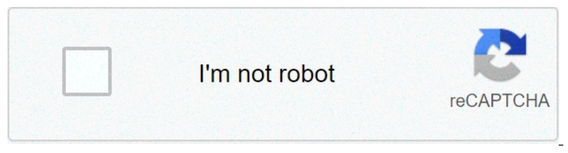

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How to make a fleet enema at home

Constipation, as defined succinctly by Urban Dictionary, is when you've gotta go, but your ass says "no!" It is a diagnosis that I can truly empathize with – who hasn't been at least a bit bunged up before? The constipated patients that present to the ED take this everyday ailment to a whole new level. No one shows up a little constipated. Those that know they're constipated come in as a last resort after trying the homemade remedies they saw on Dr. Oz. Those that don't are diagnosed through a combination of clinical acumen, exclusion and a FOS x-ray. Regardless, it's no fun to deal with for the nurses, the doctor or (most importantly) the patient. Regardless, they're sick and tired of it and they want YOU to fix it. Help them Obi-Wan Kenobi, you're their only hope. While I have diagnosed and treated constipation, I didn't have a great understanding of the treatment options or have a good Cocktail of my own. I suspect this is because: -As a resident on the ward, I don't actually take care of constipation. On the wards the nurses are monitoring the patient's bowels and noting what treatments have been tried and worked (or didn't). -In the ER, I don't know if my remedies worked or not unless there were instant results because my follow-up of constipation cases is nonexistent. -Constipation cocktails seem to be as numerous as the bartenders that mix them with many doctors having their own "special recipe" and different services (ie gen surg vs peds vs obstetrics vs internal medicine) having different approaches at my institution. This has given me some experience with many treatments but minimal experience with any specific one. -Poop, like me, doesn't make it onto EMCrit. Scatology just ain't that cool. To make up for my ignorance, I have developed coping/survival strategies such as ordering whatever the nurses on the ward ask for (at least that way if it doesn't work it's not blamed on me) and, when in the ED, picking something the patient hasn't already tried and sending them home to deal with their situation in precious privacy. I really wish I could just order up some lactu-seno-pico-glycol and let 'er buck, but because I can't it's time to learn about it: BoringEM Style. My goal for this post is to delve into a Constipation Cocktail in sufficient depth to adopt it for my own practice (and maybe yours?). Rather than coming up with my own untested Cocktail, I have adopted one that I was introduced to through #FOAMed on ERCast's Constipation Manifesto podcast. Thanks to Rob Orman for his excellent podcast and Dr. Aaron Wall for sharing his recipe. Dr. Wall's Constipation Cocktail (aka the Orange Poly-Fleet – sounds yummy): -Perform manual disempaction if indicated by stool in the rectal vault (the podcast has a great overview of an approach for this procedure) -Provide 1/2 bottle (8oz or ~250mL) of Magnesium Citrate orally in the ED -Advise the patient to mix 3-4 17g doses of Polyethylene Glycol daily until a soft stool is produced and then mix 1 17gdose daily for 3-4 weeks -Recommend 1-2 Fleet Enemas daily for the next 2 days -Counsel the patient to stop/limit the use of offending agents and to maintain well hydrated with oral fluids So how do these drugs work? What are their contraindications? Complications? What should I tell the patient to expect? How much will they cost? Manual Disempaction These are available free to all Canadians through sponsorship by our government (although you might have to wait in the queue for a bit). See the ERCast podcast for an excellent overview of how to perform this procedure. I've done it as many times as ZDogg. Magnesium Citrate It's a generic, OTC osmotic laxative aka Citromag that is made up of magnesium and citric acid. As the magnesium salt is poorly absorbed in the intestine, fluid is retained in the bowels. This fluid should soften the stool by increasing its water content and also increase the intraluminal pressure to help push things along. Notably, it should be given on an empty stomach with water. Because it contains magnesium, hypermagnesemia (hypotension/resp depression) is a possible complication and it should be used cautiously in patients with poor renal function. As an osmotic diuretic, other electrolyte abnormalities could develop and are more likely with frequent/excessive use. There have also been case reports of paralytic ileus secondary to hypermagnesemia. The patient should be told to expect increased abdominal cramping and flatulence. If they are purchasing the product themselves a 16oz bottle (2 doses) costs