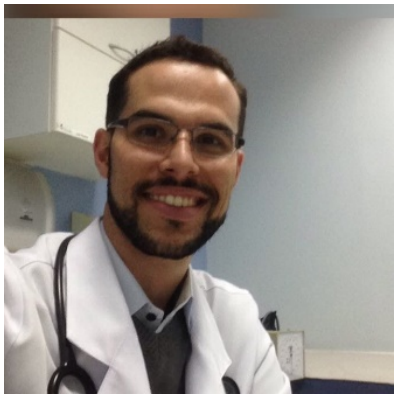

Pedro S. de Paula MD
pedro@sobramfa.com.br

95 – Palliative Care and Constipation

Pedro S. de Paula MD
Palliative Care Program Coordinator at SOBRAMFA-Medical Education and Humanism, Brazil

Introduction

Palliative care is deeply inserted into the core of family medicine. And this is not for other factors than the strong values family medicine holds. Values like loyalty and compassionate care generates a relationship that goes lifelong and has a special role on the end-of-life care. Aiming on comfort and on dignity, compassionate and efficient symptom control is essential and should be considered urgency even more important than signs that the patient is about to die.

To conquer the optimal comfort and avoiding the loss of patient adhesion to the treatment, fundamental concepts raise: Anticipatory Prescribing and awareness of symptoms. (1) Although mostly we would first think on cancer patients when we consider palliative care and symptoms control, other terminal diagnosis are very common on family medicine daily practice such as dementia, frailty and advanced organs impairment. This article will focus on one of the most common, important and often ignored symptoms faced by patients receiving palliative care: intestinal constipation.

Constipation affects up to 48% of all palliative care patients (2) and up to 87 % of patients receiving palliative care who also are taking opioids. (3) Opioid-induced constipation is such an important symptom that some patients may avoid opioid therapy and choose inadequate analgesia over constipation. (4) It might threaten the patient´s general comfort, causing loss of quality of life mainly for abdominal pain, anorexia and low treatment adhesion. (1) It might also threaten dignity, through making a bad death context due to severe intestinal obstruction and ruining precious conscious moments on that very delicate period of a patient´s life once it might cause *delirium.* (5)

Causes

On palliative practice, constipation is more often related to the medications used in symptom control, such as opioids, tricyclic antidepressants and anticonvulsants. Even though, it might also be caused by the natural development of the disease. Not only cancer, but dementia, frailty and other syndromes might develop constipation manifestations. Clarifying the cause before starting treatment is important once some drugs might be more effective over one cause than to others.

Possible causes of the constipation (1):

- Medication: opioids, antacids, diuretics, iron, 5HT3 antagonists
- Secondary effects of illness (dehydration, immobility)
- Tumour in, or compressing, bowel wall
- Damage to lumbosacral spinal cord, cauda equina or pelvic nerves
- Hypercalcaemia
- Concurrent disease such as diabetes, hypothyroidism, diverticular disease, anal fissure, haemorrhoids, Parkinson's disease, hypokalaemia.

Another important cause of constipation is low food intake. It is very common palliative care patients to come to the doctor´s office eating very badly. Anorexia is one of the most important problems on cancer patients (especially under chemo or radiotherapy) and on demented ones, but wrong information about very strict diets for advanced cancer, diabetes or hypertension also does a very powerful harm, especially on patients that have already lost much weight. Usually, patients that have already lost weight will need a review on the strategy for his or her chronic diseases, including diet counselling update.

Other spaces would be more appropriated to explore the anorexia problem, but we will strongly recommend to actively search for exaggerated diets and eating concepts that will not make sense when the palliative perspective is predominant. For example, many patients and families think they should not allow patients to eat ice-cream because it is considered unhealthy, but it is an excellent option for nauseated patients undergoing chemotherapy that cannot stand the smell of the food. The benefits of it would surely overcome any harm it could make – we shall also remember we are taking care of someone who will have a relative short prognosis; no long-term health consequences would make sense, though. Palliative patients very rarely would have important food limitations; most of them will be very glad to hear they can eat whatever they wish to.

Medication (1)

The options below may be equally effective.

Patient preferences should be taken into consideration.

While separate softener and stimulant allows better titration, a combined preparation means less medication burden for the patient.

Rectal treatment may be needed if rectum loaded or impacted.

Do not give rectal treatment if rectum is ballooned and empty.

If there is a clinical picture of obstruction with colic, stimulant laxatives should be avoided.

- **Option A (stimulant ± softener)**

Senna 2 to 4 tablets or bisacodyl 5 to 10mg, at bedtime.

If stools become hard or colic supervenes add in softening agent, such as docusate sodium 100mg capsule, twice daily.

- **Option B (osmotic laxative)**

Macrogol 1 to 3 sachets daily

If severe constipation, consider a higher dose for 3 days.

- **Rectal treatment**

Soft loading: bisacodyl suppository, sodium citrate or phosphate enema.

Hard loading: glycerol suppository as lubricant or stimulant; then treat as above.

Very hard loading: arachis oil enema overnight, followed by phosphate enema.

Take Home Message

- ANTICIPATE AWARENESS, ASSESSMENT AND RESOLUTION OF CONSTIPATION.
- Stimulate patients to eat and try to do all that is possible on that direction. Make patients and families aware of the real needs of the patients- they must not be under strict diets and we should always try to use medication always when needed, with the effective dose, not on fear of the effects.
- The majority of palliative care patients on opioids need a regular oral laxative – remember to prescribe both together and review laxative regimen when opioid medication dose is changed.
- Lactulose is not effective without a high fluid intake; it can cause flatulence and abdominal cramps in some patients. Macrogol should be preferred- but caution is needed with frail or nauseated patients who may not be able to tolerate the fluid volume needed along with it. Bulk-forming laxatives are not suitable if the patient has a poor fluid intake and reduced bowel motility
- Methylnaltrexone may be suitable for opioid induced constipation resistant to standard therapies, but this should be under specialist palliative care advice only. (1,5)

Original Abstract

http://www.woncaeurope.org/content/pp-289-factors-related-elderly-chronic-constipation

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Receiving palliative care does not mean that you will no longer receive treatment for the disease. People often receive treatment to slow, stop, or eliminate cancer in addition to treatment to ease discomfort. In fact, research shows that people who receive both types of treatment often have less severe symptoms, a better quality of life, and report they are more satisfied with treatment. How palliative care differs from hospice care. Although you may hear â€œpalliative careâ€ and â€œhospice careâ€ used in similar ways, they are not the same. Palliative care is given at every step of the treatment p Constipation and diarrhoea. Marie Fallon, Bill Oâ€™Neill. Prevalence of constipation.Â mimic features of the underlying disease. About half of patients. admitted to specialist palliative care units report constipation, but about 80% of patients will require laxatives. Assessment of constipation. Palliative care:useful international organisations. Palliative care: some references.Â Â„ Palliative Care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.Â Constipation. Nausea-vomiting Drowsiness Neurotoxicity. Characteristics. Palliative care can be given in a hospital setting, often times in conjunction with other therapies and treatments such as chemotherapy or radiation. It can also be delivered outpatient, in a clinic or at a patientâ€™s place of residence such as the patient's own home, the home of a family member, or a nursing home.Â Your doctor, case manager nurse, or social worker can direct you in finding palliative care. As of today, finding palliative care in an outpatient setting proves challenging but that is changing as more and more hospice organizations begin to offer traditional palliative care in addition to hospice care. Who Can Benefit. Anyone who has a life-limiting illness can benefit from palliative care. The classic example -and where palliative care has had the largest role in the last decades- is cancer.