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Buckinghamshire Hospitals
NHS Trust



**NATIONAL SPINAL INJURIES CENTRE
SPINAL OUTPATIENT SERVICES
STOKE MANDEVILLE HOSPITAL**

**BOWEL MANAGEMENT
FOLLOWING SPINAL CORD INJURY**

**Maureen Coggrave, RN, MSc
Nursing Research Fellow
NSIC**

**Anne McCreath, RGN
Deputy Sister
Spinal Outpatient Services**

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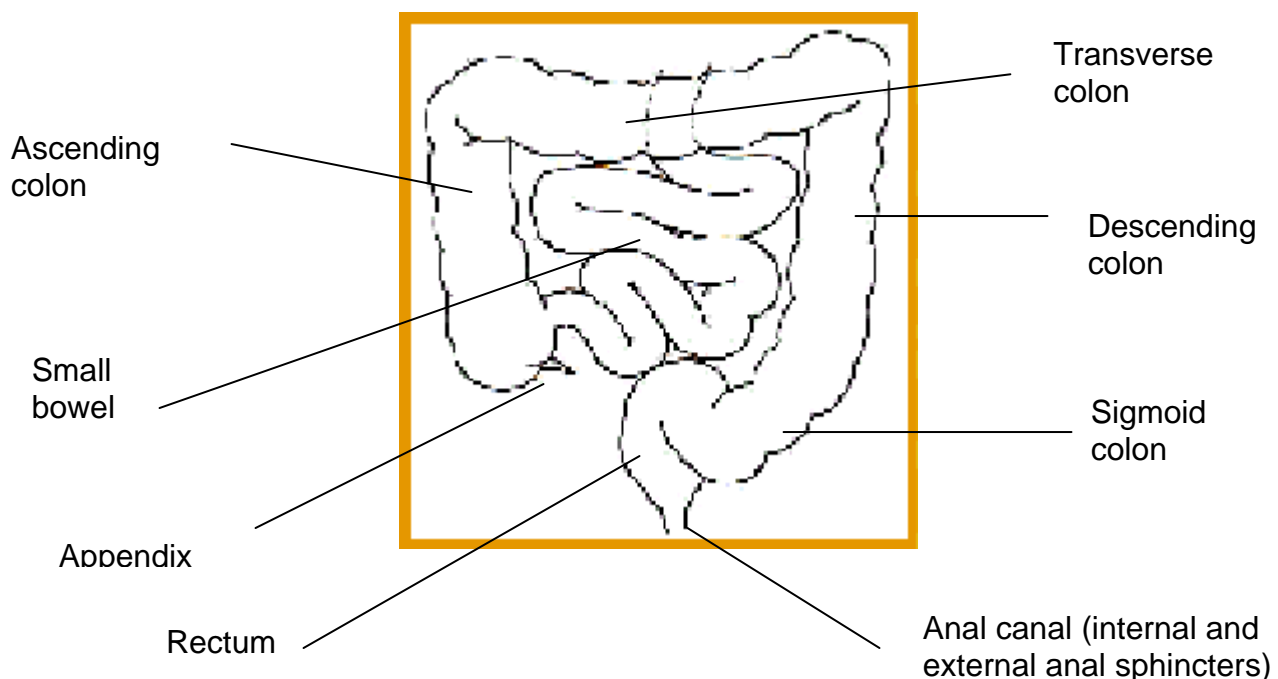
Establishing an effective bowel management programme after spinal cord injury is essential for the future well being of each individual. If this is not achieved there is a likelihood of faecal incontinence, which will interfere with an individual's physical, psychological, social, recreational and sexual function. Many spinal cord injured clients have said that after loss of mobility, loss of bowel control is the next most distressing aspect of SCI. The way the bowel is managed can be called 'managed continence' – the aim is not only to ensure adequate bowel emptying but to achieve control over bowel function.

1. Normal Defaecation

Defaecation is both an involuntary and voluntary process which is controlled by the spinal cord and the brain.

The sigmoid colon is the storage area for stool and the rectum is usually empty until just before defaecation. When stool is pushed through from the sigmoid colon to the rectum the increased pressure and distension cause sensory impulses to initiate reflex impulses in the internal anal sphincter and muscle of the rectum, and the urge to open the bowel reaches consciousness. The internal sphincter relaxes and the rectum contracts, moving the stool to the anal canal. If the urge to defaecate is acted on, the external sphincter is voluntarily relaxed and the stool is expelled. If the urge to defaecate is inconvenient, the external sphincter remains closed and the urge to defaecate soon wanes.

The nerves which provide sensation and both voluntary and involuntary motor control of the anal canal arise from the sacral (S)2, S3, S4 nerve roots.. Any spinal cord injury at this level or above will cause damage to the nervous control of defaecation.



2. Bowel function after Spinal Cord Injury

After a complete spinal cord injury the descending input from the brain to the colon and ano-rectum is lost. These changes result in the loss of sensation of the need for defaecation, loss of voluntary control of defaecation and loss of the brain's influence over reflex activity.

