Constipation in Older People?
Investigation and Management

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Chronic Constipation
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• Good review
  but

• Tertiary centre colorectal surgical unit approach was described
Rome criteria

Chronic constipation

• Criteria to be met for the previous three months

• Onset of symptoms 6 months prior to diagnosis

• < 3 bowel movements / week
Presence of two or more of the following symptoms:

During at least 25% of defecations

- Straining
- Lumpy or hard stools
- Sensation of incomplete evacuations
- Sensation of anorectal obstruction
- Manual manoeuvres
But what about

- Faecal loading
- Large amounts of soft stool
- Faecal incontinence with leakage > once per day
Problem based learning resource

Lern yerself - bowel management in older people
Objectives

- Consider the definition of chronic constipation
- Investigation of acute constipation
- Physiology
- Older patient issues
- Faecal loading
- Goldilocks stool
- Management
Red flags

- Rectal bleeding
- Mass
- Unexplained change in bowel habit
Which investigation?

- Colonscopy
- CT colonography
- Barium enema

Sensitivity v Prep v Dignity
Normal colonic activity

• Stimuli
  – Physical activity
  – Eating
Fig. 2  Anteroposterior view of anus and rectum.
Fig. 4  Anorectal manometry trace demonstrating normal anal resting and squeeze pressures.

Fig. 5  Anorectal manometry trace demonstrating low anal resting pressure but normal squeeze pressure. A cough artefact is also demonstrated.

Fig. 6  Anorectal manometry trace demonstrating low anal resting and squeeze pressures.
Fig. 7  Normal recto-anal inhibitory reflex in response to rectal distension preceded by external anal sphincter contraction (inflation reflex).
Fig 1 The correct position for defecation

<table>
<thead>
<tr>
<th>Place of defaecation</th>
<th>Own homes</th>
<th>Acute care wards</th>
<th>Rehab wards</th>
<th>Nursing homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet</td>
<td>28 (93%)</td>
<td>10 (33%)</td>
<td>16 (53%)</td>
<td>15 (50%)</td>
</tr>
<tr>
<td>Commode</td>
<td>1 (3%)</td>
<td>8 (29%)</td>
<td>5 (17%)</td>
<td>7 (23%)</td>
</tr>
<tr>
<td>Bed</td>
<td>1 (3%)</td>
<td>12 (40%)</td>
<td>9 (30%)</td>
<td>8 (27%)</td>
</tr>
<tr>
<td>Privacy while defaecating</td>
<td>28 (93%)</td>
<td>15 (50%)</td>
<td>16 (53%)</td>
<td>7 (23%)</td>
</tr>
</tbody>
</table>
Behind Closed Doors
Using the toilet in private

- Leaflets
- Standards
- Decision aid re toileting
- Care setting toilet audit proforma
- Action plan
Objective. Constipation is an often quoted problem after stroke but this has not been studied in any detail. The prevalence of constipation and frequency of bowel movements at different time points has been studied in this longitudinal stroke cohort study prior to reviewing the contributory factors.

Methods. 195 consecutive stroke patients (median age 75 years IQR 67-82) were assessed within 24 hours of admission to hospital for the clinical effects of stroke and their bowel habit in the previous 7 days. The participating survivors were reviewed on days 7, 14, 28 and 90 after stroke onset and again at 30 months.

Constipation was defined as either the self report of infrequent stools (2 or less stools in the previous 7 days), hard stools, straining or defaecatory difficulty.

Results. 32 (16.4%) of the study group were constipated prior to their stroke.

At the day 7 review 136/167 (81.4%) of all the strokes were constipated see Fig 1). The relative prevalence of constipation after that was 103/151 (68.9%) on day 14, 27/119 (22.7%) on day 28, 24/114 (21.1%) on day 90 and 33/71 (46.5%) at the 30 month review.

The frequency of bowel movements per week in the previous 7 days (median and IQR) was 7 (4-7) before stroke onset, 4 (2-7) on day 7, 5 (4-7) on day 14, 6 (4-7) on day 28, 7 (4-7) on day 90 and 7 (4-7) at 30 months review.

