Buckinghamshire Healthcare NHS
NHS Trust

Bowel Management after Spinal Cord Injury

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Safe & compassionate care,
every time

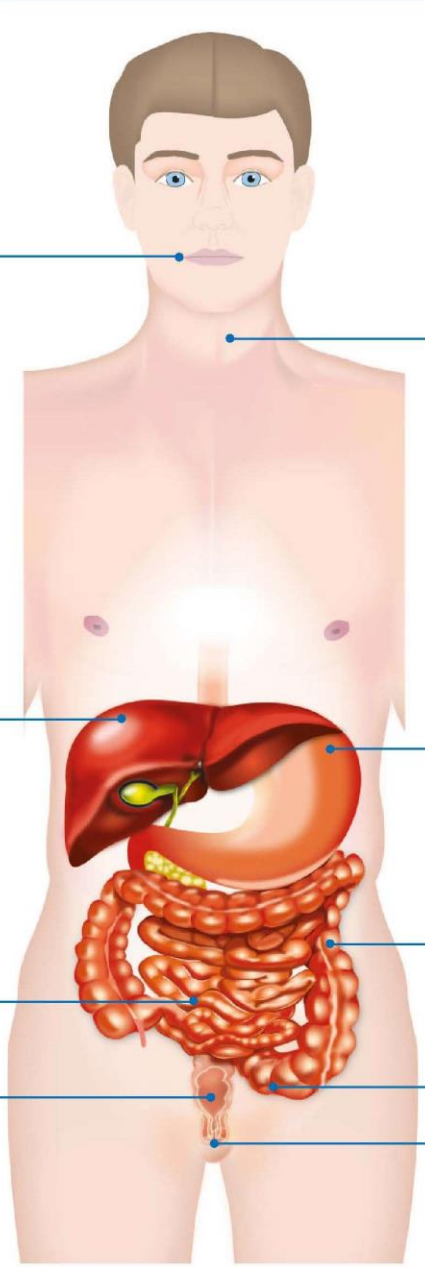
Why do you need to look after your bowel after Spinal Cord Injury?

- The feelings from your bowel may have changed
- Your control of your bowel may have changed
- The movement of stool (poo) through your bowel may have slowed down

Why learn about bowel care?

- To stay in control of your bowel and avoid accidents
- So that you can open your bowels regularly and at a time that suits you
- So you don’t spend too long on the toilet
- To avoid constipation and Autonomic Dysreflexia
- To keep healthy

The Gut or Gastrointestinal Tract



1 Mouth

- Breaks down food into more digestible sizes by chewing.
- Produces saliva to lubricate.
- **Gastro-colic reflex stimulated.**

2 Oesophagus

- Transports the food.
- Lubricates with saliva.
- Ensures the food does not go into the lungs instead.

Liver

- Responsible for detoxification and produces bile to break down fats.

3 Stomach

- J shaped organ.
- **Churns food**, mixing it with hydrochloric acid and gastric juices.
- Kills bacteria in the food.
- Stores food for 3-5 hours as we can eat quicker than we can digest it.
- Some absorption of nutrients.

4 Small intestine

- Enzymes break down food into its most basic parts.
- Structure contains multiple folds increasing the surface area available for **absorption of all useful food.**
- 4–6m long.
- 95% of nutrient absorption occurs here.

5 Large intestine (colon)

- Cells designed for **reabsorption of water** and producing mucus to move the stool through.
- 1.5l enters and 100–200mls exits.
- Approx 1.25m long.

6 Sigmoid colon

- Acts as a **holding area** before stool and/or gas is moved down into the rectum.
- Draws water for the stool.

7 Rectum

- 10–15cm long.
- Stretching of its walls by the stool sends impulses to the brain via the spinal cord.
- Has the ability to define **between gas, liquid and formed stool.**
- If call to stool is ignored at this point, stool will be moved back up to the sigmoid colon until later, causing it to become drier.

8 Anus

- Has an internal sphincter under autonomic control and external sphincter under voluntary control, **giving choice on** whether to pass the gas, liquid stool or formed stool through or not.

How do we have our bowels open?

