CLINICAL PRACTICE GUIDELINE

Bowel Care

This document should be read in conjunction with the Disclaimer

Contents

Bowel care

Assessment

Take a thorough bowel history and medication/ medical history.[1] When assessing the severity of the problem consider the woman's:

- Usual bowel patterns.[1] Time since last normal bowel action. Record on chart.
- Diet (fluid and fibre intake), mobility, activity, functional status, medications[1]
- Symptoms[1], general condition (including symptoms like weight loss or blood in faeces)[2]
- Previous history, any previous perineal-pelvic-abdominal or obstetric-gynaecological surgery[2], and any treatment that has worked in the past.
- Concerns: straining, feeling of incomplete defecation, tenesmus
- Assess lifestyle measures and risk factors – see sections below

Lifestyle measures

Lifestyle issues are associated with constipation, particularly the level of fluid intake, dietary fibre, history of laxative usage, sedentary habits and delaying the urge to defecate. Risk factors include:

- Low fluid / dietary fibre intake[3]
- Reduced mobility, extended bed rest[3]
- Environmental issues, delaying defaecation urge[3]

Risk factors

- Medical conditions,[2] for example: anxiety, depression, eating disorders, endocrine (hypothyroidism, hyperparathyroidism, diabetes), neurological (Hirschprung's disease, multiple sclerosis, Parkinson's disease, spinal cord injury, impaired cognitive function), gastrointestinal (lesions, prolapse, obstructions),[3] & negative outcomes of abdominal / gynaecological surgery[2]
- Medications[1-3] (e.g. ferrous compounds, diuretics, antacids, opioids, anti-depressants, anti-cholinergics, and chronic laxative use).

Treatment of constipation

Step-wise treatment

STEP 1

Identify and, if possible, avoid causative drugs.

A change in dosage regimen or formulation may alleviate constipation (e.g. CR iron and iron polymaltose (Maltofer) claim to have fewer GI adverse effects).

Examples of causative drugs: opioids, drug with anticholinergic effects, antacids containing aluminium or calcium, iron supplements, calcium supplements, verapamil.

STEP 2

Identify and manage possible underlying causes

- E.g. chronic use of laxatives, dietary habits, lack of physical activity, dehydration, depression, neurological disorders (Parkinson's disease, stroke), metabolic disturbances (diabetes mellitus, hypercalcaemia, hypothyroidism), malignancy, pelvic floor dysfunction, faecal impaction or obstruction, anal fissure.
- **Postnatal**: In patients with perineal tears, it is recommended to use stool softeners and osmotic laxatives for about 10 days after the repair. See KEMH Clinical Guidelines, O&M, Intrapartum, Perineal Trauma: Third and Fourth Degree and the RANZCOG Guidelines

STEP 3

- Encourage mobility and adequate fluid intake (at least 2 litres per day).
- Encourage adequate fibre intake (e.g. whole grains, rice, bran, beans, lentils, nuts, dried fruit, fresh fruit and vegetables. Introduce these foods gradually if the woman is not used to these foods as bloating and flatulence may occur otherwise.
- Encourage responding to the urge to defecate immediately.

STEP 4

If above strategies insufficient, the addition of pharmacological treatment should be used for a short period of time where possible, until the woman has returned to regular and full bowel evacuation.

Refer to **Pharmacological Step-wise Treatment section.**

1st option- Bulk-forming laxatives

2nd option- Osmotic laxatives

3rd option- Stool softeners

Last option- Stimulant laxatives

Acknowledgements- [4, 5]

Aperients

Key points

- The use of aperients should only be considered when other options such as exercise, diet and fluid intake have been assessed and refined appropriately.
- The first choice laxative for an ambulant older woman (with no fluid restrictions) is a bulking agent, and if non-ambulant use osmotic and stimulant laxatives.[1]
- Orders for pharmacological treatment of constipation shall be written as PRN to enable assessment of need and to direct appropriate use of different classes of laxative before commencing treatment. Aperients may be prescribed regularly for patients on large doses of opioids or those at risk of constipation (e.g. surgery, immobility).
- For procedural information on enemas, suppositories, and other bowel care see SCGH Nursing Practice Guideline No. 63: Bowel Procedures.

  Please note that SCGH guideline is for clinical information only. Information contained in it regarding contacts, policies and paperwork (e.g. MR numbers) may not be applicable for KEMH.

Pharmacological step-wise treatment

1. First option: Bulk-forming laxatives[4]

- Do not use for acute relief of constipation as can take several days to work [4, 6]
- Do not use for opioid-induced constipation. [1, 4]
- Onset of action: 48-72 hours[4]
- Ensure adequate fluid intake[1, 4]
- Introduce to diet slowly to prevent abdominal discomfort
- Should not be taken immediately before going to bed[4]

Active Ingredient	Available Products at KEMH
Psyllium* safe to use in pregnancy[6]	Metamucil® capsules Metamucil® oral powder
Ispaghula* safe to use in pregnancy[6]	Fybogel® oral granules
Wheat dextrin* Note: no reference available regarding safety in pregnancy	Benefiber® oral powder

2. Second option: Osmotic laxatives[4]

- Saline osmotic laxatives to be used with caution in pregnancy due to maternal sodium retention and electrolyte imbalance[6]
- Ensure adequate fluid and fibre intake.[4]
- Use with caution when inadequate fluid intake, especially in the elderly.
- Caution with irritable bowel syndrome and women with functional bloating due to discomfort and bloating.[1]

