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MULTIPLE SCLEROSIS AND YOUR BLADDER & BOWEL

3RD EDITION

ms.

Multiple Sclerosis Society of New Zealand

MS AND YOUR BLADDER & BOWEL

PART 1

BLADDER PROBLEMS IN MS

PART 2

BOWEL PROBLEMS IN MS

AUTHOR

Adapted from the older editions: *Multiple Sclerosis and Your Bladder*, prepared by Nancy Holland from the National MS Society of America and *Understanding Bowel Problems in MS* by the same author.

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INTRODUCTION

Multiple Sclerosis can affect both the bladder and the bowel's ability to function effectively.

Damage to nerve pathways in the brain or spinal cord in MS interferes with the signals from the bowel or bladder to the brain indicating the need to go to the toilet and/or the responding signals from the brain to the bowel or bladder to maintain normal functioning.

The first section of this booklet explains bladder dysfunction caused by MS and describes the range of solutions available.

The second part sets out to clarify the common bowel problems associated with MS, the range of solutions available and how these problems can be better managed in day to day life.

Many people are often too embarrassed to seek help over losing control of their bodily functions, but with a little forward planning, expert medical advice and input, plus good management techniques, these problems can be brought under control.

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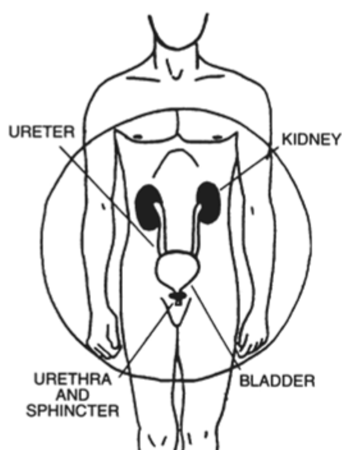
THE URINARY SYSTEM: WHAT IT IS, HOW IT WORKS

The diagram shows the urinary tract. Urine is formed in the kidneys from a combination of excess fluid and impurities from the blood stream. Urine flows from the kidneys through the ureters to the bladder where it is stored before being released through the urethra.



The bladder is a muscular bag. This slowly expands as urine collects, similar to the way a balloon expands as air is blown into it. The muscular part of the bladder is called the detrusor. At the opening of the bladder, where it meets the urethra, there is a muscle called the sphincter that remains contracted and closed between times of urination.

The bladder and sphincter are normally under voluntary control, which means a person can control when they urinate. The bladder has a capacity of about 500mls before the urge to urinate is felt.

The brain controls urination. Although the process is not clearly understood, the brain sends nerve impulses down the bottom of the spinal cord to the detrusor and sphincter.

These impulses synchronise the contraction of the bladder and opening of the sphincter to ensure the urine proceeds in a coordinated way into the urethra.

HOW MS AFFECTS BLADDER FUNCTION

Multiple Sclerosis can cause damage to the nerve pathways that control the urinary system. This can affect the bladder's ability to store urine, or the ability to empty itself of urine. In some cases these problems can occur at the same time.

FAILURE TO STORE URINE

Sometimes the mix up in messages from the nerve pathways mean the bladder detrusor muscle (see previous section) is overactive—contracting the bladder when only small amounts of urine are present.

This type of bladder dysfunction can cause:

- Urinary urgency—a strong sensation that urination is imminent and cannot be postponed;
- Urinary frequency— the need to urinate more frequently than every three or four hours;
- Incontinence—involuntary discharge of urine; and/or
- Nocturia—having the need to urinate one or more times during the night.

Management

The idea is to relax the bladder detrusor muscle so that a normal amount of urine may accumulate before the urge to urinate is felt. This can be achieved by medication (see page 9).

FAILURE TO EMPTY THE BLADDER

Difficulty emptying the bladder usually occurs because the sphincter is spastic, meaning it is unable to relax easily and the bladder cannot complete its discharge into the urethra.

As there is less pressure on the sphincter to relax, the bladder retains urine instead of discharging it. Conversely, the weakened detrusor may no longer be able to apply enough pressure to push the urine through the sphincter.

Problems with the sphincter and detrusor allowing the bladder to empty can cause:

- Urinary hesitancy—difficulty in starting a flow of urine;
- Overflow incontinence—loss of urinary control due to a very full bladder ('dribbling' or 'leaking');
- Sensation of incomplete emptying—feeling that some urine remains in the bladder after urinating; and/or
- Lost sensation—no awareness of urine being retained.

