ICR-BWL-043

Critical care · GI

Updated 21 Jun 2026

CRITICAL CARE ORDER SET

Bowel Regimen

Prophylaxis and stepwise escalation for constipation in the critically ill. Start prophylaxis early in sedated, opioid-treated, and enterally fed patients, anchor every decision to the last bowel movement, and rule out ileus or obstruction before reaching for stimulants and enemas. Target ≥ 1 soft BM every 24–48 h. Adapt to your formulary and the patient.

01 General principles

TARGET **≥ 1 soft BM every 24–48 hours.** Start prophylaxis within **24–48 h of ICU admission** in most patients.

ESPECIALLY IN PATIENTS ON

- [ ] Opioids, sedatives, anticholinergics, neuromuscular blockade
- [ ] Enteral nutrition
- [ ] Postoperative (esp. abdominal, spine, trauma)

BEFORE ESCALATING

- [ ] Review and minimize constipating medications

RED FLAGS Increasing distension, vomiting, high NG residuals, severe pain, leukocytosis, metabolic acidosis, or hemodynamic instability → **evaluate for ileus / obstruction before stimulants or enemas.**

02 Prophylactic bowel regimen — start Day 0–1

Osmotic agent · first-line

- [ ] **Polyethylene glycol 3350** — `17 g PO/NG in 120–240 mL water once daily`, may increase to `17 g BID`
- [ ] Alt — **lactulose** (esp. with hepatic encephalopathy) `20–30 g (30–45 mL) PO/NG once–twice daily`, titrate to 2–3 soft stools/day

Stool softener · optional adjunct

- [ ] **Docusate sodium** `100 mg PO/NG BID`

If opioids started / anticipated

- [ ] Scheduled stimulant from the outset — **senna** `8.6–17.2 mg PO/NG qHS` (→ BID), or **bisacodyl** `5–10 mg PO/NG daily`

03 Assessment & stepwise escalation

ANCHOR Use the **last documented BM time** as the anchor for every step.

24 h — Step 1

No BM at 24 h — confirm tolerance, then intensify oral/NG

- [ ] Confirm feeds tolerated, no obstruction/ileus — abdominal exam, NG/OG output, KUB if concern
- [ ] Increase **PEG 3350 to 17 g PO/NG BID** (if not already)
- [ ] Add stimulant if not ordered — **senna 8.6–17.2 mg BID** or **bisacodyl 10 mg daily**. If on lactulose, increase to q8–12h (watch electrolytes)

48 h — Step 2

No BM at 48 h — add rectal therapy

- [ ] Reassess for ileus/obstruction (exam ± imaging). If no contraindication to rectal meds:
- [ ] **Bisacodyl suppository 10 mg PR daily PRN** no BM in 24 h
- [ ] Hyperosmolar rectal — **glycerin suppository 1 PR daily PRN**, or **sodium phosphate enema 118–133 mL PR daily PRN** (avoid in renal failure / elderly / CHF / electrolyte issues; monitor)
- [ ] Continue existing oral/NG regimen

72 h — Step 3

No BM at 72 h — refractory; high suspicion for ileus / obstruction

- [ ] **Obtain imaging** if not already done. If abdomen soft, non-tender, no obstruction:
- [ ] **PEG electrolyte solution (GoLYTELY) 1–2 L via NG over 2–4 h**, up to 4 L total as tolerated (start 1 L in frail/small; watch aspiration & hemodynamics)

- [ ] **Tap water / soap-suds enema 500–1000 mL PR**, may repeat ×1 (avoid in neutropenia / severe thrombocytopenia)
- [ ] Refractory **opioid-induced**, no obstruction — **methylnaltrexone SC every other day PRN**: `12 mg (62–114 kg)`, `8 mg (38–61 kg)`; reduce/avoid if CrCl < 30

CONSULT GI / SURGERY Persistent distension · worsening pain, lactic acidosis, or leukocytosis · **cecal diameter ≥ 9–10 cm** on imaging, or suspicion for acute colonic pseudo-obstruction.

04 Holding parameters / contraindications

HOLD / DO NOT INITIATE ORAL / NG / RECTAL AGENTS IF

- [ ] Suspected / confirmed mechanical obstruction or perforation
- [ ] Hemodynamic instability on escalating vasopressors (esp. enemas & high-volume PEG)
- [ ] Severe neutropenia / thrombocytopenia (avoid traumatic rectal procedures; prefer oral)
- [ ] Severe ileus with high residuals, vomiting, or marked distension
- [ ] Recent colorectal anastomosis / perineal surgery (rectal route per surgeon)

AGENT-SPECIFIC CAUTIONS

Sodium phosphate enema
Avoid / extreme caution in CKD, CHF, elderly — hyperphosphatemia, hypocalcemia, volume shifts

Lactulose
Watch hyponatremia, volume depletion; caution with large NG volumes if aspiration risk

Methylnaltrexone
Avoid with obstruction; monitor for abdominal pain and, rarely, perforation

05 Maintenance & de-escalation

ONCE HAVING REGULAR SOFT BMS — TAPER TO LOWEST EFFECTIVE REGIMEN

- [ ] Maintain one oral osmotic (e.g., **PEG 17 g once daily**)
- [ ] **Stop rectal therapies**
- [ ] Reduce stimulant to once daily → PRN, especially as opioids are weaned

DAILY ROUNDING CHECKLIST

Last BM	Abdominal exam	Opioid / sedative need	Enteral intake

QUICK REFERENCE

Simplified order set

Time-anchored to the last bowel movement.

Default prophylaxis · 24–48 h of admit

- [ ] PEG 3350 17 g PO/NG daily (→ BID); docusate 100 mg BID; senna 8.6–17.2 mg HS (BID if scheduled opioids)

24 h no BM

- [ ] Increase PEG to 17 g BID; ensure senna 8.6–17.2 mg BID ordered

48 h no BM, no obstruction

- [ ] Add bisacodyl suppository 10 mg PR daily PRN no BM in 24 h

72 h no BM, no obstruction / ileus

- [ ] PEG electrolyte solution 1–2 L via NG over 2–4 h (max 4 L/day); tap water enema 500–1000 mL PR ×1, may repeat. Refractory OIC → methylnaltrexone SC per weight every other day PRN

EDUCATIONAL USE ONLY

Not a substitute for clinical judgement. Always exclude ileus / obstruction before stimulants or enemas. Verify doses, allergies, renal/hepatic function, and contraindications. Adapt all agents and thresholds to your institutional protocol and the individual patient.

Spreading knowledge
Improving outcomes