

Bowel problems

Fact Sheet

Multiple
Sclerosis
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Bowel problems

Date of issue: February 2011

Review date: February 2012

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1. Introduction

Bowel problems are commonly experienced by people with MS. Estimates vary about the number of people affected and the problem is thought to be underreported. However, it is believed that around half of all people with MS experience bowel problems at some stage^{1,2}.

Common bowel problems in MS include:

- constipation and difficulties in emptying the bowel;
- faecal incontinence and lack of control over bowel opening.

It is not uncommon for people with MS to experience both constipation and faecal incontinence at the same time.

Bowel control is an extremely complex process that involves the coordination of many different nerves and muscles. For people with MS, bowel and bladder problems are often accompanied by problems with mobility, presenting

additional management difficulties. However, with the right information and support, the majority of bowel problems can be managed satisfactorily. Though bowel problems are often difficult to talk about and can cause some embarrassment, it is important to know that there are teams of health professionals who are dedicated to the management and support of people who experience these problems. It is important for people to know that they are not alone in their experiences and the sooner help is sought, the sooner the focus can shift from the problem to the solution.

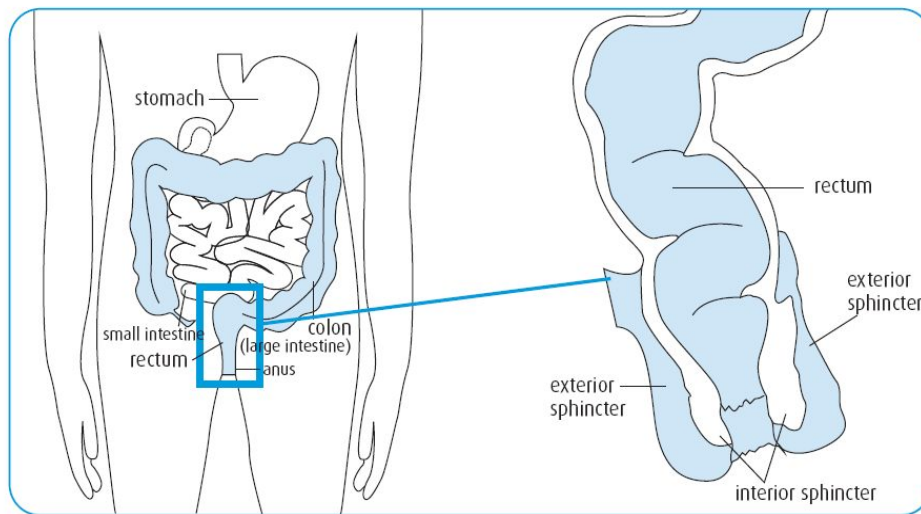
Many hospitals and primary care trusts (PCT) or health board now have a continence advisor or continence nursing service that deals specifically with bladder and bowel problems. To find services, contact NHS Choices. The Bladder & Bowel Foundation has a map of continence clinics on their website (see Useful organisations). In some areas people may be able to refer themselves to continence services, or MS specialist nurses and GPs can make a referral.

While bowel problems are a common symptom of MS, it must be remembered that there can be other causes such as medications or other underlying conditions. It is therefore essential that any bowel problems are properly assessed by a continence advisor or an MS specialist nurse.

2. Why do bowel problems arise in MS?

In normal bowel function, digested food passes from the stomach into the colon, where water is extracted before the waste is passed through to the rectum to be expelled. When waste moves into the rectum, it causes it to expand, which triggers messages to the brain causing an awareness of the need to evacuate - known as the 'call to stool'. The rectum is filled with sensitive nerve endings, that can tell the difference between solid or liquid stool, or wind. In MS, these messages can be interrupted, so that awareness of bowel movements can be affected³. Other bowel problems in MS may arise as a result of disruption between messages from the brain to various parts of the digestive system.

Diagram of the bowel



3. Common bowel problems in MS

3.1 Constipation

Constipation can be defined as: "the passage of hard stools, less frequently than the patient's own bowel pattern"⁴.

Constipation is more prevalent in the developed world and it is estimated that around one-fifth of the adult population who consume a western diet experiences constipation at some stage in their lives³.

Although it is not fully understood how and why constipation happens in MS, research has identified a number of particular causes and contributing factors. Some people may experience a combination of these.

