



I M P A C T

BOWEL CARE FOR THE OLDER PATIENT | AUSTRALIA

A GUIDE TO THE MANAGEMENT OF CONSTIPATION
AND FAECAL IMPACTION IN THE OLDER PERSON



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A Guide to the Management of Constipation and Faecal Impaction in the Older Person

INTRODUCTION

Background

Constipation, faecal impaction and faecal incontinence are particularly prevalent in the older population.¹⁻³

Up to 38% of people aged over 74 years who are living at home and up to 81% of people in hospital in the older age group suffer from constipation.²

However, despite the fact that constipation is a common problem for older people, there is a lack of clear advice uniformly agreed upon for the management of constipation and impaction in this patient population.

Guideline development

With these needs in mind, a team of health professionals assembled to develop guidelines for the management of constipation and impaction in older patients (those aged 60 years and over).

The IMPACT Scientific Faculty has developed a comprehensive set of guidelines and assessment tools to help health professionals and carers to identify, assess and treat constipation in older people, whether they are in the community, in hospital or in a residential care setting.

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The IMPACT Guidelines were developed with the assistance of an unrestricted educational grant from Norgine Pty Ltd, 3/14 Rodborough Road, Frenchs Forest NSW 2086.



IMPACT Scientific Faculty Members



VIC

Professor Peter Gibson (Chair)

Gastroenterologist, Box Hill Hospital, Melbourne



NSW

Dr Rod Beckwith

GP with expertise in servicing aged care facilities, Wyoming



Associate Professor Pauline Chiarelli

Program Convener of the Bachelor of Physiotherapy Program, University of Newcastle, Newcastle



Dr Michael Johnston

Part-time GP and Medical Editor for *Broadcast GP*, North Sydney








Ms Bernadette Grattan

Continence Advisor/Clinical Nurse Consultant, Armidale Community Health Centre, Armidale



IMPACT Scientific Faculty Members

	<p>QLD Ms Erin Dunn Pharmacist with interest in medication management of the elderly, The Prince Charles Hospital, Brisbane</p>
	<p>Dr Jeffrey Rowland Geriatrician and general physician, The Prince Charles Hospital, Brisbane</p>
	<p>Ms Rebecca Smith Clinical Dietitian, The Prince Charles Hospital, Brisbane</p>
	<p>SA Ms Leigh Pretty Clinical Nurse Consultant/Practice Manager, Urology and Continence Unit, Repatriation General Hospital, Adelaide</p>
	<p>ACT Dr Seeva Sivakumaran Senior Staff Specialist, Aged Care and Rehabilitation Service, The Canberra Hospital, Woden</p>

DEFINITIONS, PREVALENCE AND CAUSES

Introduction

Constipation is a common problem, even in otherwise healthy people in the general community.¹

Although it affects children and adults of all ages, constipation, faecal impaction and faecal incontinence are particularly prevalent in the older population.²⁻⁴ However, constipation is not a natural part of ageing so no one needs to put up with the discomfort of constipation when there are many treatment options available.^{2,5}

Constipation, faecal impaction and faecal incontinence are conditions which may result from other significant medical causes.⁶ Medical review of new, persisting or progressive constipation is recommended.

CONSTIPATION

Acute constipation

Definition

Acute constipation is usually considered to have similar symptoms to that of chronic constipation; however, it has been present for less than three months.

Chronic constipation

Definition

As opposed to acute constipation (which lasts less than three months), chronic constipation is defined as the presence of symptoms for at least three months.⁷

Look for the presence of at least one of the following symptoms in the preceding 12 weeks:

- less than three bowel movements weekly
- hard or lumpy stools
- straining on defaecation
- sensations of incomplete evacuation
- need for manual manoeuvre to pass stool.

Clinical signs associated with constipation

Health professionals often regard “normal” frequency of defaecation to be three times a day to three times a week.⁸ However, given that there is a wide variation in what is “normal”, a more useful guide for the individual would include the notion that the defaecation is “less than your usual frequency”.

In any case, as the definition above indicates, constipation is not just about the frequency of defaecation but also about consistency, level of straining and feelings of incomplete evacuation.⁸

As well as the above definition, there are certain clinical signs that may accompany constipation, including:^{9,10}

- pain (such as abdominal or back pain), urinary tract obstruction, fever, delirium and confusion, which may be caused by constipation
- diarrhoea, which may be due to overflow incontinence as a result of faecal impaction
- bloating and flatulence, which often accompany constipation and impaction.



Prevalence

Prevalence rates are complicated by the varying definitions of constipation that are available. Another contributing factor is that many studies rely on patient self-report, and many older people who have constipation would not consider themselves to be constipated.

As a result of these complications, constipation rates in Europe range from 0.7% to 81% in the general population.¹ In the Australian region, the average rate of constipation in the general population has been estimated at 15%.¹ However, for older people, a realistic prevalence rate for constipation is more likely to be as follows:

Type of residence	Prevalence of constipation
Hospital	~ 80%
Residential nursing home	~ 60%
Day hospital	~ 30%
Living at home (age >74 years)	~ 38%
Living at home (41–50 years)	up to 20%

Adapted from Kinnunen, 1991.⁴

Faecal impaction

Definition

Impaction is a state in which the person becomes so severely constipated that they are unlikely to be able to pass faeces of their own accord. It is usually, but not necessarily, associated with hardened stools and patient discomfort.

Symptoms associated with faecal impaction

Faecal impaction is a complication of chronic constipation and is a major cause of faecal incontinence.^{3,11}

Symptoms associated with impaction include:³

- faecal incontinence
- rectal discomfort
- loss of appetite
- nausea
- vomiting
- abdominal pain and distension
- urinary frequency
- urinary overflow incontinence.

Prevalence

About 30% of older people in institutional care suffer from faecal impaction. It is particularly common in people with dementia and those who have problems with mobility.¹¹

Faecal incontinence

Definition

Faecal incontinence refers to the uncontrolled passage of faecal material.¹²

Symptoms of clinical importance

- Faecal incontinence may occur due to overflow as a result of faecal impaction further up the bowel, so always consider constipation when a person experiences faecal incontinence.
- Faecal incontinence as a result of impaction is unlikely to present as a single episode. A single episode or limited period of faecal incontinence may be due to acute gastroenteritis or illness elsewhere in the patient, such as delirium, which affects bowel control, rather than constipation.
- Leakage with flatulence is commonly seen in people with impaction.
- Faecal incontinence can also occur from poor muscle control (anal sphincter damage).

Prevalence

It is estimated that more than a million people in the Australian community have some degree of faecal incontinence, and the risk increases with age – a person aged over 80 years is 7–8 times more likely to have faecal incontinence than someone who is under 30.¹³⁻¹⁷

In nursing homes and institutions, faecal incontinence occurs in up to 46% of residents.¹²



The process of defaecation

Rectal filling

The rectum distends, signalling the time to defaecate. Faeces are held in the descending and sigmoid colon. Distension of the left colon results in peristaltic waves, which move the faeces down into the rectum. Stretch receptors in the rectum and surrounding pelvic floor muscles signal the presence of faeces in the rectum. Further rectal filling results in an increasing urge to defaecate (the defaecation threshold volume).

Possible problems

If pelvic muscles are over-stretched, the person may have a decreased sensation of the need to defaecate and miss their chance to empty the bowel.

Recto-anal inhibitory reflex (RAIR) and sampling

The internal anal sphincter (IAS) automatically relaxes, allowing the sensitive nerve endings in the anal canal to distinguish between solids, liquids and gases. The external anal sphincter (EAS) automatically contracts when the IAS relaxes to prevent involuntary leakage, unless defaecation is underway. The puborectalis muscle and external anal sphincter maintain anal closure until a person is ready to pass the stool.

Possible problems

Faecal incontinence could result from abnormal functioning of anorectal sensation, abnormal reflex mechanisms or problems with the actions of the IAS or EAS.

Decision not to empty

The brain suppresses the signals from the anorectum, leaving the faeces unexpelled. The IAS returns to its normal resting state, the faeces move back into the rectum, and the rectum relaxes to accommodate the faeces.

Possible problems

The person may have a full rectum but feel no urge to defaecate. The longer the faeces are stored in the rectum, the more fluid that is absorbed from the faeces into the body, resulting in a harder stool.

Decision to empty

When appropriate, the person sits or squats to defaecate, relaxing the puborectalis and opening the anorectal angle from its resting position of 85° to about 135°. The EAS relaxes, abdominal pressure rises, and the pelvic floor descends by about 2-3 cms moving the stool into the lower rectum. This movement initiates a spontaneous contraction, which pushes the stool through the relaxed anal canal.

Possible problems

Inefficient straining may result in incomplete defaecation. Muscle weakness may not provide enough support for the rectum during the passage of stool – ineffective funnelling of the stool may result in the EAS failing to open effectively.

Stool is passed

Contractions of the rectum continue until the rectum is empty.

Possible problems

If the stool consistency is too hard, the person may have to strain to expel the stool, resulting in some faeces remaining in the rectum.

Defaecation completed

The pelvic floor and anal canal return to their resting state. The anal canal is closed.

Possible problems

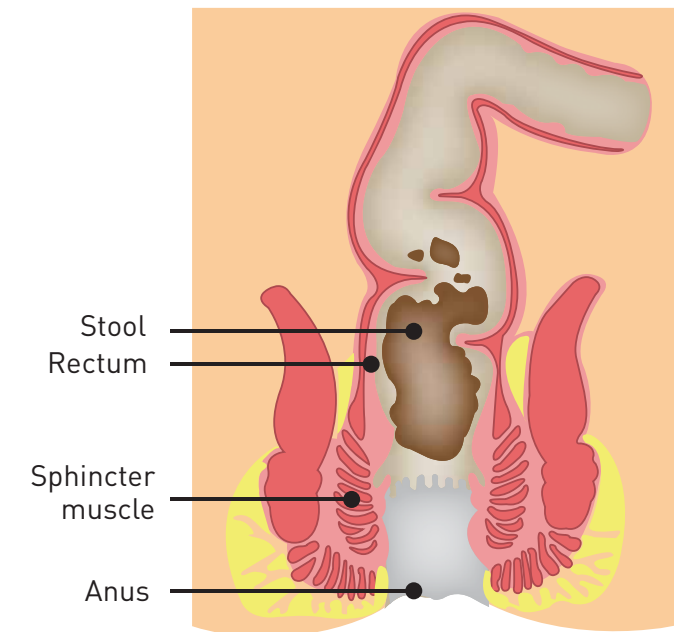
Any conditions such as poor muscle tone or bulging haemorrhoids that do not allow complete closure of the anus may result in faecal leakage.

Physiology of defaecation^{2,9,18-22}

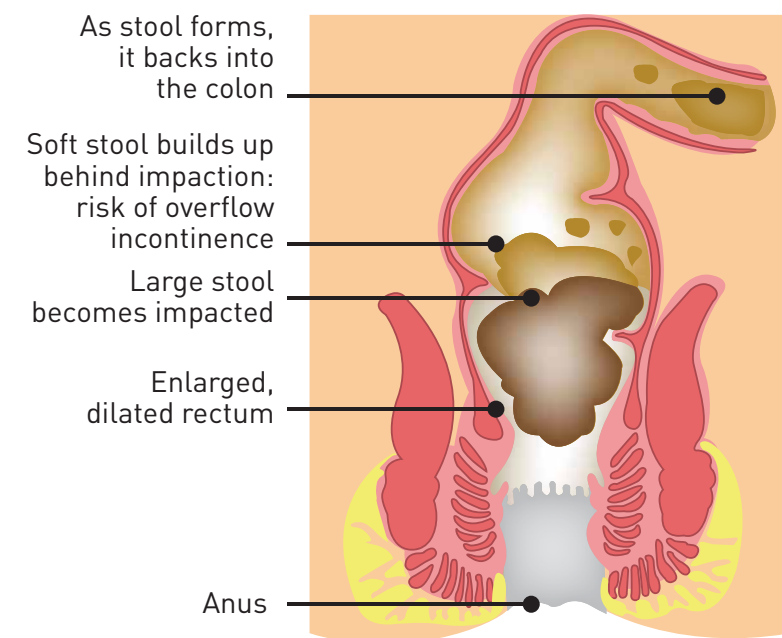
Both faecal continence and defaecation depend on complex processes involving sensory and motor function, whether voluntary, through the central nervous system, or involuntary, through intrinsic reflex mechanisms. Problems can arise from a disorder involving the central or peripheral nervous systems; from an intrinsic disorder of the colon, rectum, or anal sphincters; or from a combination of these mechanisms.



