# How to Manage Constipation and Prevent Accidents

## Bowel Management Strategies

You can view this presentation at: youtu.be/jD0pE9vmTm0

[00:00:00] **Roberta Pesce:** Our next talk of the day is about managing constipation and preventing accidents. I am joined by Dr. Margaret Jones, assistant professor in physical medicine and rehabilitation at Vanderbilt University Medical Center, who will tell you a little bit more about the different bowel management strategies that are available. Dr. Jones, welcome. Over to you.

[00:00:25] **Dr. Margaret Jones:** Hi. Yeah. Thank you. Thank you, everybody, for joining today. I know this is a sensitive, but important topic, and one that I pretty much talk about in every aspect of life. So, I have no disclosures except that I am coming back from vacation with my dogs. But goals of today's talk, first is just to define neurogenic bowel and why this is important for this community. Then I'm going to review the role of a bowel program, common ways to manage the bowels and then alternate strategies if conservative measures are not enough.

[00:01:03] So a little bit of my background, and I was looking at the other speakers at this talk and listening and know that it's a good mix of physiatrists and neurologists, and just for a little bit of a plug of physical medicine rehabilitation because not every patient actually knows who we are. But physical medicine rehabilitation, if you go to see a cardiologist, you're going to see someone who focuses on the heart. If you go to see a pulmonologist, that's someone who focused on the lungs, and we in physiatry really focus on function. And so that means doing everything to get out of bed, to get around in the world, to get out into the community, and that becomes important when we're talking about bowel management.

[00:01:47] In particular with my background, I am trained in spinal cord injury medicine and also have a background in brain injury medicine, so a lot of central nervous system issues, of which many of the rare neuroimmune disorders are a subset. And so, I do see a fair number of patients with TM, NMO, MOG, MS, various subsets of all of that. And so, it does become into my clinical practice all the time, and in particular in talking about bowel management, it's just super important because so many people feel restricted by the complications that come from this. So neurogenic bowel, the technical definition is a complication that occurs when there is a dysfunction of the colon or the rectosigmoid, so the rectum, due to a lack of nervous control.

[00:02:38] So those are a lot of, maybe, more big medical terms, but really, I look at this as a mis-messaging between the brain and the spinal cord injury and then the rest of the gut. What this can result in is constipation,

  

diarrhea, inability to feel when you need to have a bowel movement and, of course, fecal incontinence as related to those two entities and the balance thereof. But the big thing I want to remind everyone of every being on this Earth is that poop really happens. It is something that we all have to manage. Again, it can be quite a sensitive topic. It can feel so embarrassing, but it is your body's response to eating, taking in nutrition, trying to feed your body to be the healthiest it can be.

[00:03:24] And if we can get bowels under better control and management, perhaps you can get out into the community better and longer the next time. So, in terms of having an actual bowel movement, it is a giant coordination between the brain, the spinal cord, local peripheral nerves and then the local chemistry, meaning hormones, secreted enzymes, whatnot, that control the gut and then control the movement of waste through the GI system resulting in a bowel movement. In order for this to happen, there's a coordination, both locally and, meaning at the gut or at the bowel, and then further up the chain through the central nervous system, so places like the brain and the spinal cord injury. And there's a big transmission of messages throughout the whole system to result in that bowel movement.

[00:04:18] So there are various ways when this messaging system gets thrown off that we can consider performing a bowel program in order to help have better bowel movements. So, what is a bowel program? As I was looking through these slides, I sort of realized that it would be great to do this talk or have an additional talk with a nurse because the nurses are often the ones helping to teach this. But for either kids, their parents, caregivers, adults, whoever might be doing this, it is a team effort. It is a team effort with what's going on at home or wherever you might live as well as your clinic or your inpatient nurse, the provider who's caring for you. But what we want with a bowel program is to have a planned predictable and effective bowel movement. The bowel movement should confer the most independence of function, if at all possible, for both the patient and the caregiver or else have a good plan together to make that happen smoothly.

