Fact Sheet

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Managing your Bowels after Spinal Cord Injury

A Guide to Upper Motor Neuron Bowels

Spinal Cord Injury and Bowel Function

The main changes to bowel function after spinal cord injury occur in the lower section of the digestive tract – the large intestine, rectum and anus. To understand the effect of these changes, you must first understand their roles in elimination.

Large Intestine

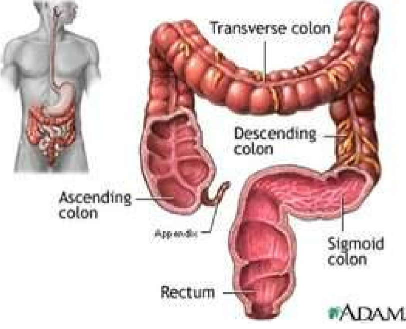
- responsible for absorption of water from the faecal mass for use in all our bodily cells and functions
- propels the waste through the large intestine in wave like contractions of muscle towards the rectum for evacuation

Rectum

- holds the faecal bulk ready for evacuation

Anus

- controls the release of faeces during defaecation



Changes to the nerves supplying the muscles of the large intestine wall result in a decreased "push" effect in the bowel. **This means that the faeces takes LONGER to work its way around the bowel.** The longer it takes for the faeces to be pushed around the bowel, the more water can be absorbed out of the faeces. The more water that is absorbed out of the faeces, the harder the resultant stool gets = CONSTIPATION

There are also some changes to the moistness of the bowel wall, causing a decrease in lubrication, and potentially further slowing the transit of faeces around the bowel = CONSTIPATION

Changes to the nerves supplying the muscles in the rectum and anus can result in an inability to predict or control bowel movements = ACCIDENTS +/- CONSTIPATION

We refer to the changes to the bowel after spinal cord injury as **Neurogenic Bowel.**

How Do I Manage a Neurogenic Bowel?

To be able to manage these changes effectively, you must understand what TYPE of bowel you have after your injury. There are two main types of Neurogenic Bowel, which are determined by your level of injury, and the potential interruption of processing of messages through the Defaecation Reflex Centre.

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The Defaecation Reflex Centre controls the muscles and feeling to the lower colon, rectum and anus, and works in conjunction with the brain to determine when to "hold" or "go". When mass is detected in the rectum, the reflex initiates a strong contraction of these muscles, assisting in defaecation. The disruption of this reflex can result in either:

1. Upper Motor Neuron (Reflexive) Bowel
2. Lower Motor Neuron (Flaccid) Bowel

The management for each of these bowel types differs significantly. This booklet specifically targets the management of **Upper Motor Neuron** bowels. If you are unsure of your bowel type, please talk to your Spinal Injuries Consultant, Outpatient Service, or the Spinal Outreach Team (SPOT) for further advice.

What is an Upper Motor Neuron (UMN) bowel?
Upper Motor Neuron bowel types most commonly occur in people with spinal cord injuries above the T12/L1 level. The presentation of this type of bowel is influenced by the **intact** action of the Defaecation Reflex centre, which causes an involuntary spasm- like contraction of the muscles of the rectum and anus.

However, due to disruptions in the message pathways up and down the spinal cord due to spinal cord injury, people with UMN spinal injuries generally are unable to control the relaxing of this muscle to allow or prevent defaecation. They also may have difficulty determining whether their bowel is full, has already evacuated, or whether wind or solid matter has been passed.

Why Do I Have to Change the Way I Manage My Bowel?
Left untreated, people with UMN bowels will likely experience symptoms such as chronic constipation and recurring bowel accidents. This can then further impact on many other facets of your health, work and social life, as well as personal relationships. A regular bowel routine can also help reduce neurogenic (nerve) related pain.

Good Bowel Routines = More Effective and Predictable Emptying = Social Continence

The 5 "Rights" of Bowel Management

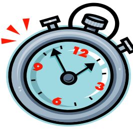
Due to the complexity of the many different issues affecting bowel function after spinal cord injury, it is not possible to fix the problems simply by taking a tablet.

To make it easier to understand, UMN bowel management has been broken in to 5 categories that need to be working well together to put you back on the "Right" path!

