SPINAL BOWEL QUICK GUIDE

Bowel Sounds Present

1. Commence enteral feeding and refer to a Dietician.
2. Commence laxative regime: stool softener (e.g. sodium docusate) twice daily, bowel stimulant (e.g. senna) at night (i.e. 8 – 12 hours before bowel care).
3. **Daily DRE** and digital removal of faeces.

Faecal incontinence does NOT exclude the presence of hard stool in the rectum or bowel.

Preparation and DRE as section 1				
	Is stool present?			
Digital removal of faeces	Yes		No	
	As section 1		Patient **has** passed liquid stool within past 6 hours	Patient has **NOT** passed liquid stool within past 6 hours
			Withdraw the finger	o Insert 2 glycerin suppositories or a micro-enema to stimulate the reflex bowel. o Leave for 20 minutes while applying abdominal massage (unless contra-indicated). o Repeat DRE. Remove any faeces in the rectum (as section 1). o Leave for 10 minutes and repeat DRE. o Repeat until no further stool present in the rectum
	Clean and dry the patient's skin thoroughly. Document the procedure thoroughly.			

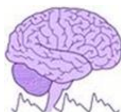
If the procedure above does not produce results, consider using gastro-colic stimulation, rectal stimulation or both.

Abdominal massage Stimulate peristalsis and aids mass movement toward rectum **May be contra-indicated in cases of abdominal trauma – seek surgical advice**	o If possible, explain procedure and obtain consent. Ensure privacy. o Follow the line of the colon from the lower right abdomen clockwise to the lower left abdomen. o Use the heel of the hand or a tennis ball. o Apply and release firm but gentle pressure to each portion of the colon in turn, pushing down and in the direction of flow.

Gastro-colic stimulation Stimulates mass movement toward rectum	o Give 200ml water or feed enterally 15 – 30 minutes before starting bowel care. o If the patient is bolus fed, time bowel care for 15-30 minutes after feeding.

Digital rectal stimulation Stimulates reflex bowel activity	o Preparation as for DRE o Inform the patient you are about to begin. o Insert a lubricated double-gloved finger gently into the rectum. o Slowly rotate the finger in a circular movement, keeping the pad of the finger in gentle contact with the rectal mucosa. o Continue until – - the external sphincter relaxes - stool or flatus is passed - the internal sphincter constricts o This typically takes 15 – 20 seconds o Remove the finger to allow reflex activity to happen o Repeat every 5 – 10 minutes until evacuation is complete (no further stool is passed or felt in the rectum.

If a patient with active bowel sounds does not pass stool for more than 72 hours after the start of enteral feeding despite active bowel care, or if the abdomen is distended, consider an abdominal x-ray.



Bowel Sounds NOT present

Paralytic ileus is common during the first 48 hours following SCI. The aims of active bowel management in this phase are 1) to assess anal sphincter function and 2) to keep the rectum clear of stool.

- Nil enterally
- Twice daily assessment for return of bowel sounds.
- Daily digital rectal examination / digital removal of faeces.

<table>
<tr><td>Preparation</td><td colspan="3">o If possible, explain procedure and obtain consent.
o Ensure privacy.
o The patient should be lying on his left side. The procedure should be timed to coincide with the turning schedule.
o Ensure all necessary equipment is to hand</td></tr>
<tr><td>DRE</td><td colspan="3">▪ Inspect the peri-anal region for faecal smearing and for skin integrity.
▪ Inform the patient you are about to begin
▪ Insert a lubricated double-gloved finger gently into the rectum.
▪ Ask the patient to say if he can feel anything.</td></tr>
<tr><td rowspan="3">Digital removal of faeces</td><td colspan="3">Is stool present?</td></tr>
<tr><td>Yes – soft stool</td><td>Yes – hard stool</td><td>No</td></tr>
<tr><td>Use the finger gently to break up the stool and remove small sections until no more can be felt. Apply more lubricant as needed.</td><td>Insert 2 glycerin suppositories or micro-enema to lubricate the stool. Leave for 20 minutes, and then proceed as for soft stool.
If stool is still too hard to break, stop the procedure and seek advice.</td><td>Withdraw the finger</td></tr>
<tr><td></td><td colspan="3">o Clean and dry the patient's skin thoroughly. Document the procedure thoroughly.</td></tr>
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