The enteric nervous system, which lies within the walls of the colon, remains functionally intact. Therefore peristalsis continues, but without the co-ordination from the brain and spinal cord it is less effective, and colonic transit time can be extended to around 80 hours on average. This is an increase of approximately 50 hours above the average for the able bodied population and this extended time in the colon results in a drier stool and an increased likelihood of constipation.

Other effects on the bowel depend on the part of the spinal cord that is damaged. When spinal shock has resolved, one of two types of neurogenic bowel may develop.

2.1 Reflex bowel

Injuries to the twelfth thoracic vertebra (T12) and above result in what is known as a 'reflex bowel'. Injuries at this level result in damage to upper motor neurons (lying within the spinal cord) leaving the reflex arc from the cord to the colon and ano-rectum intact.

This remaining reflex activity can be utilised for effective bowel management. By stimulating the rectum the bowel *may* push faeces from the rectum through reflex contraction, reducing the need for aperients or manual evacuation. This reflex activity can be triggered using a gloved lubricated finger to stimulate the rectum (see ano-rectal stimulation below), or by the insertion of a suppository or micro enema, or both combined. It is then advisable for the SCI individual or his carer to check that the rectum is empty to prevent embarrassing accidents occurring later on. It is advisable to aim for a soft formed stool which is easier for the rectum to expel (Bristol Scale 4 – see page 19).

2.2 Flaccid bowel

Injuries to the first lumbar vertebra (L1) and below result in a flaccid bowel with a lax anal sphincter and pelvic floor. Injuries at this level damage the reflex arcs between the spinal cord and the colon and ano-rectum and the reflex activity of the bowel is lost. This results in slow stool propulsion through the descending and sigmoid colon and a high risk of faecal incontinence through the lax anal sphincter. The management for this type of bowel is based on a manual evacuation of the stool, therefore a slightly firmer stool which is easier to remove digitally is advised (Bristol Scale 3).

Where the SCI is incomplete remaining bowel function may not fit neatly into these definitions. It is important therefore to base bowel management on individual assessment.

3. Aims of Bowel Management

The changes in bowel function following SCI mean that there is a need to actively manage the bowel – managed continence - the main aims being to:

- Achieve regular and predictable emptying of the bowel at a socially acceptable time and place
- Avoid constipation, faecal incontinence and Autonomic Dysreflexia
- Complete bowel management within a reasonable time i.e. ideally up to one hour
- Use minimum necessary physical or pharmacological interventions
- Maintain short and long term gastrointestinal health.

The overall aim of bowel training is to enable the SCI individual to be in control of his bowel function, independently or through a carer, and to promote his reintegration into society. The individual requiring assistance must give his consent for any intervention, usually verbally. This supports the individual's right to self-determination and autonomy (RCN 2000).

4. Factors Affecting Bowel Management

Bowel management will be affected by various factors including:

- Previous medical history, particularly any pre-existing bowel condition
- Pre injury bowel habit
- Current medication, which may affect bowel activity
- The level of injury i.e. whether the patient has a reflex or flaccid bowel
- Psychological and emotional factors

It is important to be aware that some SCI individuals disassociate themselves from their bowel care as it can be an embarrassing topic to discuss and to manage, especially, but not only, in the weeks immediately following injury. However, the SCI individual should realize that by taking control of their own bowel management they can retain greater dignity and independence.

- Lifestyle
It is important for bowel management to suit the lifestyle of the individual and factors such as working patterns and cultural issues should be taken into consideration when planning bowel care.

5. Moving Stool Through the Bowel

A major aspect of bowel management following spinal cord injury focuses on methods to encourage the movement of stool through the bowel. This can be aided by the following:

5.1 Exercise and activity

Physical activity helps to promote peristalsis in the colon, which in turn helps to keep stools moving. SCI individuals should carry out as much of their own care as possible, such as transferring and pushing, bathing and dressing, as these activities help to provide daily exercise, thereby helping to move the stool through the colon and avoid constipation. Other activities such as passive movements, stretching and using a standing frame can also be beneficial and can be timed to help with bowel management.

5.2 Diet and fluid intake

Diet is of vital importance in achieving successful bowel management as both **what** is eaten and **when**, has a major effect on bowel function.

It is important to eat a balanced diet which is rich in fruit, vegetables, bread and cereals, to ensure an adequate fibre intake. Fibre holds water and adds bulk to the stool, which aids the movement of the stool through the bowel. Excessive amounts of fibre should, however, be avoided and raw bran is no longer recommended. Diet should also contain a moderate amount of dairy products, meat, fish or pulses. Foods containing fats and sugars should only be consumed in small amounts. It can be useful to note foods which have a marked effect on the bowel and which may need to be avoided. However, these foods can be used positively to help in bowel management. I.E prunes, figs etc

Another important aspect of the diet is **when** the meals are taken. Meals should be taken at regular times throughout the day to keep the digestive process working thus helping to prevent flatulence and bloating.

