In patients with SCI and neurogenic bowel, bowel care is best scheduled at the same time of day to develop a habitual, predictable response and eating or drinking about 30 minutes prior to bowel care may be needed to stimulate the gastrocolic reflex.

Bowel care should be carried out at least
once every 2 days in the long-term to avoid chronic colorectal distension.

Reflexic (UMN) bowel:

Initially bowel care consists of placing a chemical stimulant into the rectum (suppository) and performing digital stimulation.

The goal is soft-formed stool which can be readily evacuated.

Areflexic (LMN) bowel:

The bladder must first be emptied. Then an upright or side-lying position adopted. Gentle Valsalva manoeuvres and/or manual evacuation are performed. This may need to be done daily or sometimes twice daily.

The goal is firmly formed stool that can be retained between bowel care sessions and easily manually evacuated.

Chemical stimulants include glycerin and bisacodyl.

Hypertonic phosphate enemas should be used with caution, especially in patients with haemorrhoids. However, mini-enemas may be used to act as a trigger for reflex-mediated colonic peristalsis.

Push-ups, abdominal massage and a forward-leaning position may aid evacuation by increasing abdominal pressure.

Massaging the abdomen is best done in a clockwise motion up the ascending colon (on the right side of the abdomen), across the transverse colon and down the descending colon (left side of abdomen) leaning forward can be tried if balance is sufficient or movement not restricted.

It is helpful to use high colonic motility periods such as after a meal (10-15 minutes) in which to perform bowel care.

Valsalva manoeuvre (bearing down as if to empty the bowel) should not be performed with a full bladder. Attempts to increase intra-abdominal pressure and to strain do not in fact result in anal relaxation.

High fibre diet may not have the same effect on SCI patients as on patients whose bowel functions normally.

Individuals with SCI should not be uniformly placed on high fibre diets: the effects of current fibre intake on consistency of stool and frequency of evacuation should be assessed.

It may in fact be necessary to decrease fibre in some cases.

As to fluid intake, it is generally recommended that SCI patients aim to take in about 500ml/day over the standard recommended amount for healthy adult individuals.

This works out at 1ml fluid/Kcal of energy needs or 40ml/kg body weights (bot+500ml for SCI patient). Increased fluid helps to prevent the occurrence of hard, impacted stool and reduces the associated discomfort.

However, if there are bladder problems in addition to neurogenic bowel (a fairly usual occurrence) then measures may need to be implemented to cope with the increased urine volume (see separate article on Genitourinary Problems).

PROKINETIC AGENTS:

These drugs enhance intestinal motility by either promoting the effect of motility agonists or antagonising the effect of inhibitory neurotransmitters. (Note: Cisapride)

They are currently being used to treat proximal (upper) gut disorders but large intestine motility disorders such as chronic constipation secondary to systemic conditions such as diabetes, systemic sclerosis or SCI may respond to these agents.