Constipation and bowel obstruction

Constipation

- Infrequent or difficult defecation with reduced number of bowel movements, which may or may not be abnormally hard with increased difficulty or discomfort

Constipation

- One of the most common complaints- in general population 1,9-27,2%, more than 50% od patients in palliative care unit
- In pallitive care the constipation should be defined according to patients experience

Causes of constipation

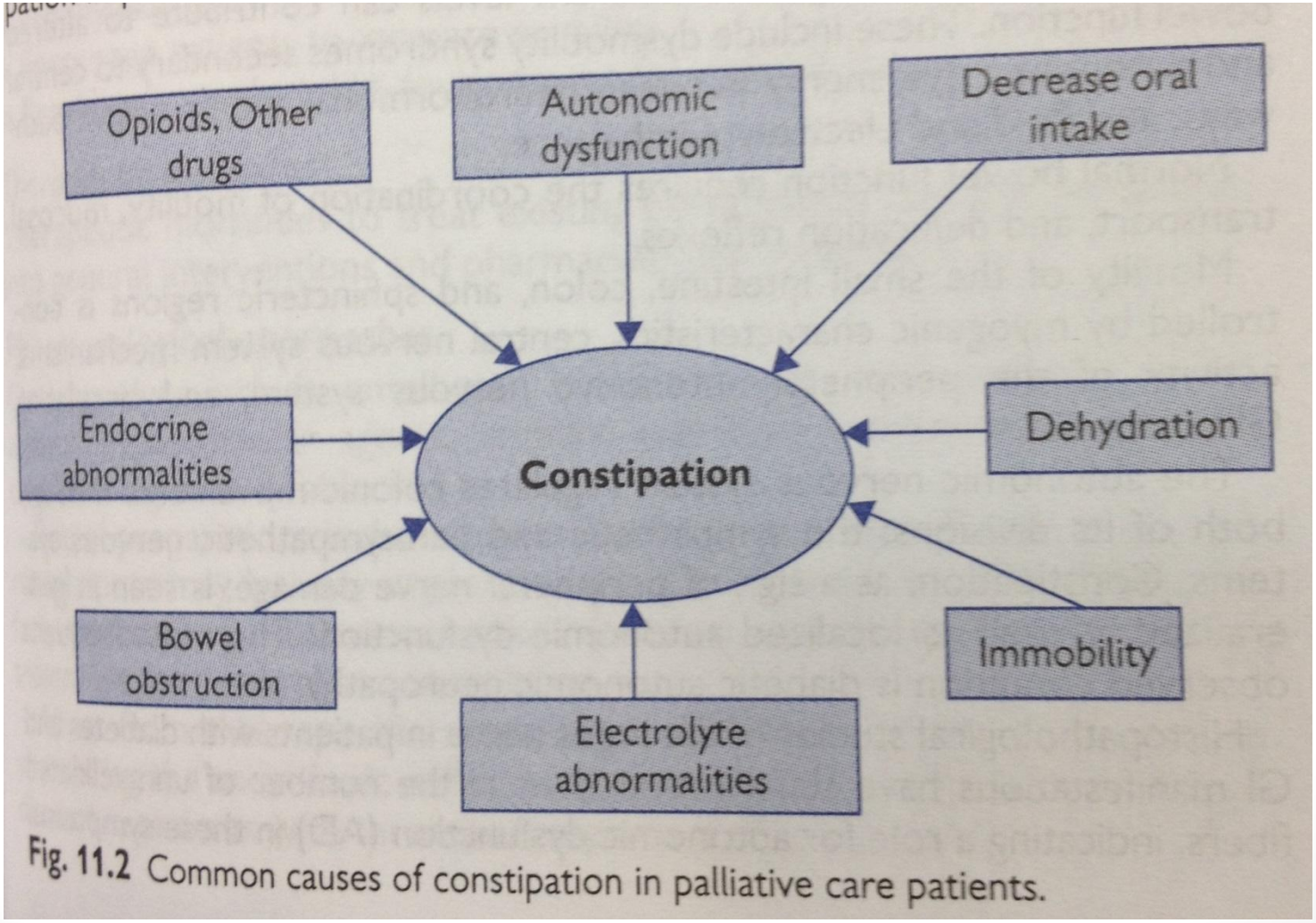


Fig. 11.2 Common causes of constipation in palliative care patients.

