End of Life Continence Care

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End of Life Continence Care

• Continence care is often the Cinderella of symptom management
• Continence care, whether urinary or bowel, involves all aspects of intimate care.
• Appropriate end of life continence care is therefore essential.
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• Poorly managed bowels and bladder can lead to disabling complications for the patient causing the onset of secondary problems:
  – urinary retention
  – urinary incontinence
  – delirium in the older patient.

• A dying patient with a full, uncomfortable rectum or a distended bladder may present with terminal agitation/restlessness.
Terminal restlessness / agitation

• Dramatic end of life symptom
• Can be multifactorial
• Distressing for the family – witnessing someone they love in anguish, may affect bereavement outcome
Government reforms

End of Life Care Strategy (DoH 2008),

Core competencies for end of life (EOL) care (DoH 2009)

- Communication
- Assessment and care planning
- Symptom management, comfort and well being
- Advanced care planning
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Dying Process

- Changes to musculoskeletal system cause general muscle weakness making it difficult for patients to swallow especially large amounts of fluid or food.
- Mouth droops,
- Swallowing difficulties making oral medication difficult……..syringe driver
- Implications for laxative therapy
- Changes to swallowing reflex
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Dying Process

- Decreased cardiac function results in reduced kidney function
- Decreased urine, urine becomes darker, thicker and possibly offensive.
- Asymptomatic bacteriuria
- Final hours urinary sphincters may relax → incontinence of urine.
- The administration of opioids can cause urinary retention (Ferris et al 2002).
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Dying Process

- Myth that patients who are unable to eat will not need to open their bowels.
- Faecal matter continues to be formed even if a patient is cachectic.
- 50% faecal content consists of unabsorbed gastrointestinal secretions, shed epithelial cells and bacteria.
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Bladder

- Management of urinary problems at the end of life is about containment of urinary incontinence and the management of retention.

- Catheterisation is an invasive procedure and it is therefore important to explore alternatives (Pratt et al 2007, NICE 2006).
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Bladder

– Alternatives:
  • Pads & urinals
  • Sheaths, different sizes, styles and materials (latex or silicone). One size does not fit all! Change every 24 hours
  • Retracted penis, penile length is short, the ‘Bioderm’ is an external device that fixes just to the glans of the penis.
    Change every 3 days.
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Indications for urethral catheterisation at the end of life include:

- management or prevention of wound damage, for example sacral pressure ulcers and or fungating wounds or soreness of the anus, perineum, vulva and penis.

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Further indications for urethral catheterisation at the end of life include:

- pain or difficulty for female patients getting in and out of bed to use a commode (Pitorak 2003, Ferris et al 2002, NICE 2006).
- Urine incontinence associated with obstruction
- Urine retention / distended bladder - commonest cause of retention in the terminal phase is constipation and morphine, (Regnard and Tempest 1998)
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Bowels – faecal incontinence

– Faecal incontinence can be a sign of imminent death (WHO 2003).
– Commonest cause is faecal impaction (spurious diarrhoea)
– Avoid invasive procedures
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Bowel - faecal incontinence

• Neurological disease e.g MS, Parkinson’s disease, stroke or spinal cord compression
• Symptomatic of end stage disease - dementia.
• Treat faecal impaction
  • Movicol, rectal intervention, DRF - issues of competency.
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Bowel - faecal incontinence management

– If faecal incontinence is very loose at the end of life consider a faecal collection system (NICE 2007),
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Bowels - constipation

– Bowel interventions for severe constipation or faecal loading are invasive and uncomfortable particularly in the last hours of life and need to be prevented.

– The need to treat constipation is a failure in prevention (Regnard and Tempest 1998).

– **Proactive** approach needs to be adopted to **prevent** constipation or faecal loading occurring at the end of life (NICE 2007).
Why is constipation difficult to manage in palliative care / end of life?

• No clear definitive definition for constipation
• Subjective
• Pall. Care assessment continues to be based on bowel frequency (Goodman et al 2005)
• European Consensus Group on constipation in palliative care support the view that it should be the patient who fundamentally defines constipation (Larkin et al 2008).
Why is constipation difficult to manage in palliative care / end of life?

Assessment is complex

• No comprehensive validated assessment tool.

