Guideline for the Management of Systemic Anti-Cancer Therapy (SACT) Induced Constipation in Adult Haematology and Oncology Patients

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1. Introduction

Constipation is the passage of small, hard faeces infrequently or with difficulty, and less often than is normal for that individual. Constipation can be a side-effect of SACT and supportive medication e.g. vinca alkaloids, $5HT_3$ receptor antagonists (ondansetron, granisetron, palonosetron) and opioid analgesics.

2. Area of Application

This policy applies to all adult SACT services across the North region, except for the administrative areas of Argyll and Bute in NHS Highland which are linked to the WOSCAN CEL 30 (2012) governance framework.

3. Initial Assessment

- Document symptoms of presenting complaint:
    - Ascertain when bowels/stoma last moved
    - Normal bowel habit (note some patients may have overflow diarrhoea)
    - Any difficulty passing urine, nausea/vomiting or abdominal pain?
- Any concurrent medication and any recent changes?
- Assess food and fluid intake
- Abdominal examination
- Rectal examination (Avoid rectal examination/ suppositories/ enemas until neutropenia and thrombocytopenia excluded).

4. Points to Consider

- Patients on SACT are at risk of neutropenic sepsis. Check SACT regimen and date of last administration.
- Consider if constipation could be caused by other factors not related to malignancy,
  (i) Opioids, antacids, diuretics, iron, $5HT_3$ antagonists
  (ii) Dehydration, immobility, poor diet, anorexia, hypokalaemia
  (III) Concurrent disease such as diabetes, hypothyroidism, diverticular disease, anal fissure, haemorrhoids, Parkinson's disease
- Constipation can be a presenting symptom of **intestinal obstruction, malignant spinal cord compression** or **hypercalcaemia** all of which should be treated as oncological emergencies.

5. UKONS Toxicity Grading & Management

Grading should be recorded in patient's case notes or formal toxicity grading charts.

Table 1: Grading and Management

Grade 1	Grade 2	Grade 3	Grade 4
Mild – no bowel movement for 24 hours over pre-treatment normal	Moderate – no bowel movement for 48 hours over pre-treatment normal	Severe – no bowel movement for 72 hours over pre-treatment normal	No bowel movement for >96 hours, consider paralytic ileus.
	⇩	⇩	⇩
Consider: • Hard, dry stool? • Increased anorexia? • Decreased fluid intake? If associated with abdominal pain or vomiting consider admission for further investigation		**Consider:** Admission for further investigation and management if associated with: • Abdominal pain • Nausea and vomiting	**Consider:** • Severe abdominal pain and/or distension? • Nausea and Vomiting • Faecal smelling vomit? • Rigid abdominal
ACTION: Dietary advice including good fluid intake (2 litres per day if able). Limit caffeine and alcohol consumption. Address any reversible factors causing constipation. Stop or change constipating drugs if possible. See below for treatment options. Encourage mobility Patient to make contact if symptoms persist or worsen.		**ACTION**: Review prescribed stool softeners/ laxatives/concomitant medication which may affect bowels, e.g. opiates. Dietary advice including good fluid intake. Surgical review if indicated.	**ACTION:** Admission may be required for: • Further management • Senior medical and/or surgical review • I.V. access and fluid replacement • Analgesia • Emesis control • Medication review

6. Choice of Therapy

The options below may be equally effective.

- Suggested starting doses are provided; these should be increased as appropriate depending upon individual response.
- Patient preferences should be taken into consideration.
- Rectal treatment may be needed if rectum loaded or impacted.
- Do not give rectal treatment if rectum is ballooned and empty.
- **If there is a clinical picture of obstruction with colic, stimulant laxatives should be avoided.**

Option A (stimulant +/- softener)

- Senna 15mg or bisacodyl 5 to 10mg, at bedtime
- If stools become hard or colic supervenes add in softening agent, such as docusate sodium 100 - 200mg twice daily

Option B (osmotic laxative)

