

Definition(s)
<p>Constipation: A subjective experience of an unsatisfactory defecation characterized by infrequent stools and/or difficult stool passage (e.g. straining, incomplete evacuation, hard/lumpy stools, prolonged time to pass stool, need for manual maneuvers)</p>

Focused Health Assessment	
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PHYSICAL ASSESSMENT	SYMPTOM ASSESSMENT
<p>Abdominal Assessment</p> <ul style="list-style-type: none"> Auscultate abdomen - assess presence and quality of bowel sounds Any abdominal pain, tenderness, distention? Any palpable fecal masses? <p>Digital Rectal Exam (DRE)</p> <ul style="list-style-type: none"> Do NOT perform DRE if patient has neutropenia or low platelet count Place in left, lateral recumbent position Assess for: <ul style="list-style-type: none"> - Hemorrhoids, fissures, abscesses - Hard impacted stool of tumor mass <p>Hydration Status</p> <ul style="list-style-type: none"> Assess mucous membranes, skin turgor, capillary refill, amount and character of urine <p>Weight</p> <ul style="list-style-type: none"> Take current weight and compare to pre – treatment or last recorded weight <p>Vital Signs</p> <ul style="list-style-type: none"> Include as clinically indicated <p>Functional Status</p> <ul style="list-style-type: none"> Activity level/ECOG or PPS 	<p>*Consider contributing factors</p> <p>Normal</p> <ul style="list-style-type: none"> What are your normal bowel habits? Explore patient’s definition of constipation <p>Onset</p> <ul style="list-style-type: none"> When did change in bowel habits begin? When was your last bowel movement? When was your bowel movement prior to this one? <p>Provoking / Palliating</p> <ul style="list-style-type: none"> What makes the stools harder/softer, watery, more/or less frequent? What has your diet been like? What are you drinking? Eating? How much? How active are you? (% of day spent in bed or chair) <p>Quality</p> <ul style="list-style-type: none"> Describe your last bowel movement – amount, consistency, colour Passing flatus? Is straining required to pass stool? Any blood or mucus in your stool? <p>Region / Radiation – N/A</p> <p>Severity / Other Symptoms</p> <ul style="list-style-type: none"> How bothered are you by this symptom? (on a scale of 0 – 10, with 0 being not at all to 10 being the worst imaginable) Have you been experiencing any: <ul style="list-style-type: none"> - Abdominal distention, cramping, severe pain, nausea or vomiting – possible bowel obstruction - Sensory loss, +/- motor weakness, urinary changes such as incontinence or trouble emptying your bladder – possible spinal cord compression - Diarrhea accompanying constipation – possible leaking around fecal impaction - Rectal bleeding or pain - Loss of appetite <p>Treatment</p> <ul style="list-style-type: none"> What medications or treatments have you tried? Has this been effective? Has the patient been prescribed a bowel management protocol? If so, what step? What tests have been done? Any previous impactions since diagnosis? <p>Understanding / Impact on You</p> <ul style="list-style-type: none"> Have your symptoms been interfering with your normal activities (ADLs)? How bothered are you? <p>Value</p> <ul style="list-style-type: none"> What do you believe is causing your constipation?

The information contained in these documents is a statement of consensus of BC Cancer professionals regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult these documents is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient's care or treatment. Use of these documents is at your own risk.

CONSTIPATION GRADING SCALE

NCI CTCAE (Version 4.03)

<u>GRADE 1</u> <u>(Mild)</u>	<u>GRADE 2</u> <u>(Moderate)</u>	<u>GRADE 3</u> <u>(Severe)</u>	<u>GRADE 4</u> <u>(Life - threatening)</u>	Grade 5
Occasional or intermittent symptoms; occasional use of stool softeners, laxatives, dietary modification, or enema	Persistent symptoms with regular use of laxatives or enemas; limiting instrumental ADLs	Obstipation with manual evacuation indicated; limiting self care ADL	Life-threatening consequences; urgent intervention indicated	Death

***Step-Up Approach to Symptom Management:
Interventions Should Be Based On Current Grade Level and Include Lower Level Grade Interventions As Appropriate**

GRADE 1 – GRADE 2



NON – URGENT:

Prevention, support, teaching, and follow-up as clinically indicated

Patient Care and Assessment	<ul style="list-style-type: none"> Assess pattern (number of days since last stool), characteristic of stool (solid/hard/pellet) and degree of effort/straining required to defecate (minimal/moderate/major or unable to defecate despite maximal effort/strain) Assessment and management of contributing factors. If opioid related, See opioid-induced Constipation: Special Considerations below <p>* Avoid suppositories, enemas, disimpaction, or rectal exams if patient neutropenic or has low platelets</p>
Pharmacological Management	<ul style="list-style-type: none"> Use a step – up approach according to bowel protocol to ensure regular bowel movements See BC Cancer Bowel Protocols in Resources Section below Appendix A: Pharmacological Agents that may be used to Manage Constipation below 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.
Bowel Routine	<p>Encourage:</p> <ul style="list-style-type: none"> Attempts to defecate 30-60 minutes after meals to take advantage of gastrocolic reflex Prompt response to the urge to defecate Privacy and uninterrupted time when toileting Sitting or squatting position, consider raised toilet seats or commodes or stool to elevate feet Adequate pain control for optimal bowel movement and comfort Monitor and record bowel movements for pattern, characteristic and degree of effort/strain <p>Avoid:</p> <ul style="list-style-type: none"> Excessive straining
Physical Activity and Dietary Management	<p>Physical Activity:</p> <ul style="list-style-type: none"> Promote regularly physical activity and mobilization as able and appropriate <p>Fluid Intake:</p> <ul style="list-style-type: none"> Encourage 8-12 cups of fluids throughout the day to maintain normal bowel habits. Caution in patients with comorbidities that affect fluid balance (e.g. congestive heart failure) Encourage a warm drink before usual time of defecation Limit caffeine consumption (coffee 1-2 cups a day, black tea 4-5 cups a day) Limit alcohol consumption as it can contribute to fluid loss

Physical Activity and Dietary Management	Foods: <ul style="list-style-type: none"> • Encourage natural laxatives (e.g. prunes, dates, figs, raisins and wheat bran) • Aim for 20-35 grams of dietary fiber per day through diet or supplements • Gradually increase daily fiber intake; to reduce associated symptoms of bloating and distention, ensure patient consumes at least 1500mL (6 cups) fluid per day • High fiber intake is contraindicated in patients with poor fluid intake and at high risk for bowel obstruction
Patient Education and Follow - up	<ul style="list-style-type: none"> • Normal bowel movements vary amongst people and can be altered by food consumption • A daily bowel movement is not necessary • Even with minimal intake patients should still have a bowel movement • Reinforce with patients when to seek immediate medical attention: <ul style="list-style-type: none"> - Fever - Severe cramping, acute onset of abdominal pain, distention with or without nausea and vomiting – may mean a possible bowel obstruction - Sensory loss (+/- motor weakness) – possible spinal cord compression - Dizziness, weakness, confusion, excessive thirst, dark urine – possible dehydration - No bowel movement in 3 days –require adjustment to bowel protocol • Instruct patient/family to call back in 24 hours if symptoms worsen or do not improve • If indicated, arrange for nurse initiated or physician follow-up See Resources & Referrals

GRADE 3 AND/OR the presence of either: <ul style="list-style-type: none"> • No bowel movement for >3 days and not responding to a bowel protocol • Increasing abdominal pain & distention 	GRADE 4 AND/OR the presence of either: <ul style="list-style-type: none"> • Temperature $\geq 38^{\circ}\text{C}$ • Acute abdominal pain and distention (+/- nausea or vomiting) • Sensory loss (+/- motor weakness)
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URGENT: Requires medical attention within 24 hours	EMERGENT: Requires IMMEDIATE medical attention
Patient Care and Assessment	<ul style="list-style-type: none"> • Collaborate with physician: <ul style="list-style-type: none"> - To rule out other causes or concomitant causes of constipation (e.g. bowel obstruction and spinal cord compression) See Alert Guidelines in Resources Section below - Need for further patient assessment at clinic or if patient requires hospital admission • Lab and diagnostic tests that may be ordered: <ul style="list-style-type: none"> - Complete blood count and electrolyte profile - Abdominal X-ray or CT scan <p>* Avoid suppositories, enemas, disimpaction, or rectal exams if patient neutropenic or has low platelets</p>
Dietary Management	<ul style="list-style-type: none"> • If patient unable to maintain adequate daily oral intake, IV hydration may be required to replace lost fluid and electrolytes • Patients with possible bowel obstruction will be NPO • Depending on severity, IV hydration, enteral or parenteral (TPN) nutrition may be indicated
Pharmacological Management	<ul style="list-style-type: none"> • Avoid/discontinue any medications that may cause or exacerbate constipation in collaboration with physician and pharmacist • Enema, disimpaction may be needed • See BC Cancer Outpatient Bowel Protocols in Resources Section below Appendix A: Pharmacological Agents that may be used to Manage Constipation below

OPIOID-INDUCED CONSTIPATION: SPECIAL CONSIDERTIONS

- Constipation is a common side effect of all opioids. The constipating effects are not dose dependent and tolerance to the constipating effects does not occur
- Opioids cause decreased motility by suppression of intestinal peristalsis and increased water and electrolyte re-absorption in the small and large intestine
- Is easier to prevent than treat. Initiation of a prophylactic bowel protocol is recommended for patients regularly taking opioids. Unmanaged constipation can result in patients discontinuing opioid therapy
- Transdermal fentanyl and methadone are less constipating than other opioids
- Opioid rotation may be considered for severe refractory constipation
- For severe opioid induced constipation unrelieved by bowel protocol, consider Methylnaltrexone Bromide subcutaneous injection (Relistor®). Contraindicated in patients with bowel obstruction