It is also essential to have an adequate daily fluid intake in order to avoid constipation. The body should be well hydrated in order to prevent too much absorption of water by the colon, which results in a hard, dry stool. A fluid intake of at least 2 litres daily is recommended made up mostly of water. This may need to be adjusted where bladder management or other medical conditions dictate.

5.3 Stimulation of the gastro-colic reflex

Eating and drinking initiates peristalsis throughout the digestive system thus moving stool through the colon towards the rectum. This is called the gastro-colic reflex. It can be beneficial to make use of this reflex and plan to empty the bowel 20 to 40 minutes after a meal or at least a hot drink I.E after breakfast or the evening meal.

5.4 Abdominal massage

Massage is thought to mechanically push stool through the colon and to stimulate the colon to push stool towards the rectum. The abdomen is massaged gently by using a half-closed fist or the heel of the hand in a kneading action. The massage follows the lie of the colon towards the rectum – that is up the right hand side of the abdomen, across the abdomen at around the umbilical level and down the left hand side of the abdomen

5.5 Oral laxatives

While laxative medication is not essential for all SCI individuals, many find that they do need to take some form of medication to aid the passage of stool through the colon; by trial and error, individuals find which types and amounts suit their needs. In some cases there may be a need for a combination of medications influencing stool consistency and stimulating peristalsis but all medication should be reviewed periodically as bowel habits change with the passing of the years after injury.

The following is a list of medication commonly used by the National Spinal Injuries Centre which we have found to be appropriate for our patients' needs.

Senna directly stimulate peristalsis of the bowel, helping to push stool along. Given 8-12 hours prior to planned evacuation only.

Bisacodyl Work within 6-12 hours. May cause abdominal cramps and loose stool. Given 8-12 hours prior to planned evacuation only.

Docusate sodium (Dioctyl) stool softener which also has some stimulant effect. It enables the stool to retain more water. Should be taken regularly to maintain appropriate stool consistency. Useful for individuals prone to hard stools though diet should be addressed first.

Fybogel (Ispagula husk) Bulk forming – keeping the stool soft and aiding stimulation of peristalsis. Takes several days for bulk formers to be effective. Should be taken within 30 minutes

of a meal with plenty of fluid. Usually gentle but can cause bloating and wind. Should be taken regularly to maintain appropriate stool consistency.

Lactulose

Osmotic – pulls fluid into the bowel and stool so increasing bulk and softening stool. Should be taken regularly to maintain appropriate stool consistency.

Can cause wind, bloating, cramping and dehydration

Movicol

- Iso-osmotic – similar to osmotic but also provides electrolytes to avoid imbalance of fluids and electrolytes due to excessive loss in stool.

Can cause bloating, nausea and pain or very loose stool if taken too frequently or in large quantities. Should be taken regularly to maintain appropriate stool consistency.

6. Removal of stool from the lower bowel and rectum

When stool has reached the sigmoid/rectum the following factors can aid the evacuation process:

6.1 Posture

Where an individual is able to transfer or use a hoist it is generally more effective to sit upright on a padded toilet seat, commode or shower chair in order to manage his bowels. Peristaltic activity is greater when sitting upright and gravity can aid the expulsion of stool from the rectum.

6.2 Abdominal massage

Gentle massage of the left side of the abdomen, down towards the rectum, can aid a reflex evacuation by keeping the stool moving downwards, thereby achieving a more complete evacuation. Massage can also help to push stool out of a flaccid bowel or to move stool down ready for manual evacuation.

6.3 Ano-rectal stimulation

Ano-rectal stimulation makes use of the remaining reflex activity in individuals with a cervical or thoracic injury by triggering relaxation of the anus and peristalsis in the lower colon and the rectum.

This is achieved by the insertion of a gloved, lubricated finger into the anus followed by a gentle circular motion of the finger for 20-30 seconds. The finger should remain in contact with the wall of the rectum and stimulation should not be continued for more than one minute.

The finger is then removed to allow the reflex contractions to move stool down into the rectum from where it is expelled. This stimulation can be repeated every 5-10 minutes, until the bowel has emptied and no more stool can be felt in the rectum. Stimulation more than 2 or 3 times is not usually necessary but the needs of the individual and their responsiveness to the technique should determine how many times stimulation is conducted.

The strength of reflex contractions can vary greatly from one individual to another and in many cases may not produce a complete emptying of the rectum. In this case it will be necessary to carry out a manual evacuation of the remaining stool.

6.4 Manual evacuation -

Manual or digital evacuation of stool involves the use of a single finger to remove stool from the bowel to avoid incontinence or impaction of faeces, occasionally when other methods have failed, or as part of routine bowel management.

It may be used to break up a hard constipated stool in the rectum to promote evacuation, or to remove stool prior to the insertion of a suppository/micro enema against the rectal mucosa for reflex bowel care (Consortium for spinal cord medicine 1998). It may be used by individuals with new SCI of any level, where all other physical stimulation and oral/rectal laxatives have failed to produce emptying of the rectum (Addison 1995, Correa and Rotter 2000, Powell and Rigby 2000) and by individuals with chronic SCI where manual evacuation forms an established part of their bowel management routine.