The problem of constipation



Normal



Constipation



Causes of constipation

Constipation can be divided into two groups: primary and secondary constipation.⁵

Primary constipation

There are three sub-groups of primary constipation:

- **Normal transit constipation**, also called functional constipation, in which the stool passes through the colon at a normal rate but which results in persistently difficult passage of stools, including straining, hard, lumpy stools, feelings of incomplete evacuation or obstruction, and infrequency of defaecation.^{5,23}
- **Slow transit constipation**, or colonic inertia, in which the stool takes longer than usual to travel from the proximal to the distal colon and rectum, resulting in bloating and infrequent bowel movements.^{5,8,21}
- **Pelvic floor dysfunction**, in which the muscles used to evacuate the bowel are inefficient, so even if transit through the bowel is normal, stools are retained in the rectum, resulting in feelings of incomplete evacuation and obstruction.^{5,8}

Although some people may have colonic inertia and pelvic floor dysfunction, and some people may have both, the majority of people with constipation have normal transit times and normal anorectal function.²³

Bowel transit time and the frequency of bowel movements do not diminish with age, so constipation is not a natural consequence of ageing per se.^{2,3,5}

However, there are many factors that contribute to the prevalence of constipation in the older age group, and these factors should be considered as possible causes of secondary constipation.

Secondary constipation⁵

Among the many factors that may contribute to secondary constipation are:

- physical and psychological conditions (e.g. diabetes, Parkinson's disease, depression)
- structural abnormalities (e.g. anal fissures, rectal prolapse, pelvic mass)
- medications, especially those that affect smooth muscle function, nerve conduction or central nervous system function (e.g. narcotics, opioids)
- lifestyle issues (e.g. lack of hydration & inadequate oral intake/foods, lack of mobility, lack of adequate toileting facilities).

See the **Assessment section (section 3)** of these guidelines for more details about the causes of secondary constipation.

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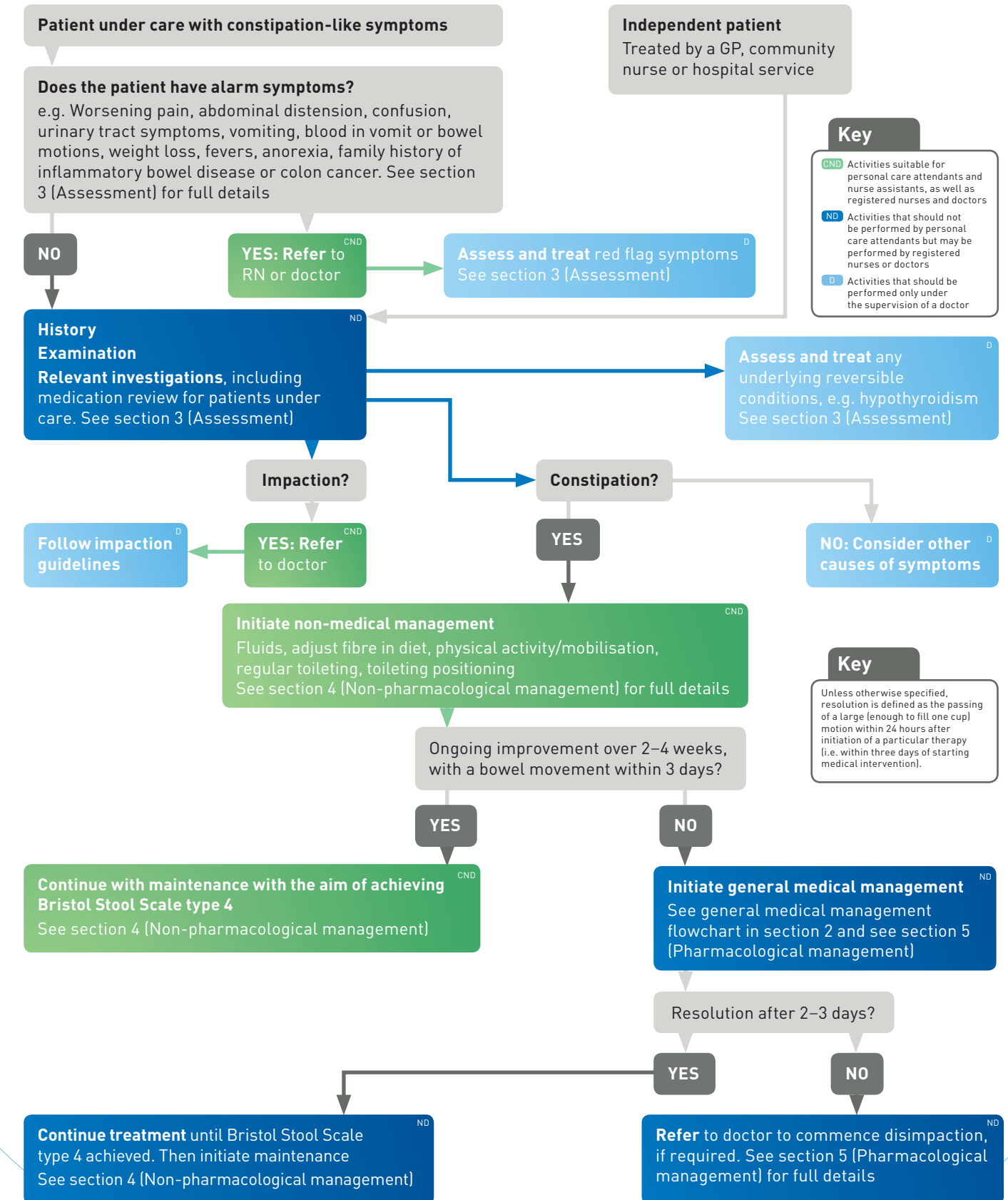
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MANAGEMENT PATHWAYS

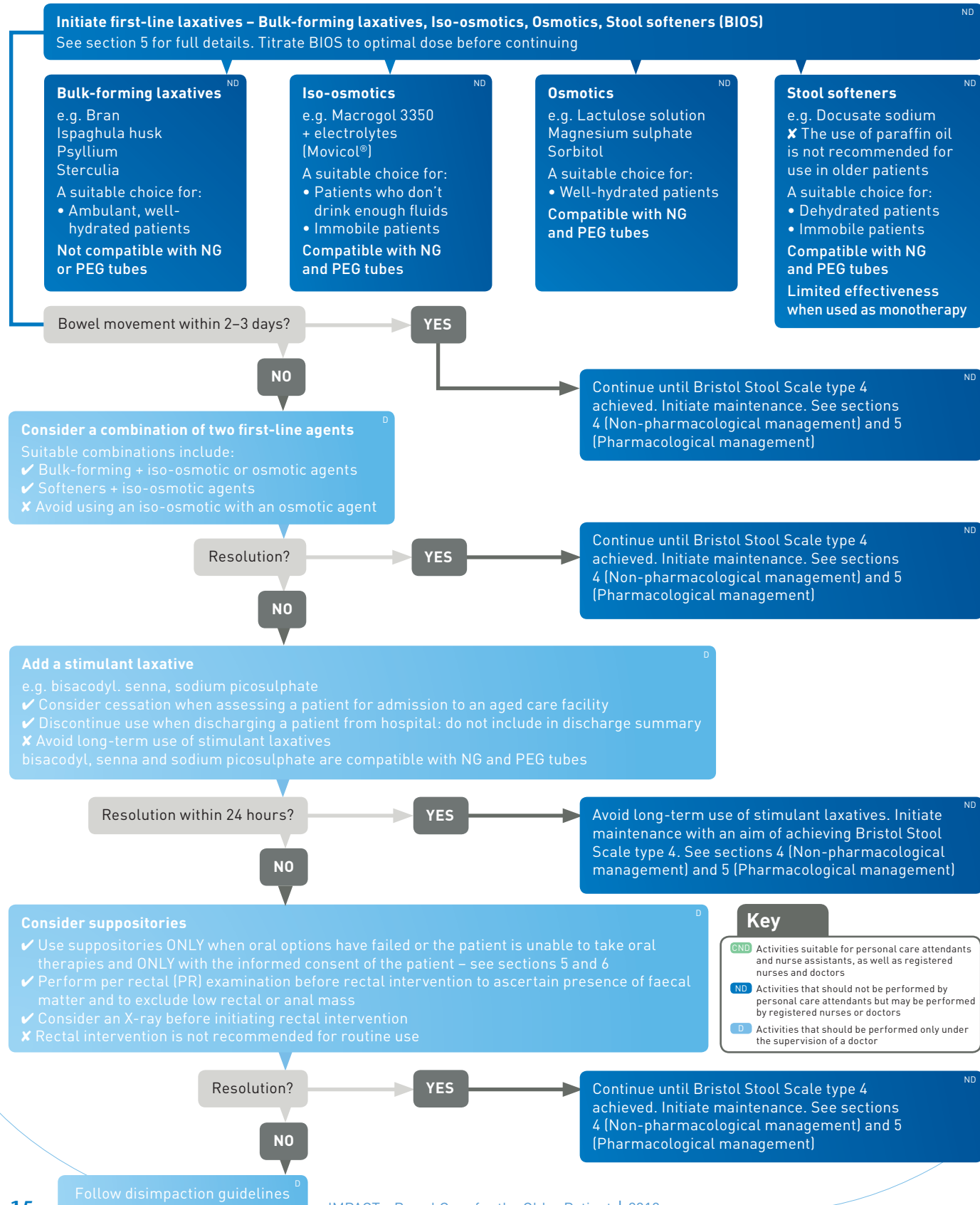
IMPACT GUIDELINES: Management Pathway for Constipation in the Older Person





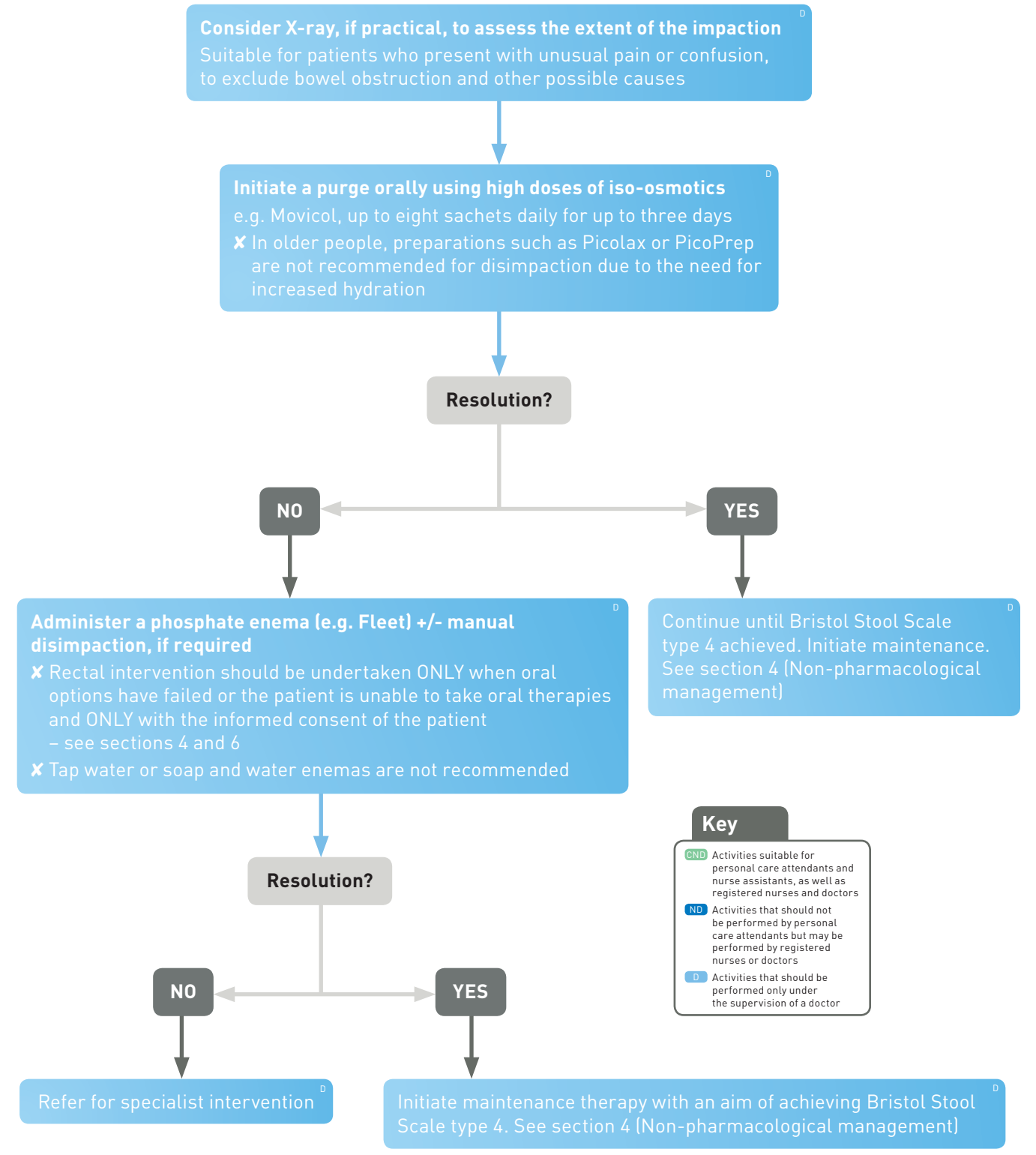
IMPACT GUIDELINES: Medical Management of Constipation in the Older Person

To be initiated when the patient has been assessed, history taken and non-medical management has produced no resolution of symptoms. Some of the laxatives listed below may not be appropriate for patients with nasogastric (NG) tubes or percutaneous endoscopic gastrostomy (PEG) tubes. For further information regarding the use of suppositories, see section 5 (Pharmacological management).



