I Like to Move it, Move it

by Dr Mark Wong

Dump those myths about bowel movements

BOWEL MOVEMENTS ARE one of many normal bodily functions and we often take them for granted. Conversely, there have been numerous myths that have been perpetuated through the years that cause us to worry unnecessarily and in some cases, we end up causing more harm to ourselves. Here are some questions that are commonly asked by patients about their bowel habits.

You do not need to have daily bowel movements to be healthy, as patterns and habits vary from one person to another. As long as your bowel habits are constant and you feel well, there is usually no cause for concern. For instance, some people may have the urge to go every morning after breakfast, as opposed to others who might only need to go once every two days; both individuals may be equally healthy.

You should always 'listen to your body' and only move your bowels (defecate) when you feel the urge to do so. Forcing yourself to defecate in a ritualised manner (e.g. every morning) when there is no urge often results in excessive and unwanted straining that can cause more harm in the form of haemorrhoidal (piles) problems like bleeding.

If you start to experience a change in your usual habits, either increasing or decreasing in frequency of bowel movements or an alternating/disturbed pattern with no return to the normal pattern, you should seek medical attention to address these symptoms.

Everyone experiences constipation at some point in their lives. Constipation is a symptom and not a disease in itself. You should, with the help of a doctor, seek out and address the underlying cause of the constipation (often dietary or medication related) so that it is promptly resolved.

Constipation occurs when bowel movements become difficult or less frequent than usual. In general, when movements stop for more than three days, the stools can become harder and more difficult to pass. Patients may experience abdominal bloating, cramping pain or even vomiting in extreme cases.

Constipation lasting more than three months (chronic) certainly warrants medical attention to also exclude more sinister causes such as colorectal cancer, particularly if there are 'red flag' signs like pain, rectal bleeding, unexplained loss of weight or appetite, family history of colorectal cancer or polyps, and aged above 50 years without a recent scope.

Involuntary loss of stool control (or faecal incontinence) is NOT normal. It should be recognised and investigated as we have good treatment methods available. Faecal incontinence (FI) occurs due to weakness of the muscles of the anus and rectum or the nerves supplying these muscles, resulting in a loss of muscle strength that usually keeps the anal opening closed and stools within, until an appropriate time to defecate. This can lead to embarrassment and social isolation for sufferers.

FI occurs due to childbirth related injuries to the birth canal, treatment for conditions of the anus/rectum/cervix/prostate (e.g. piles, rectal cancer surgery and radiotherapy for prostate and cervical cancer) and neurological disease (e.g. stroke, diabetes), to name a few. As a result, those most at risk of FI are women and the elderly. The incidence is approximately 4.7% in our local population (approximately 200,000 people) and with the impending 'silver tsunami' of an ageing population fast upon us, the figures are set to rise rapidly. Fortunately, there are now methods to investigate and treat sufferers and improve their quality of life.

Can medications like laxatives address all types of constipation?

Answer: NO.

For most cases of constipation, a short period of laxatives can solve the problem. However, up to one-third of patients we see have a functional type of constipation which either requires longer term laxatives or other forms of treatment altogether.

These patients are grouped into one of two groups:

- ***Colonic inertia*** – A condition characterised by a lack of urge to open the bowels, resulting in very infrequent bowel habits (sometimes only one to two times per week). This is due to poor colon contractions resulting in the retention of stools. This condition can start in the teens and typically affects females, and they often need long-term laxatives.
- ***Obstructed defecation*** – A condition where there is usually an urge but a person has to strain excessively during bowel movements. This may be due to a lack of coordinated anal muscle contractions, structural problems like rectal prolapse, or a combination of both. Laxatives are often less effective and patients usually benefit from either specialised pelvic floor therapy called biofeedback, or surgery.

Does everybody with a change in bowel habit need to be investigated?

Answer: NO.

Most people do not need extensive testing, particularly if this change is transient. Only a small number of patients will have a more serious underlying problem. However, any person with 'red flag' symptoms (as mentioned previously) should be promptly investigated. Your doctor may perform these tests to diagnose the cause of your constipation: Blood tests if a hormonal imbalance is suspected; Scopes (e.g. colonoscopy) or imaging (CT-colonography or barium enema) to exclude colorectal cancer.

