Guidelines for bowel management in paraplegia & tetraplegia

Preamble
Management is governed by the level of the vertebral lesion:
- above T12–L1 = cauda equina intact → spastic bowel, generally with preserved sacral reflex; often responds to digital stimulation of the rectum
  (The presence of an anal reflex is indicative of an intact sacral reflex)
- below T12–T1 = cauda equina involved → flaccid bowel;
  generally requires digital evacuation of the rectum.

Aim
To achieve controlled regular evacuation of softish formed faeces, generally every day in long-term paraplegia/tetraplegia (e.g. post-traumatic) and every 1–3 days in late-stage cancer, in order to prevent either incontinence (faeces too soft; over-treatment with laxatives) or an anal fissure (faeces too hard; under-treatment with laxatives) which can cause autonomic dysreflexia in paraplegia above T7 vertebra and tetraplegia (*see end footnote*).

Non-drug treatment
In patients with a good appetite:
- maintain a high fluid intake
- encourage a high roughage diet, e.g. wholegrain cereals, wholemeal foods, greens, bran or a bulking agent, e.g. Regulan, Fybogel.

In patients with a poor appetite, particularly if taking morphine or other opioid, a bulking agent is generally contra-indicated.

Spastic bowel
1. If rectum very full, consider a digital evacuation, otherwise
2. Insert 2 glycerine suppositories or a micro-enema deep into the rectum, and wait 30–60min
3. If strong sacral reflex, some faeces will be expelled
4. If necessary, proceed to digital stimulation:
   - insert gloved and lubricated finger
   - rotate finger clockwise 3–4 times
   - withdraw and wait 10min
   - if necessary, repeat 3–4 times.

If glycerine suppositories and micro-enemas do not work satisfactorily, substitute:
- bisacodyl suppositories 10–20mg *or*
- a sodium acid phosphate & sodium bicarbonate suppository (Carbalax); causes rectal distension by producing CO_2 and thereby stimulates reflex evacuation.
  (Note: may cause pain in people with normal rectal sensation.)

Patients who are too weak or otherwise unable to transfer themselves to the toilet or a commode will need nursing assistance to do this. *However, sometimes it is preferable for a patient to defaecate into strategically placed pads on the bed.*

Flaccid Bowel
Generally requires digital evacuation.

A pattern will emerge for each patient, allowing the rectal measures to be adjusted to the individual patient's needs and response.

Use of laxatives

1. Some people with paraplegia/tetraplegia, particularly if taking opioids or other constipating drugs, require oral laxatives in addition to the rectal measures described above. Which laxative is used depends partly on local availability, fashion, and individual preference.

2. For someone taking opioids, cautiously prescribe a colonic stimulant laxative, e.g. senna 15mg b.d., bisacodyl 5–10mg b.d., or the locally preferred alternative. Adjust the dose as necessary to produce softish formed faeces in the rectum.

3. Beware:
   - docusate, a faecal softener, may result a soft faecal impaction of the rectum, and faecal leakage through a patulous anus
   - *oral* bisacodyl in someone not on opioids often causes multiple uncontrolled evacuations, at the wrong time and in the wrong place.

Autonomic dysreflexia is a potential problem in paraplegia above T7 vertebra and in tetraplegia:

- typically is caused by a distended bladder, constipation/faecal impaction, or anal fissure
- manifests as headache (often pounding), profuse sweating, nasal stuffiness, facial flushing, and bradycardia
- caused by a stimulus below the level of the lesion causing sympathetic autonomic overactivity → vasoconstriction and hypertension; this stimulates parasympathetic overactivity above the lesion via the carotid and aortic baroceptors.

As a general rule, headache in someone with paraplegia/tetraplegia should lead to action: check the urinary catheter and, if draining satisfactorily, proceed to rectal examination.