Inpatient Constipation

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KEYWORDS

• Inpatient constipation • Prevention • Behavioral therapy • Pharmacologic therapy

HOSPITAL MEDICINE CLINICS CHECKLIST

1. Any of the following signs should raise concern for inpatient constipation:
   a. A decrease in the frequency of a patient's bowel movements compared with their ambulatory baseline.
   b. The absence of sensation of complete evacuation.
   c. Reported need for increased straining with defecation.
   d. The need for digitalization or per rectum therapy to evacuate.
2. Thorough medication reconciliation should be performed at the time of admission for all patients to identify common medications that could predispose them to constipation.
3. Strategies for preventing inpatient constipation should take into account a patient's risk factors for developing constipation (age >60 years, history of outpatient constipation, need for intensive care unit stay or intubation, intra-abdominal surgery within the last week, or planned use of a known constipation-causing medication for longer than 24 hours).
4. For patients deemed at high risk for developing constipation, a scheduled osmotic laxative such as polyethylene glycol should be initiated.
5. New-onset inpatient constipation should be viewed with a critical eye for evidence of serious underlying pathophysiology (eg, obstruction, motility disorder, systemic illness).

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6. Treatment of constipation can begin with an osmotic laxative (and rectal stimulant laxative in certain populations).
7. Treatment-resistant constipation should prompt a thorough reevaluation of the patient, including a physical examination and potential abdominal imaging to assess for ileus or obstruction. If reevaluation is unrevealing, an osmotic laxative bowel preparation should be considered.

DEFINITIONS

How is constipation defined?

Colloquially, constipation is thought of as a problem with stool frequency. Normal frequency is reported to be between 3 bowel movements per day and 3 per week.[1] Qualitative features of defecation (eg, straining, stool character, sensation of incomplete evacuation) are an equally important component of constipation. Assessment of both of these elements can help in determining the cause and treatment plan for this common problem.

The Rome III criteria offer a consensus definition of constipation that accounts for both qualitative and quantitative functioning.[2] Per these guidelines, a patient must:

1. Have rare loose stool without use of laxatives
2. Fail to meet criteria for irritable bowel syndrome
3. Demonstrate 2 of the following: straining during at least 25% of defecations, lumpy or hard stools in at least 25% of defecations, sensation of incomplete evacuation for at least 25% of defecations, sensation of anorectal obstruction/blockage for at least 25% of defecations, manual maneuvers required to facilitate at least 25% of defecations (eg, digital evacuation, support of the pelvic floor), or fewer than 3 defecations per week.

How is inpatient constipation defined?

Existing diagnostic criteria for constipation such as the Rome III focus on chronic bowel disorders in the ambulatory patient and not the acute inpatient disorders focused on herein. For this purpose, the authors propose a new mechanism for defining inpatient constipation. A hospitalized patient meeting any of the following criteria should be considered to have inpatient constipation:

1. A decrease in the frequency of bowel movements compared with their ambulatory baseline
2. The absence of sensation of complete evacuation
3. Reported need for increased straining with defecation
4. The need for digitalization or per rectum therapy to evacuate.

EPIDEMIOLOGY

How common is constipation in the general population?

Prior estimates of constipation prevalence in community-dwelling adults have ranged from 2.5% to 79%.[3] Precision with this estimate is impaired by several factors, including poor reporting and heterogeneous definitions of disease.