PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #15
CONSTIPATION

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Constipation – it's not fun to have or to treat. As with other symptoms, rational therapy should be based on a sound understanding of underlying physiology. Our goal in treating constipation is generally not to "cure" something, but to help the patient return to the best possible balance that will allow a normal bowel movement to be passed. Four major components affect the production of a normal BM: solid waste, water, motility and lubrication.

Solid Waste – Too much or too little is a problem. The intestine is most efficient pushing intermediate volumes. Patients on fiber-poor diets may improve if fiber is added. **Note**: In patients on opioids or patients with minimal fluid intake or poor gut motility (e.g. the dying patient) additional fiber can worsen the situation, causing a 'soft impaction'.

Water Content – Stool water content depends on how much water we drink, our general hydration status, how much water is absorbed from and secreted into the intestine and how fast stool moves through the bowel. Any of these variables can be manipulated. It is easiest to limit absorption (and increase secretion into the gut) by adding osmotically active particles that retain water (e.g. Magnesium salts, non-absorbable sugars such as sorbitol and lactulose, or polyethylene glycol [PEG]). Note: Magnesium and phosphorus salts are contraindicated in renal failure. Hyperosmolar solutions may worsen dehydration by drawing body water into the gut lumen. Sickly-sweet sorbitol and lactulose may be difficult to for patients to tolerate. PEG is flavorless and may be better tolerated.

Motility – Patients with low-activity levels (bed-ridden, dying patients and patients with advanced neurodegenerative disorders) and use of certain drugs (see below) lead to motility problems. Senna preparations, which stimulate the myenteric plexus are generally favored. Use senna tablets (or granules, liquid, or tea), starting with 1 tab QHS, may be gradually increased to 4 tabs BID if needed. Before increasing motility, evacuate existing constipated stool with an enema or cramping can result.

Lubrication simply eases passage and minimizes pain that can interfere with excretion. Most commonly used is dioctyl sodium sulfosuccinate (DSS, or docusate), which decreases stool surface tension much like soap. Usual dosage is 240 mg PO daily or BID. DSS also tastes like soap, so liquid DSS should never be given PO, but may be given to tube-fed patients. Note: DSS is commonly used in combination with senna in opioid-induced constipation, but is generally inadequate as a sole agent. Mineral oil can be used as an enema but should not be given PO, as pneumonitis can result if aspirated. Glycerin suppositories can provide lubrication and draw-in water due to osmotically active particles.

Medications that can cause/exacerbate constipation: Opioids, anticholinergics (tricyclic antidepressants, scopolamine, oxybutinin, promethazine, diphenhydramine), lithium, verapamil, bismuth, iron, aluminum, aalcium salts. See *Fast Facts* #294 and #295 for more information on opioid induced constipation.

References

1. Klaschik E, Nauck F, Ostgathe C. Constipation--modern laxative therapy. *Support Care Cancer.* 2003; 11(11): 679-685.
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Version History: 2nd Edition published August 2005; 3rd Edition May 2015. Current version re-copy-edited May 2015.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the Palliative Care Network of

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