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SA Palliative Care

Community Pharmacy Update

A joint initiative of SA Palliative Care Services and Ambulatory & Primary Health

With some understanding of available strategies, pharmacists may contribute strategies to manage or prevent constipation in palliative patients.

Bowel Management

Normal bowel function results from three elements working together, including: (1) sufficient fibre and fluid in diet, (2) normal peristalsis and (3) good abdominal-pelvic control. As death approaches, these elements can often diminish. The situation is exacerbated by the use of various medicines (see table 1), bowel obstruction, reduced physical activity, depression, metabolic abnormalities (e.g. hypercalcaemia) and the presence of a neurological disorder.

Table 1. Medicines associated with constipation

Opioids
Medicines with anti-cholinergic activity (e.g. TCAs)
Iron and Calcium supplements
Calcium channel antagonists
Anti-convulsants
Aluminium-containing antacids
5HT3 antagonists

Bowel obstruction is relatively common in cancer patients and while it may be confused with constipation, it requires exclusion prior to considering therapy. People presenting with constipation and concurrent blood in stools, weight loss, sudden onset vomiting, abdominal swelling or cramping should be referred for further investigation.

Constipation is best managed actively and pre-emptively. While addressing the underlying cause is important, frequently this will be impractical. Therefore aperients are often necessary, including in patients with poor oral intake.

A combination of a faecal softener and a bowel stimulant (e.g. **docusate and senna**) is the best choice to commence with, particularly in patients also using medicines that exacerbate constipation. Stool softeners are ineffective when used alone.

In patients where this combination is ineffective, **macrogol** sachets can be added to the regimen.

Bisocodyl tablets can be used to improve peristalsis in palliative patients having difficultly expelling soft stools.

Glycerol suppositories or **sodium lauryl sulfoacetate** (Microlax®) enemas soften the stool and increase peristalsis and are useful where faecal impaction is suspected.

Subcutaneous **methylnaltrexone** is listed on the PBS for palliative patients with opioid-induced constipation if administration of oral laxatives is ineffective.

An **Oxycodone-naloxone** combination product (Targin®) aims to reduce opioid induced constipation, yet the evidence is limited.

While **bulk-forming agents** (fibre based) are commonly used in the general community, they may make the situation worse in palliative patients. Bulk forming agents require good fluid intake – this may be challenging in palliative care.

Useful Resources

- Palliative Care Therapeutic Guidelines, 3rd ed.
- Caresearch.com.au
- Australian Medicines Handbook 2013

For more information

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