IMPACT GUIDELINES: Medical Management of Impaction in the Older Person

To be initiated **ONLY** under medical supervision ^D





ASSESSMENT

Diagnosing constipation is complicated by the fact that there are multiple causes and contributing factors,¹ so it makes sense to take a multi-faceted approach when assessing a patient who may have constipation.

Listen to what your patient tells you

- Is the patient complaining of constipation?
- What does the patient mean by “constipation”?
- Is the patient complaining of diarrhoea? This may be overflow incontinence due to faecal impaction.
- Is the patient complaining of other problems which may be caused by constipation, such as back pain or urinary obstruction?

Make a thorough assessment and follow what you observe.

- Consider the possible factors that put a patient at risk of constipation.
- Use the [Constipation assessment form](#) in these guidelines to record the relevant information for each patient.

Step 1 – Check for red flag symptoms

Does the patient have any symptoms indicative of an underlying disorder?

- | | |
|--|---|
| • Cramping ² | • Rectal bleeding ² |
| • Confusion ³ | • Rectal pain ² |
| • Delirium ³ | • Urinary incontinence that is new or worsening ⁴ |
| • Fever ² | • Urinary tract symptoms, such as pain or decreased flow ^{4,5} |
| • Pain, including abdominal or lower back pain that is new or worsening ² | • Vomiting, especially if blood is present ² |

Adapted from the following sources: Arce DA et al, 2002;² Porter RS ed, 2003;³ Charach G et al, 2001;⁴ MacDonald A et al, 1991.⁵

ACTION: If any red flag symptoms are present, immediately refer the patient to a registered nurse or doctor for assessment and treatment.

**Step 2 – Patient history****Bowel behaviour and toileting history**

Ask about the following:

- regular toileting routine
- duration of constipation symptoms
- change in the frequency of stools
- change in stool consistency: see the Bristol Stool Form Scale (see [Bowel Health Assessment Form](#) page 2)
- abnormal straining
- any bloating or flatulence
- any mucus
- any soiling
- any urinary incontinence
- any faecal incontinence – consider overflow due to impaction
- any pain on defaecation
- any associated nausea and vomiting
- effect on appetite
- weight loss
- previous management for constipation, including medication used
- previous investigations.

Psychosocial history

Assess:

- for anxiety²
- for depression²
- for somatisation²
- for cognition impairment, taking note of any decline in cognitive abilities.⁶ If the person is cognitively impaired, ensure you obtain a history of the patient from a family member or carer.



Other medical history

Ask about the following:

- previous and existing conditions
- previous hospitalisations
- family history of bowel disorders
- other relevant family history
- any allergies
- new or recently changed medications.

Consider underlying conditions that may contribute to constipation

A thorough history and physical examination should help to confirm or rule out the presence of any of the following conditions which are known to cause or worsen constipation.

<p>Endocrine and metabolic diseases</p> <ul style="list-style-type: none"> • Diabetes mellitus • Hypercalcaemia • Hypocalcaemia • Hyperparathyroidism • Hypothyroidism • Uraemia <p>Intestinal disorders</p> <ul style="list-style-type: none"> • Decreased motility • Diverticular disease • Hernia • Inflammation • Irritable bowel syndrome • Neoplasm • Post-surgical abnormality • Volvulus 	<p>Myopathic conditions</p> <ul style="list-style-type: none"> • Amyloidosis • Myotonic dystrophy • Scleroderma <p>Neurologic conditions</p> <ul style="list-style-type: none"> • Autonomic neuropathy • Cerebrovascular disease • Dementia • Hirschsprung's disease • Multiple sclerosis • Parkinson's disease • Spinal cord injury <p>Psychological conditions</p> <ul style="list-style-type: none"> • Anxiety • Depression • Somatisation 	<p>Structural abnormalities</p> <ul style="list-style-type: none"> • Anal fissures, strictures, haemorrhoids • Colonic inertia (slow-transit constipation – primary constipation) • Colonic strictures • Inflammatory bowel disease • Obstructive colonic mass lesions • Pelvic floor hypertonicity (primary constipation) • Rectal prolapse or rectocele
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Adapted from the following sources: Beers MH ed, 2000;⁷ Hsieh C, 2005;⁸ American Gastroenterological Association, 2000.⁹

Step 3 – Consider medication that may contribute to constipation

Check if the patient has been taking any of the following medications, which are commonly associated with secondary constipation.

<p>Anaesthetics</p> <p>Analgesics</p> <ul style="list-style-type: none"> • Non-steroidal anti-inflammatory drugs (NSAIDs) • Opioids <p>Antacids</p> <ul style="list-style-type: none"> • [containing aluminium or calcium] 	<p>Anticonvulsants</p> <p>Antidepressants</p> <ul style="list-style-type: none"> • Monoamine oxidase inhibitors • Tricyclic antidepressants <p>Antihistamines</p> <p>Antihypertensives</p> <ul style="list-style-type: none"> • Calcium channel blockers • Clonidine 	<p>Anti-Parkinson's drugs (especially levodopa)</p> <p>Antipsychotics</p> <p>Antispasmodics</p> <p>Calcium</p> <p>Diuretics</p> <p>Iron</p>
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Adapted from: Beers MH ed, 2000.⁷ Hsieh C, 2005.⁸ Prather CM and Ortiz-Camacho CP, 1998.¹⁰

Step 4 – Consider other factors that may contribute to constipation

<p>A change in diet</p> <p>Inadequate intake of food volume/ kilojoules</p> <p>Decreased intake of fibre</p> <p>Decreased intake of fluid</p>	<p>Immobility</p> <p>Poor access to toileting facilities</p> <p>Poor toileting positioning</p> <p>Weakness</p>
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Adapted from: Beers MH ed, 2000.⁷



Step 5 – Examination

As well as discussing the patient's history and current health, a physical examination will help to assess or rule out a co-morbid condition or a physical cause of constipation.

General physical examination

Assess the following:

- general appearance
- abdomen – check for distension, tenderness, faecal mass, high-pitched or absent bowel sounds²
- chest/cardiothorax
- mouth – check the state of dentition and ability to eat
- skin – check for pallor and signs of hypothyroidism (skin dryness, reduced body hair, fixed oedema)²
- vital signs – temperature, pulse, respiratory rate and blood pressure
- weight.

Neurologic examination

Assess for:

- focal deficits²
- delayed reaction phase of the deep tendon reflex (e.g. at the knee or Achilles tendon in the ankle) – indicative of hypothyroidism².

Perianal or rectal examination

Ensure the patient is able to give consent before undertaking perianal or rectal examination as some people with dementia may be confused about the procedure and become distressed (see [section 6](#) of these guidelines for more details).

Examination can help to locate faecal mass and assess local anorectal conditions such as:

- anal and perianal fissures²
- anal strictures¹
- pelvic floor hernias, including rectocele¹
- nonrelaxing puborectalis¹
- descending perineum.

Step 6 – Investigations

Unless there are red flag signs, the routine approach to constipation is to treat the symptoms of constipation, without the need for diagnostic testing.¹¹ However, consider further investigations if you suspect an underlying condition, or if the patient's constipation fails to respond to the recommended treatment.²

Blood tests

To help rule out underlying causes of constipation, check for occult blood in the stool and consider the following blood tests:

- calcium²
- complete blood count^{1,2}
- creatinine^{1,2}
- erythrocyte sedimentation rate²
- glucose^{1,2}
- potassium²
- thyroid stimulating hormone^{1,2} and parathyroid hormones.

Procedures

To help rule out structural abnormalities, consider the following:

- CT colonography (virtual colonoscopy)
- colonoscopy^{1,2}.

To exclude bowel obstruction and assess the extent of faecal impaction consider:

- abdominal X-ray – which shows the amount and location of stool in the colon⁷.

If these tests do not produce answers, consider further investigations to test the function of the colon, anal sphincter, rectum and pelvic floor, which include the following:

- **Anorectal manometry** – to check rectal sensation and anal sphincter pressure, pelvic floor and associated nerves^{1,2}
- **Balloon expulsion test** – to check evacuation ability. Inability to expel the balloon is indicative of pelvic floor dysfunction^{1,2}
- **Colonic transit tests** – useful for the assessment of people with pelvic floor disorders²
- **Defaecography** – helpful for those with anatomical or functional problems such as rectal prolapse or rectocele².



Summary checklist

Ensure you complete the following for each patient

- Address acute symptoms
- Assess current status
- Assess bowel history
- Take medical history
- Assess and treat underlying medical conditions
- Review and record medications
- Assess other contributing factors such as fluids, nutrition, mobility
- Perform physical examination

Tests if required

- Perform blood tests, if required, to help rule out underlying conditions
- Perform endoscopic or radiological investigations, if required, to rule out physical problems or if constipation does not respond to recommended treatment.

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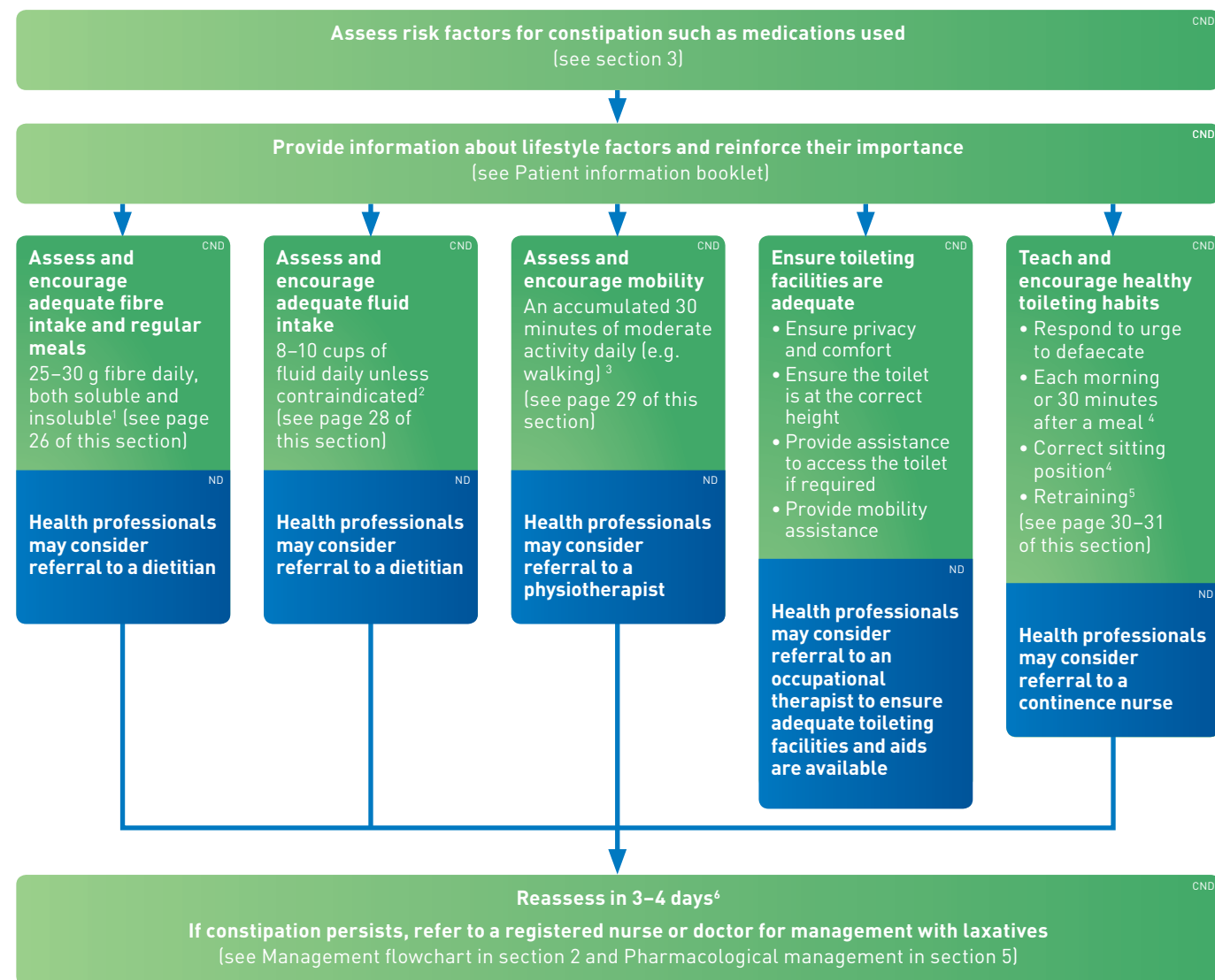


MANAGEMENT OF CONSTIPATION: NON-PHARMACOLOGICAL INTERVENTIONS

The management of constipation in the older person has four key components:

- Prevention of constipation in people who may be at risk
- Lifestyle and behavioural interventions
- Pharmacological interventions
- Maintenance and prevention of recurrence.

