OBSTETRICS AND GYNAECOLOGY CLINICAL PRACTICE GUIDELINE	
# Bowel care	
Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting staff (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)
This document should be read in conjunction with this Disclaimer	

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Treatment of constipation: Quick reference guide

Step-wise treatment

STEP 1

Identify and, if possible, avoid causative drugs.

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

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

STEP 2

Identify and manage possible underlying causes

E.g. chronic use of laxatives, dietary habits, lack of physical activity, dehydration, depression, neurological disorders (Parkinson's disease, stroke), metabolic disturbances (diabetes mellitus, hypercalcaemia, hypothyroidism), malignancy, pelvic floor dysfunction, faecal impaction or obstruction, anal fissure.

Postnatal: In patients with perineal tears, it is recommended to use stool softeners and osmotic laxatives for about 10 days after the repair. See WNHS Clinical Guidelines, Obstetrics and Gynaecology, Perineal Care and Repair: Third and Fourth Degree and the RANZCOG Guidelines

STEP 3

Encourage mobility and adequate fluid intake (at least 2 litres per day).

Encourage adequate fibre intake (e.g. whole grains, rice, bran, beans, lentils, nuts, dried fruit, fresh fruit and vegetables. Introduce these foods gradually if the woman is not used to these foods as bloating and flatulence may occur otherwise.

Encourage responding to the urge to defecate immediately.

STEP 4

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

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

1st option- Bulk-forming laxatives

2nd option- Osmotic laxatives

3rd option- Stool softeners

Last option- Stimulant laxatives

Acknowledgements- [1]

Bowel care

Assessment

Take a thorough bowel, medication (prescription, over the counter, complementary and alternative therapies and laxatives) and medical history (e.g. age, severity of symptoms, presence of clinical features that warrant further investigation).[2] When assessing the severity of the problem consider the woman's:

- Usual bowel patterns. Time since last normal bowel action. Record on chart.
- Diet (fluid and fibre intake), mobility, activity, functional status, medications
- Symptoms, general condition (including symptoms like weight loss or blood in faeces)[3]
- Previous history, any previous perineal-pelvic-abdominal or obstetric-gynaecological surgery[3], and any treatment that has worked in the past.
- Concerns: straining, feeling of incomplete defecation, tenesmus
- Assess lifestyle measures and risk factors – see sections below

Lifestyle measures

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

Even where laxatives are required, encourage and continue (considering individual patient limitations), adequate dietary fibre (18-30g daily), adequate fluid intake, increasing activity/exercise and immediately responding to the urge to defecate[1] (e.g. after meals[1] and upon waking[2]).

Risk factors

- Lifestyle:
  - Low fluid / dietary fibre intake[4]
  - Reduced mobility, extended bed rest[4]
  - Environmental issues, delaying defaecation urge[4]
- Medical conditions,[3] for example: anxiety, depression, eating disorders, endocrine (hypothyroidism, hyperparathyroidism, diabetes), neurological (Hirschsprung's disease, multiple sclerosis, Parkinson's disease, spinal cord injury, impaired cognitive function), gastrointestinal (lesions, prolapse, obstructions),[4] and negative outcomes of abdominal / gynaecological surgery[3]
- Medications[3] (e.g. ferrous compounds, diuretics, antacids, opioids, anti-depressants, anti-cholinergics, and chronic laxative use)

Aperients

Key points

- The use of aperients should only be considered when other options such as exercise, diet and fluid intake have been assessed and refined appropriately.
- The first choice laxative for an ambulant older person (with no fluid restrictions) is a bulking agent, and if non-ambulant use osmotic and stimulant laxatives.[2]
- Orders for pharmacological treatment of constipation are written as PRN to enable

assessment of need and to direct appropriate use of different classes of laxative before commencing treatment. Aperients may be prescribed regularly for patients on large doses of opioids or those at risk of constipation (e.g. surgery, immobility).

- For procedural information on enemas, suppositories, and other bowel care see SCGOPHCG Nursing Practice Guideline No. 63: Bowel Procedures.

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

Pharmacological step-wise treatment

1. First option: Bulk-forming laxatives

- Do not use for acute relief of constipation as can take several days to work[1]
- Do not use for opioid-induced constipation[1, 2]
- Onset of action: usually within 24 hours[2], but may require 2-3 days[1, 2]
- Ensure adequate fluid intake[1]
- Introduce to diet slowly to prevent abdominal discomfort
- Should not be taken immediately before going to bed

Active Ingredient	Common products
Psyllium* safe to use in pregnancy	Metamucil® capsules Metamucil® oral powder
Ispaghula* safe to use in pregnancy	Fybogel® oral granules
Wheat dextrin* Note: no reference available regarding safety in pregnancy	Benefiber® oral powder

2. Second option: Osmotic laxatives

- Saline osmotic laxatives to be used with caution in pregnancy due to maternal sodium retention and electrolyte imbalance
- Ensure adequate fluid and fibre intake
- Use with caution when inadequate fluid intake, especially in the elderly
- Caution with irritable bowel syndrome and women with functional bloating due to discomfort and bloating[2]

Active ingredient	Common products	Onset of action
Lactulose* Safe to use	Actilax® oral liquid	1-3 days[1]
Macrogol laxatives* Considered safe to use in pregnancy	Movicol® oral powder	
Sorbitol* Considered safe to use in pregnancy	Sorbilax® oral liquid	
Saline laxatives* Considered safe to use in pregnancy. Note: May cause electrolyte disturbances especially in elderly and patients with renal impairment or cardiovascular disease [1]	Microlax® rectal enema	2-30 minutes[1]
Glycerol* Considered safe to use in pregnancy. Note: useful if stool present in lower rectum[1]	Petrus® rectal suppository	5-30 minutes[1]