See Procedure/ and Protocol for Digital Evacuation of Faeces in Spinal Cord Injured Patients for more information (see attached leaflet)

6.5 Rectal Laxatives

Many individuals with spinal cord injury also require rectal medication although the use of suppositories and enemas is not an essential part of bowel management for all spinal cord injured people.

Those listed below are commonly used in the NSIC.

Glycerine suppository - irritates the colon wall, encouraging peristalsis and providing lubrication. Acts within 20 – 30 minutes

Most commonly used and mildest suppository.

Bisacodyl suppository (Dulcolax) - stimulates peristalsis. Acts within 30 – 60 minutes

Raises blood pressure slightly. May cause headache or abdominal cramps and “accidents”

Carbalax - Gives off carbon dioxide gas when wet in the rectum – this stimulates the rectum wall, stimulating peristaltic activity.

Availability may be limited during summer months due to temperature/storage problems; this may lead to withdrawal of this product from the market in the future

Micralax enema - contains a stimulant laxative (Sodium Citrate). For treatment of acute constipation only.
NOT recommended for routine maintenance

Large volume enemas are not generally used after spinal cord injury because:

- Due to lack of sensation in the rectum there is a risk of damaging or perforating the wall of the rectum
- They present a risk of Autonomic Dysreflexia
- Many spinal cord injured individuals are unable to retain large volume enemas
- They are thought to make the bowel ‘lazy’, leading to a dependence on the use of enemas to empty the bowel
- The amount of fluid required to produce results increases with repeated use and using large amounts of fluid can wash important nutrients from the bowel.

7. DEVELOPING A BOWEL MANAGEMENT ROUTINE

Developing an individual bowel routine is a very personal and individual process, which often involves a certain amount of trial and error, especially in the early stages. For this reason it is advisable to keep a record of daily bowel management outcomes, which can be recorded using the Bristol Stool Scale (see page 19), together with such details as oral and rectal medication used, how long bowel management takes and whether there have been episodes of incontinence (unplanned bowel evacuation).

The first point to consider is the individual’s bowel habit prior to injury, i.e. how frequently did they open their bowel and at what time of day. It is then advisable to establish a daily or alternate day routine, at a time that will be most appropriate to their intended lifestyle. For example, if they have to get up early to go to work or to school, they may prefer to manage their bowels in the evening when they have more time.

If aperients are required they should be taken 8 – 12 hours prior to the bowel management episode. The bowel management process should not be hurried – adequate time should be allowed to promote a relaxed and complete evacuation. In order to make use of the gastro-colic reflex, which kick-starts the bowel into action, a meal or hot drink should be taken first.

Once individuals of C6 level and below are capable of transferring on and off a shower chair or toilet with a padded seat, either alone or with help from carers, bowel management can be conducted over the toilet. Individuals who are sufficiently able can insert their own suppositories, either while still on the bed or once over the toilet and then use abdominal massage to help move the stool down. For those that require assistance, these tasks can be carried out by nursing staff or other carers.

For the individual with a **reflex** bowel, the act of inserting the suppositories may produce a reflex emptying of the rectum. In this case, when reflex activity has stopped a gloved, lubricated finger should be gently inserted through the anus to check if the rectum is empty. If stool can be felt, abdominal massage should be continued and further ano-rectal stimulation should be carried out to produce further reflex activity. Digital stimulation more than 2 or 3 times is not usually necessary but the needs of the individual and their responsiveness to the technique should determine how many times stimulation is conducted. Wait 5 – 10 minutes between each episode of stimulation. If no stool is felt 5 – 10 minutes after the last stimulation bowel management should stop as **over stimulation must be avoided**. Over stimulation can lead to delayed reflex activity after the bowel management episode is completed resulting in incontinence, and the production of excessive mucous resulting in soiling.

Individuals with a **flaccid** bowel are usually able to be independent in their bowel management because their level of injury leaves them with full trunk and arm function. Due to the absence of reflex activity in the rectum the individual is advised to perform abdominal massage to encourage the movement of stool down towards the rectum and then to use manual evacuation of the stool to empty the rectum. When no further stool has been felt in the rectum for 5 – 10 minutes bowel management should stop. Glycerine suppositories may be used to provide lubrication, if required, but will not stimulate any reflex activity.

Straining briefly is a normal way of instigating defaecation for many people. However, prolonged straining can contribute to the development of haemorrhoids and bowel prolapse in the long term. Therefore straining should not be used as the primary method of emptying the bowel.

When returning to the community SCI individuals should understand their bowel management needs and have an established bowel routine. The individual should be either physically independent in this aspect of their care or verbally independent, in that they are able to instruct others as to their needs.

