16.6: Constipation

*Constipation* is defined by NANDA-I as, “A decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool.”[1] Typically a patient is diagnosed with constipation if they have less than three bowel movements per week. Constipation can be caused by slowed peristalsis due to decreased activity, dehydration, lack of fiber, medications such as opioids, depression, or surgical procedures in the abdominal area. As the stool moves slowly through the large intestine, additional water is reabsorbed, resulting in the stool becoming hard, dry, and difficult to move through the lower intestines. See Figure 16.6[2] for the Bristol Stool Chart used to assess the characteristics of stools ranging from constipation to diarrhea.

![Bristol Stool Chart](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/16%3A_Elimination/16.06%3A_Constipation/BRISTOL_STOOL_CHART.png)

The patient may experience associated symptoms such as rectal pressure, abdominal cramps, bloating, distension, and straining. **Fecal impaction** can occur when stool accumulates in the rectum, usually due to the patient not feeling the presence of stool or not using the toilet when the urge is felt. Large balls of hard stool need to be digitally removed or treated with mineral oil enemas.
Interventions

The goal of interventions implemented to treat constipation is to establish what is considered a normal bowel pattern for each patient and to set an expected outcome of a bowel movement at least every 72 hours regardless of intake. Treatment typically includes a prescribed daily bowel regimen, such as oral stool softeners (e.g., docusate) and a mild stimulant laxative (e.g., sennosides). Stronger laxatives (e.g., Milk of Magnesia or bisacodyl), rectal suppositories, or enemas are implemented when oral medications are not effective.

Patients should be educated about the importance of increased fluids, increased dietary fiber, and increased activity to prevent constipation. Some food sources, such as prune juice, prunes, and apricots, are helpful in preventing constipation. Over-the-counter medication, such as methylcellulose or psyllium, can be used to increase dietary fiber. When administering these medications, mix in a full 8-ounce glass of water to avoid the development of an intestinal obstruction.

Note

Read more about laxatives used to treat constipation in the “Gastrointestinal” chapter in Open RN Nursing Pharmacology.

Intestinal Obstruction or Paralytic Ileus

Intestinal obstruction is a partial or complete blockage of the intestines so that contents of the intestine cannot pass through it. It can be caused by paralytic ileus, a condition where peristalsis is not propelling the contents through the intestines, or by a mechanical cause, such as fecal impaction. Patients who have undergone abdominal surgery or received general anesthesia are at increased risk for paralytic ileus. Other risk factors include the chronic use of opioids, electrolyte imbalances, bacterial or viral infections of the intestines, decreased blood flow to the intestines, or kidney or liver disease. If an obstruction blocks the blood supply to the intestine, it can cause infection and tissue death (gangrene).

Symptoms of an intestinal obstruction or paralytic ileus include abdominal distention or a feeling of fullness, abdominal pain or cramping, inability to pass gas, vomiting, constipation, or diarrhea. Because of the common occurrence of paralytic ileus in postoperative patients, nurses routinely monitor for these symptoms, and diet orders are not upgraded until the patient is able to pass gas.

Treatment may include insertion of an NG tube attached to suction to help relieve abdominal distention and vomiting until peristalsis returns. Obstructions may require surgery if the tube does not relieve the symptoms or if there are signs of tissue death.

Note

Read more about NG tubes in “Enteral Tube Management” in Open RN Nursing Skills.


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