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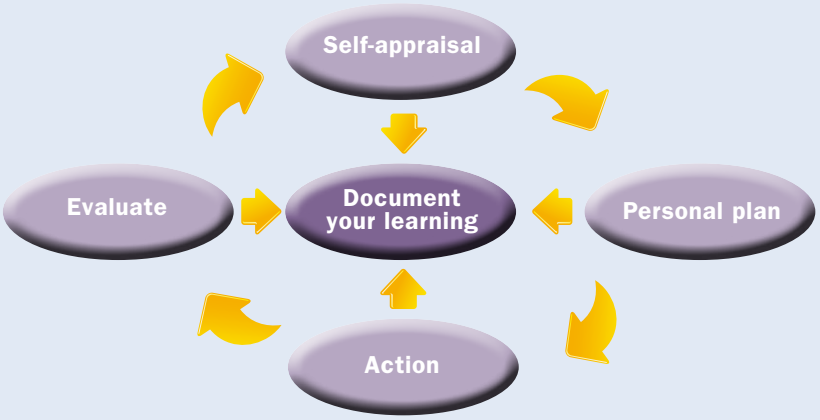


Constipation in Palliative Care

This is the first part of a four-part series of articles on Palliative Care, which will focus on the following topics: constipation; opioid use; nausea and vomiting; and syringe pumps.

"You matter until the last moment of your life, and we will do all we can, not only to help you die peacefully, but to live until you die" – Dame Cicely Saunders, founder of the hospice movement.

Myth: Palliative care is only for people who are approaching the end of their lives and are no longer receiving any treatment for their illness.

Fact: People can receive palliative care alongside any ongoing treatment or drug therapies and at any point of a life-limiting condition. They could be in their last months, weeks, days or hours of life.

Palliative care is an approach that improves quality of life for people and their families facing the problems associated with life-limiting illness. A life-limiting illness means a condition, illness or disease which:

- Is progressive and fatal; and
- The progress of which cannot be reversed by treatment.

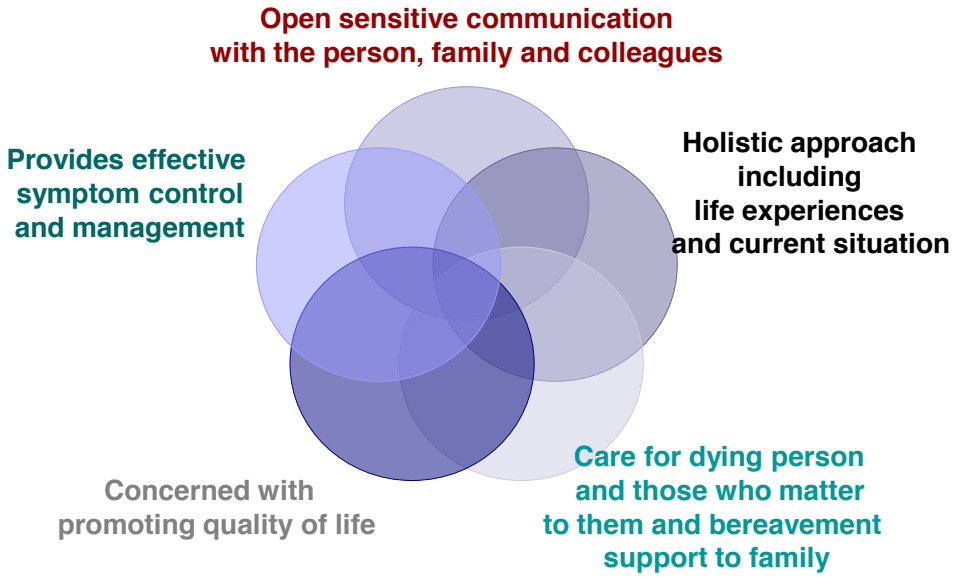
This approach is described in Figure 1.

