Examining dangers of constipation in older adults

Constipation is a common problem experienced by institutionalized patients and most of the times it can be regarded as trivial and thus missing a serious pathology, unfortunately there is a discrepancy in description of constipation between the patients and the medical professionals. Patients definition of constipation relies on the degree of straining associated with defecation or their stools consistency rather than the stooling frequency. Therefore according to the medical professionals, constipation occurs when there is infrequent bowel movements (less than every 3 days) associated with difficulty passing stool, excessive straining, and inability to defecate at will and hard feces (Klingman, 2009). A patient’s change in stooling frequency to less than three times per week may be considered normal if the defecation is not associated with discomfort (Schafer and Cheskin, 1998). If the constipation is not relieved, fecal impaction occurs, a collection of hardened feces wedged in a rectum that a person cannot expel. In severe cases of impaction, the fecal mass extends up to the sigmoid colon. The person may not pass stool for several days, despite having an urge to defecate. A continuous oozing of diarrhea stool may occur because the liquid feces located higher in the colon seeps around the impacted mass.

Ernest and Eric (2009) indicated that studies suggest that the prevalence rate for constipation is about 15%, the estimate ranges from 2% – 27%, whereby the definition used and the population sampled accounts for the variability. Like the definition used, patients’ constipation perception varies too. Epidemiologic studies reports a higher constipation prevalence and use of laxatives to as high as 50%, with up to 54% of nursing home residents using laxatives daily (Ernest and Eric, 2009). The risk factors that are

associated with constipation being a persistent problem in the older adults are not limited to advanced age alone but a combination of other factors such as, being a female, non white race, physical inactivity, low income and educational level, medication, dietary intake and depression. Elderly women reports higher rates of constipation which are two to three times higher than that of their males counterpart as indicated by Ernest and Eric (2009).

It is evident that aging all aspects of the body are affected by aging; sense of taste is affected by reduction in number of taste buds, missing tooth or wearing dentures which affects the ability to chew and slow peristalsis leading to difficulty swallowing, these changes affect the amount and type of food eaten which can increase constipation risks in the elderly population. Sometimes due to decline in their health, the elderly patients can be depressed which can cause constipation through regret, poor diet and failure to pay attention to defecate. Diseases which are found primarily in the older patients such as Parkinson’s diseases and Dementia increases constipation folds by reducing sensory judgments and the defecation urge (Apau, 1999).

Constipation Quality Measures Among Health Homes

Unlike other quality measurement data which is available on the Medicare Nursing Home Compare website, constipation is not one of them which leave a gap on how we are supposed to define the issue as well as suggesting on the methods and frequency of measurements. As indicated earlier, since there is no universally accepted definition of constipation among the health care workers and patients, the Spinzi and colleagues (2009) proposed the following definition of constipation as difficulty passing feces or less than

three evacuations per week. In Rome III classification, a functional constipation occurs when no organic causes present with two or more of the following symptoms, fewer than three evacuations per week, straining, hard lumpy feces, incomplete sensation of evacuation, ano-rectal obstruction or blockage and need for digital maneuvers (Spinzi et al 2009). Such definitions are more appropriate than considering the number of evacuations in a week because in some case less than three evacuations per week can be normal, and without considering other signs of constipation cannot be sufficient, therefore the Rome III classification will be deemed appropriate to diagnose of constipation (Spinzi et al 2009).

The method and frequency of measurement should be in line with the definition adopted from the Rome III classification. To accurately determine and evaluate this quality measure, the health care workers need to be trained and educated on how to assess the patient thoroughly, to be at par with other nursing home institutions if this data is to be used to compare institutions. Taking a good history in order to reveal underlying information which sometimes is not apparent during physical examination is important. This can be accomplished through investigation by asking the patients when they felt completely well to their current health state using OPQRST mnemonic – onset, palliation, quality, recurrence, severity, timing, and patients understanding on what is wrong (Apau, D. 1999). Daily assessment should be carried by asking the patient about the frequency of defecation, roughage in diet, stool consistency, color, blood presence, mucus or features associated with constipation such as abdominal pain, distension and bloating. Incorporation of Rome III criteria during history taking such as

asking the patient about their last bowel movement, the color, consistency, amount, the manner of evacuation whether straining was present, whether the patients feels relieved, has a feeling of incomplete evacuation is used to aid in constipation diagnosis. The findings should be documented appropriately and the data analyzed appropriately for example by calculating the constipation prevalence within a period of time in order to facilitate comparison of this quality measure with other similar institutions.

