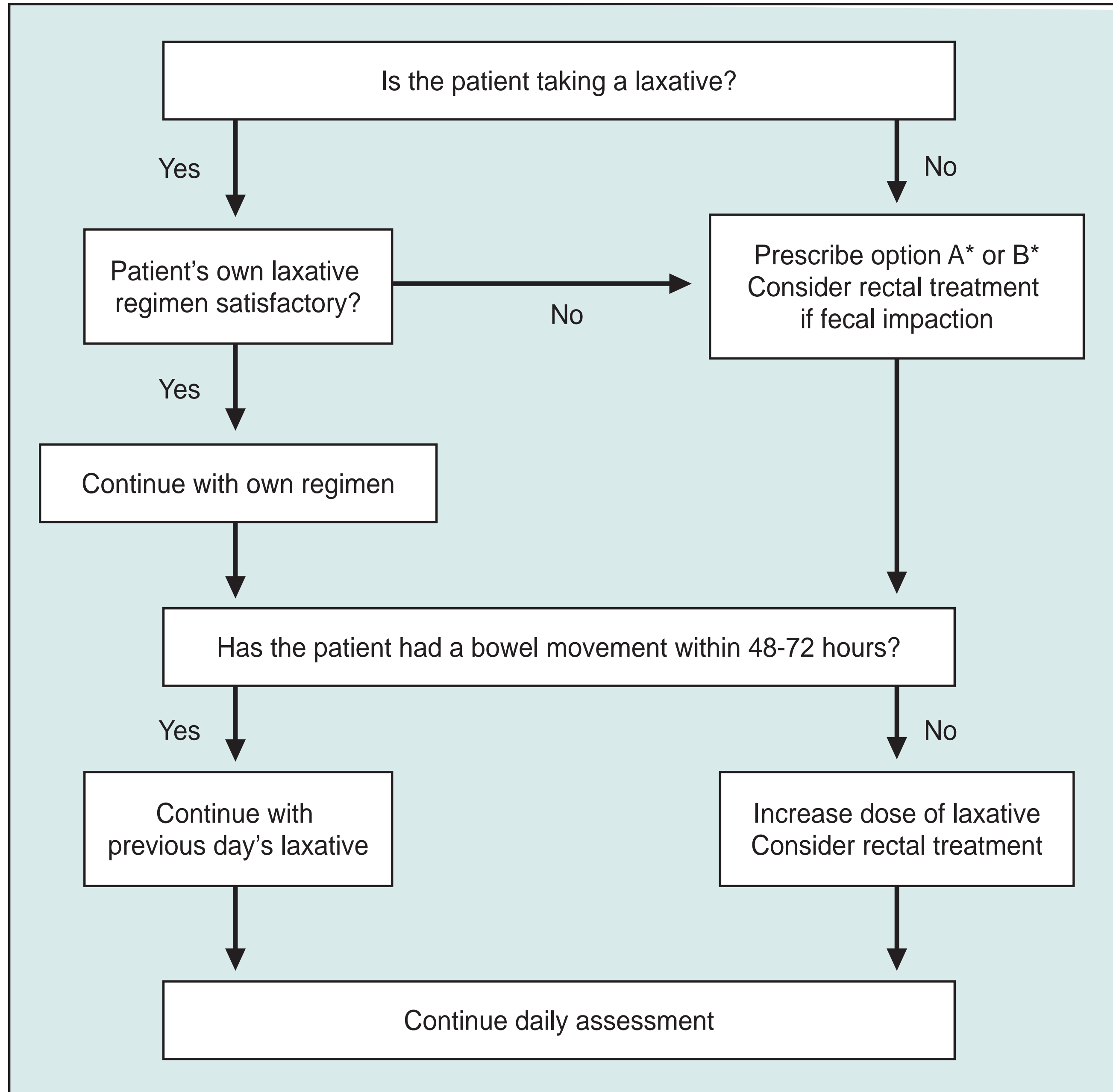
- All patients taking opioids require a regular laxative prescribed
- A combination of stimulant and softener is usually required.
- Laxative doses often need to be increased along with increased doses of opioids.
- Titrate doses of laxatives according to response and before changing to an alternative laxative.
- Patients with advanced cancer may require higher doses of laxatives than recommended by the formulary.
- If a patient's laxative requirements exceed the quoted formulary maximum, the patient needs to consult with the physician.

References

1. McShane RE, McLane AM. Constipation: consensual and empirical validation. *Nurs Clin North Am*. 1985;20:801-808.
2. Connell AM, Hilton C, Irvin EG, et al. Variation in bowel habits in two population samples. *Br Med J*. 1965;2:1095-1099.
3. Kallman H. Constipation in the elderly. *Am Fam Phys*. 1983; 27:179-184.

Clinical Approach

This guideline has been adapted and reprinted with permission of NHS Fife (part of the NHS [National Health Service] Scotland) from the work of its Area Drug and Therapeutics Committee.
http://www.show.scot.nhs.uk/fifeadtc/



* Option A (starting doses): 2 senna tablets once daily
* Option B (starting doses): 1 senna tablet twice daily plus 1 docusate sodium 100-mg capsule twice daily

Note: Additional guidelines have been published as follows:

Robinson DB, Fritch M, Hullett L, et al. Development of a protocol to prevent opioid-induced constipation in patients with cancer: a research utilization project. *Clin J Oncol Nurs*. 2000;4:79-84.

Smith S. Evidence-based management of constipation in the oncology patient. *Eur J Oncol Nurs*. 2001;5:18-25.