Prevention of constipation and management of short-term constipation



Key

- CND** Activities suitable for personal care attendants and nurse assistants, as well as registered nurses and doctors
- ND** Activities that should not be performed by personal care attendants but may be performed by registered nurses or doctors



NON-PHARMACOLOGICAL MANAGEMENT OF CONSTIPATION

Assess and encourage adequate fibre intake

- Stools comprise about 75% water and 25% dry matter, which consists of undigested material, bacteria and bacterial cells.⁷
- Dietary fibre is a very effective treatment for constipation because it helps improve stool bulk and consistency.¹
- However, an increase in the weight of the stool does not necessarily result in relief from constipation. For example, the amount of water consumed has an effect on the benefits of fibre, so it's important that a person who increases their dietary fibre also consumes adequate fluids.⁴
- Adding too much fibre too quickly may result in bloating and excessive wind, so increase the fibre intake by 5 g per day each week until the daily recommended intake is achieved.⁸

Fibre requirements	Daily dietary fibre
Men older than 51 years	At least 30 g
Women older than 51 years	At least 25 g

Adapted from NHMRC Nutrient Reference Values for Australia and New Zealand, 2006.¹

- Dietary fibre is either soluble or insoluble and effective constipation treatment will include a mix of both types.^{4,7}
- Most insoluble fibre passes through the colon unchanged while also storing water, and so it helps to increase stool bulk.⁷
- Soluble fibre increases stool bulk by stimulating the growth of bacteria, which make up much of the stool's consistency.⁷

Types of soluble fibre	Found in:	Types of insoluble fibre	Found in:
Pectins	Fruits and seeds	Lignin	Wheat bran, legumes, vegetables and some fruits
Hemicelluloses	Cereals, fruits and nuts	Cellulose	Vegetables, legumes, cereals, fruits and nuts
Mucilages	Seeds and bulking supplements		
Gums	Seeds, cereals and as a food additive		



Resistant starch

Resistant starch comprises starch and products of starch degradation that resist digestion in the small intestine. When it reaches the large intestine it stimulates the growth of ‘good’ bacteria which helps keep the cells of the bowel healthy. Resistant starch is found in:

- slightly under-cooked pasta
- cooled cooked potato
- products containing ‘hi-maize’ flours, such as white, high-fibre bread
- green bananas and custard apples
- peas, corn and baked beans
- barley, cooled cooked rice, cracked wheat.

Sources

- In Australia, the majority of our dietary fibre comes from breads and other cereal foods.¹
- We get about 30% of our fibre from vegetables and about 10% from fruit.¹

Selecting the right type of food is important. Advise people with constipation to choose high-fibre options and combine soluble and insoluble fibre (see the appendix in this section for sources of fibre).^{9,10}

For people who are unable to obtain an adequate amount of fibre in their diet, a fibre supplement may be suitable. However, the person needs to have a minimum fluid intake of 1500 mL in 24 hours, unless contraindicated.⁶ Fibre supplements include psyllium/ispaghula husks, wheat bran and oat bran.

Foods used in the prevention and management of constipation include:

- pear juice 150 mL twice daily; contains sorbitol and fructose, which may act as a laxative¹¹
- prunes
- rhubarb
- dried fruit such as dates, figs and currants – fruit has a combination of soluble and insoluble fibre which may help with constipation.¹²

Assess and encourage adequate fluid intake

- Adequate fluid intake may be affected by several factors in older people, such as a reduced capacity to feel thirsty, limited mobility, reduced kidney function, and medication use.²
- It’s essential for older people to drink enough fluids*: dehydration not only affects saliva production and contributes to constipation but may also lead to cognitive impairment and functional decline.² In addition, reduced fluid intake may contribute to faecal impaction so remaining suitably hydrated is important for bowel motility.^{2,8}
- Water intake is related to metabolic needs so every individual has different requirements. For adults, solid foods contribute about 20% of total water intake, or about 700–800 mL, while metabolism contributes about 250 mL and the remainder is sourced from water and other fluids.²
- In adults, the normal turnover of water is about 4% of total body weight, not including perspiration, so in someone who weighs 70 kg, this equates to about 2500–3000 mL/day.²

Fluid requirements*	Total water from food and fluids	Fluids alone, including water, milk and other drinks
Men older than 51 years	3.4 L/day	2.6 L/day (about 10 cups)
Women older than 51 years	2.8 L/day	2.1 L/Day (about 8 cups)

Adapted from NHMRC Nutrient Reference Values for Australia and New Zealand, 2006.²

*Patients with CHF, or who are taking diuretics, should check with their doctor about suitable fluid requirements.



Assess and encourage mobility

- A low level of physical activity is linked to a two-fold risk of constipation so it's no wonder that people who are immobile or who need prolonged bed rest often have this problem.⁸
- It's important to encourage the older person to be as physically active as possible – the large-scale Nurses' Study found that physical activity two to six times a week was linked to a 35% lower risk of constipation.^{8,13}
- The Australian Government's recommendations encourage all older people to accumulate at least 30 minutes of activity a day, no matter what their state of health or level of ability. Most physical activities can be adjusted to suit older people, including those in residential care facilities.³

Physical activity recommendations

Older people should:

- try to do some form of physical activity, no matter what their age, weight, health problems or abilities
- be active every day in as many ways as possible, doing a range of activities that incorporate fitness, strength, balance and flexibility
- accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all, days
- begin at an easily manageable level and gradually build up to the recommended amount, type and frequency of activity
- continue enjoying physical activity into later life, provided it's safe to do so.

Adapted from Recommendations on physical activity for health for older Australians, 2009.³



Teach and encourage healthy toileting habits

Timing

- Encourage the person with constipation to attempt a bowel movement in the morning, soon after waking, or about 30 minutes after a meal. This helps the person take advantage of the body's natural gastrocolic reflex.⁸
- Encourage the person to respond immediately to the urge to defaecate and not to put off going to the toilet.⁶

Sitting position

- Advise the person not to strain down while attempting to defaecate as this won't empty the bowel effectively, and will place excessive strain on to the muscles that support the pelvic floor.⁴
- Advise the person to use a footstool. A knees-above-hips position places the pelvic floor muscles in the correct position to assist defaecation.



- To assist defaecation, advise the person with constipation to:⁶
 - » keep legs apart with feet flat on the ground or supported on a footstool (consider safety with footstool)
 - » relax the tummy and back passage
 - » keep the lower back straight, leaning forward (or backwards if this is preferred e.g. by women with rectocele) – whatever position allows easy bowel evacuation
 - » bulge the abdominal wall and widen at the waist
 - » hold this position while the bowel opens
 - » repeat until the bowel is empty
 - » tighten and draw in the back passage when finished.



Toilet facilities and environmental issues

- Toileting facilities need to be private and comfortable. Many people find it difficult to have a bowel action on a commode chair or on a bedpan with other people in the room. A dividing curtain will not eliminate smells or inadvertent noises during bowel action. People in this situation will then often put off defaecation, which can cause hard stools because in the lower bowel, water is absorbed from the faeces into the body.
- People with arthritis have difficulties lowering themselves onto a regular height toilet. They need a raised toilet seat to feel comfortable and safe. They are also not always able to get up independently from a low seat. Refer to an occupational therapist for appropriate equipment.
- Provide a call bell to the person to alert staff when the person needs assistance to access the toilet. Refer to a physiotherapist for mobility aids if indicated.

Pelvic floor retraining

- For older people who have pelvic floor dysfunction, or who tend to tense up when defaecating, biofeedback and relaxation therapies may be helpful.^{4,5}
- Biofeedback can help people to relax their pelvic floor muscles when they strain, and it can help them link relaxation with pushing to pass a stool. At its simplest, this may involve retraining the muscles with the aid of a physiotherapist, or it may involve strategies such as intrarectal balloon training, intra-anal electromyography (EMG) or perianal EMG.⁴
- By retraining the muscles, the non-relaxing pelvic floor is suppressed, allowing normal co-ordination to be restored.⁵
- Consider referring suitable patients to a continence physiotherapist or continence nurse.

Management with medications

- **For simple (short-term) and long-standing constipation:** If, after about two weeks of lifestyle adjustment the constipation persists, commence treatment with a pharmacological agent.
- **For severe constipation (bowel action every 2–3 weeks and underlying bowel pathology):** Commence with pharmacological agent while addressing lifestyle changes.⁶
- For detailed guidance on the use of medications in the management of constipation and impaction, see the flowchart in [section 2](#) and read [section 5](#) of these guidelines.



Management of impaction

- Disimpaction should be prescribed by a medical officer and undertaken by a qualified health professional. It requires the use of medications, possibly along with rectal intervention. For further details, see the flowchart in [section 2](#) and read [section 5](#) of these guidelines.

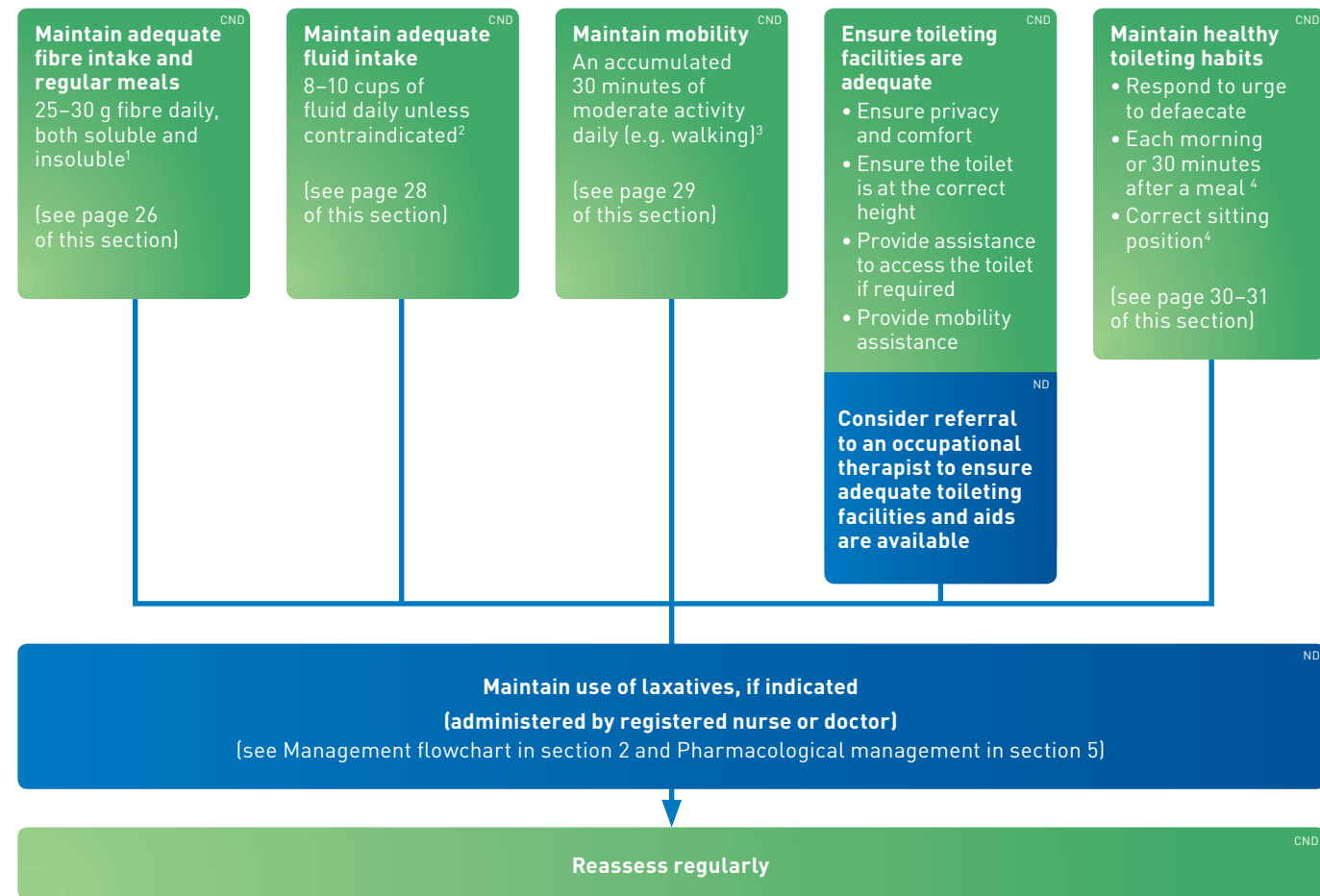
Follow-up

- Follow-up procedure will depend on the person's individual needs and circumstances. While the person is hospitalised or resides in an aged care setting, daily bowel charts are completed.
- For community-dwelling older people, a suggested schedule may involve regular contact via telephone or at an outpatient's clinic at the following intervals after resolution of symptoms:
 - » one week
 - » two weeks
 - » one month.
- Here are some suggested questions to ask during follow-up.
 - » How is your general health?
 - » How many bowel movements do you have per week?
 - » How often do you need to strain to open your bowels?
 - » How often do you feel that you are not fully emptying your bowels?
 - » What are your bowel movements like? (Bristol Stool Form Scale)
 - » Are you using any laxatives or opening medicines?
 - » How is your toileting routine going?
 - » Are you happy with your progress?
 - » Are there any other problems or concerns you'd like to talk about?



