Assessment/Description

Constipation is defined by the patient and is a symptom not a disease. The cause of the constipation should be identified and treated, managing bowel obstruction where appropriate. Aim to prevent constipation by the early introduction of laxatives, especially if patients are taking pain killers regularly.

- History, normal bowel habit, medicines other causative factors; review and discontinue any possible contributory medication as appropriate
- Focus on clinical assessment through history; abdominal examination, auscultation and rectal examination when appropriate
- Consider checking calcium levels
- Treatment should be individualised to the patient and what they are able to tolerate. In most cases the oral route to manage constipation should be used initially. If constipation is not resolved after 5-7 days seek specialist advice

Causes to consider:

- Drug-induced including opioids, diuretics, anti-cholinergics, ondansetron, chemotherapy
- Dehydration
- Review diuretics and fluid intake
- Reduced mobility
- Hypercalcaemia—consider IV fluids and bisphosphonates
- Environmental—lack of privacy
- Concurrent disease
- Altered dietary intake—increase fluid and fibre intake if possible
- Neurological
- Intestinal obstruction
- review meds and de-prescribe as appropriate

- For patients with established constipation, it is usually most effective to combine faecal softeners and stimulant laxative. If necessary, an osmotic agent can then be added on a prn or regular basis.
- Oral laxatives should be reviewed every 3 to 4 days using stool consistency chart (e.g. Bristol stool chart)
- The use of rectal interventions should be guided by the findings on rectal examination.
- Consider bowel regime for Metastatic Spinal Cord Compression
- Enemas including phosphate and sodium citrate versions - follow local guidance.

Treatment and Management : Oral laxatives commonly used in palliative care

Indications (Bristol Stool Chart)	Type of laxative	Drug name	Starting dose	Additional notes
Soft, bulky stools - low colonic activity	Stimulant laxatives *Avoid if possibility of bowel obstruction*	Senna tablets	1-2 tabs at night	Takes 8-12 hours to have effect. May cause abdominal colic.
		Senna syrup	5-10 ml at night	See above—Reduce dose if colic develops.
		Bisacodyl tablets	1-2 tabs at night	
Hard dry faeces	Softener (weak stimulant at higher doses)	docusate sodium	Start at 100 mg BD or TDS	Takes 24-48 hours to have an effect. Mainly acts as softener, but doses over 400 mg may have weak stimulant action. Syrup is available but the taste is unpleasant.
Colon full and colic present	Osmotic laxatives	Macrogols	1—3 sachet BD	May be used to treat faecal impaction. Give 8 sachets in 1 litre of water, over 6 hours. Contraindicated in complete bowel obstruction .
		Lactulose	15 ml BD	Can be associated with flatulence/ abdominal colic. Can take 48 hours to have an effect.
Colon full, no colic	Combination laxatives (stimulant + softening agent)	senna + docusate		Use senna alone initially.
		senna + lactulose		
		co-danthramer suspension	5-10 ml at night and increase to BD as needed	Only licensed for use in terminally ill patients of all ages. May cause abdominal colic. May cause skin irritation– avoid in faecal incontinence.
Hard faeces - colon full		Codanthramer Strong Capsules and Codanthramer strong suspension	See BNF for additional guidance	May cause skin irritation– avoid in faecal incontinence. (More expensive and may be hard to source)
Opioid induced constipation resistant to above methods		Naloxegol	25 mg OD (12.5 mg in frailty)	For opioid induced constipation that has failed to respond to standard measures (oral laxatives and rectal intervention) - seek specialist advice.