Symptom Management Guidelines: CONSTIPATION

NCI CTCAE GRADE AND MANAGEMENT | RESOURCES | CONTRIBUTING FACTORS | APPENDIX

Definition(s)

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)

Focused Health Assessment

PHYSICAL ASSESSMENT

Abdominal Assessment
- Auscultate abdomen - assess presence and quality of bowel sounds
- Any abdominal pain, tenderness, distention?
- Any palpable fecal masses?

Digital Rectal Exam (DRE)
- Do NOT perform DRE if patient has neutropenia or low platelet count
- Place in left, lateral recumbent position
- Assess for:
  - Hemorrhoids, fissures, abscesses
  - Hard impacted stool of tumor mass

Hydration Status
- Assess mucous membranes, skin turgor, capillary refill, amount and character of urine

Weight
- Take current weight and compare to pre – treatment or last recorded weight

Vital Signs
- Include as clinically indicated

Functional Status
- Activity level/ECOG or PPS

SYMPTOM ASSESSMENT

***Consider contributing factors**

Normal
- What are your normal bowel habits? Explore patient's definition of constipation

Onset
- When did change in bowel habits begin?
- When was your last bowel movement? When was your bowel movement prior to this one?

Provoking / Palliating
- 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)

Quality
- Describe your last bowel movement – amount, consistency, colour
- Passing flatus? Is straining required to pass stool?
- Any blood or mucus in your stool?

Region / Radiation – N/A

Severity / Other Symptoms
- 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:
  - 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

Treatment
- 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?

Understanding / Impact on You
- Have your symptoms been interfering with your normal activities (ADLs)?
- How bothered are you?

Value
- What do you believe is causing your constipation?

CONSTIPATION GRADING SCALE NCI Common Terminology Criteria for Adverse Events (CTCAE) (Version 5.0)				
GRADE 1 (Mild)	**GRADE 2 (Moderate)**	**GRADE 3 (Severe)**	**GRADE 4 (Life - threatening)**	**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 ADL	Obstipation with manual evacuation indicated; limiting self care ADL	Life-threatening consequences; urgent operative 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	• 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*** * Avoid suppositories, enemas, disimpaction, or rectal exams if patient neutropenic or has low platelets
Pharmacological Management	• 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	**Encourage:** • 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 **Avoid:** • Excessive straining
Physical Activity and Dietary Management	**Physical Activity:** • Promote regularly physical activity and mobilization as able and appropriate **Fluid Intake:** • 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:** • 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	• 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: - 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:	**GRADE 4 AND/OR the presence of either:**
• **No bowel movement for >3 days and not responding to a bowel protocol** • **Increasing abdominal pain & distention**	• **Temperature ≥ 38°C** • **Acute abdominal pain and distention (+/- nausea or vomiting)** • **Sensory loss (+/- motor weakness)**
↓	↓

URGENT: **Requires medical attention within 24 hours**	**EMERGENT:** **Requires IMMEDIATE medical attention**
Patient Care and Assessment	• Collaborate with physician: - 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: - Complete blood count and electrolyte profile - Abdominal X-ray or CT scan * Avoid suppositories, enemas, disimpaction, or rectal exams if patient neutropenic or has low platelets
Dietary Management	• 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	• 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	• Patient Support Centre • Telephone Care Management • Oncology Nutrition Services (Dietitian) • Physiotherapist • Home Health Nursing • Pain and Symptom Management/Palliative Care
Patient Education	Nutrition Handouts http://www.bccancer.bc.ca/health-info/coping-with-cancer/nutrition-support - 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	• Victoria Bowel Performance Scale http://www.bccancer.bc.ca/family-oncology-network-site/Documents/BPS-PPS%20reference%20sheet%20REVISED%20draft%20Jan%2025%202010%20DP.pdf
Alert Guidelines	H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Telephone Nursing Guidelines\Alert Guideline(available to internal BCCA staff only): • Intestinal Obstruction • Spinal Cord Compression
BC Inter-professional palliative symptom management guideline	• https://www.bc-cpc.ca/cpc/wp-content/uploads/2019/03/6-BCPC-Clinical-Best-Practices-colour-Constipation.pdf
Bibliography List	• http://www.bccancer.bc.ca/nursing-site/Documents/Bibliograpy%20-%20Master%20List.pdf

Contributing Factors	
Chemotherapy Agents	• Vinca alkaloids (e.g. vincristine, vinblastine, vinorelbine) • Platinums (e.g. carboplatin, oxaliplatin) • Taxanes (e.g. paclitaxel) • Thalidomide
Medications	• 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	• Metabolic disturbances - Electrolyte imbalances (e.g. hypercalcemia, hyponatremia, hypokalemia) - Hypothyroidism - Uremia - Diabetes • Neurological disturbances - Spinal cord involvement (e.g. compression and injuries) - Sacral nerve infiltration - Autonomic dysfunction • Structural Abnormalities - Narrowing of bowel lumen-tumor compression, radiation fibrosis/scarring, surgical anastomosis - Patients with advanced ovarian cancer have a high incidence of obstruction
Bowel Disturbances	• Bowel disorders (e.g. irritable bowel syndrome, diverticulitis) • Altered bowel habits - ignore urge to defecate • Pain associated with defecation
Diet and Activity	• Diet-reduced food and fiber intake • Dehydration • Decreased physical activity and mobility
Other	• Advanced age • Advanced illness • Altered cognition, sedation • More common in women

Consequences
• 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**

Date of Print:
Revised: October, 2014; February 2025 (limited revisions to include new NCI CTCAE scale)
Created: January, 2010

Contributing Authors:
Revised by: Jeevan Dosanjh, RN BScN, Michelle LaFreniere, RN (2025)
Revised by: Jagbir Kaur, RN, MN (2018); Lindsay Schwartz, RN, MSc(A) (2014)
Created by: Vanessa Buduhan, RN MN; Rosemary Cashman, RN MSc(A), MA (ACNP); Elizabeth Cooper, RN BScN, CON(c); Karen Levy, RN MSN; Ann Syme, RN PhD (C)

Reviewed by: Laurie Barnhardt, MN, NPF (2018); Jenna Osavitsky, RN (2018); Pippa Hawley, MD (2014); Elizabeth Cooper, RN, BScN CON(c) (2014)