Maintenance

When a person with constipation achieves a Bristol Stool Form Scale Type 3–4, has at least three bowel actions per week or has resumed the bowel pattern prior to their constipation episode, initiate a maintenance regimen to help prevent the recurrence of constipation.



Key

CND Activities suitable for personal care attendants and nurse assistants, as well as registered nurses and doctors

ND Activities that should not be performed by personal care attendants but may be performed by registered nurses or doctors

Record-keeping

Whether a person is treated with medications or with non-pharmacological interventions, the importance of accurate record-keeping cannot be over-emphasised. Remember to record all recommendations and the actions taken, including fluid and fibre intake, daily exercise and the teaching of toileting procedure, as well as any medications taken.

To assist with record-keeping, see the following resources in this guideline:

[Bowel record chart](#)

[Constipation assessment tool](#)








Summary checklist

Ensure you have addressed the following for each person with constipation

- Maintain daily fibre intake of 25–30 g per day, including a mix of both soluble and insoluble fibre
- Maintain an average fluid intake of 8–10 cups per day (1500 mL–2000 mL per day)
- Encourage mobility most days – ideally, at least 30 minutes of moderate activity such as walking
- Teach and encourage a suitable toileting position and regular defaecation
- Provide optimal toileting facilities
- Ensure accurate and up-to-date records are maintained



Appendix: Fibre Counter^{9,10}

	Excellent source of fibre ≥ 6 g fibre/serve	Good source of fibre ~ 3–6 g fibre/serve	OK source of fibre ~ 1.5–3 g fibre/serve
	½ cup muesli	2 biscuits Weet-bix®/ Vitabrits®	30 g nuts
	½ cup All Bran®	2 slices multigrain bread	1 slice of high fibre white bread
	2 slices of wholegrain wholemeal bread	1 cup cooked pasta	1 cup boiled white rice
	2 biscuits Weet-bix Hi Bran®	1 cup boiled brown rice	½ cup mashed potato
	½ cup baked beans	¾ cup cooked porridge	1 tbs seeds (sunflower etc.)
	1 cup cooked wholemeal pasta	⅓ cup lentils	1 cup salad vegetables
	2 tbs psyllium husk	1 medium boiled potato with skin	½ cup corn
		⅓ cup peas	½ cup cooked carrots
		1 medium piece fruit	
		⅓ cup dried fruit	
		½ cup Brussels sprouts	
		½ cup cauliflower	

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MANAGEMENT OF CONSTIPATION AND FAECAL IMPACTION: PHARMACOLOGICAL INTERVENTIONS

Lifestyle measures, such as adequate fluid and fibre intake, mobility and adequate toileting habits should be attempted before resorting to medications, unless significant morbidity occurs requiring more rapid intervention. Patients with swallowing difficulties who may be unable to maintain adequate fluid and fibre intake may require more rapid progression to pharmacological intervention.^{1,2}

Polypharmacy should also be addressed, where appropriate, and medication review should be undertaken with a view to minimising anticholinergic burden. See [section 3](#) for a table of medications that may contribute to constipation.

However, laxatives play an important role in the management of constipation, as they can improve stool consistency and the frequency of bowel movements.³

Although the American Gastroenterological Association has produced algorithms for the treatment of constipation, to date, there are still no hard and fast rules or evidence-based guidelines on the preferred order of laxative use.^{1,4}

The choice of which laxative to use depends on many factors, such as:

- presence of impaction
- availability of oral route of administration
- texture-modified diets
- hydration status
- mobility status
- patient preference
- cause of constipation.

To follow the suggested treatment algorithm for constipation, see [Flowchart 2: Medical management of constipation in the older person](#) and for impaction, see [Flowchart 3: Medical management of impaction in the older person](#) in [section 2](#) of these guidelines.



Types of laxatives and their use

Bulk-forming laxatives
Iso-osmotic laxatives
Osmotic laxatives
Stool softeners

“BIOS” – Suggested use ORAL treatments

First-line, when non-pharmacological approaches have produced no result

NOTE

Medications administered rectally should be reserved for:

- disimpaction, when iso-osmotics have produced no result
- people who cannot swallow oral therapies

Stimulant laxatives

Suggested use ORAL treatments

Add-on therapy following failure of:

- non-pharmacological approaches
- first-line laxatives
- a combination of first-line agents

NOTE

Medications administered rectally should be reserved for:

- disimpaction, when iso-osmotics have produced no result
- people who cannot swallow oral therapies

Bulk-forming laxatives

Examples

Oral	Rectal
Bran	–
Guar gum (Benefiber®)	
Ispaghula husk (Fybogel®)	
Psyllium (Metamucil®, Nucolox® – psyllium + maize starch)	
Sterculia (Normacol® Plus – sterculia + frangula, Normafibe® – sterculia)	



Mechanism of action

Dietary fibre (bran)⁵

Bran contains water-insoluble fibre and may also provide water-soluble fibre. Dietary fibre may exert a laxative effect through several mechanisms:

- Binding water and ions in the colonic lumen, thereby softening faeces and increasing bulk
- Supporting the growth of colonic bacteria, which in turn increases faecal mass
- Adding to the osmotic activity of luminal fluid – via digestion of some components by colonic bacteria to metabolites with osmotic activity.

Ispaghula husks, psyllium⁶

These bulk laxatives absorb water in the gastrointestinal tract to form a mucilaginous mass, which increases the volume of the faeces and hence promotes peristalsis. They act as soluble fibre and have the effects of dietary fibre (above).

Sterculia⁶

Sterculia is a vegetable gum which absorbs up to 60 times its own volume of water. It is not fermented by bacteria, so does not produce more gas and does not expand the bacterial mass. Frangula bark (present in Normacol[®] Plus) is a peristaltic stimulant.

Dosage and administration for constipation^{6,7}

The following dosage guidelines assume 1 teaspoonful = 5 mL level spoon and one glass = 200 mL unless otherwise specified.

Guar gum (Benefiber[®])

2 teaspoonfuls of powder mixed into at least ½ cup of fluid or soft food (hot or cold) twice a day (maximum 8 teaspoonfuls/day). Appropriate for oral intake and tube feeding.

Ispaghula (Fybogel[®])

1 sachet or 1 teaspoon twice daily.
Stir into glass of water and take immediately, preferably after meals.

Psyllium (Metamucil[®])

Smooth texture orange: 1.5 teaspoonfuls mixed with one glass of water 1–3 times daily.
Regular texture: 2 teaspoonfuls mixed with one glass of water 1–3 times daily.
Orange: 3 teaspoonfuls mixed with one glass of water 1–3 times daily.

Psyllium + maize starch (Nucolox[®])

7.5 g (approximately two level teaspoons) 1–3 times a day mixed with one glass of water or fruit juice.



Sterculia + frangula bark (Normacol[®] Plus)

1–2 heaped teaspoonfuls once or twice daily after meals.

The granules should be placed dry on the tongue (in small quantities if necessary) and, without chewing or crushing, swallowed immediately with plenty of liquid (water or cool drink).

Alternatively, the granules may be mixed with jam, honey or ice cream.

Sterculia (Normafibe[®])

1–2 heaped teaspoonfuls 1–2 times daily after meals. May be taken similarly to Normacol[®] Plus, as above.

Possible adverse effects of bulk-forming laxatives⁶⁻⁸

- Abdominal cramps
- Abdominal distension
- Flatulence

Recommendations^{7,8}

- Ensure that plenty of fluid is consumed and that each dose is taken with a full glass of water.
- Allow 1–3 days for treatment to work.
- Bulk-forming laxatives should not be given to patients with pre-existing faecal impaction, intestinal obstruction or colonic atony.
- Bulk-forming laxatives are less effective in non-ambulatory older adults.
- Apart from Benefiber[®], bulk-forming laxatives are not compatible with nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) tubes.



Iso-osmotic laxatives

Example

Oral	Rectal
macrogol 3350 + electrolytes (Movicol®)	–

Mechanism of action^{6,9}

Movicol® is the only product of this type available in Australia. It contains macrogol, which is classified according to its average molecular weight. Macrogol of high molecular weight, like Macrogol 3350, is unchanged in the passage along the gut. One sachet of Movicol®, when dissolved in 125 mL (½ a cup) of water, results in a solution that has an osmotic pressure equal to that of the colonic extracellular fluid. As a result there is no net loss of water or electrolytes.

Movicol® works by increasing the stool volume, thereby directly triggering colonic propulsive activity and defaecation via neuromuscular pathways. It has four main actions:

- Bulks: the water retained helps increase faecal bulk
- Softens: retained water softens the faeces
- Stimulates: the increased stool volume directly triggers colonic propulsive activity and defaecation
- Lubricates: rehydrated and softened stools make a comfortable bowel movement possible.

Dosage and administration for constipation⁶

macrogol 3350 + electrolytes (Movicol®)

1 sachet daily, which may be increased to 2–3 sachets daily. Each sachet should be dissolved in 125 mL water.

Possible adverse effects of iso-osmotic laxatives⁶

- Abdominal distension and pain
- Borborygmi (rumbling in the gut)
- Nausea
- Mild diarrhoea – which usually responds to dose reduction
- Allergic reactions

Recommendations⁶

- The length of therapy and the laxative action of macrogol will vary according to the severity of the constipation being treated.

Osmotic laxatives

Examples

Oral	Rectal
<p>Lactulose solution (Actilax®, Duphalac®, Genlac®, Lac-dol®, Lactocur®)</p> <p>Magnesium sulphate (Epsom salts)</p> <p>Sodium picosulphate (stimulant) + magnesium citrate (osmotic) (Picolax®, PicoPrep®)</p> <p>Sorbitol (Sorbilax®)</p>	<p>Sodium lauryl sulphoacetate, sodium citrate, sorbitol, sorbic acid (Microlax® enema)</p> <p>Sodium phosphate (Fleet Ready-to-Use® enema)</p>

Mechanism of action

Lactulose⁶

Lactulose is a disaccharide that cannot be hydrolysed in the small intestine, so it reaches the colon virtually unchanged. There it is metabolised (fermented) by colonic bacteria to low molecular weight acids (short chain fatty acids) and gas (hydrogen, carbon dioxide).

A small quantity of lactulose is probably hydrolysed in the colon into its constituent monosaccharides, galactose and fructose. The end result is a change in osmotic pressure and acidification of the colonic contents, resulting in an increase in stool water content, which softens the stool and promotes increased peristalsis and bowel evacuation.

Magnesium sulphate⁸

Like other osmotic laxatives, magnesium sulphate works by drawing water into the bowel, hydrating and softening the stool to make it easier to pass.

Sodium picosulphate⁶

A stimulant laxative related to bisacodyl which is used in combination with an osmotic in some preparations (see above). It is metabolised by colonic bacteria to the same active compound as bisacodyl, bispyridyl-2-methane. It is usually effective within 10 to 14 hours after administration

Sorbitol⁶

Sorbitol is poorly absorbed from the gastrointestinal tract. It has an osmotic laxative effect similar to lactulose and works by drawing water into the small bowel osmotically. It is fermented by bacteria similarly to lactulose.



Dosage and administration for constipation – oral therapies⁶

Lactulose preparations

The usual initial dose is 15–30 mL daily, and is increased to 45 mL daily if necessary. After three days, the dose may be reduced to 10–25 mL daily for maintenance.

Magnesium sulphate (Epsom salts)

15 g in 250 mL water daily.