3. Third option: Stool softeners

- Ensure adequate fluid and fibre intake
- There is limited evidence of efficacy when used alone for constipation[1]
- Not recommended for long term use
- Contraindicated for use in patients with intestinal obstruction, inflammatory bowel conditions or acute abdominal conditions e.g. appendicitis

Active Ingredient	Common products	Onset of action
Docusate *	Coloxyl® tablets	1-3 days[1]
Liquid Paraffin* Note: Avoid chronic use as it may affect absorption of fat-soluble vitamins	Agarol® Vanilla oral liquid Parachoc® oral liquid	

4. Last option: Stimulant laxatives

- Stimulant laxatives:
  - are usually reserved for opioid-induced constipation or severe constipation if unresponsive to other laxatives mentioned in previous sections.[1]
  - In pregnancy:
    - should be avoided except for occasional doses[1]
    - should not be given to pregnant women with a history of preterm labour without medical consultation.
  - are usually given at night.[1]
- Castor oil should be avoided in pregnancy as it may induce premature labour.
- Misuse of stimulant laxatives may affect resumption of normal bowel patterns when laxatives ceased.[2]

Active ingredient	Common products	Onset of action
Senna* In pregnancy: Consider an alternative	Senokot® oral tablets	Oral: 6-12 hours[1] Rectal: 5-60 min[1]
Senna combined with Docusate* In pregnancy: Consider an alternative. Avoid prolonged use as maternal adverse effects possible.	Coloxyl with Senna® oral tablets	
Bisacodyl* In pregnancy: Consider an alternative. In lactation: Safe to use but avoid prolonged use. Observe for adverse effects (e.g. diarrhoea, irritability) in breastfed infants	Bisalax® oral tablets Dulcolax® rectal suppositories	
Sodium picosulfate In pregnancy: Consider an alternative. Avoid prolonged use as maternal adverse effects possible.	Unavailable	

***** May be used in pregnancy at recommended doses

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

Treatment of faecal impaction and severe constipation

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

1. Warm the suppository or enema and leave in the rectum with the foot of bed elevated.
    a) Initial therapy: Glyceryl 2.8g suppository rectally, as a single dose[2]
    b) If the above is ineffective, add an osmotic enema (sorbitol + sodium citrate + sodium lauryl sulfoacetate) enema rectally, as a single dose[2]
2. **If there is no result,** manual removal of faeces is indicated. Refer to the Medical Officer.
3. When impaction has resolved, consider the need for maintenance laxative therapy.[2]

Severe constipation (5 days or more):

- Ask the Medical Officer to assess the woman. Rectal and abdominal examinations and an abdominal x-ray may be performed[5] (non-pregnant patients).
- Exclude the possibility of a bowel obstruction before beginning treatment.[5]
- Consider whether manual removal of faeces may be necessary before beginning treatment.

References and resources

1. Australian Medicines Handbook. Gastrointestinal drugs: Laxatives: Constipation: AMH; 2023. Available from: https://amhonline-amh-net-au.kelibresources.health.wa.gov.au/chapters/gastrointestinal-drugs/laxatives/constipation
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5. Alame AM, Bahna H. Evaluation of constipation. **Clinics in Colon and Rectal Surgery**. 2012;25(1):5-11. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23449159

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RANZCOG. The Management of Third- and Fourth-Degree Perineal Tears. 2015.

The Royal Women's Hospital. Pregnancy and breastfeeding medicines guide [Internet]. Parkville (VIC): The Royal Women's Hospital; 2023 [cited 2023, Jun 30]. Available from https://thewomenspbmg.org.au/ [subscription required]

Related policies, procedures and guidelines

SCGOPHCG NPG No. 63: Bowel Procedures (available to WA Health staff via HealthPoint)

WNHS Clinical Guidelines:

- Obstetrics and Gynaecology: Perineal Care and Repair: 'Third and Fourth Degree Perineal Trauma Management'
- Pharmacy: Obstetrics and Gynaecology (Adult) Medication Monographs A-Z

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Version history

Version number	Date	Summary
1	Sept 2017	First version **History**: Sept 2017 amalgamated 6 individual guidelines (4 Gynaecology Bowel guidelines and 2 Obstetric/Midwifery Constipation guidelines, dated from August 1993) into one document 1. Bowel Care (C1.2) 2. Administration of Aperients (C1.2.1) 3. Administration or Rectal Suppositories (C1.2.2) 4. Administration of Enema (C1.2.3) 5. Constipation: Management during Pregnancy (B1.1.10.1) 6. Constipation: Postnatal Management (B6.2.2.7) Archived- contact OGD Guideline Coordinator for previous versions. For a list of previous changes- see OGD Guideline Updates by month/year of review date.
2	May 2018	• Procedural information on enemas, suppositories and other bowel care removed- refer to SCGH guideline • Caution with osmotic laxatives in women with irritable bowel syndrome or functional bloating • Abuse of stimulant laxatives may affect resumption of normal bowel patterns when laxatives ceased • Updated medications regarding use in pregnancy
3	July 2023	• Updated medication information, including safety in pregnancy and onset of action • Lifestyle considerations: Even where laxatives are required, encourage and continue adequate dietary fibre, fluid intake, increasing activity/exercise and immediately responding to the urge to defecate • Faecal impaction for gynaecology patients updated- read section

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