COMPLICATIONS

Urine can 'back up' in both the kidney and the urinary tract. This built-up urine can crystalise into stones, or provide a breeding ground for infection. These issues must be treated.

Symptoms of possible infection or stones include:

- Urgent or frequent urination;
- Burning or discomfort when urinating;
- A change in colour or odour of urine;
- Back, side and groin pain;

- Fever;
- Nausea and vomiting; and/or
- Blood in the urine.

There are some steps you can take to prevent infection:

- Avoid holding urine for long periods of time;
- Empty your bladder frequently and completely;
- Drink plenty of fluids to keep the bladder flushed;
- Take extra Vitamin C (e.g. cranberry juice) to make the urine more acid and inhibit bacterial growth in the urinary tract; and
- Women should avoid wearing synthetic fibre underwear, as this tends to trap moisture and improve conditions for bacterial growth.

Urinary tract infections are treated with antibacterial solutions available from pharmacists, but serious infections require antibiotic treatment from a GP.

The chances of developing stones can be decreased through changes to food and liquid intake. Kidney and bladder stones predispose to infections and may need surgical treatment.

MANAGING BLADDER PROBLEMS

These solutions may require the input of a continence advisor, to whom your GP can provide a referral. Alternatively, the urology department of the local hospital can provide information on specialists in your area.

CONTINENCE PRODUCTS

Besides medication (discussed below) and catheters (see page 13), there are a wide range of products and appliances available to assist with managing bladder problems. These are constantly being redesigned and re-evaluated by the manufacturers. Some products are available on prescription and some you have to buy.

The best resource for products, availability and funding is Enable New Zealand. Alternatively, an MS Field Worker will be able to provide one-on-one advice that reflects your situation (see Sources of Support and Information on page 35).

For men, a condom urinal may be a more suitable alternative to an indwelling catheter. A continence advisor can provide you the best advice here.

MEDICATION

Antibiotics

Those most commonly used to clear infections are norfloxacin, trimethoprim and nitrofurantoin. At times, long term treatment may be given to prevent infections, but that may cause complications.

Anti-spasmodics

These are used to reduce contractions of the main bladder muscle, oxybutinin (Ditropan) is most commonly-used. Tricyclic antidepressants such as amitriptyline and nortriptyline are mainly used in MS to relieve pain, but also reduce bladder muscle spasms.

Terazocin (Hytrin) relaxes the involuntary muscle controlling urine outflow from the bladder. It is usually used in men with an enlarged prostate (benign prostatic hyperplasia or BPH) causing difficulty urinating (hesitation, dribbling and weak stream with incomplete bladder emptying) and may be used for similar symptoms in MS. It may also be used to treat high blood pressure.

Reduction of kidney urine production

Desmopressin (Minirin) is a synthetic form of a hormone which works on the kidneys to reduce urine volume. It is given as a nasal spray and used mainly at night.

BLADDER FUNCTION TESTS

Tests of bladder function may include one or more of the following:

- Urinalysis to see if infection is present.
- Post-void residual urine, where a person urinates normally, followed by catheterisation to determine how much urine has remained in the bladder. This is the simplest test to determine bladder function.
- Intravenous urogram OW or IVP) where an x ray is taken of the entire urinary system that provides information about the kidneys as well as the bladder.
- Ultrasound scan and/or CT urogram to image the different parts of the urinary tract.

- ➲ Urodynamic studies under the direction of a Urologist to determine the storage capacity of the bladder and how it functions as it is progressively filled through a urethral catheter.

FLUIDS AND DIET

It is tempting to cut down on the amount you drink so that you will need to use the toilet less often, but please don't do this.

A low fluid intake can lead to:

- ➲ Urine infections
- ➲ Stone formation
- ➲ Constipation
- ➲ Further bladder problems

Concentrated urine can also aggravate the bladder, causing people to urinate more frequently.

It is important to drink at least eight glasses of water a day. Some people find it helps to drink more during the day and less in the evening, to reduce the urge 'to go' in the night.

It may be helpful to reduce tea and coffee as these are diuretics (substances that make you pass urine more frequently) but you will need to find an alternative.