There are three levels of palliative care provision:

- Level 1: A palliative care approach; provided in any location by all healthcare professionals;
- Level 2: General palliative care; provided in any location, using a palliative approach by some healthcare professionals who have

Figure 1: **Palliative Care Approach (NPPC 2014)**

What is a palliative care approach?



additional knowledge of palliative care principles and use this as part of their role; and

- Level 3: Specialist palliative care; provided by specialised interdisciplinary teams for patients with more complicated physical, psychological, social or spiritual problems (HSE 2017).

All three levels are essential within the healthcare system. The level a patient requires depends on the nature, extent and complexity of their individual needs and preferences. For many people, palliative care delivered by their usual treating health and social care professionals is sufficient to meet their needs and preferences. Specialist Palliative Care is only one component of palliative care delivery.

The *HSE Palliative Care Programme Competence Framework* describes the common core and discipline specific training, education and skills required to deliver services across all three levels. This is available online at https://aiihpc.org > Our Work > Education > Competence Framework.

Many pharmacists already use a palliative care approach in their daily practice, as described in Figure 2.

Figure 2: **Pharmacists' Palliative Care Approach**

Constipation in adults with palliative care needs

A patient's description of their experience of constipation – "It's collecting, collecting, collecting. And that's not normal" (Dhingra, et al., 2012).

Introduction

Constipation is the infrequent (relative to the patient's normal bowel habit), difficult passage of small hard faeces. It is a highly subjective symptom. Both aspects should be considered when assessing constipation. Constipation is:

- The third most frequently encountered symptom after pain and anorexia;
- Can occur at any stage in the disease trajectory;
- Multi-factorial;
- Reported to rival the distress caused by pain;
- Can impact a patient's decision to use opioid analgesics;
- May lead to a hospital admission; and
- Despite prevalence, patient impact and healthcare system burden, uncertainty still persists in clinical practice about the best management.

Many factors may increase the risk or contribute to the development of constipation, such as physical illness, neurological problems, reduced mobility, reduced fluid intake, nutritional issues, metabolic issues, social issues and medications. Constipation can cause considerable distress for patients, impacting significantly on their quality of life and potentially leading to a hospital admission. It can lead to a range of symptoms including some serious medical complications.

Assessment

"It just makes me miserable. You know it can be fixed eventually, but you want something that works now, like "bam". You don't want it to back-up on you . . . I'm miserable" (Dhingra, et al., 2012).

In a community pharmacy setting, the assessment of constipation should include a comprehensive history to establish the difference between the patients current and usual bowel pattern, a medication history and the effectiveness of any previous management strategies. Prompts to assess current bowel performance should include:

- Onset of symptoms;
- Aggravating and alleviating factors;
- Frequency and pattern of bowel motions;
- Stool volume and appearance; and
- Nausea/abdominal discomfort/bloating/pain on defecation.

This can be a sensitive issue, and the patient and or carer can be invited to the pharmacy consultation room in order to maintain privacy and dignity. If there are concerns, the patient may have faecal impaction or obstruction, refer the patient to their GP for further assessment.

Management

"My son told me to drink ginger tea . . . that's supposed to help . . . I tried it before and it didn't do any good" (Dhingra, et al., 2012).

The objective of any management strategy is to prevent constipation occurring. Once established, the aim of treatment should be to avoid constipation-related complications and re-establish a comfortable bowel habit for the patient. The degree of intervention should be guided by the patient's clinical status and preference.

Preventative measures should be ongoing throughout the patient's disease trajectory and patients/carers should be encouraged to take a proactive role. Practical advice may include: the prevention strategies as set out in Table 4.

Pharmacological management

"You take them and they don't work. It's frustrating, and after a while it's like, why bother?" (Dhingra, et al., 2012).

Although nonpharmacological measures (e.g. maintaining fluid intake, mobility, abdominal massage), may help some patients, this depends on the patient's clinical status and may not be suitable for a frail patient. Therefore, pharmacological treatment will usually be necessary. Laxatives are commonly prescribed, with 50% of patients receiving two or more simultaneously. Oral laxatives work via a variety of mechanisms to improve frequency of bowel movements, consistency of stool or to facilitate defecation. There are two broad categories, those that predominantly:

- Soften faecal matter; and
- Stimulate gut peristalsis.