- ✓ Time
- ✓ Place
- ✓ Amount
- ✓ Consistency
- ✓ Trigger

Right Time

This refers to the need to **re-establish a routine for bowel emptying** post spinal cord injury. The bowel needs to be "re-trained" to empty at a regular and consistent time each day, which will allow you some predictability around when your bowels may open. You need to be in control of your bowels to prevent your bowels controlling your life!



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Firstly, you will need to establish how often you attend your bowel routine. We recommend either **daily or second daily**, depending on your pre-existing bowel habit. We do not recommend attending your bowel care any less than 3 times per week.

Some factors to consider when choosing a time:

- Work hours
- Any previous bowel habit prior to injury
- Availability of toileting facilities and care support

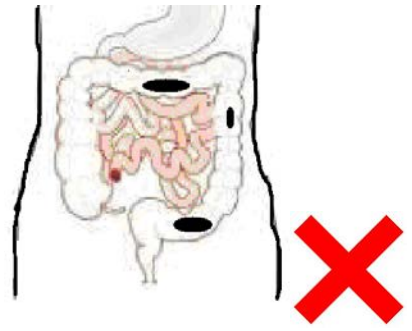
The other aspect of the 'right time' is how much time should be spent on the routine. An average amount of time can be from 15-45 minutes, which depends on the stool being in the "Right Place".

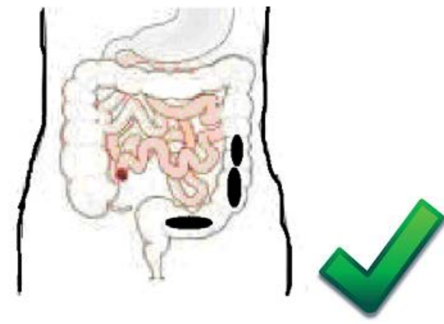
Right Place

Undoubtedly the right place for bowel motions is in the toilet! However, this guideline refers to **where the faeces is in the bowel**, when you are ready to go to the toilet.

If the faeces is **too high** in the bowel, you are unlikely to have a result at the time you are sitting over the toilet. The faeces then may work itself down later, resulting in an **accident**.

Alternatively, if the faeces is **too low** in the bowel, you may have an accident **prior** to getting to the toilet.





So How Do I Influence the Right Place?

The most common method for influencing Right Place is using a Bowel Stimulant – either food or medication.

Diet:

Most people can readily identify foods that stimulate the bowel. These are the foods that had you going to the toilet before your spinal cord injury. Commonly named examples are:

- Prunes
- Kiwi fruit
- Fruit or concentrated Fruit Juice – particularly stone fruits and citrus fruits
- Spicy/Hot foods
- Liquorice
- Nuts and seeds

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- Alcohol and Caffeine
- Foods high in fat (eg Take Away Fried Chicken)

Over consumption of foods that stimulate may create accidents. Alternatively, some of these foods can be of benefit if used in your daily diet (in small doses).

Adequate dietary stimulation may negate how much oral medication is required to assist with stool transit through the bowel.

Medication:
Common bowel stimulant medications are **Senna (Senokot)** and **Bisacodyl (Durolax)** tablets. These medications work by **stimulating peristalsis** (a wave-like motion which pushes the faeces along your bowel), with the best effect of the medication between 10-16 hrs after taking the tablet. This means the time you take these tablets should be **adjusted to suit your bowel routine time**.

An example of how to use and adjust a stimulant medication:

- If you wish to toilet at 8am, the senna dose should be given at approximately 8pm the night prior, as a starting point.
- If you are having accidents prior to getting over the toilet (8AM), try taking the tablet a bit later – try 10pm.
- If you must sit on the toilet for 1hr before you get a result, try taking the tablet earlier – try 6 pm.

Senna is also found in many different brands and strengths over the counter and at health food shops. The table below shows some of the common medications available and the approximate compared strengths. Never take more than the recommended dose as this can 'overstimulate the bowel' causing problems with the co-ordinated movement of the faeces. This may result in the "churning" of faeces in the intestines instead of movement of faeces through the intestine.