Active Ingredient	Available Products at KEMH	Onset of Action
Lactulose* (preferred agent) [4] Safe in pregnancy[6]	Actilax® oral liquid	24-72 hours[4]
Sorbitol*	Sorbilax® oral liquid	24-72 hours[4]
Macrogol laxatives* Note: - limited data available in pregnancy, should only be considered on doctor's advice, occasional doses appears safe) [4]	Movicol® oral powder	1-4 days[3]
Saline laxatives* Note: - Microlax® brand is safe to use in pregnancy. [4] - May cause electrolyte disturbances. [4]	Microlax® Rectal Enema	2-30 minutes[4]
Glycerol* Note: useful if stool is present in lower rectum[4]	Petrus® Rectal Suppository	5-30 minutes[4]

3. Third option: Stool softeners[4]

- Ensure adequate fluid and fibre intake [4]
- There is limited evidence of efficacy when used as monotherapy[4, 5]
- Not recommended for long term use.
- Contraindicated for use in patients with:
  - Intestinal obstruction
  - Inflammatory bowel conditions
  - Acute abdominal conditions e.g. appendicitis.

Active Ingredient	Available Products at KEMH	Onset of Action
Docusate *	Coloxyl® tablets	24-72 hours[4]
Liquid Paraffin* Note: - Do not give dose immediately before lying down to avoid aspiration[4] - Avoid chronic use as it may affect absorption of fat-soluble vitamins[6]	Agarol® Vanilla oral liquid Parachoc® oral liquid	24-72 hours[4]
Poloxamer In pregnancy: Consider alternative[6]	Coloxyl® oral liquid drops	24-72 hours[4]

4. Last option: Stimulant laxatives[4]

- Stimulant laxatives:
  - are usually reserved for severe constipation or if unresponsive to other laxatives mentioned in previous sections.[4]
  - are used if colon motility is poor (e.g. from opioids).[4]
  - are category A in pregnancy and do not cause congenital abnormalities, however should be avoided except for occasional doses[4] due to potential maternal adverse effects with extended use or high doses [6]
  - should not be given to pregnant women with a history of preterm labour without medical consultation.

- are contraindicated where there is an intestinal obstruction, acute abdominal conditions, and inflammatory bowel conditions.[4]
- are usually given at night.[4]

- Ensure adequate fluid and fibre intake[4]
- Castor oil should be avoided in pregnancy as it may induce premature labour.
- Abuse of stimulant laxatives may affect resumption of normal bowel patterns when laxatives ceased.[1]

Active Ingredient	Available Products at KEMH	Onset of Action
Senna* In pregnancy: Consider an alternative[6]	Senokot® oral tablets	6-12 hours[4]
Senna combined with Docusate* In pregnancy: Consider an alternative. Avoid prolonged use as maternal adverse effects possible.[6]	Coloxyl with Senna® oral tablets	6-12 hours[4]
Bisacodyl* In pregnancy: Consider an alternative.[6] In lactation: Safe to use but avoid prolonged use. Observe for adverse effects (e.g. diarrhoea, irritability) in breastfed infants[6]	Bisalax® oral tablets Dulcolax® rectal suppositories	6-12 hours[4] 5-60 minutes[4]
Sodium picosulfate In pregnancy: Consider an alternative. Avoid prolonged use as maternal adverse effects possible.[6]	Unavailable	6-12 hours[4]

* May be used in pregnancy at recommended doses

Additional information

While a stepwise approach as outlined above is preferred, treatment approach should be individualised to each woman. Acute constipation usually benefits from aperients with a quick onset of action such as suppositories or osmotic laxatives, whilst for chronic constipation; a bulk forming laxative may be useful.

Treatment of severe constipation/ faecal impaction

Faecal impaction treatment (Gynaecology only. **Not** for Obstetric patients)

1. Warm the oil infusion retention enema and leave in the rectum with the foot of bed elevated for at least one hour.
2. Give a warmed disposable enema.
3. **If there is no result,** a manual removal of faeces is indicated. Refer to the medical officer.

Severe constipation (5 days or more):

- Ask the medical officer to assess the woman. Rectal and abdominal examinations and an abdominal x-ray may be performed[7] (non-pregnant patients).
- Exclude the possibility of a bowel obstruction before beginning treatment.[7]
- Consider whether manual removal of faeces may be necessary before beginning treatment.

References and resources

1. eTG Complete. Constipation in adults. 2018. Available from: www.tg.org.au
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3. Lee-Robichaud H, Thomas K, Morgan J, Nelson RL. Lactulose versus polyethylene glycol for chronic constipation. **Cochrane Database of Systematic Reviews**. 2010 (7). Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007570.pub2/pdf.
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5. Cullen G, O'Donoghue D. Constipation and pregnancy. **Best Practice & Research Clinical Gastroenterology**. 2007;21(5):807-18.
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Related policies, procedures and guidelines

SCGH Nursing Practice Guideline No. 63: Bowel Procedures

KEMH Clinical Guidelines:

- O&G: Perineal Trauma: Third & Fourth Degree Management;
- Pharmacy: Medications A-Z

Keywords:	Aperients, rectal suppository, enema, tap water enema, retention enema, management of constipation, defecation, bowel care, management of stools , Constipation in pregnancy, bowel management, laxatives, stool softeners, bowel stimulant, postnatal constipation		
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