Many individuals will require some support with their bowel care in the community, often from District Nurses or other carers. **The importance of effective bowel management to the SCI individuals' quality of life cannot be over emphasized. Where possible the established routine should be maintained. If the routine is considered to be ineffective, changes should only be made in consultation with the SCI individual themselves.**

Special equipment may be required to enable appropriate bowel management in the community. Every effort is made by the NSIC multi-disciplinary team to ensure that all necessary equipment is in place prior to discharge.

8. Long term issues

Alterations or problems in bowel routine may occur anytime following spinal cord injury though these changes appear to be more frequent several years following paralysis. Also the way the bowel is managed in the early years post-injury may well affect how it works in later years.

These changes may be due to:

Life style	less activity away on holiday admission to hospital being on bed rest
Diet	less fibre unfamiliar foods
Fluid intake	too much or too little fluid drinking beer and Guinness
Illness	having a high temperature following surgery/during illness
Medication	Many different types of medication affect the bowel causing constipation or diarrhoea e.g. antibiotics, pain killers, anti spasm drugs
Weather	becoming dehydrated in the heat
Ageing	Normal ageing process (may be more apparent due to spinal cord injury)

Problems which may occur include:-

- Prolonged evacuation
- Constipation.
- Overloaded Bowel.
- Diarrhoea.
- Rectal bleeding
- Haemorrhoids (Piles).
- Anal Fissure (see Separate heading).
- Autonomic Dysreflexia (especially in levels of T6 or above).
- Rectal Prolapse

8.1 Prolonged evacuation

Our experience would suggest that bowel function becomes more sluggish as time passes following spinal cord injury. The reasons for this are not clear but may be due, in part, to reduced levels of activity and other conditions and illnesses. It is also thought that laxatives become less effective following prolonged use over the years. These factors can mean that after many years of injury, bowel management may take longer and be less successful and it is for this reason that the use of laxatives should be minimised and always used in conjunction with diet and appropriate physical interventions. The use of ano-rectal stimulation and manual evacuation has not been associated with any adverse effects.

8.2 Constipation

Infrequent bowel actions and hard, dry stools indicate constipation (Bristol Scale 1 – 2).

Causes of constipation include:

- Diet lacking in fruit, vegetables and fibre
- Poor fluid intake.
- Small or irregular meals.
- Change in routine, e.g. bed rest.

- Irregularity in bowel management.
- Certain drugs - Oxybutynin, some antibiotics and analgesics (painkillers).
- High temperature from infections e.g. bladder infection.
- Emotional or psychological upset – i.e. bereavement etc
- Not enough aperients (dosage and frequency)

Signs and Symptoms may include:

1. Passing none or only small amounts of hard stool which will probably be difficult to evacuate. There may also be blood on the stools caused by damage to the lining of the rectum.
2. Headache and sweating - see separate handout "Autonomic Dysreflexia".
3. An increase in spasms.
4. Abdominal distension - the stomach may feel hard and distended causing the patient to feel very uncomfortable and in some cases may experience pain.
5. Loss of appetite, nausea and/or vomiting.

6. Passage of very thin, offensive stool-coloured liquid. This indicates 'Constipation with overflow' - hard, dry stool remains in the bowel while the liquid seeps around it and leaks out. This may be confused with diarrhoea.

Treatment:

If constipation occurs: -

1. Increase the amount of fibre in the diet.
2. Increase fluid intake.
3. Increase alternate day bowel evacuations to daily until the problem has been resolved.
4. Eat small meals regularly.
5. Increase aperients and faecal softeners if already using them.
6. Introduce aperients or softeners into the bowel management routine

NOTE:

Aperients are usually taken approximately twelve hours before the bowel is to be emptied. However if severe constipation is present the aperient may not be able to move the stool within the usual time scale. Aperients still need to be taken, and routine suppositories/evacuations done but bowel emptying will probably be erratic until the constipation is cleared.

It is also **important** to note that once the episode of constipation has been resolved, attention should be paid to identifying the cause of the problem. It is not advisable to simply continue with the increased use of laxatives without reviewing all the factors affecting bowel function. This may involve change to several aspects of the bowel management routine and it is advisable to discuss these issues with nurses on the Spinal Outpatient Team at the National Spinal Injuries Centre.

Constipation can be prevented by:

1. Maintaining an effective routine – if it works don't change it!
2. Paying attention to diet – see diet section page 5
3. Where short-term lifestyle changes increase the risk of constipation, action to avoid the problem should be taken. For instance, if prolonged bed rest is necessary, for example after surgery or with a pressure sore, then an increased amount of fibre and fluids should be taken. Once the usual lifestyle is re-established the usual bowel routine should be resumed.

4. While aperients are not always required, if they are needed they should be used regularly. It is important to maintain a balance between constipation and diarrhoea, and to aim for an appropriately formed stool at regular intervals. Constipation should not be used as a method for controlling the bowels; this inevitably results in more problems.
5. A fluid intake of at least 2 litres daily should be taken regularly during the day and evening. Water combines with fibre and promotes an appropriate stool form.
6. If it is necessary to take Oxybutynin, antibiotics, analgesics (painkillers) or any other medication which affects bowel function, diet and aperients should be reviewed.