Drug	Senna Dose	Measure	Other Ingredients
Senokot Tablets	7.5mg sennosides B OR 412mg senna leaf	1 tablet	
Coloxyl & Senna	8mg sennosides B OR 440mg senna leaf	1 tablet	50mg coloxyl/tablet
Ford Pills	10mg sennosides B OR 550mg senna leaf	1 tablet	
Laxettes	12mg sennosides B OR 660mg senna leaf	1 tablet	
Nulax	14mg sennosides B OR 800mg senna leaf	10g or 2 tsp	Dried fruit
Agiolax	15mg sennosides B OR 825mg senna leaf	5g dose or 1 tsp	Fibre, swallow whole
Herbelax	24.5mg sennosides B OR 1.35g senna leaf	1 tsp	Liquorice, dill, psyllium husk 31mg per teaspoon

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Right Amount

Regularly monitoring the results of your daily bowel routine provides a "checks and balances" system to ensure that your bowels are on track, and early warning if things are starting to go wrong!

The amount of faeces you pass should relate directly to the amount of food you are eating. If you are eating well, but not passing much faeces, this should be an early alert to potential impending constipation.

What you eat will also influence the size of your stool. A diet consisting of fibre will result in larger motions than one devoid of fibre.

Why is Fibre Important?

Fibre is a cellulose product found in plant foods that cannot be digested by our bodies, which is then eliminated in our faeces.

- **Soluble fibre**- Soluble fibre soaks up the water and helps form the stool. The soluble fibre passes more slowly though the system than insoluble fibre. This is more noticeable with someone who has a spinal cord injury as a high soluble fibre intake can lead to constipation. For this reason, it is recommended that someone with a spinal cord injury have a total of 15g of fibre daily instead of the recommended 30g. This can be increased slowly if required. **Soluble fibre is mainly found in bran, breads and cereals which are essential in your diet in moderation.**

- **Insoluble fibre**- Insoluble fibre doesn't soak up water and passes through the gut more quickly than soluble fibre. It is mainly found in fruits, nuts and seeds but excess consumption of these foods can lead to diarrhoea, and as mentioned previously, can also influence the "Right Place" of bowel management.

- **Please Note: There is no fibre in meat or dairy products.**

Dietary Fibre Chart			
Food	**Fibre Content (grams)**	**Food**	**Fibre Content (grams)**
Bread, average slice		**Fruit, average serve**	
Dark rye	3.6	Apple	3.5
Fruit loaf	1.0	Apricots	3.0
High fibre white	1.3	Avocado, half	2.0
Lebanese	3.0	Banana	3.0
Multigrain	1.4	Grapes, 200g	2.0
Rye	1.7	Grapefruit, half	1.0
White	0.8	Kiwi fruit	2.5
White, toast thickness	1.1	Mango	3.5
Wholemeal	2.0	Melon, 200g	2.0
Bread roll – white	1.8	Orange	3.0
Bread roll – wholemeal	5.00	Passionfruit	3.0
		Paw paw, fresh	1.5
Breakfast cereal, average serve		Peach	2.0
Allbran	9.5	Pear	4.0
Bran Flakes	7.0	Pineapple, 120g slice	2.5

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Dietary Fibre Chart			
Corn Flakes, Special K	1.0	Raspberries – half punnet	9.0
Just Right	4.0	Rockmelon	0.5
Muesli	8.0	Strawberries – half punnet	3.0
Nutrigrain, Rice Bubbles	0.5	Watermelon, 20g slice	1.5
Porridge	5.0	Dried figs, 50g	6.5
Sultana Bran	6.5	Prunes, 6	5.0
Weetbix, 2	3.0	Raisins or sultanas, 50g	2.5
		Dried dates, 4	4.5
Vegetables, average serve			
Asparagus fresh/can	1.5	**Nuts, 50g serve**	
Green beans	3.0	Almonds	4.5
Baked beans (canned)	13.0	Cashews	3.0
Broccoli	4.0	Hazelnuts	5.0
Brussel Sprouts ½ cup	3.0	Macadamias	3.0
Cabbage	2.0	Peanuts	4.0
Capsicum	1.0	Pecans	4.0
Cauliflower	3.0	Pistachios	4.5
Carrots	3.0	Walnuts	3.0
Celery	1.0		
Corn on cob, 1	6.5	Pasta, 2 cups cooked	6.5
Cucumber	0.5	Rice, white, 1 cup cooked	1.5
Kidney beans ½ cup	4.5	Rice, brown, 1 cup cooked	3.0
Lettuce	1.5	Unprocessed bran, 1 tablespoon	3.0
Mushrooms	2.5	Lentils	7.5
Peas	7.0	Peanut butter, 1 tablespoon	2.5
Potato – with skin	3.5	Popcorn, 1 cup	1.0
Potato – peeled	1.5	Muesli bar	4.0
Pumpkin	1.5	Meats of all types	0
Spinach	4.5	Poultry	0
Sweet potato	2.5	Seafood	0
Tomato can/fresh	2.0	Milk, cheese, dairy products	0
Zucchini	2.0	Eggs, fats, sugar	0
Reference: Eating for Peak Performance, Rosemary Stanton. Allen & Unwin. 1994			