Primary causes

Intestinal abnormality

Tumor compression

Neural plexus invasion

Idiopathic constipation

Secondary causes

- Electrolyte imbalance (hypercalemia, hyperkalemia)
- Endocrine abnormality (hypothyroidism, diabetes mellitus)
- Neurogenic disorders (multiple sclerosis, spinal cor injury)
- Drugs (analgetics-opioids, anticholinergic)
- Other causes (dehydratation, immobility, decreased oral intake)

Assessment

- History of the previous normal bowel habits
- Defining pattern of change in terms of frequency, consistency, straining, drug history, associated symptoms
- Subjective measuresof constipation- VAS
- Physical examination: abdominal auscultation, inspection, palpation, percussion, digital rectal examination
- Check for correctable reasons- electrolyte imbalance, endocrine disorders

Management-prevention

- Patient education
- Increase dietary and fluid intake
- Prophylaxis laxatives when initiating opioids
- Increase mobility
- Confortable environment for defecation

Pharmacotherapy

Oral laxatives:

- Emollients
- Bulk-forming agents
- Osmotic agents
- Hyperosmolar agents
- Contact cathartics
- Prokinetic drugs
- Opioid antagonists

Pharmacotherapy

Rectal preparations (unpleasant, but quick results)

- Suppositories
- Enemas

Opioid antagonists

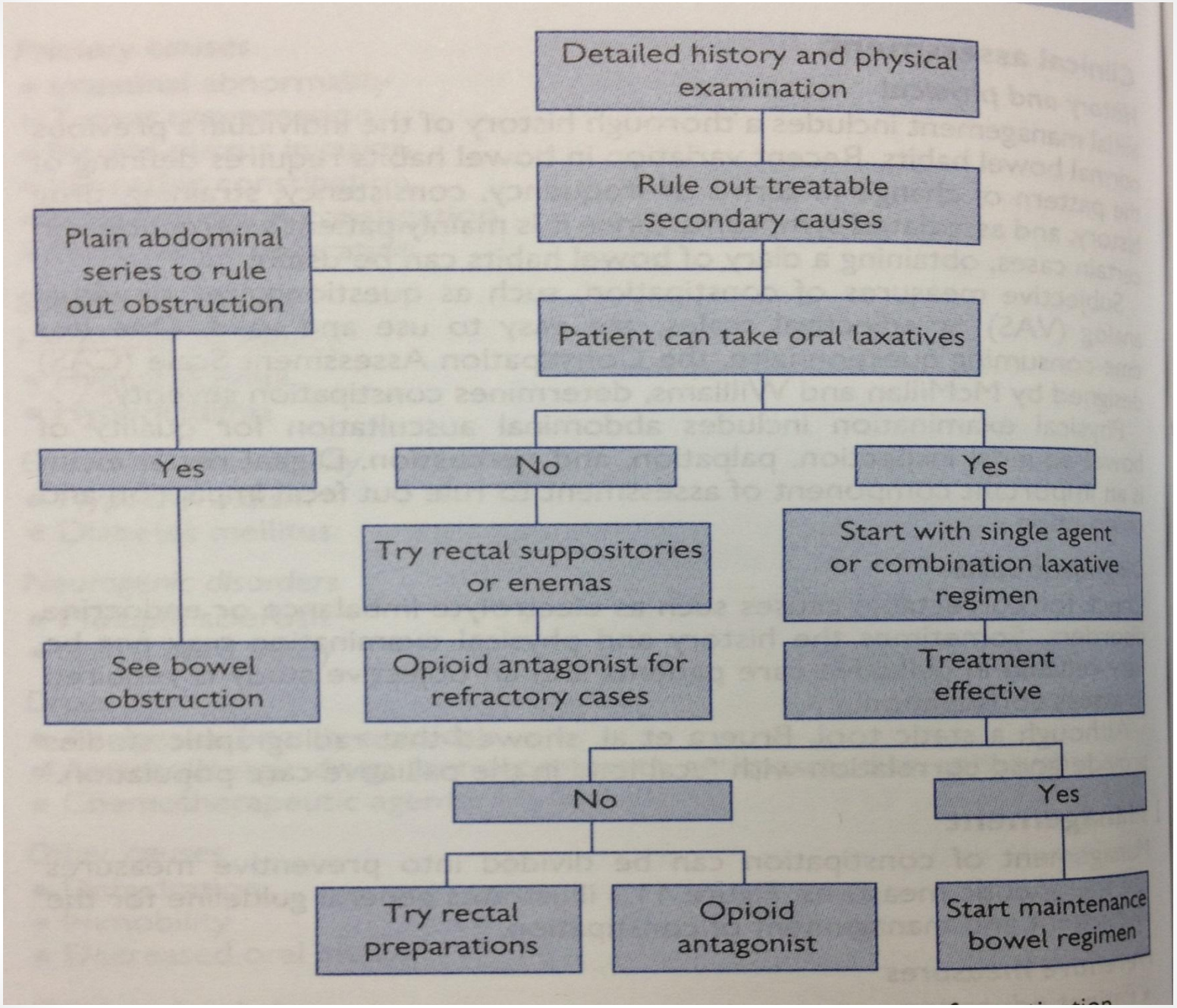
- Opioid-induced constipation mediated by mu receptors in GI system
- Methylnaltrexone- restricted ability to cross the blood-brain barrier and does not affect opioid analgesic effects