Causes of constipation

- ***Sluggish bowel/slow transit bowel***

In some people with MS, waste travels through the colon much more slowly than in healthy people⁵. This delay in transit time is most likely explained by the disruption in messages to the brain that can occur in MS. As digested food moves through the colon, water is extracted and waste product is pushed through to the rectum to be expelled. Slow transit time in the colon increases the amount of water that will be squeezed out of digested foods, making stools much harder, smaller, and difficult to pass, leading to constipation.

A simple test for the sluggish bowel is to eat a large tablespoon of sweetcorn with a meal. Record when it was eaten, and then monitor when

it is passed (the sweetcorn will be easy to see). This will give a rough indication of how long it takes food to pass through the bowel. For women, this is normally about 32 hours, and for men, about 27 hours. If it takes longer than this, then an individual may have a sluggish bowel.

Various medical assessments, performed by an MS specialist nurse or continence advisor, can also be used to determine whether a sluggish bowel is the cause of any bowel problems experienced.

- ***Reduced sensation***

Some people with MS may have limited sensation in the rectal area. This can result in reduced awareness of the need to empty the bowel. If this is ignored for too long, constipation can result.

- ***Evacuation difficulties***

Some people with MS have a problem passing stool out of the rectum, although it may have travelled normally through the colon. Sometimes this may feel like being constipated but with soft-formed stool. A possible cause is a lack of coordination of the muscles around the pelvic floor that control bowel emptying.

- ***Reduced fluid intake***

Some people with MS manage their bladder problems by reducing the amount of fluids they drink. To compensate, the body will try to extract as much water as possible from food waste, leading to harder stools and the increased likelihood of constipation. It is important to drink enough.

Current recommendations are at least 1.5-2 litres of fluid a day, around 8 glasses. The exact amount will vary according to someone's weight and height as the calculation is based on 30mls of fluid per 1kg of body weight⁶. It's worth discussing the amount of fluid needed with a continence advisor or MS specialist nurse, particularly if it causes or increases bladder problems.

- ***Reduced mobility***

Reduced mobility can lead to a lack of exercise and, sometimes, weaker muscles. Exercise and muscle strength are thought to be important as they can help increase the muscle contractions within the gut, improving an individual's ability to pass waste.

Reduced mobility can also create difficulties in getting to a toilet promptly, causing someone to hold on to stools, which can also lead to constipation. Needing help with toileting -'performing' at the convenience of carers - can also create problems with constipation, which are not easy to manage.

- **Medications**

Many common MS medications list constipation as a possible side-effect, including:

- many of the drugs used for bladder problems such as tolterodine (Detrusitol) and oxybutynin (Ditropan, Lyrinel);
- anti-spasticity drugs such as carbamazepine (Tegretol);
- antidepressants such as amitriptyline (Triptafen), imipramine (Tofranil), which may be prescribed for pain relief, and the selective serotonin reuptake inhibitors (SSRI) such as fluoxetine (Prozac) and paroxetine (Seroxat);
- some dietary supplements such as iron tablets.

- **Other causes**

There may be other causes of constipation. For example, many women experience changes in bowel pattern at times of hormonal fluctuation such as menstruation or during pregnancy.

Management of constipation

There has been very little research into which treatments for bowel problems are most successful in MS. Consequently, management is based on the experience of people with MS and continence advisors.

The main steps for managing constipation are:

- **Assessment of daily diet**

looking particularly at fibre and fluid intake.

Fibre: Adequate amounts of fibre are necessary to help soften stools.

However, the right type of fibre is important. For people with a sluggish bowel, too much bran (eg bran-based breakfast cereals) can bulk up stools and slow down the gut even further. Fibre from the recommended five portions of fruit and vegetables per day should help with constipation.

Significant increases in fibre should be introduced gradually, to minimise unwanted side effects such as bloating and wind.

Fluid: Sufficient fluid intake is important. As discussed above, exact amounts vary from person to person. More fluid is needed in warm weather.

- **Regular bowel habit**

Often people will learn to open their bowels at a specific time of day. The most active time for the reflexes that empty the bowel is around half an hour after breakfast. It is important that a continence advisor provides advice on how to develop and practise a regular bowel routine.

- **Give it time**

It is important that people are not rushed when trying to open the bowel. If, after twenty minutes, nothing has happened, the person should stop and try again after the next meal (eating and drinking will stimulate bowel movement), or the next day.