- Macrogol (e.g. Laxido®) 1 to 3 sachets daily
- If severe constipation, consider a higher dose for 3 days
- Faecal impaction: 8 sachets dissolved in 1000mls water and taken over a 6 hour period or until bowel movement

Option C (combined stimulant and softener for terminally ill patients)

- Co-danthramer suspension 5 to 10ml at bedtime
- Co-danthramer strong suspension 5ml at bedtime

Rectal treatment

- Soft loading: bisacodyl suppository, sodium citrate or phosphate enema.
- Hard loading: glycerol suppository as lubricant or stimulant; then treat as above.
- Very hard loading: arachis oil enema overnight **(contains peanut oil, contraindicated in nut allergy),** followed by phosphate enema.

Paraplegic or bedbound patient

- Adjust laxatives or loperamide to keep stool firm, but not hard**.**
- Use rectal intervention every 1 to 3 days to avoid possible impaction resulting in faecal incontinence, anal fissures or both.

Opioid-induced constipation

- Naloxegol can be used for opioid-induced constipation when response to other laxatives has been inadequate. An inadequate response was defined as having opioid-induced constipation symptoms of at least moderate severity while taking at least one laxative class for a minimum of four days during the previous two weeks. When naloxegol is initiated, it is recommended that all currently used maintenance laxative therapy should be halted until the clinical effect of naloxegol is determined.

- Methylnaltrexone bromide can also be considered when response to other laxatives has been inadequate. Use is restricted to physicians with expertise in palliative care.

Table 2. Oral preparations

Oral laxative	Starting dose	Time to act	Comments
Bisacodyl tablets 5mg	1 to 2 at night	6 to 12 hours	Can cause abdominal cramps
Senna tablets	15mg at night	8 to 12 hours	Can cause abdominal cramps
Senna liquid	10 to 20ml at night		
Co-danthramer suspension	5 to 10ml at night	6 to 12 hours	Combination laxative containing dantron and a softener. Colours urine red. For terminally ill patients only. Avoid if incontinent as can cause as local skin reactions.
Co-danthramer strong suspension	5ml at night		
Docusate sodium capsules 100mg	1-2 twice daily	24 to 36 hours	Maximum 500mg daily in divided doses
Macrogol (e.g. Laxido®)	1 to 3 sachets daily	1 to 3 days	Made up in 125ml of water per sachet High dose (up to 8 sachets per day for 1 to 3 days in impaction)
Naloxegol tablets	25mg* in the morning	5 hours	Taken on an empty stomach at least 30 minutes prior to the first meal of the day or two hours after the first meal of the day.

* In patients with moderate or severe renal insufficiency or in patients taking moderate CYP3A4 inhibitors (e.g. diltiazem, verapamil), the recommended starting dose is 12.5mg once daily which, if well tolerated, can be increased to 25mg once daily.

Table 3: Rectal preparations

Rectal preparation	Starting dose	Time to act	Comments
Bisacodyl suppository 10mg	10mg	15 to 60 minutes	Must be in contact with bowel wall
Sodium citrate microenema	1 to 2	30 to 60 minutes	
Phosphate enema	1	15 to 30 minutes	Can cause local irritation Warm to body temperature
Glycerol suppository	1	15 to 30 minutes	Combined irritant and softener
Arachis oil enema	1	15 to 60 minutes	**Contains peanut oil**; contraindicated in nut allergy

7. References

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- NHS Highland Formulary, 7th Edition
- National Cancer Institute. Common Terminology Criteria for Adverse Events (CTCAE), Version 4. 28th May 2009
- Clinical Knowledge Summaries http://cks.nice.org.uk/constipation#!scenario

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02/11/17	N/A	Hypokalaemia added as a cause of constipation	3
		Grading changed from NTCAE to UKONS	4
		Grade 1 / Grade 2 - If associated with abdominal pain or vomiting	4
		Caution using stimulant laxatives in bowel obstruction	4
		Addition of Naloxegol	6

* Changes marked should detail the section(s) of the document that have been amended i.e. page number and section heading. (If there is no previous document insert N/A into the boxes in the top row of the table below)