Alcohol increases the amount of urine formed, so drink in moderation.

It's essential to maintain a balanced diet to ensure proper bowel function. Constipation can interfere with bladder function by:

- ➲ Creating pressure on urethra, causing an obstruction.

- Pressing on the bladder, aggravating the bladder muscle and causing urgency.
- Stretching the pelvic floor muscles
- Distorting the angle of the bladder neck.

A balanced diet should include plenty of fresh fruit, vegetables and fibre as well as plenty of fluid. An MS Field Worker or a registered dietician can all provide information on MS and diet.

PELVIC FLOOR MUSCLE EXERCISES

Simple exercises to strengthen the muscles that support your bladder are useful if you experience stress incontinence. Actions such as laughing or sneezing create pressure on weak bladder neck muscles. This causes urine to leak out.

Exercises will not cure your bladder symptoms, but should strengthen your pelvic floor muscles and give you more control and time to reach a toilet.

Identify the muscles of the pelvic floor by stopping the flow of urine, then restart it. The muscles you use are your pelvic floor muscles. Tighten the muscles while counting slowly to four, then release them.

Do this four times every hour. Do it anywhere—sitting or standing, waiting for the bus—there is no need to set aside a special time.

After several weeks you will probably feel stronger control.

BLADDER DRILL

It may be worth trying some exercises to ‘retrain’ your bladder. If you have a storage dysfunction and are passing urine frequently:

- ➲ When you feel the urge to go, tighten your pelvic floor muscles.
- ➲ Hold on for five minutes—use a distraction if necessary.
- ➲ Increase the holding on time gradually.
- ➲ If you have an emptying dysfunction, use the clock and go at regular intervals, say two hours, even if you don't have to.

This will make sure you empty your bladder before it empties voluntarily.

BLADDER MASSAGE

This is a commonly used technique that facilitates more complete bladder emptying. After as much urine has been emptied as possible, lean forward and apply pressure in a downward movement to the lower abdomen with both hands. It is necessary for men and women to sit firmly on the toilet seat to use this technique.

CATHETERISATION

Intermittent Self-catheterisation

A thin tube is inserted into the urethra to drain the urine from the bladder. Although it sounds somewhat invasive, it is actually safe, effective, painless and easy to perform.

Most people are advised to self-catheterise two or three times a day and perhaps before going to bed. Apart from the catheter itself, no other special equipment is needed and the bladder can be emptied as per usual in any toilet.

Poor hand function, tremor and leg spasms can make this method more difficult, although poor eyesight does not prevent people from administering the system.

Self catheterisation can help to:

- ➲ Prevent infections of the urinary system, by regularly eliminating residual urine.
- ➲ Avoid bladder stretching, caused by over filling.
- ➲ Prevent kidney damage, caused by urine reflux towards the kidneys.

Provided the catheter tubes are kept clean and standard hygiene practices are followed there is very little chance of infection.

After a period of self-catheterisation, the tone of the bladder muscles may improve, eliminating the need for this management technique.

Permanent or 'Indwelling Catheters'

An indwelling catheter is a small tube that is passed into the bladder, most commonly through the urethra but sometimes through the abdomen. It is attached to a disposable bag that collects the urine. The tube and bag can be neatly strapped to the leg and worn discreetly under clothing.

Because the catheter is permanent, this increases the chances of infections and stones, thus it is not recommended for day-to-day bladder management. However, an indwelling catheter may be preferable when:

- ➲ There are no available toilets, or using them is not possible;
- ➲ Persistent bladder problems occur;
- ➲ The bladder has been excessively stretched by fluid retention and needs a few weeks' break to recover;
- ➲ A person who cannot perform intermittent catheterisation on

themselves does not have access to a carer or continence nurse for several days;

- Pressure sores develop in the areas close to the urethra; and/or
- Recovering from surgery or labour.

As an indwelling catheter can provide bacteria with a direct route to your bladder, care must be taken to minimise the risk of infection. Fluid intake should be at least three litres a day to irrigate the bladder and reduce this risk.

Suprapubic Catheter

A suprapubic catheter is a tube that is inserted through the abdominal wall into the bladder to drain urine into a bag. The bag has a tap and can be emptied into the toilet.

