

CLINICAL CASE STUDY: COMPLEX BOWEL ISSUES

With World Continence Week taking place on 23–29 June, Sue Croft, APAM, shares a case study of her experiences treating a mother whose severe rectal prolapse went undiagnosed for 13 years.

Kath was referred to me by the fourth gastroenterologist she had consulted over a 13-year period since the birth of her first son. Her son's birth, in the words of Kath, was 'long and traumatic' and what followed for the next 13 years was an inexplicable journey of misdiagnosis and a lack of early intervention in what was obviously a significant birth injury.

This case study illustrates how early, routine post-natal intervention could have manifestly changed the symptoms of distress and anxiety suffered by this patient and may have limited the extent of further pelvic floor dysfunction (PFD).

The theme of this year's World Continence Week is 'Pregnancy and pelvic floor health: managing the mother load'. Continence and women's health (CWH) physiotherapists play an integral role in preventative health within the area of continence promotion (both faecal and urinary) as well as red-flagging patients who will experience further PFD if their symptoms are left untreated.

This case report also demonstrates the role of CWH physiotherapists to oversee patient progress and ensure all appropriate health professionals (such as dieticians, colorectal surgeons, urogynaecologists, and psychologists) are integrated early on into the treatment plan for the patient.

History

Kath presented to me with serious ongoing bowel issues since the birth of her first child. She had two vaginal deliveries, without the obvious risk factors of baby weight (>4000g), instrument deliveries (forceps, vacuum) or perineal lacerations (tear or episiotomy) (Leanza 2011; Memon 2013). However, the first birth was prolonged—a risk factor for PFD (Memon 2013). She reported that she had been diligent with doing pelvic floor exercises before, during, and after each of the deliveries.

From early on, she had painful defecation which continued for six months, after which she had an anal fissure repair. There was no ano-rectal testing done prior to the surgery, only a quick physical examination. Most of the pain disappeared after the surgery, but she still had urinary leakage and so she continued with unsupervised pelvic floor exercises.

The defecation difficulties emerged again following the birth of Kath's second son four years later. She had constipation, obstructed defecation symptoms (where the pelvic floor does not provide the necessary support to enable good evacuation or when there is an incoordination between the external anal sphincter and pubo-rectalis), bloating, regular faecal urgency and burning pain. She began to discharge clear mucus and blood from her bowels, necessitating the use of continence pads.

Over 13 years since the birth of her first baby, she sought help from her GP on numerous occasions, saw four different gastroenterologists, had three colonoscopies (NAD except

for the last one, which showed colonic ulcers), was diagnosed with irritable bowel syndrome (medications made no difference) and was diagnosed with anaemia from the constant rectal bleeding. Interestingly, the 'American Gastroenterological Association Medical Position Statement: Guidelines on Constipation' (Bharucha 2013) states that pelvic floor defecatory training (as taught by a CWH physiotherapist) is at the top of the algorithm for managing defecatory disorders.

It was the fourth gastroenterologist who at last understood there was significant pelvic floor dysfunction and referred Kath for further investigations, including colorectal studies, which demonstrated she had significant pathology (poor resting and squeeze pressure and poor sensation); anal ultrasound (showed minor sphincter defects from both traumatic deliveries and the previous lateral sphincterotomy); and a defecating proctogram (demonstrated significant rectal intussusception, early full thickness prolapse, a large rectocele and solitary rectal ulcer syndrome). Kath was also referred to a colorectal surgeon and, lastly, to me for her first physiotherapy contact—some 13 years after her first vaginal delivery.

Signs and symptoms

By the time Kath presented to me, her symptoms were severe. She complained of significant pain before, during, and after defecation; mucous discharge and bleeding; decreased ano-rectal sensation resulting in faecal urgency and faecal incontinence, including during sexual

intercourse; a thrombosed, excoriated haemorrhoid; and severe evacuation difficulties, rectally digitating every time to evacuate. She had significant levator avulsion of her pelvic floor muscles on the right as well as a poor squeeze pressure at the anus. However, despite these weak muscles, she had a good stabilising effect when she activated her pelvic floor muscles (the 'knack') with increased intra-abdominal pressure (IAP cough, sneeze, bending).

Analysis

It was important that, early on, Kath believed that physiotherapy had an integral role to play in the immediate and long-term management of her condition. A key feature when Kath was reporting her history was repeated failure by all the gastroenterologists to comprehend the extent of her symptoms and problems. Three of them kept repeating she was too young to have significant issues and one even said 'It's not cancer', which was somehow supposed to make her feel better.

This lack of validation was a key feature for Kath and caused significant emotional distress. Bowel dysfunction itself can cause significant psychological distress and interfere with the patient's daily living and wellbeing (Irvine 2002; Sonnenberg & Chang 2008). So acknowledging the severity of Kath's symptoms, solving her defecation difficulties and decreasing her pain to significantly improve her psychological wellbeing and quality of life were key goals of my treatment plan.