8.3 Faecal Impaction

This is a severe form of constipation usually defined as the absence of stool passage for at least 5 days.

Treatment:

Seek advice from a healthcare professional with experience in dealing with SCI individuals as soon as possible.

8.4 Overloaded Bowel or Soft Impaction

This is usually indicated by irregular bowel emptying, often associated with taking a high fibre diet and or faecal "bulk formers". The stools are not constipated i.e. dry and hard, but are soft and "putty like". This condition is difficult to identify by feeling the abdomen, but a severe backlog of stool can be seen on x-ray examination.

Causes of Overloaded Bowel:

- Not enough stimulant aperients.
- Too much "Bulk forming" preparations or stool softeners.
- Too much coarse fibre i.e. neat Bran fibre.
- Not emptying bowels regularly.

Signs and Symptoms may include:

1. Irregular results from bowel management
2. Abdominal distension, the abdomen may feel hard and blown up - this may be very uncomfortable.
3. Unable to pass "wind" through the anus or burp up wind.
4. Feeling of fullness and or nausea/vomiting.
5. Increased spasm.

6. Headache/sweating. (Please see separate handout on Autonomic Dysreflexia.)
7. Severe "wind" pain.

Treatment:

1. Introduce or increase stimulant aperients (dosage and frequency) until the problem is resolved.
2. Reduce bulk formers/faecal softeners. Smaller, but more frequent doses may help.
3. Increase bowel emptying to daily until the backlog is cleared.
4. Increase fluid intake

Prevention:

1. If "bulk forming" preparations or stool softeners are taken, they should be taken with or straight after food. The initial dose should be small and gradually increased, until the stool is of an appropriate consistency.
2. The usual dose of aperient should be maintained when commencing bulk formers or stool softeners. Once the stool has softened it may be possible to reduce the amount of aperient.
3. Adequate fluids, i.e. at least 2 litres per 24 hours must be taken when on bulk forming agents and faecal softeners.

8.5 Diarrhoea

Before treating diarrhoea ensure that the problem is not 'constipation with overflow' – see Constipation section.

Diarrhoea is the term for loose stools and this may be caused by:

- Spicy foods.
- Certain foods which do not agree with the individual.
- Some medications, e.g. antibiotics.
- Overdose of aperients, e.g. Senokot.
- Gastrointestinal infection (tummy bug).

Signs and Symptoms:

1. Frequent loose, watery stools
2. Bowel emptying may be sudden and explosive.
3. Abdominal cramps and pain may be felt.
4. Autonomic dysreflexia - see separate handout.

Treatment – individuals are advised to:

1. Remain on bed rest if the diarrhoea is severe to avoid skin problems.
2. Stop taking aperients, stool softeners and bulk formers.
3. Eat bland, low fibre foods while diarrhoea persists.
4. Increase fluid intake to replace that lost in diarrhoea.
5. If diarrhoea persists for 3 days or more consult a GP.
6. If the diarrhoea is related to medication discuss the problem with the prescriber before stopping the medication.
7. Keep the skin clean. Wash with a mild soap and water, and dry the skin thoroughly but gently, as often as necessary. A barrier cream may be helpful I.E Cavalon Cream
8. Immodium (Loperamide) may be used if necessary but it is essential to exclude 'constipation with overflow' first.

Prevention – Individuals are advised to:

1. Avoid foods which are known to cause diarrhoea
2. Monitor stool consistency and regulate aperient dose accordingly.
3. Be meticulous in the storing and preparation of food.

8.6 Rectal Bleeding

Rectal bleeding is not uncommon in SCI individuals and is often related to the problems discussed below. It is essential to identify the cause of any new bleeding, through consultation with the GP or District Nurse.

Bright red blood usually indicates bleeding in the lower rectum or anal canal. If bleeding is occurring higher in the gut stool may be black, possibly tarry, and the GP should be consulted.

8.7 Haemorrhoids

Haemorrhoids are sometimes called Piles. They are veins inside the anal canal, which become distended with blood and may break and bleed. Active or inflamed haemorrhoids may give rise to Autonomic Dysreflexia during bowel management.

Causes:

- Changes in the nervous control of blood vessels after SCI make SCI individuals more prone to haemorrhoids.
- Constipation.
- Straining (pushing down) too hard or for too long to empty the bowel.
- Long periods spent sitting on the toilet.

- Rough manual evacuation, or manual evacuation of hard, dry stool
- Pregnancy and labour.