Right Consistency

The consistency of the stool is controlled by the amount of water that is taken out of the stool by the digestive system. How fast the faeces passes through the system can directly affect the consistency of the result. The shorter the transit time, the less water is re-absorbed from the faeces by the bowel, resulting in a softer stool.

With an UMN injury, the aim is for a stool consistency of a type 2-4 on the Bristol Stool Scale. Very soft or 'sticky' stools (best described as toothpaste or peanut butter) are difficult for the digestive system to pass and can be hard to achieve a complete empty from the rectum. The pooling of soft stools within the bowel can also lead to constipation over time.

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Bristol Stool Chart

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 blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Diarrhoea may have undigested food particles **Liquid Only Can Be Overflow** **This may indicate you are constipated**

Fluids
Getting the right consistency can be as simple as drinking enough water. The **recommendation is for 2-3 litres of fluid a day**. The type of fluids you drink can also make a difference. Drinking fluids that are diuretics (increase urine volumes) such as caffeinated (e.g. tea, coffee, cola) and alcoholic beverages can dehydrate you. They may also irritate the bladder. Some people limit fluids to prevent bladder leaking. Please be aware that this may influence bowel patterns as well!

'Softeners'
'Softeners' work by retaining or drawing water back into the faeces. They work best when taken a few times during the day. Dietary 'softeners' can be fruit, juices high in sorbitol (pear juice, apricot nectar, kiwi fruit juice or prune juice) or prunes. It is important to have natural softeners in your diet for your vitamin and nutrient intake. Common medications that can soften the stool are Coloxyl, Movicol/Clearlax, Sorbitol, Lactulose or Epsom salts.

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Some people experience ongoing problems with soft stools. It is important if the stool becomes soft or loose **without** any change to the diet or medications to:

- Rule out any food intolerances such as dairy or gluten
- Get a sample checked with your GP if you are unwell or the problem persists

Stimulants
These were discussed under the section of the “Right Place”. Please remember that changes to diet or stimulatory medications can also directly influence the consistency of your stool.

Firmers
The most common dietary firmers are dairy products (foods high in calcium), bananas or foods containing soluble fibre. Some people find they need to firm the stool and may take a fibre supplement (some examples are psyllium husk- Metamucil which is soluble fibre or wheat dextrin-Benefibre which is insoluble fibre) to help with this. A good starting dose is ½ teaspoon twice a day and increase as needed.

Please Note - if you are consuming a diet high in soluble fibre, or taking a supplement, it is imperative that you consume a high fluid intake, to prevent the possibility of the fibre “setting like concrete” in your bowel and *increasing* the potential for constipation.

Other Medications
There are other medications that can slow digestion and create problems with constipation. It is important to monitor the bowels when starting new medications.

Some common examples are:

- Pain medications- slow release pain relief (Oxycontin, Targin), narcotic pain medication (Morphine, Endone, Tapentadol), nerve pain medication (Amitriptyline), regular paracetamol
- Bladder medications – Ditropan and Vesicare
- Antibiotics- can cause constipation or diarrhea
- Antispasmodic medication – Baclofen, Dantrolene
- Supplements such as calcium and iron.