Sodium picosulphate + magnesium citrate (Picolax[®])

Add the entire contents of 1 sachet to 120 mL of chilled water and stir until effervescence ceases. The dose required should then be administered as a single dose (discard any unneeded portion of the solution prior to administration).

Best taken on an empty stomach.

For use as a purgative: 120 mL.

For use as a laxative: 60 mL.

Sodium picosulphate + magnesium citrate (PicoPrep[®])

Dissolve 1 sachet in 1 full glass (equivalent to 250 mL) of warm water, which may be chilled before drinking.

For use prior to GI examination: Usually administer 2–3 sachets on the day before the exam (i.e. 1 sachet at 3, 9 pm or 1, 5, 9 pm). No food or drink should be taken for at least 6 hours before examination.

Sorbitol (Sorbilax[®])

20 mL daily initially, increasing to 20 mL three times daily if necessary.

Dose may be reduced to 20 mL once daily depending on individual response.

Sorbilax[®] should be taken either one hour before or three hours after food, as food may affect the osmotic response.

Dosage and administration for constipation – enema⁶

Microlax[®] enema (sodium lauryl sulphoacetate, sodium citrate, sorbitol, sorbic acid)

For rectal constipation and faecal incontinence: the contents of 1 enema to be administered rectally, inserting the full length of the nozzle.

Bowel evacuation usually follows within 30 minutes after administration.

For enemas suitable for the treatment of impaction, see [Disimpaction](#) section on p48.

Possible adverse effects of osmotic laxatives^{6,8}

- Flatulence
- Intestinal cramping
- Diarrhoea

Recommendations⁸

- A more rapid effect will be achieved if the oral dose is taken on an empty stomach
- Allow up to 48 hours for treatment to work
- Preparations containing magnesium and phosphate should be used with caution or avoided in people with renal insufficiency, cardiac disease, electrolyte imbalances or those who are taking diuretics⁶
- People taking lactulose solution should have a thorough bowel cleansing before electrocautery procedures during proctoscopy or colonoscopy, due to a theoretical risk of an explosive reaction caused by hydrogen production in the colon⁶
- People taking osmotic laxatives should maintain adequate fluid intake during therapy to minimise the risk of dehydration.



Stool softeners

Examples

Oral	Rectal
<p>Docusate sodium (Coloxyl®)</p> <p>Liquid paraffin® – not recommended for older people (Agarol®, Parachoc®)</p>	–

Mechanism of action^{6,8}

Stool softeners either act as lubricants, such as liquid paraffin, or as surface-wetting agents which have a detergent-like action, such as docusate sodium. They help fluid to mix into the stool to soften it and make defaecation easier.

Dosage and administration⁶

Liquid paraffin

Liquid paraffin is no longer recommended as it may reduce absorption of fat-soluble vitamins and cause lipoid pneumonia if aspirated.¹⁰

Docusate sodium (Coloxyl®)

50 mg tablets: 2 or 3 tablets twice daily. 120 mg tablets: 2 tablets once daily after evening meal.

Possible adverse effects of stool softeners^{6,10}

- Side effects may include diarrhoea, nausea and abdominal cramps
- Faecal soiling.

Recommendations⁶⁻⁸

- Allow 1–5 days for treatment to work
- Due to limited evidence for efficacy in adults, stool softeners should ideally be used in combination with other agents e.g. iso-osmotic laxatives.

Stimulant laxatives

Examples

Oral	Rectal
<p>Bisacodyl tablets (Dulcolax®, Bisalax®)</p> <p>Senna (sennosides a and b) (Laxettes® with Sennosides, Sennetabs®, Senokot®)</p> <p>Sennosides + docusate sodium (Coloxyl® with Senna, Soflax®)</p>	<p>Bisacodyl suppositories (Dulcolax®, Fleet Laxative Preparations®)</p> <p>Bisacodyl – micro-enema + tablets (Bisalax®)</p> <p>Glycerol suppositories (Glycerol Suppositories BP)</p>

Mechanism of action^{6,8}

Stimulant laxatives provoke an irritant effect to stimulate intestinal motility.

Bisacodyl

Acts on the nerve endings in the walls of the intestine and rectum. It causes the muscles in the intestine to contract more often and with greater force.

Senna (sennosides a and b)

An anthraquinone stimulant laxative that is obtained from the plants *Cassia Senna* or *Cassia Angustifoli*. Anthraquinones are metabolised by the liver and excreted in the urine, faeces and breast milk. Unabsorbed senna is hydrolysed in the colon by bacteria to release the active free anthraquinones. Its mode of action is not clear.

Dosage and administration – oral therapies⁶

Bisacodyl (Dulcolax®)

1–2 tablets.

Bisacodyl (Bisalax®): oral + enema combination

Initially 1 micro-enema, then 1–2 tablets in the evening and 1 micro-enema in the morning for 3 days.

Senna (Laxettes® with Sennosides)

1–3 chocolate squares per day, taken at bedtime.

Senna (Sennetabs®)

1–2 tablets daily with water.

Senna (Senokot®)

2–4 tablets daily at bedtime, with or without food.



Sennosides + ducosate sodium (Soflax®)

1–3 tablets with water, taken at bedtime.

Sennosides + ducosate sodium (Coloxyl® with Senna)

1 or 2 tablets at night. Increase to 4 tablets if required.

Possible adverse effects of stimulant laxatives^{3,6,8}

- Abdominal cramps
- Electrolyte imbalance – with prolonged use
- Flatulence
- Allergic reactions
- Hepatotoxicity
- Cathartic colon has been reported with long-term use¹⁰.

Recommendations^{7,8}

- Allow 6–12 hours for oral treatments to work
- Use a stimulant laxative only when other agents, or combinations of agents, have failed (see [Flowchart 2: Medical management of constipation in the older person](#) in [section 2](#))
- Stimulant laxatives are not recommended for long-term use (more than 3 months).

Dosage and administration – suppositories and combinations⁶

Bisacodyl suppositories (Dulcolax®)

For constipation: 1 suppository at night.

When used as an enema alternative: 2 tablets at night, then 1 suppository the next morning.

Bisacodyl suppositories (Fleet Laxative Preparations®)

For constipation: 1–2 suppositories at night.

When used as an enema alternative: bisacodyl 10 mg orally at night, then one suppository the next morning.

Bisacodyl micro-enema + tablets (Bisalax®)

For acute constipation: Initially 1 micro-enema, then 1 or 2 tablets late in the evening and 1 micro-enema in the morning (after breakfast) for about 3 days.

For constipation in older people: 1 micro-enema in the morning (after breakfast) on days in which defaecation is desired.

Also indicated for use in bowel retraining.

Glycerol suppositories BP

For acute constipation: 1 suppository inserted rectally, to remain in place for 15–30 minutes.



Disimpaction

Oral therapy

Dosage and administration – Movicol®⁶

Movicol® is the treatment of choice for disimpaction.

See [Flowchart 3: Medical management of impaction in the older person](#) in [section 2](#).

8 sachets daily, dissolved in 1 L of water and consumed within 6 hours.

The maximum length of therapy for the impaction regimen is usually 3 days.

Rectal therapies

Dosage and administration – Enemas⁶

Fleet Ready-to-Use® enema (Sodium phosphate)

For constipation or impaction: 133 mL as a single dose, gently inserted into the rectum.

Manual disimpaction

This procedure is a last resort. With modern oral therapies, manual disimpaction is rarely performed. When it is, it should be performed under general anaesthetic. There are a number of concerns that manual disimpaction may damage the anal sphincter, resulting in sphincter weakness and resultant faecal incontinence.¹¹

Recommendations

- Where possible, use oral therapy to treat impaction – rectal intervention should be undertaken ONLY when oral options have failed or the patient is unable to take oral therapies, and ONLY with the informed consent of the patient. This may be difficult in cases of dementia or confusion. See [section 6](#) which discusses communication and consent.
- Tap water or soap and water enemas are not recommended.



Safety of long-term laxative use^{6,12}

Anthraquinones (stimulant laxatives such as senna) have been associated with melanosis coli. This is a discolouration of the bowel caused by the accumulation in the mucosa of macrophages containing pigmented metabolites. While this was thought to signify potential damage to the colon, large controlled studies have not found an increase in bowel cancers in those affected with the condition. Anthraquinones are best thought of as 'staining' the bowel rather than affecting it functionally.

Dependence, and possibly tolerance, may occur with stimulant laxatives and there have been reports of cathartic colon in association with chronic use.¹⁰ Electrolyte disturbances, particularly potassium depletion, can occur with prolonged excessive doses of laxative, but, at usual doses, this is not a clinical problem.

Summary checklist

- Choice of laxative depends on factors such as the person's ability to swallow
- Initiate laxative use when lifestyle factors, such as fluid, fibre, mobility, toileting habits and bathroom facilities, have been addressed and continue to implement lifestyle modification after resolution of the constipation
- Start with a choice of BIOS (bulk-forming laxatives, iso-osmotics, osmotics or stool softeners)
- If necessary, use a combination of BIOS
- Add a stimulant laxative only if these approaches produce no results
- Where possible, use oral laxatives – rectal intervention should be undertaken ONLY when oral options have failed or the patient is unable to take oral therapies and ONLY with the informed consent of the patient

Prescribing information

The registered trade names mentioned in this section are for example only and the list is not exhaustive. Please consult the full Approved Product Information before prescribing any of the medications listed here.

The Approved Product Information in this section is sourced mainly from MIMS Australia.⁶ Consult MIMS Australia for a full picture of the products that are available for constipation and impaction in Australia.

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COMMUNICATION AND CONSENT

When treating constipation in the older person, particularly in a hospital or residential care setting, it's vital to communicate important information effectively to the person involved and/or their family, especially when there may be a need for rectal interventions and manual disimpaction, which may cause distress.

According to both legal and professional standards, a competent adult has the right to give, or withhold, consent to any medical examination, investigation, procedure or treatment, and they should be given adequate information on which to base their decisions.^{1,2}

Consent:³

- should be given by someone with the mental ability to do so
- should be given only when sufficient information has been given to the person
- must be freely given by the person.

A person must not be coerced by members of the healthcare team or by other third parties. However, the person must be capable of providing consent i.e. they must understand, remember, consider, and believe clinical information given to them about their treatments.⁴

A capable person:⁵

- knows the context of the decision at hand
- knows the choices available
- appreciates the consequences of specific choices.

Digital rectal examination (DRE) and manual removal of faeces are invasive procedures and should only be performed by a qualified health professional.³ Health professionals should not undertake a DRE or manual removal of faeces when:³

- there is a lack of consent from the patient – either written, verbal or implied, or
- the patient's doctor has given specific instructions that these procedures are not to take place.

The importance of obtaining consent

Consent is an important and necessary part of good clinical practice and it is also the legal means by which the patient gives a valid authorisation for treatment or care. So for both legal and professional reasons, health professionals need to obtain consent before providing any treatment.³



The need for good communication

The moral and legal responsibility of medically-informed consent depends on the transmission of appropriate information to patients.⁴

Good communication:⁶

- builds trust between the person and their health professional
- may help the person disclose information
- involves the person more fully in health decision-making
- helps the person make better health decisions
- leads to more realistic patient expectations
- reduces the risk of errors and mishaps.

Ultimately, good communication between the person and their health professionals can contribute to better health outcomes, while poor communication may lead to poor outcomes for the person involved.⁶

Communicating important information about diagnosis and treatment

Information should be provided in a form that helps the person to understand the problem and treatment options available. The information should be appropriate to the person's circumstances, personality, expectations, fears, beliefs, values and cultural background.¹

Health professionals should normally discuss the following information with their patients:¹

- the possible or likely nature of the illness or disease
- the proposed approach to investigation, diagnosis and treatment
- other options for investigation, diagnosis and treatment
- the degree of uncertainty of any diagnosis and the degree of uncertainty about the therapeutic outcome
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all
- any significant long-term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention
- the time involved
- the costs involved.



Providing key information about interventions

When discussing what the proposed intervention involves, you should discuss the following, making sure you use plain language:^{1,6}

- a description of the intervention, e.g. enema, digital rectal examination, manual disimpaction
- what will happen to the person and what to expect
- whether the proposed intervention is critical, essential, elective or discretionary
- whether the proposed intervention represents currently accepted medical practice
- the degree of uncertainty about the benefit(s) of the proposed intervention
- how quickly a decision about the proposed intervention needs to be made
- who will undertake the proposed intervention, including their status and the extent of their experience
- how long the proposed intervention will take
- how long until the person sees the results of the intervention
- the risks of any intervention. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe, even though its occurrence may be rare. In fact, all doctors have a common law duty to take reasonable care when treating a patient,¹ and a medical practitioner who fails to provide information about the risks of any intervention, especially those that are likely to influence the person's decisions, may be open to a medical negligence claim for "failure to warn".²

Important pitfalls⁶

When discussing the health of a person, be aware that the person may not absorb all of the information you are imparting. The person may be:

- affected by their condition, illness or medication
- anxious, embarrassed or in denial about their medical condition
- inexperienced in identifying and describing symptoms
- intimidated by health care settings
- overawed by the doctor's perceived status
- disadvantaged by differences in language and culture
- confused by the use of medical jargon
- reluctant to ask questions
- concerned about time pressures.