[00:05:28] The bowel program should take approximately 1 hour or less, and that's really patient dependent, but after a survey that was done in mostly spinal cord injury patients, found that many people were doing this at least less than an hour. What we try to do with that bowel program is avoid complications. So, for someone that might get autonomic dysfunction, we're trying to minimize those issues or someone who has impaired sensation and might end up with skin issues. We try to avoid pressure injuries as possible. We're trying to do this with the least amount of interventions to have that bowel movement, and we're trying to minimize that unplanned bowel movement or incontinence, those accidents that might happen.

[00:06:12] Things that I think about when I'm talking to patients about a bowel program, and for some patients who may have congenital or pediatric disorders and may not know the answer to this, that's totally okay. What you may start to notice is that someone tends to have a bowel movement in the morning or every afternoon at 4 p.m. But for those that might have their insult happen later in life, they may be able to tell you, "Yes. For certain, no matter what. I always went after I had my morning coffee" or "I tended to go at nighttime because I worked the night shift, and it was just around 9 p.m. every night."

[00:06:48] So these are things, that's one part of what I like to know about when I'm talking to someone. Another might be, where does this neurologic lesion occur? So, for someone with a traumatic spinal cord injury, they might get a neurologic level, meaning the level at which things go from being normal to abnormal. For people with a rare neuroimmune disorders, there still may be a neurological level of more involvement, let's say the lumbar spine, the thoracic spine, or the cervical spine. And we ask all those things just to make sure that we are managing working with the parts of the body that we can control or at least utilize in doing a bowel program, such as reflexes of the body.

[00:07:30] Other issues that come in handy in thinking about this, is thinking about whether someone might have any food sensitivities or someone that gets very bloated or gassy or loose stools with dairy, we may need to really make sure that we're avoiding those in thinking about bowel program or incontinence or any other GI or gut-related issues. Sometimes prior to these neurologic events, someone may have been tended towards constipation and only gone to the bathroom two or three times a week or every 2 weeks or something like that, and so we keep that in mind in planning for what might work for that person in the future.

[00:08:06] So the two types of bowel programs, there's sort of a couple ways to look at it. I know in the staticity talk and the other talks there's probably been mention of upper motor neuron and lower motor neuron. For any providers that might be in the room, this is, of course looking at whether there's hyperreflexia, meaning increase reflexes. There's spastic staticity or hyperreflexia, meaning more of a peripheral injury, not having reflexes present either in the legs or either potentially in the muscles involved in bowel emptying. Prior to any neurologic, there are some, and what we try to take advantage of for these patients is, there are some reflexes in the body that we take advantage of to have a bowel movement.

[00:08:52] One is that the colon tends to stimulate and move along once the gastric or the stomach, the gastrum I should say, triggers that there is food present. So, the stomach will get full. It will tell the colon, "Hey. Let's start to move things because we're starting to have a bowel movement." The colo-colonic reflex is one where it's more of a local reflex where part of the colon starts to get filled and it sort of sends messaging along that says, "Hey, the rest of the colon should start to move along. Let's get this bowel movement going." Finally, the recto-colonic reflex is one where the rectum really starts to move along or be stimulated because the colon has been moving. All this to say, something going up higher, going on higher up in the system is going to help propel and have peristalsis to cause the bowel movement to happen.

[00:09:41] What happens in neurogenic bowels, we lose that control. We lose that coordination, and there may be other factors at play, whether it's fluid restriction, whether it's medications causing constipation, that things may move a whole lot slower, and so that is what we try to take advantage of. So, the goal of a reflexic bowel program is for soft, formed stool. So, it shouldn't be super, super hard because that might be hard to pass, shouldn't be very, very loose because then you may end up with more incontinence. And again, we base that timing on a schedule that may work for you. Usually with bowel programs, what we're doing is giving a little bit of a stimulant, whether it's in the form of medication or other teas or something that might stimulate the gut along. We might need to use a laxative to help change the consistency of the stool, and there's likely going to be need for some sort of rectal stimulation or use of a suppository to tell the rectum it is time to empty this bowel movement that has been moving along.