Remember that the system has been slowed and that any changes you make to diet or medication may take at least 2 days to start taking effect.

Right Trigger

The Right Trigger is about identifying the correct methods to get the stool (which needs to be in the ‘Right Place at the Right Time’) to effectively empty from the rectum.

Triggering an UMN injury involves the **stimulation of the Defaecation Reflex and the relaxing of the anal sphincter**. This can be achieved with the use of medication (eg enemas or suppositories) and/or digital stimulation.

Which should I use – an Enema or a Suppository?
Whether you use an enema or a suppository to trigger defaecation will depend on numerous factors. Some considerations are:

- **Level of injury and functional ability** – suppositories are often wrapped in foil or plastic and can be difficult to access or insert if you have decreased hand function, although aids can be utilized to assist with insertion of same. Stimulation provided during the insertion process adds to the defaecation reflex.

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- **Time available to be spent on the routine** – suppositories are "bullet – shaped" wax impregnated with medication. You must wait for the wax to heat and melt before the medication can be released and absorbed by the bowel. This absorbed medication then "irritates" the bowel wall, stimulating the defaecation reflex. This process can take anywhere between 20- 45 minutes, and is best attended whilst in bed, only sitting over the toilet towards the end of the routine when the bowel motion is expected. Alternatively, enemas can be inserted whilst seated over the toilet, and may take anywhere between 5-20 minutes to work.

- **Personal Preference** – you may find that one method simply works better for you than the other. Most medications used to assist bowel emptying come in either enema or suppository form, although more commonly used enemas (Microlax/Micolette) are mild, and do not contain medication to irritate the bowel. People requiring medicinal irritation often use suppositories (eg Dulcolax, Bisacodyl) or the enema form (Bisalax).

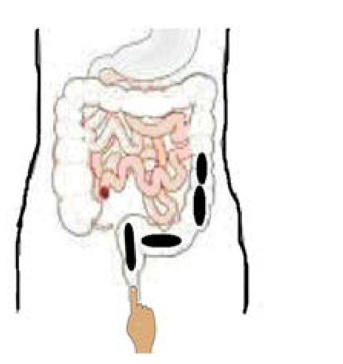
- **Care agency issues** – some care agencies will have restrictions over who can or cannot administer certain types of medication, which may influence which type you choose.

Digital Stimulation

Digital stimulation works by triggering reflexive activity in the Upper Motor Neuron bowel to initiate contractile actions in the rectum. Promoting relaxation of the bowel sphincter further assists in bowel emptying.

Procedure:

1. Prepare for the procedure – this technique can be performed over the toilet, on a shower commode or in bed (lying of the left side)
2. Don a pair of non-sterile gloves
3. Generously lubricate index finger with a water- based lubricant.
4. Gently insert index finger 2-4cm into the rectum. This relaxes both the internal and external sphincters
5. Gently rotate the straight finger in a circular motion against the rectal wall for approximately 10-20 seconds.
6. When you feel the faeces starting to move apply gentle stretch to the external anal sphincter to enable passage of faeces. Digital stimulation can assist with emptying the lower portion of the bowel (Sigmoid Colon)
7. Remove finger.
8. If required repeat stets 3-6, allowing 5-10 minutes between stimulations. This should be attended no more than 3 times.
9. Don clean gloves
10. Clean as required.
11. Remove gloves and wash hands.



Fact Sheet

Queensland Spinal Cord Injuries Service

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Cautions to Digital Stimulation:

- The presence of mucous (clear, jelly like substance) from the lower bowel may be an indicator that the lower bowel is empty – ongoing stimulation isn't recommended
- If the rectal vault feels bulbous (like a blown up balloon) this could indicate the stool is higher in the bowel and recurrent stimulation is not recommended – consider dietary and pharmaceutical methods to transit the stool lower in the bowel.
- If bleeding or pain is experienced during or after this procedure please seek medical advice
- Autonomic Dysreflexia may be triggered by this procedure. Information on Autonomic Dysreflexia. Monitor for symptoms and cease stimulation immediately.