Nonpharmacological approach

- Methodes used in prevention
- Biofeedback

Constipation

- Can present as pseudo-diarrhea- always perform DRE!
- Discontinue constipating drugs when possible
- Fiber supplements should be discouraged


Detailed history and physical examination
Rule out treatable secondary causes
Plain abdominal series to rule out obstruction
Patient can take oral laxatives
Yes
No
Yes
Try rectal suppositories or enemas
Start with single agent or combination laxative regimen
See bowel obstruction
Opioid antagonist for refractory cases
Treatment effective
No
Yes
Try rectal preparations
Opioid antagonist
Start maintenance bowel regimen

Bowel obstruction

- Common and distressing complication of intra-abdominal cancer
- Mechanical obstruction or failure of normal intestinal motility in the absence of an obstructing lesion
- Flow: partial/complete bowel obstruction
- Intestinal ischemia: simple/strangulated
- Site: small intestine/colonic
- Once malignant bowel obstruction occurs median survival is approximately 3 months

Causes

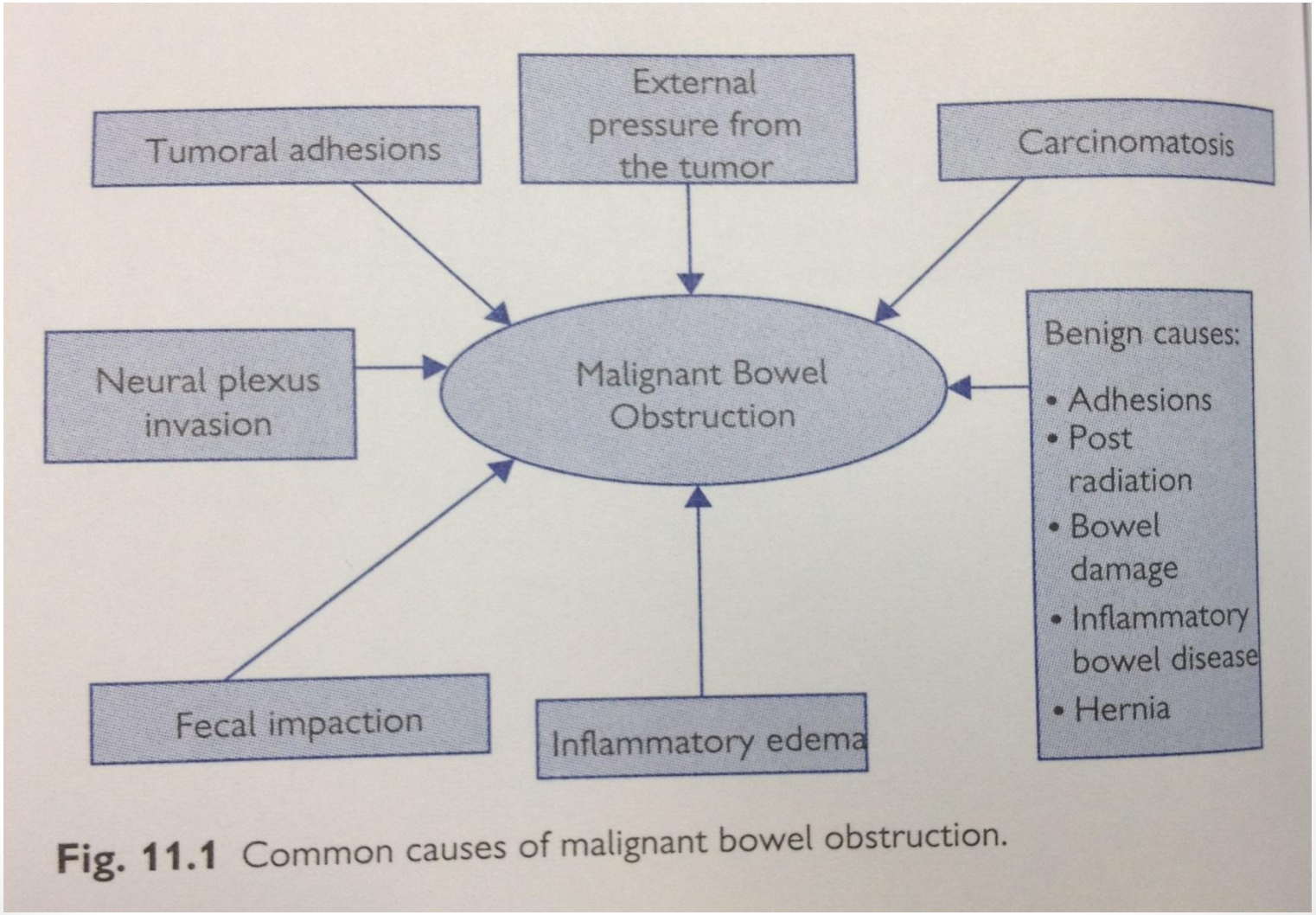


Fig. 11.1 Common causes of malignant bowel obstruction.

Clinical presentation

Depending on :

- location,
- single/multiple points of obstruction,
- mechanism,
- exacerbating medications

Clinical presentation

- Symptoms:

  - Nausea