- **Posture**

The human body's natural posture for opening bowels is to squat. However, in the western world, this is no longer common. The nearest approximation is the 'brace and bulge' technique as shown in this diagram. Sitting on the toilet, raise the knees so they are higher than the hips, and, using a footstool or a pile of telephone directories or something similar, lean forwards and rest arms on top of legs if at all possible.

- Knees higher than hips
- Lean forward
- Put elbows on knees
- Bulge abdomen
- Straighten spine



- **Abdominal massage**

This is a very specific technique used with the 'brace and bulge' position, as some people find 'brace and bulge' does not work on its own.

Abdominal massage needs to be taught by an MS specialist nurse, a continence advisor or other trained person.

- **Review of existing medications and dietary supplements**

It is possible that existing medications or dietary supplements are causing, contributing to, or worsening symptoms. It is therefore important to identify any of these potential factors and to consider alternatives where available.

Some or all of these steps should enable many people to manage their constipation.

Some people may require additional help, particularly people who are experiencing lack of sensation or lack of coordination in muscles that affects the ability to pass stool. Some people in this situation may require medicines to help with their problems, which should be discussed with a continence advisor first. Common medications include:

- **Stool softeners** eg docusate (Docusol, Norgalax) or lactulose (Duphalac, Lactugal) soften stool, making it easier to pass.
- **Enemas** are fluids injected into the rectum. They can be used to clear out the bowel and should only be administered by a health professional.
- **Osmotic laxatives** eg macrogol (Movicol) work by drawing water from the lining of the gut to smooth out the stool and make it easier to pass.
- **Stimulant laxatives** eg Bisacodyl. A stool softener used on its own may not be sufficient and a stimulant such as Bisacodyl may be added, especially in the case of a sluggish bowel. Bisacodyl acts on nerve endings in the walls of the intestine and rectum causing the muscles to contract more often and with greater force. When the intestine contracts it moves the gut contents along faster, thereby alleviating constipation. Use of Bisacodyl must be monitored by a health professional.
- **Suppositories** are capsules inserted into the rectum to help soften stools.
- **Anal irrigation** (also known as transanal irrigation or rectal irrigation) eg Peristeen. Peristeen anal irrigation is a system that can be used in the management of both constipation and faecal incontinence. The system works by introducing warm tap water into the rectum using a catheter whilst the person sits on the toilet. This encourages the muscles in the bowel to contract. The system is only available after assessment by a qualified health professional, who will also teach the method of administration. (For further information see Useful organisations).

3.2 Faecal incontinence

Faecal incontinence - having no control over passing stools - can happen in MS for a variety of reasons. This most embarrassing of symptoms is normally treatable but needs proper assessment and management by a continence advisor or MS specialist nurse.

Causes of faecal incontinence

- ***Reduced sensation***

Loss of or limited sensation can result in a lack of awareness of the need to empty the bowel. This may cause incontinence rather than constipation. The first line of treatment is to try to establish a regular bowel habit. Further treatment will depend on the success of this approach.

- ***Constipation***

Constipation that causes faecal incontinence is known as 'faecal impaction with overflow'. The rectum fills up with very hard impacted stools that effectively form a plug in the bowel. Watery matter may leak round the side of this, causing diarrhoea.

A normal treatment plan is to clear the impaction first, most often by using some form of laxative, or perhaps a suppository or enema. However, this is not always successful so it is important that long-term management takes place in consultation with a health professional, as this may involve a combination of medicines with other techniques.

- ***Other causes***

Too much fibre in the diet, over-use of laxatives, or gastrointestinal viruses can all cause incontinence. It is very important that the cause of any sudden episode of incontinence is correctly identified. Diarrhoea caused by a gastrointestinal virus may or may not need medical treatment, but should always be properly assessed by a GP. Here again, changes to diet, establishing a predictable bowel routine and sometimes prescription of some medications such as loperamide (see below) may help.