Constipation Prevention through Evidence Based Practice

Constipation being one of the major complains of the older adults which is caused by risk factors other than age related changes, especially those who live in a nursing home are at a greater risk of constipation than those living in the community because of increased exposure to contributing factors, environment, diet, fluid and activity changes (Grieve, 2006), therefore in order to reduce the prevalence of constipation among the elderly, measures should be centered around addressing the risk factors formerly addressed. It is also useful to assess and document the bowel function during the admission, for this will serve as a baseline to assess new cases of constipation. The staff who are performing this assessments should have received a prior education/ training regarding bowel function so that the assessment is done correct to reveal all the major causes of constipation. The knowledge is then shared to the patients by educating them about causes of constipation, prevention and measures that are important to prevent or relieve constipation which will ensure greater patient compliance of the suggested constipation interventions.

General measures should be taken into consideration such as providing a clean and comfortable toilet area, with a well designed lavatory area, and use of bed pans should be avoided. Since defecation is a private activity, most patients prefer to be in a locked toilet, rather than using a bedpan or using a commode. Patients can be helped to a private, unrushed environment which enables them to keep their normal bowel activity (Nazarko, 1999). Keeping a diary may be useful for some patients for they believe that a daily evacuation is essential, and therefore toileting schedules should be encouraged on observation basis that non-constipated patients have a regular toileting schedules after certain events such as waking up or mealtime, stimulate colonic activity (Spinzi et al, 2009).

Fiber rich diet has been recommended to prevent constipation. Consuming 20-30 grams of fiber a day by adding cereal, bran, fruit and vegetables to the diet (Apau, D. 1999) increases stool weight and shortens transit time in adults by increasing peristalsis, however Spinzi and colleagues (2009) feels that fiber can aggregate abdominal bloating and cause flatulence in some patients which can lead to decline in patient compliance (Spinzi et al, 2009). Bulk forming agents such as ispaghula (Fybogel), sterculia (Normacol) or methylcellulose (Celevac), are useful supplements to bulk fecal mass due to a rise in colonic bacterial number which digest fiber (Apau, D. 2009). Bulk-forming agents take several days to be effective and are therefore suitable for long term use in patients with uncompromised gut motility and they are not suitable for use in patients with fecal impaction, bowel obstruction or for short term relief as indicated by Apau (2009). Adequate fluid intake should be encouraged to maintain intestinal motility by increasing the fecal water

content making it easier to pass. Elderly patients should be encouraged to drink water often and not rely on their thirst sensation, because the sensation diminishes with age and they can get dehydrated further exacerbating constipation.

Constipation frequently occurs in inactive people and especially in bed bound patients and regular exercise has been recommended to prevent and relieve constipation through increased peristalsis. Such exercises can be as simple as turning the patient, or sitting him up on a chair to more complex exercises such as ambulating the patient which need to be evaluated by the physician.

Some medications are known to cause constipation, and should be reviewed and where possible changed, to prevent these problems. These medications includes but not limited to antidepressant, antacids containing aluminum or calcium, antihistamines, antihypertensive, diuretics and some anti-Parkinson drugs. Patients should be instructed to report unrelieved constipation to the health care providers to rule out more serious problems.

Stimulant laxatives can be used to relieve constipation and their effect can be seen within 8- 12 hours (Apau, D. 2009), this can be administered at night to provide an evacuation in the morning. They increase the intestinal motility through stimulation of colonic nerves and water re-absorption reduction and therefore side effects such as abdominal cramping can occur. Hyperkalaemia induced by diarrhea can be caused by extensive use of laxatives, and can cause tolerance which requires an increased dose to relieve constipation. Damage to myenteric plexus though rare, but for these reasons use of laxatives for a long time is not recommended (Apau, D. 2009).

Osmotic laxatives which are not absorbable compounds loosens the stool through water binding effect. They include lactulose, macrogols and magnesium salts and often cause flatus and pain. Apau (2009) indicates that magnesium salts produce quick bowel evacuation within 2 hours in large doses and some it can be unpleasant and intolerable to some patients.

Biofeedback can be used by patients with chronic constipation and constipation induced by pelvic floor dysfunction (Apau, D. 2009). This involves contraction retraining and relaxation of the anal sphincter when defecating which allows easy evacuation and Apau indicates the intervention has been successful when standard cares and laxatives fails.

Conclusion

Constipation in elderly patients requires a thorough assessment so that the underlying pathological causes can be identified. Once a cause is established, a non pharmacologic intervention such as habit changing and lifestyles changes can be used to prevent constipation but when these measures fails, constipation can be treated by use of laxatives.