Trans-Anal Irrigation

There are a variety of systems on the market that irrigate the bowel (descending colon) with warm water to soften the faeces and stimulate bowel contractions to aid in evacuation of the bowel. Trans-anal irrigation can increase the risk of Autonomic Dysreflexia if you are at risk of this. Please seek assistance and advice from a health professional before starting with an anal irrigation system to see if it is appropriate for your circumstances and to receive education on the correct use of the product.

Other Influencing Factors:

- Gastro–Colic Reflex - an increase in the contractile waves of the bowel generated after filling the stomach with either food or hot fluids (usually strongest in the morning, and 20-30 minutes after eating). This can help to achieve a better empty when incorporated in your regime
- Exercise – stimulates bowel motility, which means keeping as active as possible. (Exercise can also help with controlling pain, decreasing the need for medication which may cause constipation)
- Active abdominal muscles (if intact) can assist with bowel emptying, however excessive straining can lead to pelvic floor nerve damage. Longer term this can lead to complications such as haemorrhoids and organ prolapse

Where to from here?

Once you have co-ordinated the 5 Rights, you should have a fairly dependable bowel routine, which you can adjust on a regular basis to suit your lifestyle. Remember that bowel management is an ongoing process and needs to be **monitored and reviewed on a regular basis.**

However, please also remember that it is simply a process of trial and error, until you find out what works best for you! If you continue to experience difficulties managing your UMN bowel, please seek advice from your GP, Spinal Injuries Consultant, Outpatient Service, or the Spinal Outreach Team (SPOT).

Frequently Asked Bowel Questions

Q. Will I get recovery of bowel function?

A. Recovery is very individual and there are no 'hard and fast' rules about recovery. It is best to continue with your routine to prevent accidents unless you notice changes such as increased feeling and control of your bowels. You could start to wean off medication slowly, if you continue to monitor your results carefully and re-introduce medications should signs of constipation develop.

Q. Will I always need my bowel medications?

A. Some people can stop all their medications and some people may need to continue medications to keep their routine regular. The medications can help prevent accidents and/or constipation.

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Q. I am having trouble getting into a routine, how get I get help?
A. A good start is to keep a bowel diary of information such as the stool type; how long the routine takes; if there are any accidents; the type of food and fluids you are eating and any changes in your regular routine. It may be best to contact your Spinal Injuries Consultant, Outpatient Service, or the Spinal Outreach Team (SPOT) for further advice.

Q. My bladder leaks when I get constipated. Why does this happen?
A. A full bowel can place extra pressure on the bladder which may mean 'reduced space' for the bladder leading to accidents.

Q. I feel quite bloated at the end of the day. What can I do to stop this?
A. This may be a result of the types of fluid or food you are having. Some examples of foods/fluids that increase wind production are:

- Cucumber
- Peas
- Yeast
- Orange juice
- Fizzy or carbonated drinks
- Chewing gum
- Cabbage
- Mushrooms
- Baked beans
- Stalks of broccoli and cauliflower
- Ham
- Onions
- Beans
- Eggs
- Low calorie sweets and lollies

Sometimes a hot drink such as peppermint tea can help relieve 'wind' problems.

An Example of a Bowel Diary

Sunday	Sunday
AM **Result** Type ______________ Amount S M L XL Routine Time _______minutes	**BREAKFAST** ☐ Cereal ☐ Fruit ☐ Toast ☐ ______________
PM **Meds** ☐ Senna____tabs ☐ Coloxyl___tabs ☐ Movicol/Clearlax_____ ☐ Benefibre___tsp ☐ Other_______ **AM** **Meds** ☐ Coloxyl____tabs ☐ Benefibre___tsp	**LUNCH** ☐ Salad ☐ Sandwich ☐ Fruit ☐ ______________

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Bowel Accidents Time ______________ Type ______________ Amount S M L XL	**DINNER** ☐ Meat/Fish/Chick ☐ Vege/salad ☐ Pasta/Rice/Potato ☐ Fruit ☐ ______________
	FLUIDS ☐ Water ______________litres ☐ Juice ______________glasses ☐ Tea/coffee ______________cups

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The information contained within this guide is provided for general educatory purposes only and does not replace the need to seek appropriate professional assistance in managing specific individual cases.

Last Reviewed March 2022
Review Due March 2024