- Gas, liquid or solid stool moves from the sigmoid colon down into your rectum
- The rectum senses whether it’s gas, liquid or solid and sends messages via your spinal cord to your brain to say what it is
- Because you could ‘feel’ what's there, you could decide whether you would allow the stool or gas to pass
- If not the right time, you squeezed your rectum and it would move the stool back up into the sigmoid colon where it would wait till later

Bowel control after SCI

- No feeling or inaccurate feelings of needing to pass stool / gas
- Changed ability to resist passing, due to loss of muscle control
- Risk of ‘bowel accidents’
- Anxiety and fear of having ‘bowel accidents’
- Waste moves slower/dries more
- A risk of severe constipation

Bowel control after SCI

How we manage your bowels after injury depends on where you are injured (your level) and if you have accurate feelings of needing to go to the toilet.

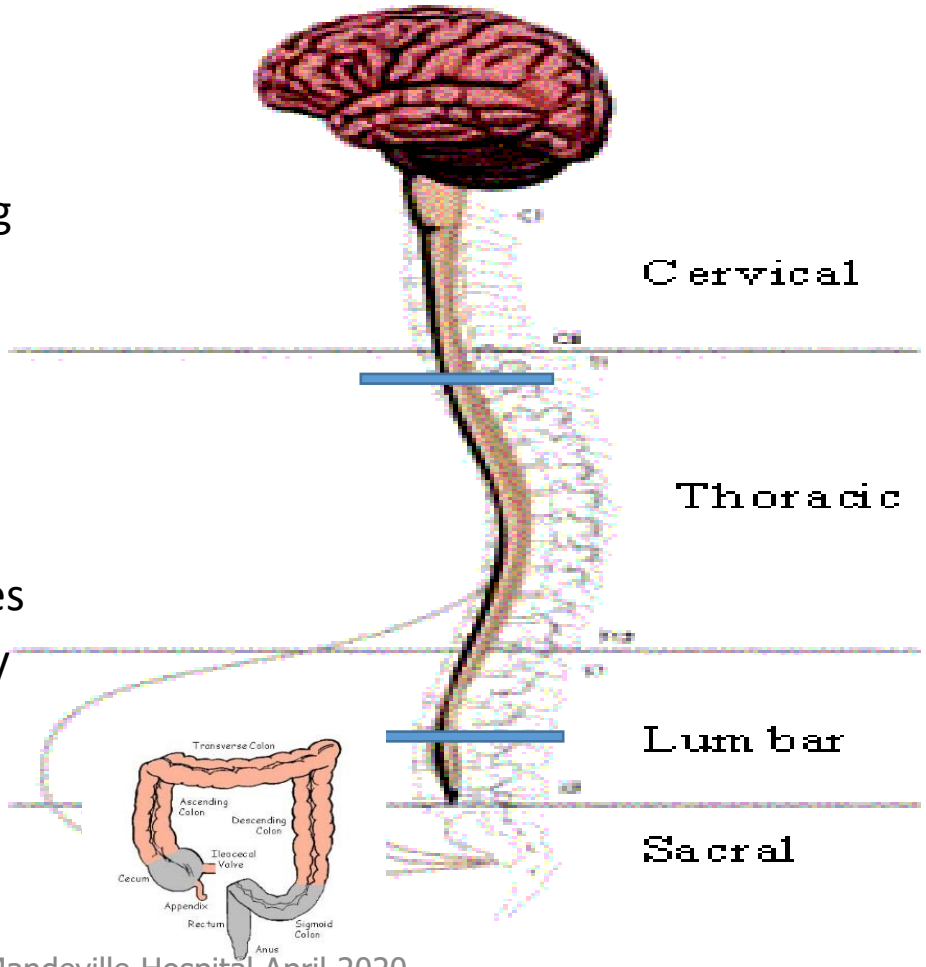
We use the term Reflex if injured above T12 and Flaccid if injured below T12/L1/cauda equina

Reflex bowel:

- Management is based on using remaining rectal reflexes to open your bowels at a planned time
- Anal sphincter remains tight
- **Type 4 stool is best**

Flaccid bowel:

- Rectum doesn't empty itself as no reflexes
- Management based on planned manually removing the stool
- Anal sphincter is loose
- **Type 3 stool is often best**



What if you are incomplete?

You may have some sensation and / or control

Is it accurate?

- Can you tell if it's gas, liquid or solid?
- Can you stop yourself from passing stool and resist going to the toilet until a time suits you?

If not…you would benefit from having a planned routine

What can help you maintain a regular and reliable bowel routine?

