Constipation

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Case Study: Mrs. L is a 48-year-old woman who was in excellent health until four years ago, when she was diagnosed with stage II infiltrating ductal carcinoma of the right breast. Her tumor was estrogen- and progesterone-receptor negative and overexpressed HER-2/neu. Her surgical management consisted of lumpectomy with axillary dissection. This was followed by four cycles of adjuvant chemotherapy with adriamycin and cyclophosphamide and four additional cycles of docetaxel.

Mrs. L remained well until two months ago when she presented with a complaint of "almost constant back and right shoulder pain." A bone scan revealed multiple lesions in the thoracic and lumbar spine, right scapula, and ribs that were thought to be consistent with metastatic disease. Computed tomography scans were performed at that juncture and demonstrated several small lesions in the liver that were too small to biopsy. In light of the bony metastases, the liver lesions were believed to represent visceral metastatic disease. Mrs. L began a weekly regimen of trastuzumab and paclitaxel, along with zoledronic acid every four weeks. She also received a prescription for oxycodone 5 mg orally every three hours as needed for control of pain.

Upon arriving for her weekly treatment, Mrs. L reported a 24-hour history of diffuse abdominal pain accompanied by mild nausea and abdominal distention.

Assessment

A thorough nursing history is essential to begin the diagnostic process, make appropriate decisions regarding management, and determine whether Mrs. L can receive her treatment as scheduled. The following information is important to note.

- The abdominal pain is described as "spasmodic" and appears to have no pattern or specific timing. It does not inhibit activity and is rated as 2–3 on a 10-point scale.
- Mrs. L reports that her appetite has declined somewhat since resuming chemotherapy. She seems to tolerate dairy products well but avoids most fruits and vegetables because of taste alteration. She also avoids water because of taste alteration and prefers to drink colas.
- Although her current treatment regimen is not particularly emetogenic, Mrs. L experiences anticipatory nausea based on previous experiences with chemotherapy. She is treated with IV ondansetron before each treatment but does not require additional antiemetic therapy. She does, however, describe mild nausea during the past 24 hours.
- During the past two weeks, Mrs. L has experienced a significant increase in lower back pain. She denies any associated symptoms such as lower extremity weakness or paresthesia. She rates the pain as 6–7 on a 10-point scale and has been using oxycodone 5–10 mg every three hours to reduce the pain to 2–3 out of 10.
- Mrs. L reports that she has not had a bowel movement in the past four days. She does not find this particularly alarming because she has "almost always been irregular." She denies any other bowel changes such as melena or rectal bleeding.
- Mrs. L takes no medications other than those mentioned previously.

Significant findings on physical examination include firm distention of the abdomen with mild diffuse tenderness to palpation. Bowel sounds are normoactive in all quadrants, no masses or organomegaly are noted, lower extremity neurologic function is intact (both sensory and motor), and lower extremity strength is 4 out of 4. Gait is normal. Because Mrs. L's total white blood cell count was within normal limits at 5,400/mm^3 and she was not neutropenic, a rectal examination was performed. The examination revealed a small amount of hemoccult negative brown stool in the rectal vault.

Based on the information from the history and physical examination, the most likely diagnosis is constipation. Other considerations include intestinal obstruction and spinal cord compression, which is of particular concern in patients with significant bony metastases of the spine. Although neither of these can be excluded completely on the basis of the history and physical examination alone, intestinal obstruction is less likely in a patient with normoactive bowel sounds, and the finding of stool in the rectal vault and the patient's intact neurologic function reassure the healthcare provider that no

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