Constipation

"What to do if they can't poo"

Approach to constipation:

- Look at the patient first!
- Examination of abdomen, bladder, etc. Review urine output, usual bowel habits.
- PR examination in all adult patients. Rectal masses, PR bleeding, impaction.
- Things to watch for:
    - Bowel obstruction: farting patients are NOT obstructed. Also, obstruction is unlikely in a virgin abdomen, although you get occasional volvuli.
    - Opiates: have the patients been on opiates without laxatives?
    - Could it be anything else?
        - Children: ask about painful stools (fissures), change in diet, loss of weight, fevers, breast feeding, toilet training. Keep open mind about CSA.
        - Adults: ask about PR bleeding, previous bowel history, LOW, night sweats, abdominal pain
- If you are worried about pathology, consider bloods to check for K+/Ca+/Hb, FOBT, referral for review.
- Cramping pain is NORMAL, severe pain is NOT.

The majority of constipation in hospitals seems to be down to pain meds, lack of mobility, poor fluid status and hospital food rather than serious pathology.

Treatment of constipation

Fibre and fluid – advise patient to increase fluid intake and fibre intake. Explain that increasing fibre without increasing fluid will worsen problem. Useful things include prunes, psyllium husk, Metamucil, apples/pears.

Children: prunes are well tolerated, and olive oil (a tablespoon mixed into other foods) can be used.

Laxatives - I use a multistep approach:

1. Work out how uncomfortable the patient is. Are they desperate, or just a little uncomfortable? If desperate, go with the PR stuff first, then the PO stuff after the crisis is passed (geddit??).
2. Review the med chart – is it possible to reduce opiates or change to non-constipating alternatives? Does the patient need fluids?
3. Start with coloxyl and senna. Coloxyl is a softening/bulking agent, senna a stimulative agent. Two tablets BD is good. Not useful if patient has been on it long term
4. Sorbitol/lactulose: 20ml tds/prn. Can be mixed into prune juice to conceal the taste.
5. Enemas
    a. Microlax: 1-2 PR daily PRN.
    b. Fleet: 1-2 PR
    c. G and O (glycerol and oil): messy, but useful. 1-2 PR.
    d. Microlax sandwich: a Repat invention! A glycerol suppository, followed by a microlax suppository, followed by a glycerol suppository. Can be very effective. Usually need to explain it to the nurses if you're not at the Repat.
6. Bowel prep: a last resort, but wonderfully effective. Either 1-2 Picolax sachets PO stat, or one (1!) sachet of Colonlytely in a glass of water. Pour part of the sachet of bowel prep into a glass of water and keep adding until it stops dissolving – then give the glass to the patient. Make sure you tell the patient it will be VERY effective and profuse, and tell the nurses so the patient can either have a commode chair or be moved to nearer the bathroom.

If you think the patient has a bowel obstruction or is at risk of aspiration:

- Follow the protocol from the intranet
- Insert large NGT and request four hourly aspirations from the nursing staff.

- Put the patient on sips/chips/drips – sips of fluid only, ice chips for comfort, IVT.
- Order AXR to confirm/deny bowel obstruction, CXR if concerned about aspiration.
- Pantoprazole IV 40mg BD will reduce gastric secretions for comfort
- Write up replacement fluids for NGT (see my cheat sheet)
- Make sure patient is not lying flat if possible.
- Do NOT give maxolon (metoclopramide) to these patients – propulsive effect. Always work from the bottom (end) first!
- Surgical review, or review by senior if concerned.

Always ask the patient what they think is going on, and ask if they have any questions. Reassurance is very important. Education helps the patient from returning with the same problem and letting another intern go through the whole process – wholegrains, vegetables, fibre, exercise – remember your role as an educator!!

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A proctologist walks into a bank to deposit a cheque at the end of his working day. Scribbling frantically, he is becoming increasingly frustrated when the man next to him points out that he is writing with a clinical thermometer. The proctologist looks up blankly, and says, "Bugger it – some arsehole's got my pen!".