- Regular meals, drinks and snacks through the day - five a day!
  Please refer to nutrition section for details

- Activity/Lifestyle
  - Exercise
  - Standing in standing frame
  - Getting out and about

- Having your bowels open daily or alternate day and recording what type of result you had!
- Keep yourself regular, same routine, same time

Diet and the role of Fibre

We need both insoluble and soluble fibre to create a stool consistency that the bowel wall can move through easily.

Insoluble fibre (roughage) is the seeds / skins and outer coatings of fruit / vegetables on grains etc.

It does not absorb or dissolve in water.

It passes through our digestive system close to its original form

- Softens and bulks stool
- Helps pass waste more easily
- Speeds up transit time

Whole wheat and whole grain products, vegetables and wheat bran

Soluble fibre

Soluble fibre consists of the insides of fruit, vegetables and grains that dissolve in water from food and digestive juices.

Soluble fibre can

- Absorb excess fluid in bowel
- Firm up a loose stool (sponge effect)

Other health benefits:

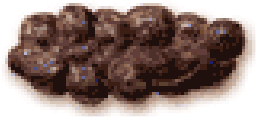
- Lowers blood cholesterol
- Lowers blood glucose

Oats, barley, nuts, seeds, beans, lentils some fruits and many vegetables

The Bristol Stool Scale

Aim for a type 4 (Reflex) or type 3 (Flaccid)

Type 1 Separate hard lumps, like nuts



Type 2 Sausage-like but lumpy

Type 3 Like a sausage but with cracks in the surface

Type 4 Like a sausage or snake, smooth and soft

Type 5 Soft blobs with clear-cut edges

Type 6 Fluffy pieces with ragged edges, a mushy stool

Type 7 Watery, no solid pieces

Oral laxatives / bowel medication

If you cannot create a Type 4 stool with diet alone because of factors like slower transit, lack of mobility, medications for pain and spasms for example you may need to take medications to help

Laxatives fall it to two broad groups:

1. Laxatives to prevent constipation and keep the stool softer

Taken regularly in small quantities to maintain appropriate stool consistency:

- Dioctyl
- Lactulose
- Movicol/Laxido
- Fybogel – bulker, absorbs liquid

2. Stimulant laxatives to help give timing to the planned routine

To prepare for evacuation – taken 8-12 hours before wanting to pass stool:

- Senna
- Bisacodyl

Reflex bowel management routine

Regular Diet and medications to adjust stool consistency to produce type 4 stool

- Start with stimulant laxative for example Senna (if needed) 8 – 12 hours before bowel care
- Stimulate Gastrocolic reflex by eating and drinking 20-30 mins before beginning routine
- Digital Rectal Examination (DRE) 'Digital Check' to assess for stool in the rectum
- Insert rectal stimulant i.e. suppository or micro enema allow time to stimulate response
- Abdominal massage following the lie of the colon
- Digital Rectal Stimulation(DRS) with single finger against rectal wall for approx 20-60 seconds. Repeat until response tires or stool is evacuated
- Digital Removal of Faeces (DRF) ie 'Manual evacuation' if stool remains in rectum after DRS – if assistance is required, this will be carried out on a height adjustable bed
- Single digital check to ensure rectum is empty after approx. 5 minutes and repeat previous 2 stages if stool present
- Document outcomes ie Amount, Type 1-7 and any unplanned results between planned bowel routine

Flaccid bowel management routine

Regular diet and medications to adjust stool consistency
(if needed / available) to produce type 3 or 4 stool

- **Start with stimulant laxative for example Senna (if needed) 8 – 12 hours before bowel care**
- **Stimulate Gastrocolic reflex by eating and drinking 20-30 mins before beginning routine**
- **Digital Rectal Examination (DRE) 'Digital Check' to assess for stool in the rectum**
- **Abdominal massage following the line of the colon**
- **Digital Removal of Faeces (DRF) ie 'manual evacuation' if stool remains in rectum – if assistance is required this will be carried out on the bed**
- **Single digital check to ensure rectum is empty after approx. 5 minutes and repeat previous 2 stages if stool present**
- **Document outcomes ie Amount, Type 1-7 and any unplanned results between planned bowel routine**

What is a ‘good’ bowel routine?

