

# Bowel Management After SCI - Overview

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## Fact Sheet

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### *What are the potential types of bowel dysfunction after a spinal cord injury?*

- Neurogenic bowel – common in injuries at or above T12. Individuals with neurogenic bowel have sphincters that will remain closed and frequently use strategies such as digital stimulation accompanied by use of suppositories to initiate bowel movements.<sup>1,2</sup>
- Areflexic (flaccid) bowel – common in injuries below T12 (at or below the level of the conus medullaris), although exact location may differ in individuals based on the length of their spinal cord relative to their vertebrae. Individuals with flaccid bowel will typically perform manual digital removal of feces, and may need to empty their rectal vault following meals.<sup>1</sup> Areflexic bowel is common in individuals classified with a lower motor neuron lesion.

### *What is the goal of a bowel management program and when is it commonly performed?*

Effective bowel management is aimed to regulate the timing and regularity of bowel movements in individuals with spinal cord injuries. Bowel programs are typically performed most frequently in the mornings after eating, as the reflex to move food through your intestines is strongest after breakfast.<sup>1</sup> However, this reflex can be stimulated by eating at any time of day and bowel programs can be modified to best meet an individual's scheduling and caregiving needs. Those with areflexic bowel will typically perform bowel management 1-2 times per day, while those with neurogenic bowel may perform their management daily or every other day.<sup>1</sup> It is extremely important to create an effective and regularly scheduled bowel management program for several reasons. Regular bowel movements reduce the chance of involuntary bowel accidents as well as reduce the risk of bowel impaction and constipation.

### *Ideal stool consistency for bowel management*

Constipation, as a result of increased colon transit time due to slowed gastrointestinal motility, is a common complication of those with both neurogenic and areflexic bowels.<sup>1</sup> The Bristol stool chart identifies objective descriptors of the consistency of stool.<sup>3</sup> To maximize the effectiveness of bowel programs, individuals with neurogenic bowel should aim for Bristol type 4, while individuals with flaccid bowel should aim for Bristol type 2-3.<sup>1</sup>

## Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. <b>Entirely Liquid</b>

### Patient References:

1. Model Systems Fact Sheet on Bowel Management:  
[https://msktc.org/sci/factsheets/Bowel\\_Function](https://msktc.org/sci/factsheets/Bowel_Function)

### References:

1. Coggrave M. Guidelines for the management of neurogenic bowel dysfunction in individuals with central neurologic conditions: Multidisciplinary association of spinal cord injured professionals, 2012.
2. Paris G, Gourcerol G, Leroi AM. Management of neurogenic bowel dysfunction. Eur J Phys Rehabil Med 2011;47(4):661-76
3. Heaton K, Radvan J, Cripps H, Mountford R, Braddon F, Hughes A. Defaecation frequency and timing and stool form in the general population: a prospective study. Gut 1992;33:818-824

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