Suprapubic catheters are used as an alternative to urethral catheterisation, especially after trauma or surgery and to:

- Provide bladder drainage for people with spinal cord damage;
- Allow healing after certain types of surgery; and/or
- Make sexual intercourse easier, as the catheter is not placed into the genitals.

A minor surgical procedure is required to insert this catheter.

As with other types of catheters, care must be taken with the equipment. The catheter, tubing and drainage bag must be kept as clean as possible and hygienic practices followed when handling the equipment. A continence advisor will help with proper management.

COMPLEMENTARY THERAPIES

There has been very little research carried out on the use of these therapies in dealing with bladder problems and, at the time of writing this booklet, virtually none that is specific to MS.

However, some people have had good experiences and report success with a wide range of treatments.

These include hypnotherapy, acupuncture, homeopathy and reflexology. Other therapies have, in their turn, all helped people and may well be worth a try, particularly if more conventional therapies have failed.

COMMON QUESTIONS ABOUT BLADDER MANAGEMENT

HOW DO I MANAGE AT NIGHT?

Stay warm and dry when you are asleep, not only for comfort and a decent rest, but also to protect your skin and your bedding.

Many continence products, including indwelling catheters, have special night versions designed to cope with periods of rest. You could consider a commode in the bedroom for bedtime use and a water resistant mattress protector will prevent damage to the bed.

HOW DO I MANAGE ODOUR?

Any degree of incontinence can cause worries about smells, but the right advice from a continence advisor can allay these fears.

It is also important that your:

- Wet pads or clothing are removed as soon as possible ;
- Skin is kept clean and dry;
- Genital area is washed and dried thoroughly every day;
- Underwear and clothes are washed regularly;
- Tubing or drainage bag, if you have one, is kept sterile.

Use barrier cream to protect your skin from the irritants in urine.

WHAT CAN I DO IF THIS IS AFFECTING MY SEXUAL ACTIVITY?

Most bladder issues can be managed effectively so that sexual ability and enjoyment is not compromised. It is important to seek advice from a continence advisor or sex therapist on this issue and your MS Field Worker may also have some solutions.

If you have a partner, it is crucial to discuss any worries with them so that mutual understanding can be achieved.

HOW DO I COPE WITH MENSTRUATION AND BLADDER SYMPTOMS?

Menstruation can be an extra issue for women experiencing bladder problems. Women who are able to use tampons should continue to do so and most incontinence pads can also provide effective sanitary protection. Alternatively, a sanitary pad can be added to the continence pad for extra protection. Of course, regular changing of sanitary products is essential for skincare and to prevent odour.

A continence advisor, or your MS Field Worker will be able to help with advice.

FINAL THOUGHTS

Your bladder can be affected in different ways by multiple sclerosis. It is estimated that more than 50 per cent of people with MS experience some bladder symptoms at some time.

While bladder symptoms vary from person to person (as with most MS symptoms), there are broadly three types of bladder dysfunction: failure to empty, failure to store and combined dysfunction.

You can overcome any embarrassment by seeking help.

Discuss your bladder symptoms with your GP or neurologist. You need the diagnosis before the correct management techniques can be started. S/he can refer you to a continence advisor or urologist for the help you need.

Your treatment could include bladder retraining, dietary changes, medication, using continence products or catheterisation. Urinary tract infections can largely be prevented, but if they do occur, they must be properly and promptly treated.

If you plan to change your routine (e.g. going on a trip), anticipate problems and plan ahead.

With good management, your bladder need not run your life.

PART 2

BOWEL PROBLEMS IN MS

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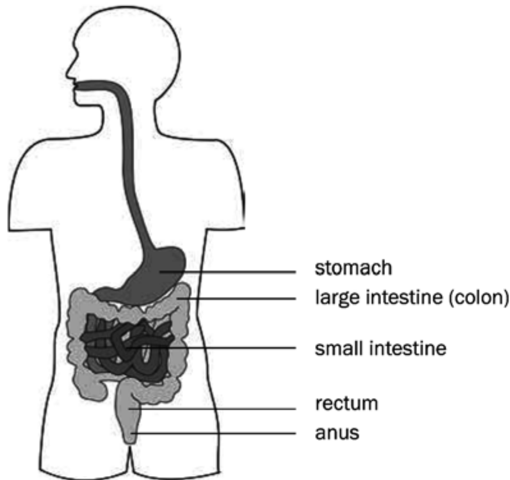
THE BOWEL: WHAT IT IS, WHAT IT DOES



Source: UK MS Society

The bowel is the internal plumbing mechanism that takes the part of our food we can't use in our bodies and makes it ready for disposal. The food we eat begins its journey at the mouth and proceeds down the oesophagus to the stomach. Major digestive action starts there and is continued in the small bowel or small intestine. The food, which is moved through the digestive system by a propulsive action has become mainly waste and water by the time it reaches the large bowel or colon, a 1.5m long tube.

