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Therapeutic treatment and management of lower bowel dysfunction

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Abstract
Lower bowel dysfunction is a very general term that covers a range of conditions affecting the colon, rectum and anal canal. The two most prevalent lower bowel conditions are anal incontinence and constipation. Lower bowel dysfunction can affect both men and women, with similar numbers experiencing faecal incontinence as they age. However, in younger women, anal incontinence is frequently associated with childbirth. Constipation has a greater prevalence than anal incontinence. Conservative therapy can be effective for both faecal urgency/anal incontinence and chronic constipation, particularly disordered defecation, and patient education is a mainstay of treatment. It can also be important to teach patients about the use of laxatives or rectal preparations, if appropriate. Other management strategies can be useful, such as devices designed to assist perineal splinting or anal irrigation devices. The aim of treatment is to improve the quality of life of this group of patients so that their bowel control issues do not have a negative impact on their lives.

Keywords: lower bowel dysfunction, management, treatment.

It was a great honour to be invited to speak at the first annual conference of the newly launched Pelvic, Obstetric and Gynaecological Physiotherapy (POGP). This presentation considered the taboo subject of lower bowel dysfunction.

Lower bowel dysfunction is a very general term that covers a range of conditions affecting the colon, rectum and anal canal. It is primarily used to refer to the two most prevalent lower bowel conditions, i.e. anal incontinence and constipation.

Faecal incontinence was defined by the Royal College of Physicians (RCP 1995, p. 24), as ''the involuntary or inappropriate passage of liquid or solid stool''; however, a more comprehensive term is anal incontinence, which also includes incontinence to flatus (Norton *et al.* 2005).

Constipation is a more difficult symptom to define. It can be caused by a disorder of the large bowel resulting in slow transit, or it can be caused by disordered defecation associated with a dysfunction of the posterior deep pelvic floor muscles (PFMs). The latter is referred to as a paradoxical contraction of the puborectalis, and it can also be associated with anismus, a paradoxical contraction of the external anal sphincter. Detailed patient assessment can give a greater insight into whether that individual is having problems with colonic motility or PFM dysfunction, or both!

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Lower bowel dysfunction can affect both men and women, with similar numbers experiencing faecal incontinence as they age (6.2% of men versus 5.7% of women over 40 years of age). However, in younger women, anal incontinence is frequently associated with childbirth, and vaginal delivery in particular. Further risk factors include a birth weight of > 4 kg, a prolonged second stage of labour, a forceps delivery, a midline episiotomy and an abnormal presentation (Sultan *et al.* 1993; Ryhammer *et al.* 1995; Zetterström *et al.* 1999).

Constipation has a greater prevalence than anal incontinence. Estimates suggest that up to 26% of women and 16% of men have symptoms of constipation; however, the true prevalence is likely to be far greater than this since many people self-

medicate and do not admit to having the problem. Up to 75% of people living in nursing homes are prescribed laxatives on a daily basis.

Conservative therapy can be effective for both faecal urgency/anal incontinence and chronic constipation, particularly disordered defecation.

Patient education is a mainstay of treatment since many patients have little or no understanding of how the bowel works. Advice and information about diet, fluids and lifestyle, including timing of defecation, can be extremely helpful.

Other conservative therapies include:

- anal sphincter exercises;
- perineal splinting;
- dynamic ultrasound;
- defecation dynamics;
- abdominal massage;
- rectal sensation retraining;
- balloon expulsion therapy;
- biofeedback, i.e. manometry or electromyography; and
- neuromuscular electrical stimulation.

It can also be important to educate patients about the use of laxatives or rectal preparations, if appropriate. Many assume that all laxatives work as stimulating laxatives, and that these should be taken at night in order to work the next day. This is not necessarily the case, particularly with osmotic laxatives, which can take effect 2–3 days after ingestion, and may require a persistent dosage to clear a chronic build-up of constipated stool. Furthermore, if the stool is reaching to the rectum, but the patient cannot get it out, it is also worth considering that a rectal preparation such as a glycerin suppository or micro-enema may be more appropriate than an oral laxative.

Other management strategies can be useful, such as the Femmeze Vaginal Trainer (de Smit Medical Systems Ltd, Bristol, UK), which is a device designed to assist perineal splinting, or anal irrigation devices, which include the Aquaflush and Qufora ranges of anal douche systems (Aquaflush Medical Ltd, Norwich, UK, and MacGregor Healthcare Ltd, By Gladsmuir, East Lothian, UK, respectively). These are very useful for patients who experience faecal staining, as well as those who have incomplete emptying, such as that experienced by women with a posterior vaginal wall prolapse. The larger irrigation systems, such as Peristeen (Coloplast UK Ltd, Peterborough, UK), Qufora Cone Toilet and Aquaflush Quick, may be helpful in assisting individuals with faecal incontinence or chronic constipation that has not responded to conservative therapy, and who otherwise may be considered for surgery.

The aim of treatment is to improve the quality of life of these patients so that their bowel control issues do not have a negative impact on their lives. For those with chronic constipation, the specific aim should be to allow them to pass stool without pain, straining or bleeding, and with a pleasant feeling of satisfaction.

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Julia Herbert has specialized in continence and women's health for over 30 years. She currently works full time in her own private practice, and is also involved in lecturing, product development and consultancy work. Julia is a trustee of the Bladder and Bowel Foundation, and was a founder member of Chartered Physiotherapists Promoting Continence. She is a faculty member of the International Continence Society, and also a member of the Association for Continence Advice and POGP.

Julia has a particular interest in the therapeutic management of lower bowel dysfunction: her Master's thesis was a qualitative study examining women's experiences of treatment following obstetric anal sphincter injuries. She is also the clinical director at Femeda Ltd, a new company specializing in the development of women's health products. Julia has lectured extensively both in the UK and abroad, and has made a number of appearances in the media to promote continence care. She is currently a clinical tutor and honorary lecturer at the University of Bradford.