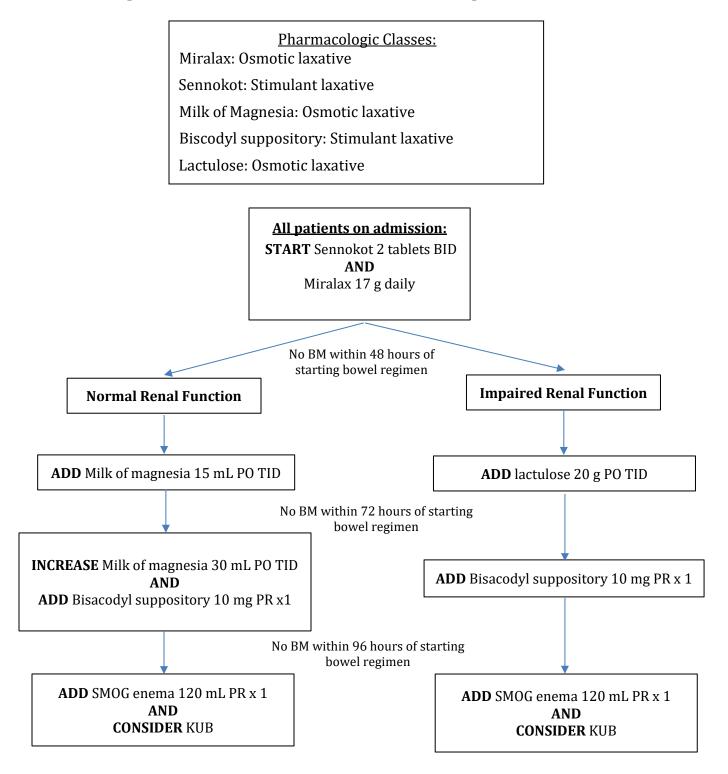


MEDICAL CENTER

DIVISION OF ACUTE CARE SURGERY

Bowel Regimen Recommendations for Functioning Gastrointestinal Tract:



VANDERBILT VUNIVERSITY

MEDICAL CENTER

DIVISION OF ACUTE CARE SURGERY

MONITOR PHYSICAL EXAM:

Obtain KUB to assess for ileus or obstruction if patient has the following symptoms in addition to constipation:

- Increased abdominal distention/discomfort/firmness
- Decreased or minimal flatus
- Increased belching or hiccupping
- Nausea or vomiting

BOWEL REGIMEN RECOMMENDATIONS FOR A NON-FUNCTIONING GASTROINTESTINAL TRACT:

If an ileus is present based on clinical presentation or imaging:

- Place NG tube to low wall suction and monitor NG tube output
- Make patient NPO
- Initiate maintenance IV fluids while NPO
- Monitor electrolytes prn while NPO
- Continue per rectal bowel regimen
- Encourage ambulation if appropriate
- KUB prn to monitor bowel gas pattern
- Discontinue or limit offending medications (e.g. opioids, anticholinergics, dopamine agonists, anti-serotonergics)
- Consider neostigmine if Ogilvie's Syndrome on imaging (can only be administered on 10N) **USE CAUTION IN PATIENTS WITH AN ANASTOMOSIS**
- Consider oral naloxone for postoperative ileus or opioid induced constipation in patients who have been receiving narcotics
 - Initial dose: 2 mg PO TID
 - Max dose: 4 mg PO TID
 - Max total duration: 48 hours
 - Monitor for opioid reversal especially in patients with liver disease
- Consider the use of methylnaltrexone 12mg SQ x 1 dose for postoperative ileus if no obstruction confirmed on imaging and failed oral naloxone (may give one additional dose 24h after 1st dose if no resolution)
 - **o** DISCUSS WITH ATTENDING PHYSICIAN BEFORE ORDERING
 - USE CAUTION IN PATIENTS WITH AN ANASTOMOSIS

RECOMMENDATIONS FOR DIARRHEA:

- Ensure bowel regimen is stopped
- Monitor electrolytes
 - If *C. difficile* is negative:
 - Imodium 4 mg q6h prn
 - o Fiber
 - No feeding tube: Psyllium 2 caps daily (max of 5 caps QID)
 - Feeding tubes: Nutrisource fiber 1 packet daily (max of 6 packets/day; found in tube feed order)
 - Increase dose and frequency as needed

VANDERBILT 🚺 UNIVERSITY

MEDICAL CENTER

DIVISION OF ACUTE CARE SURGERY

References:

Yang A, Lam T, Jierjian E, et al. An Evaluation of docusate monotherapy and the prevention of opioidinduced constipation after surgery. *J Pain Palliat Care Pharmacother*. 2022; 36(1):18-23.

Gathers K, Fawad K, Petros K. Evaluation of methylnaltrexone bromide for the treatment of postoperative ileus. *Crit Care Med.* 2013;41(12):929.

Chamie, K., Golla, V., Lenis, A.T. *et al.* Peripherally Acting μ-Opioid Receptor Antagonists in the Management of Postoperative Ileus: a Clinical Review. *J Gastrointest Surg* (2020). https://doi.org/10.1007/s11605-020-04671-x.

Valle, RG, Godoy, FL. Neostigmine for acute colonic pseudo-obstruction: a meta-analysis. *Ann Med Surg* (Lond). 2014;3(3):60–64.

Dudi-Venkata NN, Kroon HM, Bedrikovetski S, et al. Impact of STIMUlant and osmotic LAXatives (STIMULAX trial) on gastrointestinal recovery after colorectal surgery: randomized clinical trial. *Br J Surg.* 2021 Jul 23;108(7):797-803.

Beavers J, Orton L, Atchison L, et al. The Efficacy and Safety of Methylnaltrexone for the Treatment of Postoperative Ileus. *Am Surg.* 2022; 88(3):409-413.

Gibson CM, Pass SE. Enteral naloxone for the treatment of opioid-induced constipation in the medical intensive care unit. *J Crit Care*. 2014; 29(5):803-807.

Merchan C, Altshuler D, Papadopoulos J. Methylnaltrexone Versus Naloxone for Opioid-Induced Constipation in the Medical Intensive Care Unit. *Ann Pharmacother*. 51(3):203-208.

Liu M, Wittbrodt E. Low-dose oral naloxone reverses opioid-induced constipation and analgesia. *J Pain Symptom Manage*. 2002; 23(1):48-553.

Reviewed 11/2024 by:

Caroline Banes, DNP, APRN, ACNP-BC Jennifer Beavers, PharmD, BCPS Jennifer Emerson, PharmD Bethany Evans, MSN, ACNP-BC Chelsea Tasaka, PharmD, BCCCP Caroline Jackson, PharmD