The defaecogram was very difficult for Kath: 'The defecation test was an emotionally pivotal moment. Normally I would consider myself to be a strong, resilient person, but I barely kept it together during the test and I broke down emotionally afterwards. The poor doctor tried to be encouraging but I couldn't do a single thing he asked me to. I couldn't tell when I was full, I couldn't hold and I couldn't evacuate. I think I had been so used to managing that reality in private that when I had to admit it to another person, the reality of my state hit me'.

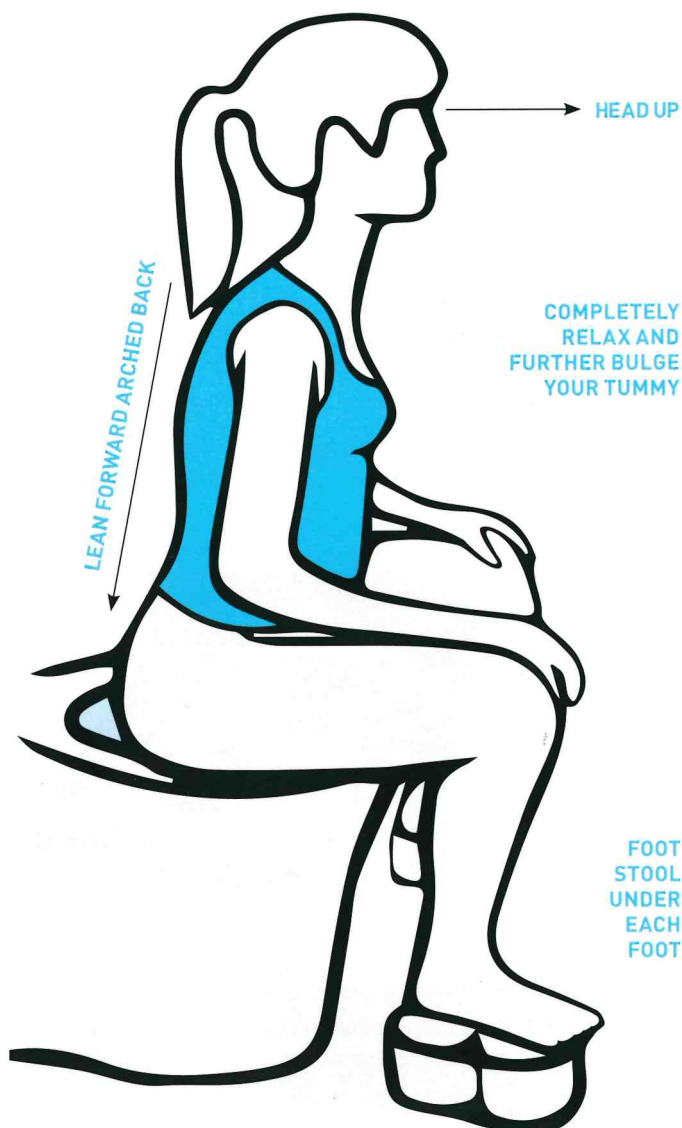
Patient motivation is critical when managing pelvic floor dysfunction. The therapy relationship makes substantial and consistent contributions to patient success and accounts for why patients improve (or fail to improve), as much as the particular treatment method. It has been shown that patients with empathetic therapists tend to progress more in treatment and experience a higher probability of eventual improvement (Norcross 2011).

Treatment consisted of extensive bladder and bowel education, particularly focusing on defecation retraining (correct position and abdomino-pelvic floor coordination); pelvic floor muscle training to understand about careful strengthening of the residual muscles (those left intact following the vaginal birth trauma causing significant avulsion) and when to engage the muscles with increases in IAP (cough, sneeze, bending, etc). It can be equally important to teach down-training of the muscles to help with the ano-rectal pain. Treatment also included bladder retraining and urge-control strategies for her urinary urgency and urge incontinence; the elimination of caffeine; and central sensitisation pain theory for her ano-rectal pain (Moseley & Butler 2003). I also

referred Kath to a dietician for assessment regarding FODMAPS (fermentable, oligo-, di-, mono-saccharides and polyols) to help manage her bloating and gas incontinence.

Also important is the prevention component of the education. Teaching effective bowel evacuation and activation of the muscles prior to increases in intra-abdominal pressure also assists in minimising downward forces on the pelvic floor, helping to prevent worsening posterior wall prolapse (rectocele), rectal prolapse and the descending perineum syndrome (further pelvic floor descent). Levator avulsion is a known risk factor for developing prolapse (Dietz 2008) so she was at risk due to both her levator avulsion and her obstructed defecation symptoms. Educating women comprehensively about the conservative management of pelvic organ prolapse by CWH physiotherapists has been shown to make a significant difference in reducing prolapse symptoms, is cost-effective as an intervention and should be recommended as first-line management for prolapse (Hagen et al 2011).

CORRECT POSUTURE FOR EMPTYING BOWELS



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