Treatment:

1. Treat and prevent constipation.
2. Always ensure that manual evacuation is conducted gently using plenty of lubrication. Water-soluble gel should always be used. Glycerine suppositories can provide additional lubrication, particularly if the stool is constipated.
3. When haemorrhoids are active or inflamed Lignocaine Gel 2% (Instillagel) can be instilled 10 minutes prior to bowel management to reduce the likelihood of autonomic dysreflexia. Lignocaine Gel is available on prescription.
4. Individuals should spend the least time necessary sitting on the toilet. Ideally this should be less than 1 hour.
5. Avoid excessive straining.
6. Seek medical advice from GP who may prescribe suppositories or creams to reduce the haemorrhoids.
7. Keep the area clean and dry.

8.8 Anal Fissure

This is a small tear around the anus (outlet of the lower bowel). Hard, constipated stool, overstraining to push stool out or being too rough during manual evacuation can cause the tear.

These tears are very painful in the able-bodied. In an SCI individual there may be an increase in spasm. Autonomic Dysreflexia may occur during bowel management and there may be some anal bleeding.

Treatment:

1. Avoid constipation.
2. Use a local anaesthetic gel, available on prescription from the GP (e.g. Lignocaine 2%, Instillagel).
3. Ensure that manual evacuation, if required, is very gentle and ample lubrication is used.
4. Individuals should avoid pushing down or straining too hard when emptying their bowel.
5. Keep the area clean and dry.
6. If no further damage is caused the fissure will heal.
7. The GP should be consulted if the problem does not resolve or if the problem recurs.

THE BRISTOL STOOL FORM SCALE

Type 1



Separate hard lumps, like nuts (hard to pass)

Type 2



Sausage-shaped but lumpy

Type 3



Like a sausage but with cracks on its surface

Type 4



Like a sausage or snake, smooth and soft

Type 5



Soft blob with clear-cut edges (passed easily)