Are there effective treatments beyond medication for constipation and faecal incontinence?

Answer: YES.

Treatment has to be individualised and depends on the cause and severity of constipation and faecal incontinence (FI). Treatment begins with dietary advice to moderate fibre intake and ensure adequate fluids. For constipation, laxatives are also useful to soften hard stools; for incontinence, stool bulking agents like fibre are good to improve and firm stool consistency to reduce leakage.

For functional causes of constipation and FI, the majority of patients will benefit from dietary modification, tailored medications and biofeedback therapy. However, when the above measures fail, surgery may offer relief of symptoms and improved quality of life.

Some of the specialised treatment options include:

- ***Pelvic floor rehabilitation exercises (anorectal biofeedback)*** – To retrain the anal muscles to contract effectively in the presence of uncoordinated movements.
- ***Neuromodulation (Sacral nerve stimulation/SNS)*** – This minimally invasive technique involves inserting a fine electrode into the lower back to stimulate nerves that control the anal sphincter muscles and rectum (Figure 1). This has been shown to be effective in improving muscle contractions to improve continence. At the same time, this technique can help to modulate colonic contractions in some patients with colonic inertia.
- ***Surgical repair of damaged anal muscles*** – This is usually performed in patients with FI from muscle damage related to birth injuries; this is more common when the baby is large or when there is vacuum or forceps assistance during delivery.
- ***Surgical repair of rectal prolapse*** – This condition can present with both constipation and FI. A specific surgery called rectopexy can be performed that involves inserting a mesh (or flexible plastic scaffolding) to lift and support the weakened supports of the rectum and pelvic floor muscles (Figure 2); this can be performed using laparoscopy or with robotic assistance.
- ***Surgical removal of the colon*** – This is now rarely performed and only reserved for the most severe cases of colonic inertia.

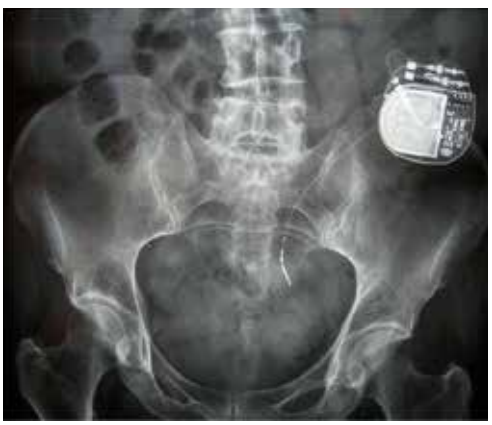

Figure 1. X-ray of a patient with an implanted device

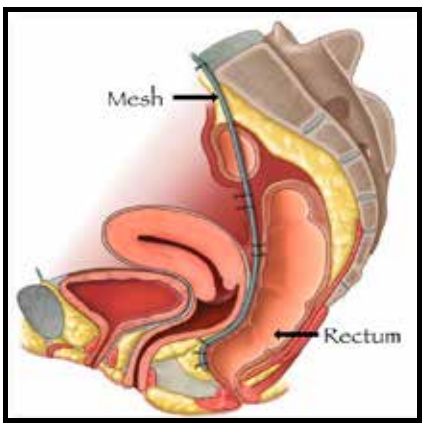

Figure 2. Rectopexy for rectal prolapse (with inserted mesh in front of rectum)

Can eating more fibre always prevent or treat constipation?

Answer: NO.

The solution is moderation! Taking an excess of any food group is not beneficial and can sometimes cause more harm. We are omnivorous and are adapted to eating most meats and vegetables. It is our task to find that balance of optimising benefits whilst avoiding the side effects of excessive intake, which can be challenging as it varies from person to person.

A simple rule is to again 'listen to our bodies' and ensure we consume all food groups in moderation. Often, taking too little or too much fibre can lead to constipation, particularly if we take in too much insoluble fibre and inadequate fluids. Tell-tale signs of excessive fibre intake causing constipation include abdominal bloating with flatulence and hard (often pellet-like) stools. In such a situation, the remedy is often to **reduce** fibre intake, contrary to popular belief! eh

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