Within each category, there is no conclusive evidence to support any specific preparation and many therapeutic recommendations remain based on clinical experience, patient status, their preference, laxative cost and reimbursement status.

Table 1: Objective versus Subjective Symptoms

Measurable Objective Symptoms	Subjective Symptoms
• Frequency of defecation; and • Stool characteristics.	• Ease of defecation; • Level of discomfort; • Flatulence; • Bloating; • Straining; and • Sensation of incomplete evacuation.

Table 2: Signs, Symptoms and Complications

Signs	Symptoms	Complications
• Abdominal pain; • Anorexia; • Early satiety; • Nausea; • Vomiting; and • Abdominal distension.	• Flatulence; • Halitosis; • Heartburn; • Anal fissures; • Haemorrhoids; and • General malaise.	• Confusion; • Faecal impaction; • Intestinal obstruction; • Intestinal perforation; and • Diarrhoea (overflow).

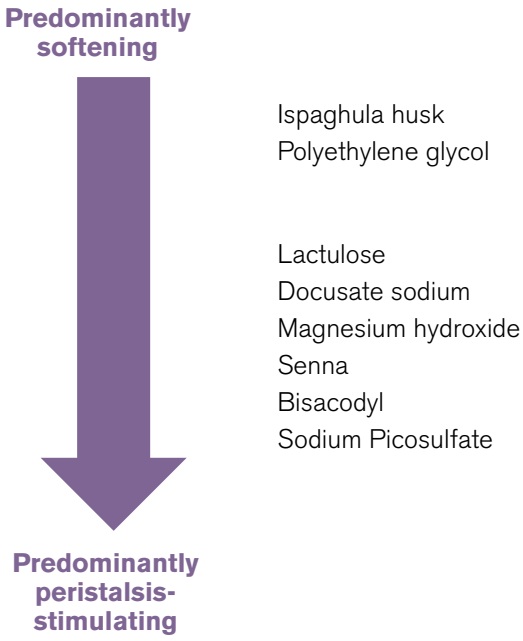
Table 3: Management

Management
• Nonpharmacological measures and laxatives are first-line approaches; • A regular stimulant laxative should be added to the first opioid prescription; • Reversible causes, e.g. medication-induced, should be corrected where appropriate; • Preventative measures should be ongoing throughout the patient's disease trajectory; and • Peripherally acting mu-opioid receptor antagonists are recommended when laxative therapy has been maximised and failed.

Table 4: Prevention Strategies

Prevention Strategies
• Privacy and comfort to enable normal defecation; • Physical activity within the patient's limits; • Increasing fluid and fibre* intake if appropriate to the patient's clinical status; and • Regular prophylactic laxative therapy for patients prescribed opioids. * Bulk forming laxatives are not suitable if the patient has poor fluid intake and reduced bowel motility

Figure 3: **Oral Laxative Classification**
(adapted with permission from Skyes 2004)



The assessment process will help to identify which type of laxative is indicated:

- Hard stools: require a softener, e.g. docusate; and
- Infrequent stools: require a stimulant e.g. senna.

In reality, patients will often present with both symptoms and therefore a combination of softening and stimulating laxatives may be most effective.

If a single agent is used, a bowel motion should be expected within three days. If ineffective, a combination of softening and stimulating laxatives should be considered; the dose should be titrated daily or on alternate days according to patient response. Development of faecal leakage suggests a need to reduce the softener and perhaps stimulant. Development of bowel colic suggests the dose of softening laxative should be increased relative to the stimulant dose.

Sometimes patients with advanced illness may require rectal suppositories or enemas. Again, hard stools will require a softening agent, while soft stools will benefit from a stimulant agent. The oral laxative classification is described in Figure 3.