By the time the stool reaches the final section of the colon, it has lost much of the water that was present in the upper part of the digestive system. The stool finally reaches the rectum and—on command from the brain—is then consciously eliminated from the body with a bowel movement through the anal canal.

Normal bowel functioning can range from three bowel movements a day to three a week. Despite the widely recommended "one movement a day," doctors agree that such frequency is not

necessary. The medical definition of “infrequent” bowel movements is “less often than once every three days.” Most doctors agree that a movement less than once a week is not adequate. One every two or three days is a preferable minimum. The rectum, the last 10 to 15 cm of the digestive tract, determines when a bowel movement is needed. It remains empty until just before a bowel movement. The filling of the rectum sends messages to the brain via nerves in the rectal wall that a bowel movement is needed.

From the rectum, the stool passes into the anal canal, guarded by ring-shaped, internal and external sphincter muscles. Just prior to being eliminated, the stool is admitted to the anal canal by the internal sphincter muscle, which opens automatically when the rectal wall is stretched by a mass of stool. The external sphincter, on the other hand, is opened by conscious decision of the brain, so that bowel movements can be performed only at appropriate times.

COMMON BOWEL PROBLEMS IN MS

Whilst a lack of bowel control is a very distressing symptom, it is not all that common in MS.

If the contents of the bowel move too fast, not enough water is removed and the stool reaches the rectum in a soft or liquid state known as diarrhoea.

If movement of the stool is slow, too much water may be absorbed by the body, making the stool hard and difficult to pass. This condition is constipation. Constipation can prevent any of the stool from being eliminated, or it can result in a partial bowel movement, with part of the waste retained in the bowel or rectum.

People may even pass faeces, or stools, at the wrong time or in the wrong place. They may also pass wind without control or totally lose control and soil themselves. This is known as incontinence.

USUAL CAUSES

It is important to also know that there can be more usual causes of bowel problems, other than MS.

Diarrhoea and constipation are frequent companions of travellers, resulting from encounters with unfamiliar or contaminated food and water, or simply because of a change in an accustomed level of activity. Diarrhoea can also be triggered by a viral, bacterial, or parasitic infection. Continued diarrhoea also stems from food allergies or sensitivity to particular kinds of food, such as highly spiced dishes or dairy products (intolerance to dairy products often

can be assisted by drinking lactose-reduced milk or by eating dairy products together with tablets containing lactose-digesting enzymes).

Non-MS related constipation may also be caused by such common medications as calcium supplements or antacids containing aluminium or calcium. Other drugs that may lead to constipation include antidepressants, diuretics, opiates and antipsychotic drugs. Ironically, one of the most common causes of non-MS related constipation is a voluntary habit: delaying bowel movements to save time on busy days, or to avoid the exertion of a trip to the bathroom. Eventually the rectum adapts to the increased bulk of stool and the urge to eliminate subsides. The constipating effects, however, continue and elimination becomes increasingly difficult. For some women, constipation is a premenstrual symptom and, during pregnancy, it may be one way that the colon reacts to a change in the level of sex hormones.

IRRITABLE BOWEL SYNDROME

This is also known as spastic colon and is a condition affecting the general population in which constipation and diarrhoea often alternate. It may cause abdominal cramps and wind pains. Irritable bowel syndrome is annoying, but not dangerous and is often associated with stress. Because the symptoms caused by irritable bowel syndrome are similar to those caused by MS, ask your doctor about the possible use and benefits of IBS medications. They may offer some relief.

CONSTIPATION AND MS

Constipation is the most common bowel complaint of people who have MS. It's easy to slip into poor dietary habits, physical inactivity and even depression when one lives with MS. All of these can disrupt the digestive system. As explained above, various medications can compound the situation.