[00:10:45] So this is for Bob Murphy or BM. Before his neurologic lesion, he used to have a bowel movement after his morning coffee, and he told you it was just like clockwork. So, keeping that in mind, the bowel program that I might come up for him, which is more of a classic reflexic bowel program, is something like a stimulant, like senna. So, there are 17 different variants of senna or Senokot. Another stimulate example is something like bisacodyl. What it does is it acts somewhere in the range of 6 to 12 hours after you take it. So, if I'm trying to plan and have a bowel movement in the morning because that's when the bowels tend to move, I'm going to be giving a stimulant in the evening so that it really acts and does its true stimulation and action of medicine right when you're trying to do that bowel program.

[00:11:35] Then what might happen in the morning is someone, Bob is going to eat that breakfast. He's then going to go back to the bedroom or the bathroom or wherever he wants to do his bowel program. He might place that suppository, and then a little while after placing that, he's going to start performing digital

  

stimulation. So, what digital stimulation does is sort of stimulates the rectum to say this is that mechanical stimulation of the bowels being present, or, excuse me, the bowel movement being present. And by simulating that action, it's really going to help promote the colon to promote peristalsis and push that stool along so then it rests down there at this rectum and then you can empty it out.

[00:12:17] What happens is the first time you do that digital stimulation; the rectum actually loosens up and relaxes a little bit. Thereafter, every 5 to 10 minutes in a clockwise sweeping motion on the inside of the rectum, you'll be using a gloved finger, usually with a little bit of lubricant or something to make sure it's not uncomfortable for someone. Every 5 to 10 minutes, you want to stimulate that stretch and try and promote the emptying and the bowel movement to come out.

[00:12:46] So that rectum is opened up. It's quite relaxed. You do that a few times. You have some results, hoping that it's the soft-formed stool, but then you'll find after you do that digital stimulation, at a certain point that rectum might kind of close back up and be tight again or tighter again. And once it ceased that relaxation, then you know you're done for the day. Everything is closed, and whether you've had results or not, may serve to be proven. But the hope is that results have happened with those digital stimulations and that it's emptied enough by the time that the bowel program is done.

[00:13:24] If you find with those results that the stool is quite hard, then you may need to take something like MiraLAX or another laxative, whether it's in diet or other options. Some people will choose juice, some people will choose coffee. Keeping in mind those other factors are going to impact the consistency of the bowels but doing this to help soften the stool and pass it along nicely. So again, that's the reflexic bowel program.

[00:13:52] The areflexic bowel program is one that we see with more peripheral lesions. So, someone that might have Guillain-Barre or AIDP, perhaps even CIDP, lower lumbar spine issues, some form of flaccid paralysis if they don't have deep tenon reflexes. This is where your provider might be coming in to help you out to say, "Hey. We have to do your bowel program a little bit differently because we don't see the body's reflexes quite intact," which is okay. That's part of the diagnosis, but it is something that helps impact our management strategies.

[00:14:26] So for those patients, again, it's another good conversation with your providers. You want to be aiming towards a more firm stool, so you may need to bulk up the stool, bind it together a little bit better either with some like Metamucil or FiberCon or some sort of dietary fiber of your choosing, and then there's a manual or evacuation to empty the bowel. Some people find that they have to do that sweeping and that emptying with a gloved finger or fingers multiple times per day.

[00:14:55] It may need to be done with bladder emptying, as many of the nerves involved with the bladder stimulation and emptying the bladder are actually the same nerves that are involved with the bowels, and that's why we often find a lot of neurogenic bowel and bladder issues at the same time. And again, that timing is maybe more than once a day. Some people still end up with some small smears. They may need to use a cover or a pad or something like that, which again is very normal within what's happening, but the management overall, a strategy working with your providers to figure it out.

