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**Title ICU BOWEL MANAGEMENT GUIDELINE**

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**TARGET AUDIENCE**

Medical and Nursing staff within the Intensive Care Unit

**PURPOSE**

This guideline has been developed for the care of the critically ill patient within the Intensive Care Unit.

This guideline is intended for use with ICU patients who can be enterally fed.

It aims to:

1. Prevent constipation / faecal impaction / bowel obstruction
2. Prevent large bowel overdistension and perforation risk
3. Promote regular bowel actions (at least once every two days)
4. Provide a feedback loop to reduce aperient overuse and resultant diarrhoea
5. Provide an easy to follow flowchart for use at the bedside

**GUIDELINE**

Delayed or non defecation (constipation) is common in Intensive Care, particularly in mechanically ventilated patients and those receiving narcotics. It is said to be present after no bowel motion for three days (72hrs). Potential sequelae include feeding intolerance, abdominal distension and perforation, bacterial overgrowth and translocation. Some papers report an association with increased length of stay, ventilator dependence and mortality.

There are many contributing factors: including the underlying pathology, multiple organ failure, fluid & electrolyte imbalance, sedation, the inability to strain, co-morbidities and medication, particularly opioids.

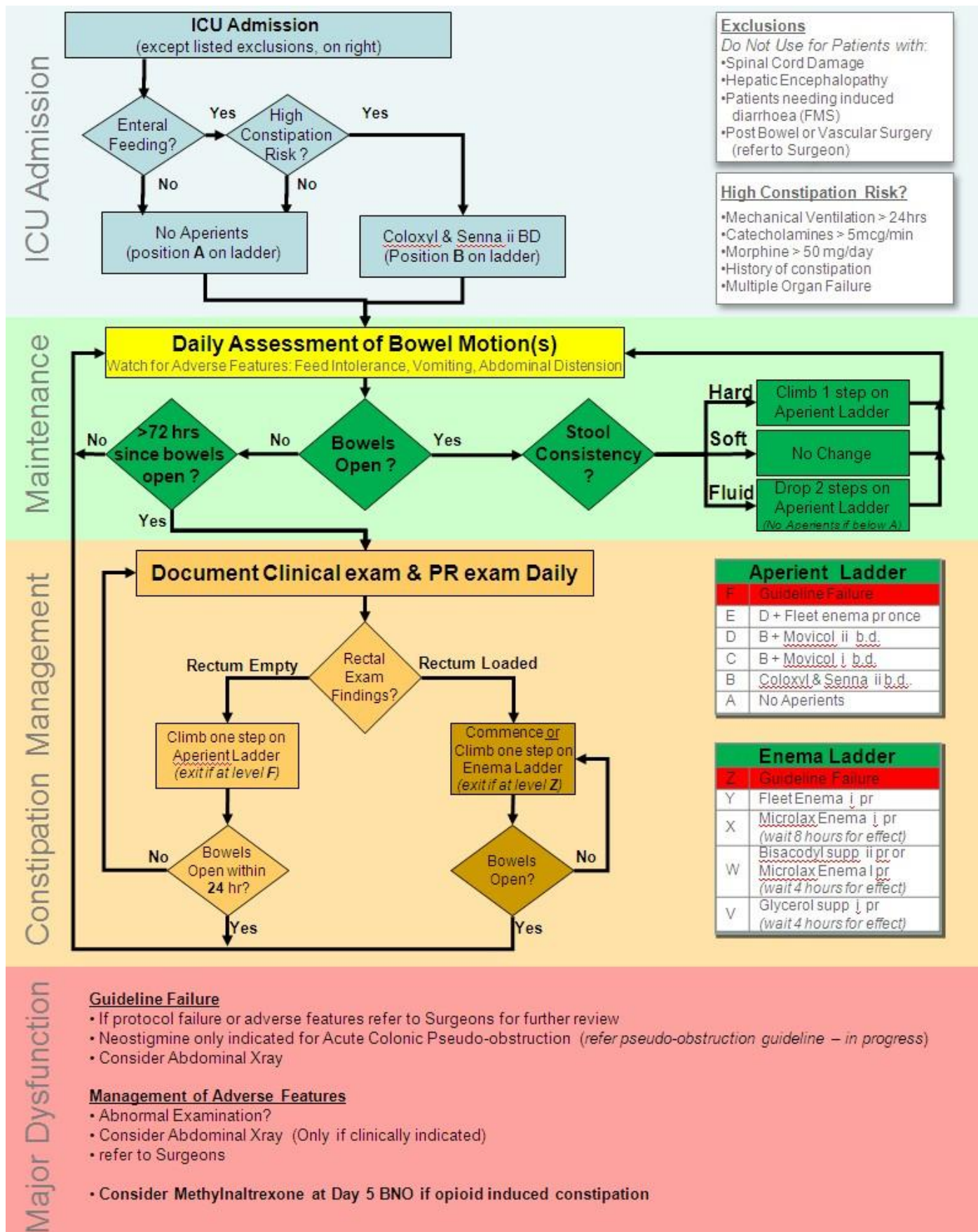
Treatment requires careful attention to all contributing factors, early enteral nutrition and the use of aperients. This flow chart has been developed to identify those most at risk of constipation with a view to early initiation of aperients.

There should be Daily Assessment of Bowel Motions with particular attention for any adverse features (Feed intolerance, Vomiting, Abdominal Distension). Follow the flow chart and alter the aperients as per the aperient ladder, increasing and decreasing according success or failure of defecation. If the Rectum is loaded with faeces, the Enema ladder is designed to ensure defecation within the next 24 hours.

If Guideline Failure is reached or there are any adverse features, consideration should be given to performing an Abdominal Xray (if clinically indicated) and/or Surgical referral.

Methylnaltrexone should be considered only in opioid induced constipation at Day 5 (discuss with unit pharmacist)

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## KEY RELATED DOCUMENTS

- **Related Guidelines**

[Management of the Acute Spinal Injured Patient Guideline](#)

[Faecal Management System Guideline](#)

[Functional Large Bowel Obstruction- Acute Colonic Pseudo Obstruction Guideline](#)

- Charter of Human Rights and Responsibilities Act 2006 (Vic)<sup>1</sup>

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## KEYWORDS

Constipation, Non-defecation, abdominal distension, aperients, enema, laxative

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<sup>1</sup> REMINDER: Charter of Human Rights and Responsibilities Act 2006 – All those involved in decisions based on this guideline have an obligation to ensure that all decisions and actions are compatible with relevant human rights.

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## GUIDELINE

### Title **ICU BOWEL MANAGEMENT GUIDELINE**

Endorsed by:	Name/Title: Alfred Health Drug and Therapeutics Committee	Date: 13 <sup>th</sup> February 2013
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