But there is more to the problem. When MS damages nerve pathways in the brain or spinal cord, a short-circuiting process occurs. This interferes with the signals from the bowel to the brain (indicating the need for a bowel movement), and/or with the responding signals from the brain to the bowel (for maintaining normal functioning).

Common MS symptoms such as difficulty in walking and chronic fatigue can lead to slow movement of waste material through the colon. Weakened abdominal muscles can also make the actual process of having a bowel movement more difficult. If the pelvic floor muscles are spastic and unable to relax, normal bowel functioning will be compromised.

Some tend not to have the usual increase in colon activity following meals which propels waste towards the rectum.

Finally, some try to solve common bladder problems by reducing their fluid intake. Restricting fluids makes constipation worse. This is so common in MS that the first step to take may be to get medical help for your bladder problems so that adequate fluid intake, so critical to bowel functions, will be possible.

A long-term delay is not an option. Besides the obvious discomfort of constipation, complications can develop. Stool that builds up in the

rectum can put pressure on part of the urinary system, increasing some bladder problems. A stretched rectum can send messages to the spinal cord that further interrupt bladder function.

Constipation aggravates spasticity, making walking more difficult. And constipation can be the root cause of the most distressing bowel symptom, incontinence (see next page).

DIARRHOEA AND MS

In general, diarrhoea is less of a problem for people with MS than constipation. Yet when it occurs, for whatever reasons, it is often compounded by loss of control. Reduced sensation in the rectal area can allow the rectum to stretch beyond its normal range, triggering an unexpected, involuntary relaxation of the external anal sphincter, releasing the loose stool.

MS sometimes causes overactive bowel functioning leading to diarrhoea or sphincter abnormalities which can cause incontinence. The condition can be treated with prescription medicines such as Ditropan.

Diarrhoea might indicate a secondary problem, such as gastroenteritis, a parasitic infection or inflammatory bowel disease. It is not wise to treat persistent diarrhoea without a doctor's advice. Diarrhoea is often managed with a bulk-former, such as Metamucil. When bulk-formers are used to treat diarrhoea instead of constipation, they are taken without any additional fluid. The objective is to take just enough to firm up the stool, but not enough to cause constipation. If bulk-formers do not relieve diarrhoea, your doctor may suggest medications which slow the bowel muscles, such as Kaopectate or Lomotil.

INCONTINENCE

Total loss of bowel control does happen to people with MS. Some people have it as a frequent symptom, others only rarely. If incontinence becomes even an occasional problem, don't be discouraged.

The problem can usually be managed, but it may take some time. Work closely with your doctor and Field Worker towards a solution which works for you. A regular schedule of elimination is key. When the bowel becomes used to emptying at specific intervals, accidents at other times are less likely. In addition to drugs, techniques such as biofeedback may help. This can train an individual to be sensitive to subtle signals that the rectum is filling.

In the meantime, don't restrict your life. Protective pants can be used to prevent embarrassing accidents or simply provide peace of mind. An absorbent lining helps protect the skin and a plastic outer lining contains odours and keeps clothing from becoming soiled.

FAECAL IMPACTION

This is a severe form of constipation where a hard mass of stool is lodged in the rectum and cannot be eliminated. This problem requires immediate attention. It can usually be diagnosed through a simple rectal examination, but symptoms may be confusing.

Impaction may cause diarrhoea, bowel incontinence, even rectal bleeding from a pressure ulcer of the bowel wall. Your doctor may want you to have a series of tests to rule out the chance of the more serious bowel diseases.

Impaction leads to incontinence when the stool mass presses on the internal sphincter, triggering a relaxation response. The external sphincter, although under voluntary control, is frequently weakened by MS and may not be able to be closed. Watery stool behind the impaction thus leaks out uncontrollably. Diarrhoea as a side effect of constipation is not uncommon in MS. The resulting incontinence may be the first warning a person has that an annoying problem has become a major issue.

SEE YOUR DOCTOR

Minor bowel symptoms may be easily treated, with the suggestions offered by this booklet, but persistent or severe symptoms should be evaluated by your doctor. There may be a simple solution, but only your doctor can rule out the more dangerous conditions which a bowel symptom may be signalling.