[00:15:30] In terms of troubleshooting, so I know I'm going through this very quickly. It's very hard if you've never heard any of this before. There are a lot of resources online, but mainly, especially if someone has known neurologic issues and they're having a lot of incontinence, it may seem counterintuitive, but the most common reason for incontinence is actually constipation. So, let's say you may not be able to move your legs. You're doing a transfer from your bed to your chair. Every time you tend to have a bowel movement,

really what that's telling me is increased pressure in your abdomen is pushing stool out because it has nowhere else to go.

[00:16:07] So with that, we have to think, "Is there some way to clean out the bowels so that we can help get on a better schedule and maybe start giving a bowel program?" Other things, if that's the case and you've been on a bowel program, you're still having incontinence, you, again, may need to figure out if you might have a UTI. You may need to figure out if you have constipation and need to get an Xray to make sure of that. There may be a different stimulant that you need to use. There may be a different laxative or different dietary changes that may need to happen or there may need to be something more potent, so to speak, then just that suppository, so a mini enema or a full enema or something.

[00:16:47] One of the challenges that comes is that you want, we all want, those changes and this to be better within a day or within an hour or yesterday, really, and what's really tough is that we have to wait three to five bowel programs, and I say bowel programs because some people do bowel programs every day, some people will do them three times a week depending when their caregiver's are available. So, we have to wait three to five bowel programs before having those results and those changes that might happen. After those changes and after what might happen, you may find that you and your provider may find that this just isn't working for you.

[00:17:23] So for some folks, they may need a stronger prescription medication, which is a prokinetic medication that sort of looks at that local chemistry, such as methylnaltrexone, lubiprostone and linaclotide. The other names for those are LINZESS, Amitiza and one other, whose name I forgot at the top of my head. But again, those require a lot of insurance monitoring and figuring out, so it's something that we try to go as last resort. Other great options for people may just be other mechanical or other sweeping options to help empty the bowels.

[00:18:01] So the Peristeen system is actually one were a catheter is inserted into the rectum to help empty the bowels, and the people that have transitioned to that after failing a more conservative bowel program have really, really appreciated it in, in my limited experience with it, but everyone that I know who works with patients in this community, those that have needed to move to the Peristeen system, have been quite happy with it. PIE, there is pulsed irrigation system.

[00:18:30] Surgeries that may need to be considered, so the MACE is Malone Antegrade Colonic Enema, which is done more in pediatric patients, particularly patients with spina bifida, but we also see, I've had one adult patient I've seen get this. Mostly it's pediatric urologists who are more familiar with this, but I have met an adult urologist who's able to perform this. Which is one way, again, a surgery is involved that some people are quite happy with being able plan for that bowel movement using that strategy. And in more extreme, it may feel more extreme, or other complicating situations, people may move to a colostomy. However, while it may seem scary to have to have a surgery to manage your bowels, it really can be great for quality of life, so people do appreciate it.

[00:19:20] In conclusion, I know I've sort of flown through all of this but try to find a provider with a good understanding of neurogenic bowel if you're having issues, whether it's a nurse practitioner. There are some great resources online for nurses available to help plug through this with you if you can't find a local provider. Bowel accidents are not the norm, so we hope to try to help you manage your bowel a little bit more regularly. I will also say that using Imodium or loperamide to help stop bowel movements is not necessarily helpful as well, and please talk to your doctors about this even though it might be a sensitive and terrible topic. I'm always happy when patients are able to get back to a better program. So, thank you for your time today.

[00:20:05] **Roberta Pesce:** Thank you so much, Dr. Jones. What a great presentation. We're incredibly thankful that you are here with us today. I believe we need to move on, but I'm sure if there are any questions, we'll send them over to you...

[00:20:15] **Dr. Margaret Jones:** Yeah.

[00:20:16] **Roberta Pesce:** in case. Perfect. Thank you so much.