

**GUIDANCE ON BOWEL MANAGEMENT IN PATIENTS WITH
 METASTATIC SPINAL CORD COMPRESSION**

THE CHRISTIE, GREATER MANCHESTER & CHESHIRE

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Target audience:	<i>All Clinicians</i>		

Introduction

Autonomic dysfunction is a late sign of spinal cord compression that can cause significant disturbance in bowel habit. This can be manifest as loss of rectal sensation, constipation, diarrhoea or incontinence.

Management may be influenced by the level of the vertebral lesion:

Above T12-L1 ‘reflex bowel’ (reflex arcs in tact)

- Cauda equina in tact → spastic bowel; sacral reflex generally preserved

Below T12 – L1 ‘flaccid bowel’ (reflex arcs damaged)

- Cauda equina involved → flaccid bowel; generally requires manual evacuation of rectum

**ABC
 guidelines**



Assessment

1. What is the level of compression?
2. Document the current bowel habit
3. Review and document the current medication
 - laxatives / suppositories
 - constipating drugs (e.g. opiates)
4. Examination – including PR, assessment of anal tone, faecal loading
5. Assess bladder function (constipation may contribute to bladder symptoms)

Baseline abdominal x-ray

if suspicion of obstruction or to assess for faecal loading

Control protocol

- **Aim is regular evacuation of formed faeces every 1-3 days**
- **Controlled continence may take weeks to achieve - the protocol below should be varied according to response to treatment and individual needs**

1. If faecal loading:

- 1st line: insert 2 glycerine suppositories or micro-enema deep into the rectum
- Digital manual stimulation may be useful if spastic bowel (lesion above T12-L1)*
- 2rd line Arachis oil enema overnight
- 3th line Phosphate enema given the next morning
- 4th line: gentle digital manual evacuation (Generally required if flaccid bowel – lesions below T12-L1)*
- **Proceed to 2.**

2. Establish regular bowel routine:

- Review diet / fluid intake (high fibre diet, high fluid intake)
- Regular oral laxatives with PR intervention every 1-3 days may be required to achieve controlled continence (see below).
- Consider anti-diarrhoeal preparations (eg loperamide or codeine) as *part of a control regime* if there is persistent faecal leakage.

Recommended regular oral laxatives regime

Softener: Sodium Docusate 200mg bd
Stimulant: Senna 2 tabs alt. nights (or night before PR intervention)**

Recommended regular PR intervention regime

Suppositories: Bisacodyl (1 spp.) – alternate nights with
Glycerine (1 spp.) – alternate nights
If not effective: Microlax enema (instead of suppositories)
If not effective: May require regular gentle manual evacuation

* follow RCN clinical nursing guidelines on digital rectal examination & manual removal of faeces

**Also consider Movicol (1-2 sachets) if required - up to 6 sachets if faecal impaction



Note: Autonomic dysreflexia

- Autonomic dysreflexia is a potential problem if the spinal lesion is above T7
- It presents as headache (often pounding), profuse sweating, nasal stuffiness, facial flushing, hypertension and bradycardia
- It is 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 baroreceptors
- Action: treat the cause - check urinary catheter; PR assessment

References:

1. Malignant spinal cord compression: a literature review. Beaston Oncology Centre, October 2003
2. Guidelines for the management of bowel dysfunction in people with neurological conditions, Bolton PCT, August 2006
3. Guidelines for the management of constipation in adults, Christie Hospital NHS Foundation Trust symptom control guidelines, 2006
4. Guidelines for bowel management in paraplegia and tetraplegia, Christie Hospital NHS Foundation Trust symptom control guidelines, March 2004
5. Constipation in complete spinal cord injuries, Stockport NHS Foundation Trust
6. Bowel management following spinal cord injury. Buckinghamshire Hospitals NHS Trust, Stoke Mandeville Hospital, November 2004
7. Digital rectal examination & manual removal of faeces, Royal College of Nursing 2004. Guidance for nurses RCN publication
8. Norton C et al, Management of faecal incontinence in adults: summary of NICE guidance, BMJ 2007;334:1370-1

For more information and protocols on management of MSCC see:
<http://www.christie.nhs.uk/MSCC>



CONSULTATION, APPROVAL & RATIFICATION PROCESS

All documents must be involved in a consultation process either locally within a department or division or throughout the trust at relevant board/committee meetings before being submitted for approval.

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
V1	Aug 2007	Richard Berman	Creation	
V2	Dec 2010	Richard Berman Vivek Misra	Update Review	Updated document Reviewed content
V3	Nov 2013 Jan 2016 Jan 2018	Richard Berman Vivek Misra Richard Berman Richard Berman Laura Flanagan	Update Review Review Review	Updated document Reviewed content Reviewed content No changes