A pre-emptive ‘conservative’ bowel routine works very well for the majority of people with a SCI

A ‘good’ routine is seen as being one that:

- Takes less than an hour
- Prevents constipation / impaction
- No unplanned results
- Enables you to carry on with life with minimal worry about your bowels

Problems / Problem Solving

Haemorrhoids(Piles)

- Swollen blood vessels in your rectum that bleed easily
- Bright red blood on your toilet paper / gloves when having your bowels open

Talk to your consultant / GP as they may want to prescribe a cream to help shrink them, or refer you to have them looked at

Problems / Problem Solving

Constipation / Impaction

- Not passing stool / passing less for several days despite planning to
- Associated hard stools, bloating and wind, increased spasms, autonomic dysreflexia
- Overflow diarrhoea – liquid stool squeezing around the hard stool
- Can lead to feeling sick / being sick
- Breathlessness - stool pushing up onto diaphragm
- If untreated, you can become very unwell

Problems / Problem Solving

Constipation / Impaction - Treatment

- Review your diet and fluids
- Talk to NSIC MDT team / GP about increasing or starting bowel medications to help push the hard stool through
- Reflect on why it happened to prevent it happening again

Are there other options?

Although a ‘conservative’ routine is successful for most for many years, for others it is less so

- They may wish to discuss trans-anal irrigation or colostomy with their NSIC team

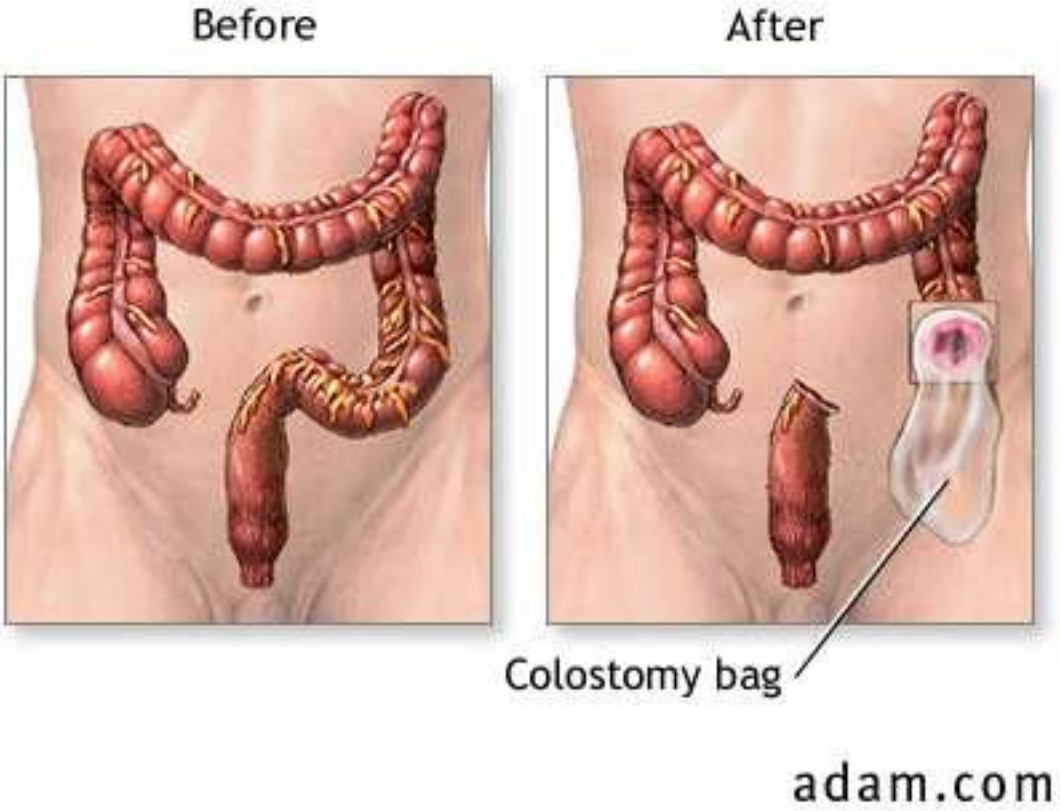
Trans-anal Irrigation

What is irrigation?

- A process of facilitating evacuation of faeces from the bowel by passing water in via the anus in a quantity sufficient to reach beyond the rectum and stimulate the stool to move down

What is a Stoma?

A Stoma is when the bowel is brought up to the surface of the abdomen, and the contents then go into a collection bag, rather than out through the anus.
It is called a **colostomy** (pictured below) when the colon is brought to the surface.



Need help?

- After discharge from the NSIC your GP team is your first line of contact
- In an emergency seek help from your local A&E
- You can call the NSIC Spinal Outpatient team for advice/telephone consultation appointment
  - Please refer to the SPOP section for details

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