All of these factors may affect the person's ability to provide, take in and retain information.



Helping people understand their options

Some techniques have been shown to help people understand their condition and their treatment options in order to give informed consent.⁷

Tactics that may enhance understanding include:

- providing consent forms that are short and easy to read⁷
- presenting information in more than one session¹
- providing simple information⁷
- providing written information as well as verbal information^{1,7}
- offering illustrated information, where appropriate^{1,7}
- providing advance notice of the information about to be presented⁷
- repeating key information and providing summaries of the information^{1,7}
- allowing enough time for the person to make their decision and consult with family or friends, if they wish¹
- providing an interpreter when the person is not fluent in English¹.

Documenting consent

Consent may be given verbally, in writing, or by implication through the person's co-operation with the procedure. You should record that the patient has given consent in their patient record.

When a person is incapable

Many older people, especially in residential care facilities, have difficulty understanding their medical treatment options and may not have the capacity to convey their consent, due to cognitive impairment or communication difficulties.⁵

Capacity and the lack of capacity are legal concepts. Capacity is determined by whether a person can understand and appreciate information about the context of their condition and their decision, not the actual outcomes of choices made, and not whether they can perform tasks.⁵

Except in cases of obvious and complete incapacity, an attempt should always be made to ascertain the person's ability to participate in the decision-making process.⁸ For example, a person with only mild cognitive impairment may still be able to make certain choices, such as nominating a family member to be their proxy decision-maker.⁸

Even if a person can't comprehend complex situations, he or she may still be capable of making a simple decision regarding their treatment.^{5,8}

If the person's level of cognition is in doubt, a doctor may decide to conduct an assessment of cognition and capacity.⁵



The following guidance may help when making treatment decisions for older people who may not be capable of deciding for themselves.

- It is recommended that, wherever possible, when a person enters residential aged care, they appoint an authorised representative and plan their wishes for treatment in advance, in case their capability is affected at a later date.⁵ Most states in Australia allow the appointment of a proxy (representative) in cases where a person is not capable of making their own decisions.⁵
- Where a person has not appointed a representative, most states in Australia have legislation to determine who is legally authorised to make medical treatment decisions on the person's behalf.⁵
- In any case, it's always advisable to discuss any proposed treatment with the resident's family or carer to avoid any misunderstanding or disagreements.⁵
- It should not be assumed that the absence of traditional representatives (next-of-kin) means the patient lacks an appropriate proxy decision-maker. Consider close friends, companions, neighbours or close members of the clergy.⁸

Confidentiality

There are situations when it may be necessary to discuss sensitive information with people other than the patient, for example in an emergency, or when the person has impaired decision-making capacity.⁶

In residential care facilities, it is important under privacy laws to ensure the consent form used on admission allows for residents' health information to be disclosed to all relevant service providers.⁵

This panel is of the opinion that DRE and manual evacuation of faeces is an important decision which requires careful consideration. Discussion with the patient, and in most instances with the next of kin or guardian, is essential. Furthermore, the local medical officer should also be involved.

Summary checklist

- Before administering any treatment, you must obtain the consent of the person involved
- Consent relies on the effective communication of important information to the person
- Key information includes: a description of the intervention, what to expect, any risks, and alternative treatment options
- Some people may not be capable of providing consent: most states allow the appointment of a proxy decision-maker in these instances⁵

REFERENCES

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ADDITIONAL RESOURCES

Australian Resources

Aged Care Assessment Teams (ACAT)

www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-acat-assess.htm

Australian Nurses for Continence (ANFC)

www.anfc.org.au

Bladder and Bowel

www.bladderbowel.gov.au

Carers Australia

www.carersaustralia.com.au

Continence Aids & Assistance Scheme (CAAS)

www.health.gov.au/internet/wcms/publishing.nsf/Content/continence-caas.htm

Continence Foundation of Australia

www.continence.org.au

Department of Veterans Affairs Rehabilitation Appliances Program (RAP)

www.dva.gov.au/health/rap/rap_index.htm

Gastroenterological Society of Australia

www.gesa.org.au/

Gut Foundation of Australia

www.gut.nsw.edu.au/

Medicines Line

National Medicines Information Service funded by the Australian Government Department of Health and Ageing
1300 888 763

National Continence Helpline

Telephone: 1800 33 00 66
[Interpreter service 13 14 50]

National Continence Management Strategy

www.health.gov.au/internet/main/publishing.nsf/Content/Continence-2

Seniors information

www.seniors.gov.au

The Big Red Book

www.thebigredbook.com.au



Global Resources

American College of Gastroenterology

www.gi.org/

American Gastroenterological Association

www.gastro.org

Continence Worldwide

www.continenceworldwide.com

International Continence Society (ICS)

www.icsoffice.org

New Zealand Continence Association

www.continence.org.nz

Rome III Diagnostic Criteria for Functional Gastrointestinal Disorders

www.romecriteria.org/rome_III_gastro/

The Australian and New Zealand Society for Geriatric Medicine

www.anzsgm.org



CONSTIPATION ASSESSMENT FORM For Health Professional Use

Patient's name: _____ Date of assessment: _____
 Date of birth: _____ Conducted by: _____
 Record number: _____

Patient History and Examination

Tick all relevant boxes and record details in the notes section below.

<input type="checkbox"/> History of constipation?	<input type="checkbox"/> Any mucus?
<input type="checkbox"/> Relevant medical history, including medications?	<input type="checkbox"/> Any soiling?
<input type="checkbox"/> Relevant family history?	<input type="checkbox"/> Any urinary incontinence?
<input type="checkbox"/> Change in the frequency or consistency of stools? See overleaf.	<input type="checkbox"/> Any faecal incontinence?
<input type="checkbox"/> Strains to defaecate?	<input type="checkbox"/> Any pain on defaecation?
<input type="checkbox"/> Sensation of incomplete evacuation?	<input type="checkbox"/> Any associated nausea and vomiting?
<input type="checkbox"/> Digital or manual removal of faeces required?	<input type="checkbox"/> Appetite affected?
<input type="checkbox"/> Any blood?	<input type="checkbox"/> Weight loss?
<input type="checkbox"/> Any bloating or flatulence?	<input type="checkbox"/> Previous management for constipation?
	Duration of current symptoms_____

Notes

References

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- NHMRC and NZ Ministry of Health. Nutrient reference values for Australia and New Zealand, 2006. Water. Accessed 24 August 2009. Available at: <http://www.nrv.gov.au/nutrients/water.htm>



CONSTIPATION ASSESSMENT FORM

For Health Professional Use

Contributing Factors

Add the ticks in each column and then add all the ticks together.

If there are more than 4 ticks, consider this patient at risk of constipation.

Assess the patient's bowel movements using the tools overleaf, and follow the management guidelines if constipation is present.

Medical conditions	Current medications	Toileting facilities	Mobility	Nutritional intake	Daily fluid intake	
<input type="checkbox"/> Cancer Type: _____ Treatment Given: _____	<input type="checkbox"/> Aluminium antacids	<input type="checkbox"/> Bed pan	<input type="checkbox"/> Restricted to bed	<input type="checkbox"/> At nutritional risk, e.g. low kilojoule intake	<input type="checkbox"/> Minimum fluids not achieved (8-10 cups per day ²)	
<input type="checkbox"/> Clinical depression	<input type="checkbox"/> Anticholinergics	<input type="checkbox"/> Commode by bed	<input type="checkbox"/> Restricted to wheelchair/ chair	<input type="checkbox"/> Inadequate fibre intake*		
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> Anti-Parkinson's drugs	<input type="checkbox"/> Supervised use of lavatory/ commode	<input type="checkbox"/> Walks with aids/assistance	<input type="checkbox"/> Difficulty swallowing/ chewing		
<input type="checkbox"/> Haemorrhoids, anal fissure, rectocele, local anal or rectal pathology	<input type="checkbox"/> Antipsychotic drugs	<input type="checkbox"/> Raised toilet seat, without foot stool	<input type="checkbox"/> Walks short distances but less than 0.5 km daily	<input type="checkbox"/> Needs assistance to eat		
<input type="checkbox"/> History of constipation	<input type="checkbox"/> Calcium channel blockers	<input type="checkbox"/> Shared facility/ limited access				
<input type="checkbox"/> Hypocalcaemia	<input type="checkbox"/> Calcium supplements					
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Diuretics					
<input type="checkbox"/> Impaired cognition/ dementia	<input type="checkbox"/> Iron supplements					
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> NSAIDS					
<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Opioids					
<input type="checkbox"/> Pelvic organ prolapse <input type="checkbox"/> Rectal <input type="checkbox"/> Uterine	<input type="checkbox"/> Tricyclic antidepressants					
<input type="checkbox"/> Post-operative <input type="checkbox"/> Pelvic Surgery <input type="checkbox"/> Colorectal <input type="checkbox"/> Gynaecological <input type="checkbox"/> Lower urinary tract	<input type="checkbox"/> Polypharmacy (more than 5 drugs, including any not on this list)					
<input type="checkbox"/> Rheumatoid arthritis						
<input type="checkbox"/> Spinal cord conditions (congenital, from injury or disease)						
<input type="checkbox"/> Stroke						
Section total						Total Ticks

*The NHMRC recommends adults consume 25-30 g of fibre daily.¹










BOWEL PATTERN ASSESSMENT

Patient's usual bowel pattern

Regular Irregular More than 1/day Daily Less than daily (____/week)

DAY	1	2	3	4	5	6	7
Number of bowel movements today							
Type/s – Bristol Stool Form Scale							

The Bristol Stool Form Scale			
TYPE 1		Separate hard lumps, like nuts (hard to pass)	Constipated
TYPE 2		Sausage-shaped, but lumpy	Constipated
TYPE 3		Like a sausage but with cracks on its surface	Ideal stool consistency
TYPE 4		Like a sausage or snake, smooth and soft	Ideal stool consistency
TYPE 5		Soft blobs with clear-cut edges (passed easily)	Slightly too soft
TYPE 6		Fluffy pieces with ragged edges, a mushy stool	Too soft
TYPE 7		Watery, no solid pieces, entirely liquid	Too loose

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BOWEL HEALTH ASSESSMENT FORM

For patients and carers

Name: _____

Doctor's / nurse's name: _____

Date of monitoring: from: _____ to: _____

Use this form to record your details below and overleaf. Take it to your next appointment. Your doctor or nurse may want to discuss this further to help assess your bowel health, and work out how to help if you are constipated. If you are unable to fill in the form yourself, ask a family member or carer to help.

My Symptoms

I have noticed the following symptoms recently (tick all relevant boxes)

<input type="checkbox"/> I've noticed a change in the frequency or consistency of my stools. Record details overleaf	<input type="checkbox"/> I need to strain to open my bowels
<input type="checkbox"/> I've had more bloating or flatulence than usual	<input type="checkbox"/> I don't feel like my bowel is comfortable and emptied properly after passing a motion
<input type="checkbox"/> I've noticed mucus when I pass a stool	<input type="checkbox"/> I need to press around my back passage or manually remove the motion
<input type="checkbox"/> I've had at least one incident of faecal incontinence lately (soiling)	<input type="checkbox"/> I've noticed a change in my bowels since a recent lifestyle change or event
<input type="checkbox"/> I have urinary incontinence which has worsened lately	<input type="checkbox"/> I have seen blood in the toilet or on the toilet paper after a bowel motion
<input type="checkbox"/> I've experienced some pain when passing a stool	<input type="checkbox"/> I have another concern about my bowel that I need to talk about
<input type="checkbox"/> I have vomited and/or felt nauseous lately	
<input type="checkbox"/> I've lost my appetite	
<input type="checkbox"/> I've lost weight	

My Health

I have been diagnosed with the following medical conditions

<input type="checkbox"/> YEAR _____	Back passage problems (e.g. haemorrhoids, fissure)
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Cancer Type: _____ Treatment given: _____
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Constipation (at any time in the past)
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Dementia or memory loss
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Depression
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Low levels of calcium (hypocalcaemia)
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Pelvic organ prolapse <input type="checkbox"/> Rectal <input type="checkbox"/> Uterine
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Spinal cord conditions
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Stroke
<input type="checkbox"/> YEAR _____	<input type="checkbox"/> Underactive thyroid (hypothyroidism)

My Medicines

I am taking the following medicines (include over-the-counter medicines, supplements and herbal products)










BOWEL HEALTH ASSESSMENT FORM

For patients and carers

My usual bowel pattern

Regular Irregular More than 1/day Daily Less than daily (____/week)

DAY	1	2	3	4	5	6	7
Number of bowel movements today							
Type/s – Bristol Stool Form Scale							

The Bristol Stool Form Scale			
TYPE 1		Separate hard lumps, like nuts (hard to pass)	Constipated
TYPE 2		Sausage-shaped, but lumpy	Constipated
TYPE 3		Like a sausage but with cracks on its surface	Ideal stool consistency
TYPE 4		Like a sausage or snake, smooth and soft	Ideal stool consistency
TYPE 5		Soft blobs with clear-cut edges (passed easily)	Slightly too soft
TYPE 6		Fluffy pieces with ragged edges, a mushy stool	Too soft
TYPE 7		Watery, no solid pieces, entirely liquid	Too loose

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For Health Professional Use

Please fill in the chart every day, referring to the Bristol Stool Form Scale provided.