A regular physical checkup normally includes a rectal exam. After the age of 40, men in particular, will want to have periodic examinations of the lower digestive system with a check of the prostate gland at the same time.

The methods include a rectal examination or such procedures as a sigmoidoscopy or colonoscopy. These last two tests, in which the bowel is viewed directly with a flexible, lighted tube, are increasingly routine as early diagnostic exams.

GOOD BOWEL HABITS

Whether you are trying to control constipation or diarrhoea or simply want to prevent such problems, following good bowel habits is essential. It is much easier to prevent bowel problems by establishing good habits than to deal with impaction, incontinence or laxative dependency later on.

If your bowel movements are becoming less frequent, take action. You may be able to prevent worsening constipation problems by following the good bowel habits outlined here. Stool that is retained for long periods tends to stretch the bowel, reducing its ability to push waste from the body. The stool also becomes harder with time, making elimination more and more difficult.

Drink enough fluids

Each day, drink eight to ten cups whether you are thirsty or not. Water, juices, coffee and other beverages all count.

But common MS-related bladder problems can easily complicate this part of good bowel habits.

It is hard to drink adequate fluid if one is wakened up at night because of the need to urinate or contending with urinary urgency, frequency, leaking or loss of bladder control. These are 'red-flag' problems for people with MS. But bladder problems can be controlled if the underlying cause is identified. See your doctor—treat bladder symptoms first.

Put fibre in your diet

Fibre is plant material which holds water and is resistant to digestion. It is found in wholegrain breads and cereals as well as in raw fruits and vegetables. Fibre helps keep the stool moving by adding bulk to the contents of the bowel and by softening the stool with water. Incorporate high-fibre foods into your diet gradually to lessen the chances of gas, bloating or diarrhoea.

Getting enough fibre in your daily diet may require more than eating fruits and vegetables. It may be helpful to eat a daily bowlful of bran cereal plus up to four slices of a bran-containing bread each day. If you have limited mobility, you may need as much as 30 grams of fibre a day to control constipation. Still, each person's fibre needs are different.

Add fibre slowly. Diarrhoea or too frequent bowel movements can result from a diet to high in fibre. If you find you cannot tolerate a high-fibre diet, your doctor may prescribe high fibre compounds such as psyllium hydrophilic muciloid or calcium polycarbophil.

Regular physical activity

Walking, swimming and even wheelchair exercises help. With age, a person's activity level decreases. Although the type of activity may need to be changed, some regular exercise is important at any age or any stage of disability.

Establish a regular time of day for a bowel movement

The best time of day is about half an hour after eating, when the emptying reflex is strongest. It is strongest of all after breakfast. Set aside 20 to 30 minutes for this routine. Because MS can decrease

sensation in the rectal area, you may not always feel the urge to eliminate. Stick to the routine of a regular time each day for a bowel movement, whether or not you have the urge.

It may also help to decrease the angle between the rectum and the anus, which can be done by reducing the distance from the toilet seat to the floor to between 30 and 38 cm. Many people, however, with mobility problems raise the seat for ease of use. A footstool can create the same desired body angle, by raising your feet once you are seated.

Avoid unnecessary stress

Your emotions affect your physical state, including the functioning of your bowel. Take your time. Use relaxation techniques. Remember that a successful bowel schedule often takes time to become established. Depression has been known to cause constipation. The constipation can upset you further, starting an unnecessary cycle of worsening conditions.

If your emotions are troubling you, talk to your doctor and/or MS Field Worker or read our booklet *MS and Your Emotions* available in this series.

IF YOU NEED MORE HELP

If these steps fail to address your constipation problems, your doctor will probably suggest the following remedies.

Stool softeners

Examples are Duphulac and Alpha- Lactulose. These products should be used sparingly, however, as some of them may increase the side effects of other drugs, especially those taken at the same time. The use of mineral oil is not advised, because it can reduce the absorption of fat-soluble vitamins and is hazardous to inhale.

Bulk supplements

Natural fibre supplements include Metamucil, which if taken daily with one or two glasses of water, help fill and moisturise the gastrointestinal tract. These bulk-forming agents are generally safe to take for long periods.