  - Vomiting-early in high intestinal tract occlusion, later in patients with large bowel obstruction

  - Intestinal colic

  -Continous abdominal pain- more than 90% of the patients

  - Absence of stool and flatus passage

Diagnosis and assessment

- History and medical exam
- Laboratory and imageing data
- Differential diagnoses

Management

- Symptoms relief!!!

Surgical approach

- Disease stage
- Patients condition
- Possibility of future therapy
- More benefitial for patients with life expectancy>2 months
- Benefitial for patients with mechanical obstruction/limited tumor

Nonsurgical approach

- Drainage with a nasogastric tube- great discomfort, many complications
- Drugs: analgetics, antiemetic, drugs decreasing bowel secretion
- Also: anticholinergic, steroids, smooth muscle relaxants
- Most patients do not tolerate oral route- consider alternative routes

Drugs

- Opioids- most effective drugs for management of abdominal pain, sc, td,iv
- Anticholinergic drugs like scopolamine (hioscine)- gold standard- can be added to opioids for colicky pain, also reduce bowel secretion sc, iv
- Corticosteroids- reducing intestinal and tumor-associated edema
- Metoclopramide- only in partial bowel obstruction, in the absence of colicky pain, contraindicated in complete obstruction
- Haloperidol- first line antiemetic- central, can be added to morphine and scopolamine butylbromide