

PROTOCOL

Title: Bowel Care Protocol for Palliative Care Patients

Date Approved: March 20, 2003

Approved By: Clinical Practice Committee

- A. **PURPOSE:** A pharmacological bowel routine is necessary for persons taking opioids regularly. Constipation can cause much discomfort and can lead to serious complications in the palliative person.
- B. **GENERAL INFORMATION:**
Constipation is a common cause of morbidity in palliative care persons. It affects up to 95% of the people who are taking opioids. Even in the absence of oral intake, the body continues to produce 1-2 ounces of stool per day. The bowel lining is continually renewing itself and sloughed cell, along with bacteria and digestive juices, comprise much of the stool. Hence, individuals can easily become constipated even when they are not eating.

Complications of Constipation

- Abdominal pain and increased cancer pain in people with abdominal or retroperitoneal malignancy
- Abdominal distention/discomfort
- Nausea, vomiting and anorexia
- Overflow diarrhea
- Hemorrhoids/anal fissures
- Bowel obstruction
- Urinary retention
- Anxiety and restlessness

C. PROCEDURE:

Suggested bowel routine for individuals taking opioids regularly:

1. Stool softeners and bowel stimulants: Must be given regularly, NOT prn, and should be started simultaneously with initiation of opioids.

Usual starting dosages: Sennosides 8.6 mg (eg. Senokot) or 12 mg (eg. Glysennid) tablets @ hs and Docusate Sodium 100 mg (eg. Colace) or Docusate Calcium 240 mg (eg. Surfak) capsules bid. Adjust dosages and frequencies as needed to ensure the person has a soft, formed bowel movement every 1-2 days.

Titrate Sennosides tablets: 2-4 tabs bid up to qid, and Docusate tid up to qid to achieve regular bowel movement.

Certain antineoplastics or specific chemotherapy agents can cause either constipation or diarrhea. If individuals experience diarrhea, hold the laxatives temporarily until diarrhea subsides.

Note: It is important to determine that the diarrhea is not overflow due to constipation

2. Stimulant bisacodyl suppository or enema (eg. Dulcolax Suppository or Dulcolax MicroEnema) which may be followed by a Phosphate enema (eg. Fleet). Administer suppository and, if ineffective, give micro or fleet enema whenever a person does not have a bowel movement for 3 days.

Note: Always remember to check the bowel routine with the patient. Ask if this pattern is unusual, or is it normal for them to have a bowel movement once every 3 days.

If:

1. Suppository and micro or fleet enemas are ineffective ... repeat, keeping in mind that the suppository and micro fleet only stimulate the rectum*
2. Still ineffective - high oil retention enema and high fleet.
3. Still ineffective - soap suds enema (irritating and often poorly tolerated)**

* Fleet Enema consists of 150 ml of Sodium Phosphate. It may be safely used in short, intermittent courses. Prolonged use of a phosphate preparation can result in hypocalcemia and rectal irritation.

** Some protocols use tap water enema rather than soapsuds enemas. The main consideration is clearing of the oil retention enema.

Note: Be sure to assess for bowel obstruction BEFORE initiating aggressive laxative and enema administration. Such therapies are contraindicated in the presence of bowel obstruction, except if obstruction is due to constipated stool.

3. Lactulose may be added to the laxative regime. Start with Lactulose 30 ml qd and titrate to tid.
4. Occasionally, one dose of Oral Sodium Phosphates solution (eg. Fleet Phospho-Soda Oral Laxative) 20-45 ml or Magnesium Citrate (eg. CitroMag) 150-300 ml. Magnesium citrate (1 bottle in 24 hours) may be needed, especially if the flat plate abdominal x-ray shows a large amount of stool in the ascending or transverse colon.

Note: Serious side effects may occur from excessive dosage of Oral Sodium Phosphate solution.

- Electrolyte shifts may occur in patients if the maximum recommended dose of 45 ml in a 24 hour period is exceeded.
- Do not use in persons with bowel obstruction, ascites, kidney disease, congenital megacolon or congestive heart failure. Hypocalcemia, hyperphosphatemia, hypernatremia and acidosis may occur with impaired renal function. Baseline and follow-up blood work for electrolytes is recommended.

5. Monitor and assess bowel movements and reassess management.

Note:

One good response to a laxative or enema may not treat the constipation fully. The sigmoid may be clear but the rest of the colon may still be full of stool, it may be useful to repeat abdominal x-ray.

Available online at www.palliative.org

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MacDonald, Neil, ed. Constipation (Chapter 6). Palliative Medicine (1997) – a case based manual.

Mancini, I et al. (2000) Opioid Type and Other Clinical Predictors of Laxative Dose in Advanced Cancer Patients: A Retrospective Study. J Pall Med, 3 (1).