Opioid Induced Constipation (OIC)

". . . mostly anger, having constipation is very frustrating and can be painful. Not being able to eliminate it as a side-effect of the pain meds makes me always irritated because I must be conscious of limiting my pain meds in order not to provoke my constipation. This unsolvable equation: needing pain meds equals constipation, vexes me greatly" (Dhingra, et al., 2012).

Opioids remain the mainstay for managing cancer pain and are increasingly used to manage non-cancer pain in advanced life-limiting illness. The term Opioid Induced Constipation (OIC) refers simply to constipation resulting from opioid therapy (Greer, Heidelbaugh, Falck-Ytter, Hanson, & Sultan, 2019). Some degree of constipation should be anticipated in patients taking opioid medications.

Opioids exert their gastrointestinal effects via kappa-receptors in the stomach and small intestine and mu-receptors in the small intestine and colon. OIC occurs primarily via activation of the mu-receptors. Opioid binding to these receptors reduces gastrointestinal motility, promotes fluid reabsorption, and inhibits fluid secretion into the intestinal lumen causing delayed transit, dry hard stools, less frequent and less effective defecation.

In practice, non-pharmacological strategies rarely relieve OIC and most patients will require aggressive pharmacological management. If OIC is unresponsive to standard laxative treatments, the use of a Peripherally Acting Mu-Opioid Receptor Antagonist (PAMORA) may be considered. PAMORAs, e.g. oral naloxone (combined with oxycodone), naloxegol and methylnaltrexone do not enter the central nervous system but block the mu-receptors in the gut wall. In doing so, they aim to directly reverse the constipating effects of opioids in the bowel without reversing their central analgesic effect. They should only be recommended by a healthcare professional experienced in their use.

Management of constipation in the dying patient

In the last day of life, bowel movements become less frequent. As a patient's level of consciousness deteriorates, oral laxatives should be discontinued.

Laxative reimbursement

See PCRS *Pharmacy Circular 048/2016 Discretionary Hardship* https://www.hse.ie/eng/staff/pcrs/circulars/pharmacy/national%20framework%20for%20the%20admnistration%20of%20discretionary%20hardship%20arragements.pdf. Type into your browser URL bar.

References available on request.

Your 5-minute assessment

Answer the following five questions true or false:

1. When a patient is referred to palliative care it means they will soon die?
2. Palliative care is provided primarily by specialist palliative care services?
3. Whole person or holistic care provides psychosocial and spiritual care in addition to symptom management?
4. Patients usually develop tolerance to the constipating effects of opioid analgesics?
5. Anxiety due to constipation may prevent some patients from taking their pain medication?

Answers: **1.** False. **2.** False. **3.** True. **4.** False. **5.** True.

CPD overview

Self-appraisal

- [ ] What do I know about the management of constipation in palliative care?
- [ ] Am I aware of the risks of constipation in palliative care?
- [ ] Am I able to assess constipation in palliative care?
- [ ] Can I support palliative care patients with constipation and their carers?

Personal plan

Including a list of desired learning outcomes in a personal learning plan is a helpful self-analytical tool.

- [ ] Create a list of desired learning outcomes.
- [ ] How will I accomplish these learning outcomes?
- [ ] Identify resources available to achieve learning outcomes.
- [ ] Develop a realistic timeframe for the plan

Action

Activities chosen should be outcomes based to meet learning objectives.

- [ ] Implement plan.
- [ ] Read this article on Constipation in Palliative Care
- [ ] Evaluate professional resource materials available in the pharmacy and source additional material if necessary.
- [ ] Evaluate patient support material and source additional material if necessary.

Evaluate

Consider outcomes of learning and impact of learning.

- [ ] Have I met my desired learning outcomes?
- [ ] Do I now feel confident to engage with patients and their carers about Constipation in Palliative Care?
- [ ] Provide an example(s) of changes that I have implemented in my pharmacy practice.
- [ ] Have further learning needs been identified?

Document your learning

- [ ] Create a record in my ePortfolio.
- [ ] As part of this record, complete an evaluation, noting whether learning outcomes were achieved and identifying any future learning needs.