Type 6



Fluffy pieces with ragged edges, a mushy stool

Type 7



Watery, so solid pieces **ENTIRELY LIQUID**

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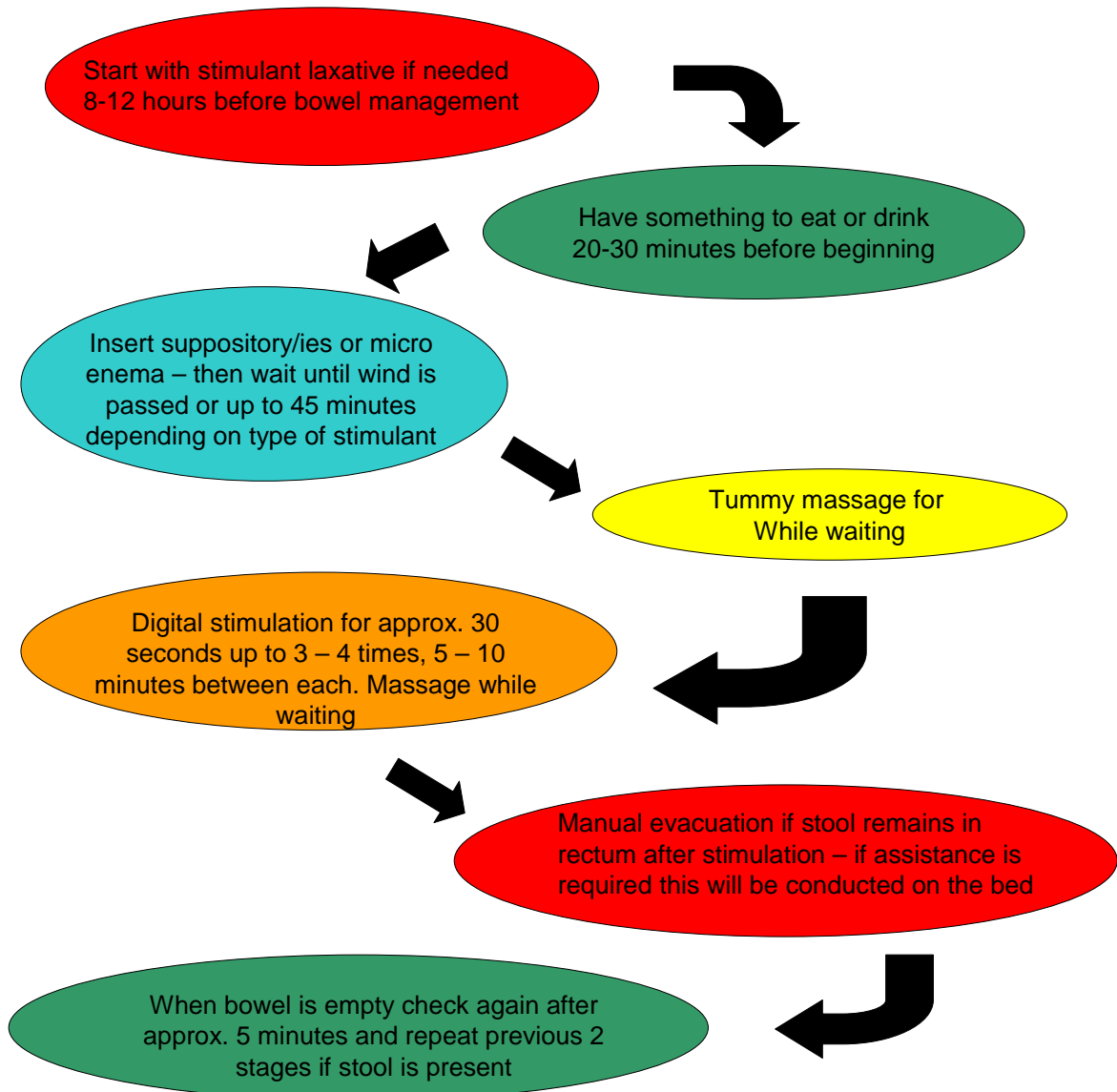
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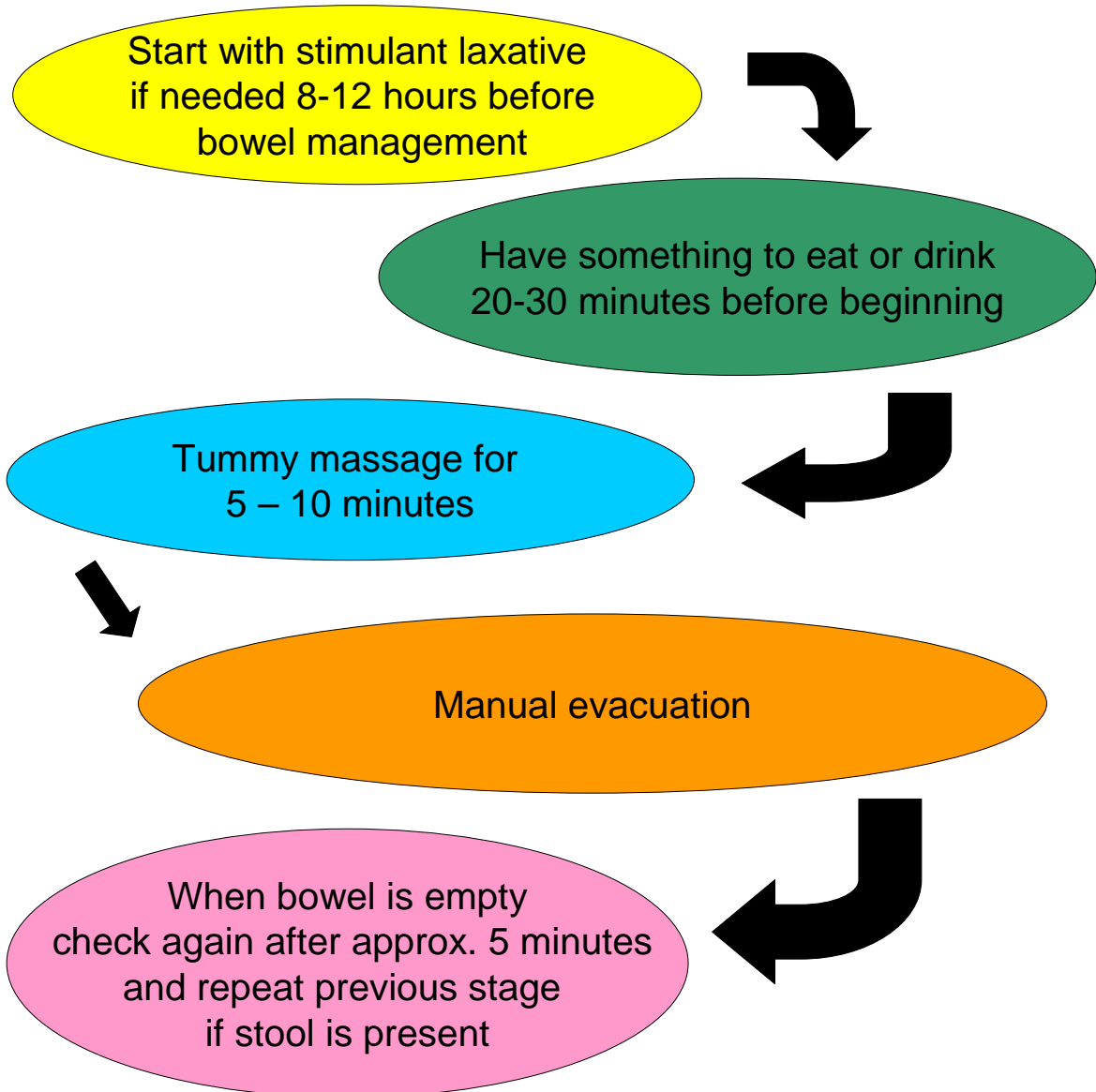
Flow chart for reflex bowel management



If you have any questions about bowel care please ask your named nurse or the nurse in charge of your ward. The 'bowel management education session' and your grey folder are also good sources of information

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Flow chart for flaccid bowel management



If you have any questions about bowel care please ask your named nurse or the nurse in charge of your ward. The 'bowel management education session' and your grey folder are also good sources of information