Mild oral laxatives

Milk of Magnesia or epsom salts are all osmotic agents. This means they promote secretion of water into the colon and they are reasonably safe. Another mild laxative is Senokot. This is an example of a stimulant laxative, which provides a chemical irritant to the bowel, thus stimulating the passages of stool. Harsh laxatives, such as Brooklax, Dulcolax or castor oil can be highly habit-forming and are rarely recommended for MS bowel problems. The gentler laxatives usually induce bowel movements within eight to 12 hours.

Suppositories

If oral laxatives fail to provide relief, you may be told to try a glycerine suppository half an hour before attempting a bowel movement. This practice may be necessary for several weeks in order to establish a regular bowel routine. For some people, suppositories are needed on a permanent basis. Dulcolax suppositories stimulate a strong, wave-like movement of rectal muscles, but they are much more habit-forming than are suppositories containing glycerine.

Enemas

Enemas should be used sparingly because the body may come to depend on them. They may be recommended as part of a therapy that includes stool-softeners, bulk supplements and mild oral laxatives.

Manual stimulation

You can sometimes promote elimination by gently massaging the abdomen in a clockwise direction, or by inserting a finger in the rectum and rotating it gently. It is advisable to wear a plastic finger covering or plastic glove.

Note: In using any of these techniques to control constipation, remember that they all take time—often several weeks before it is clear how well they are working. The digestive rhythm can be modified only gradually.

FINAL THOUGHTS

As with many other kinds of medical problems, it's easier to treat the bowel and related parts of the digestive system with good preventive habits than to wait until problems develop.

Remember:

- Treat bladder problems first.
- Eat plenty of fruits, vegetables, fibre and fluids every day.
- Exercise.
- Use the toilet half-an-hour after breakfast every day.

Dealing with impaction, incontinence and a chronic dependence on laxatives is much more difficult than preventing those situations or treating their precursors. Try the mildest therapies first, as stronger measures are more likely to have side effects.

Many MS symptoms, such as bladder problems, spasticity, weakness, immobility and demyelination which interfere with communication between your bowel and your brain can lead to bowel complications. If problems persist or worsen, ask your doctor for a referral to a gastroenterologist, who specialises in bowel and other digestive problems.

SOURCES OF SUPPORT AND INFORMATION

THE MS SOCIETY OF NEW ZEALAND

Each Regional Society has skilled and experienced Field Workers who, if required, can assist you in finding the services you need, including:

- working with those newly diagnosed with MS on a one-to-one basis;
- offering up-to-date knowledge of MS and its management;
- providing advocacy and support;
- offering counselling or referrals to appropriate agencies;
- supporting partners, carers, families, friends, health professionals, employers and workmates;
- facilitating groups for people newly diagnosed and their partners, carers, children, workmates;
- offering assessment facilitation;
- providing social contact, for those who want it, with other people with MS, on either a group or individual basis
- liaising with home-based care providers, community health services, counsellors, health professionals and Work and Income to coordinate client needs;
- carrying out assessments for total mobility.

Some MS Societies also offer physiotherapy, yoga classes, hydrotherapy at local pools and access to Riding for the Disabled, as well as assistive devices for daily living.

Our contact details are over the page.

CONTACT DETAILS

THE MS SOCIETY OF NEW ZEALAND

MSNZ

PO Box 2627 Wellington 6140 NEW ZEALAND

Phone	0800 MS LINE or 0800 675 463
OR	04 499 4677
Email	info@msnz.org.nz
Website	www.msnz.org.nz

REGIONAL MS SOCIETIES

Northland	09 438 3945	Manawatu	06 357 3188
Auckland & North Shore	09 845 5921	Wellington	04 388 8127
Waikato	07 834 4740	Marlborough	03 578 4058
Bay of Plenty	07 571 6898	Nelson	03 544 6386
Rotorua	07 346 1830	West Coast	03 768 7007
Gisborne	06 868 8842	Canterbury	03 366 2857
Hawkes Bay	06 843 5002	South Canterbury	03 684 7834
Taranaki	06 751 2330	Otago	03 455 5894
Wanganui	06 345 2336	Southland	03 218 3975

OTHER SOURCES OF SUPPORT

weka: *What Everyone keeps Asking* - about diability

website www.weka.net.nz phone 0800 17 1981

Enable NZ

website www.enable.co.nz phone 0800 362 253

Carer's New Zealand - NZ's national organisation for carers

website www.carers.net.nz email info@carers.net.nz

phone 09 406 0412

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