**Symptom Management Guidelines: CONSTIPATION**

### 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)

### 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. hypercalemia, 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

#### 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

### Consequences

- Fecal impaction, overflow 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

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# Focused Health Assessment

## GENERAL ASSESSMENT

### Contact and General Information
- Physician name - oncologist, family physician
- Pharmacy
- Home health care
- Other healthcare providers
- Allergies

### Consider Contributing Factors
- Cancer diagnosis
- Cancer treatment(s) – note type and date of last treatment(s), concurrent treatments
- Medical history
- Medication profile
- Recent lab, diagnostic reports
- Opioids
- Dehydration
- Reduced food and fiber intake

## SYMPTOM ASSESSMENT

### 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? Drinking? Eating? How much?

### Quality
- Describe your last bowel movement – amount, consistency, colour
- Passing flatus? Straining required to pass 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 – possible spinal cord compression
  - Diarrhea accompanying constipation – possible overflow around fecal impaction
  - Rectal bleeding or pain
  - Loss of appetite

### Treatment
- What medications or treatments have you tried? Has this been effective? (check to see if patient has been prescribed a bowel management protocol. If so, what step?)
- Have you had any previous impactions since your diagnosis?

### Understanding / Impact on You
- Have your symptoms been interfering with your normal daily activity (ADLs)?

### Value
- What do you believe is causing your constipation?

## PHYSICAL ASSESSMENT

### Abdominal Assessment
- Auscultate abdomen - assess presence and quality of bowel sounds
- Abdominal pain, tenderness, distention
- 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
## CONSTIPATION GRADING SCALE
Adapted from NCI CTCAE (Version 4.03)

<table>
<thead>
<tr>
<th>Normal stools - maintains normal bowel routine</th>
<th>Occasional or intermittent symptoms; occasional use of stool softeners, laxatives, dietary modification, or enema</th>
<th>Persistent symptoms with regular use of laxatives or enemas; limiting instrumental ADLs</th>
<th>Obstruction with manual evacuation indicated; limiting self care ADL</th>
<th>Life-threatening consequences; urgent intervention indicated</th>
</tr>
</thead>
</table>

### *Step-Up Approach to Symptom Management:*

Interventions Should Be Based On Current Grade Level and Include Lower Level Grade Interventions As Appropriate

### NORMAL – GRADE 2

**NON – URGENT:**
Prevention, support, teaching, and follow-up as clinically indicated

<table>
<thead>
<tr>
<th>Patient Care and Assessment</th>
<th>• 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)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Assessment and management of contributing factors. If opioid related, See <a href="#">opioid-induced Constipation: Special Considerations below</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Avoid suppositories, enemas, disimpaction, or rectal exams if patient neutropenic or has low platelets</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacological Management</th>
<th>• Use a step – up approach according to bowel protocol to ensure regular bowel movements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• See <a href="#">BCCA Bowel Protocols in Resources Section below</a> Appendix A: Pharmacological Agents that may be used to Manage Constipation below</td>
<td></td>
</tr>
</tbody>
</table>

### 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
- 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 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

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### Physical Activity and Dietary Management

**Foods:**
- Encourage natural laxatives (e.g. prunes, dates)
- 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; even with minimal intake patients should still have a bowel movement
- Reinforce with patients when to seek immediate medical attention:
  - T ≥ 38°C
  - Severe cramping, acute onset of abdominal pain, distention (+/- nausea & vomiting) – 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 – may 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

<table>
<thead>
<tr>
<th>GRADE 3 AND/OR the presence of either:</th>
<th>GRADE 4 AND/OR the presence of either:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No bowel movement for &gt;3 days and not responding to a bowel protocol</td>
<td>Temperature ≥ 38°C</td>
</tr>
<tr>
<td>Increasing abdominal pain &amp; distention</td>
<td>Acute abdominal pain and distention (+/- nausea or vomiting)</td>
</tr>
<tr>
<td></td>
<td>Sensory loss (+/- motor weakness)</td>
</tr>
</tbody>
</table>

**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 BCCA Bowel Protocols in Resources Section below

**Appendix A: Pharmacological Agents that may be used to Manage Constipation below**

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OPIOID-INDUCED CONSTIPATION: SPECIAL CONSIDERATIONS

- 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.
- It 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 or 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-professionals/professional-resources/nutrition/nutrition-handouts](http://www.bccancer.bc.ca/health-professionals/professional-resources/nutrition/nutrition-handouts)
  - 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**
- Outpatient Bowel Protocol found in “Suggestions for Dealing with Constipation”
- 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\ConstipationMARstandard.pdf
- Victoria Bowel Performance Scale. Located in the Palliative Care Guidelines as “BPS-Constipation scale”

**Alert Guidelines**
- H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Telephone Nursing Guidelines\Alert Guideline (available to internal BCCA staff only):
  - Intestinal Obstruction
  - Spinal Cord Compression

**Related Online Resources**
- E.g. Fair Pharmacare; BC Palliative Benefits. Can be found in “Other Sources of Drug Funding Section”
  - [http://www.bccancer.bc.ca/health-professionals/professional-resources/pharmacy/drug-funding](http://www.bccancer.bc.ca/health-professionals/professional-resources/pharmacy/drug-funding)

**Bibliography List**
- [http://www.bccancer.bc.ca/health-professionals/professional-resources/nursing/symptom-management](http://www.bccancer.bc.ca/health-professionals/professional-resources/nursing/symptom-management)

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### Oral Laxatives:

<table>
<thead>
<tr>
<th>Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sennosides Peristalsis stimulating - anthracenes</td>
<td>Reduces water and electrolyte absorption and purgative action</td>
</tr>
<tr>
<td>Bisacodyl Peristalsis stimulating – polyphenolic</td>
<td>Reduces water and electrolyte absorption and purgative action</td>
</tr>
<tr>
<td>Polyethylene glycol (PEG) Predominantly softening - osmotic cathartic</td>
<td>Increases fluid and purgative action</td>
</tr>
<tr>
<td>Lactulose Predominantly softening – osmotic laxative</td>
<td>Retain water in small bowel</td>
</tr>
<tr>
<td>Sorbitol Predominantly softening – osmotic cathartic</td>
<td>Retain water in small bowel</td>
</tr>
<tr>
<td>Sodium docusate Predominantly softening - surfactant</td>
<td>Detergent, increase water penetration</td>
</tr>
<tr>
<td>Methyl cellulose Predominantly softening – bulk forming agent</td>
<td>Normalizes stool volume</td>
</tr>
<tr>
<td>Magnesium sulfate Predominantly softening – saline laxative</td>
<td>Retain water and strong purgative action</td>
</tr>
</tbody>
</table>

### Rectal Laxatives:

<table>
<thead>
<tr>
<th>Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisacodyl suppository Peristalsis stimulating – polyphenolic</td>
<td>Evacuates stool from rectum or stoma: for colonic inertia</td>
</tr>
<tr>
<td>Glycerin suppository Predominantly softening – osmotic laxative</td>
<td>Softens stool in rectum or stoma</td>
</tr>
<tr>
<td>Phosphate enema Peristalsis stimulating – saline laxative</td>
<td>Evacuates stool from lower bowel</td>
</tr>
<tr>
<td>Oil enema Predominantly softening – lubricant laxative</td>
<td>Softens hard impacted stool</td>
</tr>
</tbody>
</table>

*Refer to Parenteral Drug Monograph for further information*