RESOURCES & REFERRALS

Referrals	<ul style="list-style-type: none"> • Patient Support Centre • Telephone Care Management • Oncology Nutrition Services (Dietitian) • Physiotherapist • Home Health Nursing • Pain and Symptom Management/Palliative Care
Patient Education	<p>Nutrition Handouts: http://www.bccancer.bc.ca/health-professionals/clinical-resources/nutrition/nutrition-handouts</p> <ul style="list-style-type: none"> - Suggestions for Dealing with Constipation, with “fruit lax” recipe - Dietary Fiber Content of Common Foods - Low fiber food choices for partial bowel obstruction
Bowel Protocols & Assessment	<ul style="list-style-type: none"> • Outpatient Bowel Protocol http://www.bccancer.bc.ca/managing-symptoms-site/Documents/Constipation-Patient-Handout.pdf • Management of Constipation- Inpatient protocol (available to internal BCCA staff only) H:\EVERYONE\SYSTEMIC\Chemo\Orders\VCC\Supportive • Inpatient MAR sheets (available to internal BCCA staff only) H:\EVERYONE\SYSTEMIC\Chemo\Orders\VCC\Supportive • Victoria Bowel Performance Scale http://www.bccancer.bc.ca/family-oncology-network-site/Documents/BPSCConstipationScale.pdf
Alert Guidelines	<p>H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Telephone Nursing Guidelines\Alert Guideline(available to internal BCCA staff only):</p> <ul style="list-style-type: none"> • Intestinal Obstruction • Spinal Cord Compression
BC Inter-professional palliative symptom management guideline	<ul style="list-style-type: none"> • https://www.bc-cpc.ca/cpc/wp-content/uploads/2019/03/6-BCPC-Clinical-Best-Practices-colour-Constipation.pdf
Bibliography List	<ul style="list-style-type: none"> • http://www.bccancer.bc.ca/nursing-site/Documents/Bibliography%20-%20Master%20List.pdf

Contributing Factors	
Chemotherapy Agents	<ul style="list-style-type: none"> • Vinca alkaloids (e.g. vincristine, vinblastine, vinorelbine) • Platinums (e.g. carboplatin, oxaliplatin) • Taxanes (e.g. paclitaxel) • Thalidomide
Medications	<ul style="list-style-type: none"> • Opioids • Vitamin Supplements (e.g. calcium and iron) • Antiemetics (e.g. 5-HT3 antagonists- ondansetron, granisetron) • Drugs with anticholinergic effects (e.g. antidepressants, antihistamines, antiparkinsonisms) • Antispasmodics, anticonvulsants, phenothiazines • Antacids that contain aluminum and calcium • Diuretics
Relevant Medical History	<ul style="list-style-type: none"> • Metabolic disturbances <ul style="list-style-type: none"> - Electrolyte imbalances (e.g. hypercalcemia, hyponatremia, hypokalemia) - Hypothyroidism - Uremia - Diabetes • Neurological disturbances <ul style="list-style-type: none"> - Spinal cord involvement (e.g. compression and injuries) - Sacral nerve infiltration - Autonomic dysfunction • Structural Abnormalities <ul style="list-style-type: none"> - Narrowing of bowel lumen-tumor compression, radiation fibrosis/scarring, surgical anastomosis - Patients with advanced ovarian cancer have a high incidence of obstruction
Bowel Disturbances	<ul style="list-style-type: none"> • Bowel disorders (e.g. irritable bowel syndrome, diverticulitis) • Altered bowel habits - ignore urge to defecate • Pain associated with defecation
Diet and Activity	<ul style="list-style-type: none"> • Diet-reduced food and fiber intake • Dehydration • Decreased physical activity and mobility
Other	<ul style="list-style-type: none"> • Advanced age • Advanced illness • Altered cognition, sedation • More common in women
Consequences	
<ul style="list-style-type: none"> • Fecal impaction, bypassing diarrhea (+/- incontinence) • Hemorrhoids, rectal tearing, fissures, or prolapse • Complete or partial bowel obstruction, bowel perforation • Infection, sepsis • Excessive straining contributing to syncope, cardiac arrhythmias • Impaired absorption of oral medications 	

Appendix A: Pharmacological Management of Constipation

(Adapted from the Fraser Health, Hospice Palliative Care, and Symptom Guidelines)

Oral Laxatives:	Type	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
Polyethylene glycol (PEG)	Predominantly softening - osmotic cathartic	Increases fluid and purgative action
Lactulose	Predominantly softening – osmotic laxative	Retain water in small bowel
Sorbitol	Predominantly softening – osmotic cathartic	Retain water in small bowel
Sodium docusate	Predominantly softening - surfactant	Detergent, increase water penetration
Methyl cellulose	Predominantly softening – bulk forming agent	Normalizes stool volume
Magnesium sulfate	Predominantly softening – saline laxative	Retain water and strong purgative action
Rectal Laxatives:	Type	Action
Bisacodyl suppository	Peristalsis stimulating – polyphenolic	Evacuates stool from rectum or stoma: for colonic inertia
Glycerin suppository	Predominantly softening – osmotic laxative	Softens stool in rectum or stoma
Phosphate enema	Peristalsis stimulating – saline laxative	Evacuates stool from lower bowel
Oil enema	Predominantly softening – lubricant laxative	Softens hard impacted stool

* Refer to Parenteral Drug Monograph for further information

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