Conclusion
Constipation is very common early after stroke but in most survivors it improves considerably during the first month. Future analysis is planned to determine whether this is a treatment or recovery effect.
Bowel control in TACS patients

n = 47

pre-stroke

Day 3

Day 7

Day 90

Deceased

withdrawn or not seen

No FI

Faecal incontinence
Colonic transit

• Normal whole gut transit < 5 days
  • usually about 48 hours in Western Society
  • 12 - 24 hours in Africa

• Long stay hospital patients >2 weeks
Less stimulus for colonic activity

- Physical activity - immobility
- Eating - poor appetite
- Both lead to slow transit
Constipation - Defaecatory difficulty

- Usually normal transit
- Paradoxical EAS contraction
- Rectal intussusception
- Worse when stool is hard
Constipation - Neurological disease

- Often have major problems
- Anticipate it happening !!!!!!!
  - Usually slow or no transit

- Spinal loss of parasympathetic
- Cerebral loss of mobility
NICE
Faecal Incontinence Guideline
June 2007

BMJ 2007;334:1370-1371
NICE Faecal Incontinence Guideline

- Baseline assessment
- Initial management
- Specialised management
Baseline assessment

• A focused baseline assessment should comprise:
  – relevant medical history
  – general examination
  – anorectal examination
  – cognitive assessment, if appropriate
Ano-rectal examination

- Gaping / Scars / Soiling
- Perineal descent
- Resting tone
- Squeeze
- ? Faecal loading
  - Consistency
- Abnormal mass e.g. tumour
FAECAL LOADING

- Rectum full of faeces
- Often leaks
- Usually soft consistency
- No straining
- Hard plug - rare <10%
Initial management

- Initial management should address bowel habit, aiming for ideal stool consistency and satisfactory bowel emptying at a predictable time.
Management

• Start with history
  – Top 10 Questions – NICE
  – Diet
  – Drugs including laxative use
Management

• Prevention
  – Toilet facilities
  – Understanding behaviour
  – Understanding the effect of acute illness and disability

– Appropriate use of medications with effects on bowels
Aims

• Bowel emptying to occur at a predictable time

• To produce the Goldilocks’ stool
Goldilocks’ stool

• “The ideal stool is not too hard, not too soft, just right.”

• Easier to pass

• Less likely to leak
Diet - Encourage or - Discourage

- Cardboard
- Brown bread
- Brown breakfast cereals,
  - e.g. Weetabix, bran
- Brown biscuits,
  - e.g. digestive, ginger
• Green leafy vegetables
  • e.g. cabbage, sprouts

• Fruits with indigestible skins
  • grapes
  • raisins, sultanas
  • fruit cake
  • mince pies
• Citrus fruits, marmalade
  • stimulant action on the bowels

• A large amount of chocolate
  • plain chocolate
  • stimulant laxative effect

• Rhubarb
  • indigestible fibres
  • stimulant laxative effect
Laxatives

• Bulk laxatives - nil in my formulary

• Softeners

• Pushers
Osmotic Laxatives

• Softeners
  – Lactulose
  – (Docusate)
  – Movicol
  – Magnesium sulphate
Stimulant Laxatives

• Pushers (Stimulant)
  – Senna
  – Bisacodyl
  – Sodium Picosulphate

• Mixed
  – Picolax
Predictable bowel emptying

- Normally we go to the toilet when we sense there is faeces in the rectum which is ready for defaecation.
Stimulant Laxatives

- **Oral**
  - Give at night - Orocaecal transit
  - Don’t need to give every night

- **Suppository**
  - Bisacodyl
  - Glycerine

- **Enema**
  - Microenema preferred
Fig. 34 A series of diagrams to demonstrate the action of the sphincter muscles after the introduction of a suppository into the anal canal ‘blunt end first’ and the subsequent reverse contractions which help its passage into the rectum. (Reproduced from Abd-el-Maeboud et al., 1991)
Predictable bowel emptying

- If faecally loaded and incontinent
  - Clear the bowel quickly from below with daily supps (or enemas) until clear then review
  - Longer term use oral meds if possible
Predictable bowel emptying

• If unaware of call to stool

• Planned bowel management programme
  – Defaecation by appointment

• Supps or enemas
  – +/- loperamide
Goldilocks and the Three Bears