• Assessment of constipation in palliative care continues to be poor, due to other symptoms being perceived to be more of a priority (Bruera et al 1994).
Why is constipation difficult to manage in palliative care / end of life?

- 87% of patients with malignant disease will experience pain
- 67% of patients with non-malignant disease will experience pain
- Much of this pain will be treated with opioid medication
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- Between 32-87% of palliative care patients cite constipation as a major concern (Larkin et al 2008)
- Evidence suggests that 90% of opioid dependant patients experience chronic constipation (Larkin 2009)
Opioid induced constipation (OIC)

- Opioids - most common example being morphine.
- Effective and well established treatment for moderate to severe pain and breathlessness.
Opioids

- Existence of 3 main classes of opioid receptors *mu*, *kappa* and *delta* in the body.
- These are responsible for mediating the peripheral and central action of opioids.
- The gastrointestinal effects of opioids are predominantly mediated by the *mu*$_2$ receptors.
Effects of opioids on the gut

- Delays gastric emptying due to constriction of pyloric sphincter
- Impaired transit through ileocaecal sphincter & the colon → weak gastro colic reflex.
Effects of opioids on the gut

- Reduction in propulsive component of gut motility, and increased non-propulsive activity due to enhanced ring contractions → leading to more efficient absorption of water and electrolytes.
- Enhanced internal anal sphincter tone – thus weakening the defaecation reflex.
Effects of opioids on the gut

- Acetylcholine reduced ↓ (excitatory neurotransmitter)
- Serotonin released, increases release of noradrenaline → inhibition of intestinal secretions
Burden of OIC

- Profoundly affects patients’ quality of life.
  - Refuse analgesia
  - Preoccupation with bowels
- Strain on carers
- Increased pain (abdominal)
- Confusion with malignant intestinal obstruction
Constipation at end of life

Aim of care

• The goal of treatment of constipation should be the comfortable passage of stool, rather than a specific frequency of bowel movement

• Reducing the bothersome scale
Treatment / management

• Laxatives appear less efficient in palliative care.
• Higher doses may be required due to opioid medication.
• Combinations of laxatives are required.
• Use of oral laxatives dictated by volume and palatability.

(Problem exacerbated if patient condition deteriorates → syringe driver)
Treatment / management

• Rectal interventions often required
• Impacting on quality of life
• Management can be a fine line between helping constipation and causing faecal incontinence.
• Treatment of constipation carries an economic burden
  • increase use of medical and nursing time.
  • Admission to hospice or hospital
Treatment / Management

• Lifestyle advice has limited value
  – Fluids
  – Fibre
  – Mobility
Management

• New approaches:
  – Trans anal irrigation (Peristeen)
  – Peripherally acting opioid antagonists Methylnaltrexone bromide (Relistor)
  – 5-HT₄ receptor agonist Prucalopride (Resolor)
Management

Trans anal irrigation

- Complete system for managing neurogenic bowel dysfunction.
- Proven reduction of faecal incontinence and constipation
- Self-administration of the system increases the patients’ independence, dignity and quality of life.
New management of opioid induced constipation.

- MethylNaltrexone bromide is a selective peripheral antagonist of opioid binding at *mu* opioid receptors.
- MethylNaltrexone bromide relieves OIC via 12mg/0.6ml solution for subcutaneous injection.
- Quick acting, short half life
Opioid induced constipation

- Bowel action experienced within 4 hours often much less
- Less invasive than rectal intervention.
- Enhances patients’ QOL?
- Normal laxative therapy is maintained
- Contra indicated in malignant intestinal obstruction
Management

- Prucalopride is a selective, high affinity, enterokinetic $5-HT_4$ receptor agonist, which increases colon motility and restores slow movement of the bowels. Prucalopride is an oral medication administered at 1 or 2 mgs once daily and is intended to be used in patients who fail to respond to other forms of laxatives. The cost of prucalopride is yet to be determined and also its license status as a laxative.
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• The concern for quality of life is imbedded in the philosophy of palliative care.
• Aspects of bowel and urinary dysfunction are not always predictable.
• It is not easy to maintain a patient’s dignity whilst giving the intimate care associated with continence.
• Neither is it always possible to involve patients in decision marking at this time of their life.
• Continence care at end of life must be evidence based and remain ever mindful that dignity and quality of life are paramount.