Patient's name: _____








Date chart started: _____

Date	Time	Type of stool: Bristol Stool Form Scale number (see overleaf)	Quantity of stool	Pain or distress when passing stool?	Soiling?	Good bowel habits? Fibre: 25-30 g daily, including a mix of soluble and insoluble fibre ¹ Fluids: 8-10 cups daily ² Mobility: At least 30 minutes of activity daily ³	Constipation medicine		Bristol Stool Form Scale Type/s passed following treatment?	Comments and actions
							taken?	Name		
		<input type="checkbox"/>	<input type="checkbox"/> Large <input type="checkbox"/> Medium <input type="checkbox"/> Small <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> Some <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluids <input type="checkbox"/> Fibre <input type="checkbox"/> Mobility				
		<input type="checkbox"/>	<input type="checkbox"/> Large <input type="checkbox"/> Medium <input type="checkbox"/> Small <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> Some <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluids <input type="checkbox"/> Fibre <input type="checkbox"/> Mobility				
		<input type="checkbox"/>	<input type="checkbox"/> Large <input type="checkbox"/> Medium <input type="checkbox"/> Small <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> Some <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluids <input type="checkbox"/> Fibre <input type="checkbox"/> Mobility				
		<input type="checkbox"/>	<input type="checkbox"/> Large <input type="checkbox"/> Medium <input type="checkbox"/> Small <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> Some <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluids <input type="checkbox"/> Fibre <input type="checkbox"/> Mobility				
		<input type="checkbox"/>	<input type="checkbox"/> Large <input type="checkbox"/> Medium <input type="checkbox"/> Small <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> Some <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluids <input type="checkbox"/> Fibre <input type="checkbox"/> Mobility				

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THE BRISTOL STOOL FORM SCALE

The Bristol Stool Form Scale		
TYPE 1		Separate hard lumps, like nuts (hard to pass)
TYPE 2		Sausage-shaped, but lumpy
TYPE 3		Like a sausage but with cracks on its surface
TYPE 4		Like a sausage or snake, smooth and soft
TYPE 5		Soft blobs with clear-cut edges (passed easily)
TYPE 6		Fluffy pieces with ragged edges, a mushy stool
TYPE 7		Watery, no solid pieces, entirely liquid

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FIBRE COUNTER

Excellent source of fibre More than ≥ 6 g fibre/serve	Good source of fibre About ~ 3-6 g fibre/serve	OK source of fibre About ~ 1.5-3 g fibre/serve
1/2 cup muesli	2 biscuits Weet-bix®/Vibrants®	30 g nuts
1/2 cup All Bran®	2 slices multigrain bread	1 slice of high fibre white bread
2 slices of wholegrain/wholemeal bread	1 cup cooked pasta	1 cup boiled white rice
2 biscuits Weet-bix Hi Bran®	1 cup boiled brown rice	1/2 cup mashed potato
1/2 cup baked beans	3/4 cup cooked porridge	1 tbs seeds (sunflower etc.)
1 cup cooked wholemeal pasta	1/2 cup lentils	1 cup salad vegetables
2 tbs psyllium husk	1 medium boiled potato with skin	1/2 cup corn
	1/2 cup peas	1/2 cup cooked carrots
	1 medium piece fruit	
	1/2 cup dried fruit	
	1/2 cup Brussels sprouts	
	1/2 cup cauliflower	



IS IT CONSTIPATION?

A QUICK GUIDE TO IDENTIFYING CONSTIPATION IN THE OLDER PATIENT

By the IMPACT Scientific Faculty

WATCH FOR THE SIGNS OF CONSTIPATION

Diagnosing constipation is complicated by the fact that there are multiple causes and contributing factors. Here, constipation is defined as at least one of the following in the preceding 12 weeks:

- less than three bowel movements weekly
- hard or lumpy stools
- straining on defaecation
- sensation of incomplete evacuation
- need for manual evacuation.

Ask your patient questions

“Has there been any change in your bowel habits lately?”

Any change in frequency, consistency, level of straining or feelings of incomplete evacuation should alert you to the possibility of constipation.

Listen to your patient

- Is the patient complaining of constipation?
- What does the patient mean by “constipation”?
- Is the patient complaining of diarrhoea?
- Is the patient complaining of other problems?
- Has the patient experienced excessive flatulence?

Watch for signs

The signs that may be associated with constipation include:

- confusion
- delirium
- diarrhoea, which may be due to overflow incontinence as a result of faecal impaction
- fever
- pain (such as abdominal or back pain)
- rectal pain or bleeding
- urinary tract symptoms, urinary retention.

If your patient is affected, and you are not a registered nurse or doctor, immediately refer for assessment and treatment.

MAKING AN ASSESSMENT

When assessing a patient, consider all the factors that may contribute to their current condition.

Bowel behaviour and toileting history

Ask about previous episodes of constipation and how they were treated, as well as current symptoms and toileting behaviour.



Patient history

Ask about:

- previous and existing medical conditions – many conditions are known to cause or worsen constipation, including diabetes, neurological disorders, Parkinson’s disease, pelvic organ prolapse and conditions or diseases affecting the bowel, rectum or anus
- previous hospitalisations
- family history
- psychosocial history
- previous treatment for constipation.

Medication history

Many medications can contribute to constipation including:

- anaesthetics
- antacids
- anticholinergics
- antihistamines
- anti-Parkinson’s drugs, especially levodopa
- antipsychotics
- calcium and iron supplements
- diuretics
- NSAIDs and opioid analgesics
- some antihypertensives
- some antidepressants.

Lifestyle factors

Consider recent dietary changes, lack of dietary fibre, lack of adequate fluids, lack of mobility or poor toileting positioning. Ask about recent life events or lifestyle changes that may impact on diet, mood and exercise, such as bereavement or retirement.

Examination

A thorough assessment of the patient by a registered practitioner helps to rule out a co-morbid condition or a physical cause of constipation. This may include a physical, neurological, and rectal examination (with the patient’s permission).

Investigations

Blood tests, colonoscopy and abdominal X-rays are usually required only when you suspect an underlying condition, or if the patient fails to respond to the recommended treatment.



CONSTIPATION ASSESSMENT CHECKLIST

Ensure you complete the following for each patient:

- Address acute symptoms
- Assess current status
- Assess bowel history
- Take medical history
- Assess and treat underlying medical conditions
- Review and record medications
- Assess other contributing factors such as fluids, nutrition, mobility
- Perform physical examination

Tests if required

- Perform blood tests, if required, to help rule out underlying conditions
- Perform endoscopic or radiological investigations, if required, to rule out physical problems or if constipation does not respond to recommended treatment



THE FOUR FS AND OTHER SECRETS OF A HEALTHY BOWEL

A QUICK GUIDE TO THE LIFESTYLE CHANGES YOU CAN MAKE TO HELP PREVENT CONSTIPATION

By the IMPACT Scientific Faculty

HOW CAN THE FOUR FS HELP WITH CONSTIPATION?

Constipation is a very common problem for older people. Certain medical problems, some tablets or medicines, our diet and our lifestyle can all cause or make constipation worse, but the good news is we can take steps to help it. As long as you have no serious hidden causes of your constipation, doctors generally say you should make simple changes to your life before, or in addition to, using any laxative.

If you are a carer of a person with constipation, these guidelines will still apply, so please make use of this advice for your loved one or your patient.

The Four Fs: Fibre, Fluids, Fitness and Feet

Fibre

- If you're aged 51 or over, you need to eat 25–30 g of fibre daily.
- Don't overdo it: too much fibre all of a sudden can cause bloating.
- Drink plenty of fluids to help the fibre bulk up and move easily through the gut.
- Dietary fibre is either soluble or insoluble – include a mix of both types in your diet.

Soluble fibre is found in:	Insoluble fibre is found in:	Very good sources of fibre (more than 6 g/serve)
Cereals	Cereals	½ cup muesli
Fruits	Fruits	½ cup All Bran®
Nuts	Legumes	2 slices of wholegrain/wholemeal bread
Seeds	Nuts	2 biscuits Weet-bix Hi Bran®
	Vegetables	½ cup baked beans
	Wheat bran	1 cup cooked wholemeal pasta
		2 tbs psyllium husk

Fluids

- Drink at least 8–10 cups of fluids daily, to stop your body drying out and help dietary fibre work better. Check with your doctor if you have a condition that requires you to restrict your fluid intake.
- Water is a good choice but you can also include some milk and fruit juices (pear and prune juice are very good). Soups and liquid desserts such as jellies can be included.



Fitness

- Whether you are at home or in hospital, try to do at least 30 minutes of moderate-intensity activity most days – this may be three 10-minute bursts if you prefer.
- Enjoy doing things that include fitness, strength, balance and flexibility – try swimming, walking, light weights or tai chi.
- If you have an illness or injury that prevents the suggested exercise, it's still important to move as much as you can, safely.

Feet

- The way you sit on the toilet can help make it easier to open your bowels – use a footstool to keep your knees higher than your hips.
- Keep your legs apart, with feet flat, keep your lower back straight, leaning forwards, bulge your tummy and widen at the waist – don't strain – and hold this position while the bowel opens. If you have a condition that causes difficulty with this position, speak with your doctor, nurse or physiotherapist.
- Always respond when your body feels the urge to go to the toilet to empty the bowel.
- Try to go each morning or 30 minutes after a meal.



Who can help?

- You should speak with your GP about any concerns you have.
- A continence nurse advisor can help by assessing your condition and helping you with any problems.
- A dietitian can help you with dietary fibre and fluids, and tell you which fibre supplement might be good for you.
- A physiotherapist can help your mobility and safety.
- An occupational therapist and continence nurse can tell you ways to improve your access to the toilet and your toileting posture.








What next?

- If you have no relief after 3–4 days, see your doctor or pharmacist who may recommend a laxative that is suited to your needs.



THE BRISTOL STOOL FORM SCALE

Use this scale to help you assess the nature of your stools so you can keep constipation at bay. You should aim for a Type 3 or 4.

The Bristol Stool Form Scale			
TYPE 1		Separate hard lumps, like nuts (hard to pass)	Constipated
TYPE 2		Sausage-shaped, but lumpy	Constipated
TYPE 3		Like a sausage but with cracks on its surface	Ideal stool consistency
TYPE 4		Like a sausage or snake, smooth and soft	Ideal stool consistency
TYPE 5		Soft blobs with clear-cut edges (passed easily)	Slightly too soft
TYPE 6		Fluffy pieces with ragged edges, a mushy stool	Too soft
TYPE 7		Watery, no solid pieces, entirely liquid	Too loose

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FIGHT CONSTIPATION WITH THE FOUR Fs

Fibre

- Eat 25–30 g fibre daily
- Have a mix of soluble and insoluble fibre
- Enjoy fruit, vegetables, nuts, cereals, and legumes
- Be sure to drink enough fluid too



Very good sources (more than 6g/serve)

½ cup muesli
½ cup All Bran®
2 slices of wholegrain/
wholemeal bread

2 biscuits Weet-bix Hi Bran®
½ cup baked beans
1 cup cooked wholemeal pasta

Fluids

- Drink at least 8–10 cups of fluids daily, unless you have a condition that requires you to limit your fluids – check with your doctor or nurse
 - » Prevents your body drying out
 - » Helps fibre work better
- Enjoy milk, fruit juices (pear and prune juice are very good), and plenty of water. You can also include soups and jellies



Fitness

- Be active every day in as many ways as possible
- Do at least 30 minutes in total of moderate-intensity activity most days
- Enjoy doing things that include fitness, strength, balance and flexibility – e.g. walking, light weights, tai chi
- Talk to your nurse about what exercise you could try



Feet

- Use a footstool to keep your knees higher than your hips
- Keep legs apart, with feet flat
- Keep lower back straight, but lean forwards
- Let the nurse know if you have difficulty sitting on the toilet comfortably
- Bulge your tummy and widen at the waist – don't strain
- Hold this posture while your bowel opens