Management of faecal incontinence

- **Specific exercises** practised over a period of time may help strengthen the muscles around the anus and allow the individual greater control. These exercises are typically taught by a continence advisor.
- **Loperamide (Imodium)** is an antimotility medicine that slows down the movement of the intestine. Loperamide works by making the stools more solid and less frequent. While it can be used to treat some types of faecal incontinence, it will not be effective in the treatment of others, such as faecal impaction. It is therefore necessary to follow the advice of a continence specialist or MS nurse when using loperamide.
- **Biofeedback retraining** is a technique available in some very specialised centres. It aims to retrain an individual's awareness about opening their bowel and can be quite a lengthy process involving several hospital visits. One small study suggests limited success in people with MS and found that it works better in people with limited disability and a relapsing remitting disease course⁷.
- **Anal irrigation** eg Peristeen (see p7)
- **Surgery** is an option for the very few people with severe bowel incontinence that cannot be managed in any other way. Surgery normally offered is a colostomy which involves bringing the end of the bowel out through the wall of the abdomen so the waste is collected in a special bag. While for some people this can be a positive decision, it needs to be carefully discussed with the bowel surgeon, continence advisor or MS specialist nurse.

Aside from the above mentioned management strategies, there are a number of other factors that deserve consideration by people experiencing bowel problems, including:

- **Skin care**
Caring for sore skin around the anus is important. Washing and drying the sore area carefully after every bowel movement, wearing loose cotton underwear that allows skin to breathe and avoiding perfumed soaps, creams and lotions can all help. Barrier creams such as Cavilon can be

useful to prevent soreness. A continence advisor or MS specialist nurse should be able to advise.

- ***Containing the problem***

There are some pads and pants that can help with incontinence. A continence advisor and organisations such as Promocon will offer guidance on the most appropriate continence products (see Useful organisations). Commodes and bedpans are an option worth considering if getting to the toilet in time is a problem.

RADAR, the campaigning group for disabled people's rights, operates the National Key Scheme that offers access to around 6,500 locked accessible toilets around the country. Keys are available for a small charge directly from RADAR - details in section 4 - or in some cases, from local authorities. There is a register of RADAR toilet locations available to purchase online.

Urgency cards may also prove useful as they explain why a person might need to use a toilet quickly. The 'Just Can't Wait' cards can be presented to give immediate access to a toilet when there are long queues or when an individual needs to use a shop's facilities, for example. The cards are available from the Bladder and Bowel Foundation (see Useful organisations).

4. Useful organisations

The Bladder and Bowel Foundation

A charity providing information and support for all types of bladder and bowel related problems, for individuals, their families, carers and healthcare professionals.

Website: www.bladderandbowelfoundation.org

email: info@bladderandbowelfoundation.org

RADAR

A national network of disabled people and disability organisations. It runs the National Key Scheme for access to disabled toilets.

Website: www.radar.org.uk

email: radar@radar.org.uk

Coloplast Limited

Manufacturer of Peristeen and other healthcare products and services.

Website: www.coloplast.co.uk

For further information about Peristeen Anal Irrigation, call 0800 132 787.

The Colostomy Association

Charity offering support and care for people who have undergone a stoma operation or a colostomy. It provides a helpline and has a network of 800 volunteers.

Website: www.colostomy-association.org.uk

PromoCon

A national service offering product information, advice and practical solutions to both professionals and people affected by bladder or bowel problems, including a confidential helpline.

Website: www.promocon.co.uk

email: promocon@disabledliving.co.uk

5. References

1. Wiesel P, Norton C, Glickmann S, Kamm M. Pathophysiology of bowel dysfunction in multiple sclerosis. *European Journal of Gastroenterology and Hepatology* 2001;13(4):441-448
2. Bakke A, Myhr K, Gronning M, Nyland H. Bladder, bowel and sexual dysfunction in patients with multiple sclerosis: a cohort study. *Scandinavian Journal of Urology and Nephrology* 1996; (Suppl) 179: 61-66.
3. Rigby D. Bowel dysfunction. In: MS Trust: Multiple sclerosis: information for health and social care professionals. Letchworth Garden City: MS Trust; 2007.
4. National Prescribing Centre. The management of constipation. *Prescribing Nurse Bulletin* 1999;6(1):1-4.
5. Norton C. Bowel management in multiple sclerosis. *Gastrointestinal Nursing* 2004;2(6):31-35.
6. Ritz P. Factors affecting energy and macronutrient requirements in elderly people. *Public Health Nutrition* 2001; 4(2B): 561-568.
7. Wiesel P, Norton C, Roy A, et al. Gut focused behavioural treatment (biofeedback) for constipation and faecal incontinence in multiple sclerosis. *Journal of Neurology, Neurosurgery and Psychiatry* 2000; 69(2):240-243.