

Start	End	Topic	Speakers
11:30	11:40	Introduction to the workshop and presenters	Donna Bliss
11:40	12:05	Session 1 (delegates start with a group): A. Rectal Balloon Training, hands-on practice, & questions; B. Bowel Diaries review, discussion, questions & voting; C. Trans-anal Irrigation, questions, & hand-on training	Donna Bliss Julia Herbert Carlene Igbedioh
12:05	12:30	Session 2 (delegates rotate to a second group): A. Rectal Balloon Training, hands-on practice, & questions; B. Bowel Diaries review, discussion, questions & voting; C. Trans-anal Irrigation, questions, & hand-on training	Donna Bliss Julia Herbert Carlene Igbedioh
12:30	12:55	Session 3 (delegates rotate to a third group): A. Rectal Balloon Training, hands-on practice, & questions; B. Bowel Diaries review, discussion, questions & voting; C. Trans-anal Irrigation, questions, & hand-on training	Donna Bliss Julia Herbert Carlene Igbedioh
12:55	13:00	Wrap-Up, thank you, further questions	All

Aims of Workshop

Lower bowel dysfunction, including faecal incontinence and difficult evacuation disorders, occur in about 18% of the community-living population. First-line management of bowel dysfunction is conservative. Conservative management interventions allow the patient to learn to self-manage defecation and evacuation in a predictable manner. This workshop will focus on the 'hands-on' practical training of transanal irrigation, rectal balloon training and the content and appropriate use of bowel diaries in the management of lower bowel dysfunction. Participants will have an opportunity to increase knowledge and skills about all three bowel dysfunction management strategies based on current evidence at different interactive stations.

Learning Objectives

Explain use and steps of trans-anal irrigation as part of the management of lower bowel dysfunction

Target Audience

Bowel Dysfunction, Conservative Management

Advanced/Basic

Intermediate

Suggested Learning before Workshop Attendance

Abrams P, Cardozo L, Wagg A, Wein A (2017) 6th International Consultation on Incontinence. ICUD-ICS. ISBN: 978-0-9569607-3-3.

Bliss, D.Z. Ed. (2018). Management of Fecal Incontinence for the Advanced Practice Nurse. Paris, FR. Springer.

Brandt LJ, Prather CM, Quigley EM, Schiller LR, Schoenfeld P, Talley NJ. (2005) Systematic review on the management of chronic constipation in North America. American Journal of Gastroenterology; 100 (Suppl 1): S5–S21.

Rao, S. S. C., & Patcharatrakul, T. (2016). Diagnosis and Treatment of Dyssynergic Defecation. Journal of Neurogastroenterology and Motility, 22(3), 423–435. <http://doi.org/10.5056/jnm16060>

Rao, S. S. C., Benninga, M. A., Bharucha, A. E., Chiarioni, G., Di Lorenzo, C., & Whitehead, W. E. (2015). ANMS-ESNM Position Paper and Consensus Guidelines On Biofeedback Therapy for Anorectal Disorders. Neurogastroenterology and Motility?: The Official Journal of the European Gastrointestinal Motility Society, 27(5), 594–609. <http://doi.org/10.1111/nmo.12520>

Sultan AH, Monga A, Lee J, Emmanuel A, Norton C, Santoro G, Hull T, Berghmans B, Brody S, Haylen BT (2017). An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female anorectal dysfunction. Neurourol Urodyn. Jan; 36(1):10-34. doi: 10.1002/nau.23055

<p>Chair and Speaker Donna Bliss</p>	<p>Introduction to the Workshop</p> <p>We hope that you will find this workshop stimulating and that knowledge gained will support your clinical practice ensuring a safe and effective assessment and treatment of this group of patients. Each participant will attend each session once for ~25 minutes by rotating among the speakers who will present simultaneously.</p> <p>Bowel Diaries for Assessing Anal/Fecal Incontinence</p> <p>The first line of treatment for anal or fecal incontinence is conservative management due to the minimal risk and good potential of success with completion of therapy.(1) Surgery often does not achieve a cure and carries a risk of worsening incontinence severity.(2) Success of conservative management of anal/fecal incontinence depends in part on self-management by the patient, a plan recommended by an informed healthcare provider, and consideration of the patient’s goals for treatment.</p> <p>There are a variety of conservative management strategies for community-living. Conservative management strategies range from educating patients and caregivers about normal defecation and possible alterations in anal/fecal incontinence, setting goals for therapy, making lifestyle modifications for dietary intake and weight loss, using anti-motility medications, emptying the rectum vis trans-anal irrigation, and selecting/using containment products and devices (e.g., absorbent products, anal plug or insert, vaginal bowel device).(1)</p> <p>Assessing the severity and pattern of anal/fecal incontinence is an important part of the initial and ongoing assessment of the patient with anal/fecal incontinence.(3) Assessment is achieved using a bowel diary that the patient reports, providing information about and the severity of anal/fecal incontinence symptoms and the effectiveness of their self-management and management plan. Information from the bowel diary can be used to guide clinical recommendations and monitor improvement or worsening of symptoms.</p> <p>However, there is no standardized bowel diary or items to be collected on the diary.(3). This interactive session will include a discussion of the content sample bowel diaries provided by clinicians in different countries that were analyzed and summarized. Participants will review similarities and differences in the components/items of the diaries and the duration for which they are completed. We will discuss pros and cons in terms of patient burden and accuracy, desired information, the most useful items, and ways clinicians use the information. The aim of this session is to identify common essential items to include on a bowel diary.</p> <p>References</p> <ol style="list-style-type: none"> 1. Bliss D, Mimura T, Berghmans B, et al., eds. Assessment and conservative management of faecal incontinence and quality of life in adults. In Abrams P, Cardozo L, Wagg A, & Wein A, Eds. Incontinence, 6th ed. Bristol, UK: International Continence Society; 2017. 2. Abbott S, O’Connell R. Surgical management of fecal incontinence and implications for postoperative nursing care. In DZ Bliss (Ed.). <i>Management of Fecal Incontinence for the Advanced Practice Nurse</i>. Paris, FR. Springer, 2018. 3. Hunter KH, Dickinson T, Haggart V. et al. Clinical Assessment and differential diagnosis of fecal incontinence and its severity. . In DZ Bliss (Ed.). <i>Management of Fecal Incontinence for the Advanced Practice Nurse</i>. Paris, FR. Springer, 2018.
<p>Speaker Carlene Igbedioh</p>	<p>Trans-anal irrigation</p> <p>Trans-anal irrigation therapy (TAI) is a treatment that can be used to manage obstructed defecation and faecal incontinence. TAI involves instilling tap water into the rectum via the anus using either a balloon catheter or a cone delivery system attached via a plastic tube to an irrigation bag holding up to 2 litres of water. Alternatively, a low volume system consisting of a hand pump and a cone may be employed. By regularly emptying the bowel this way, TAI is intended to reduce leakage, help re-establish controlled bowel function, and enable the user to choose the time and place for rectal evacuation.</p> <p>TAI is safe and its effectiveness is at least comparable with pharmacological therapies; in selective cases, it can be used in combination with them.</p> <p>A variety of systems, are available that differ in design and use. These choices should be discussed by clinician and patient, and a number of systems may be tried before a preferred device is found.</p>

	<p>The effect of TAI varies among patients; some report full satisfaction and improvements in quality of life, while others have poor efficacy and abandon treatment. Response to treatment depends not only on the correct indications but also on the patient’s motivation and their degree of manual dexterity.</p> <p>A digital rectal examination is mandatory before using TAI to exclude localized anal disorders, and assess for faecal impaction, and sphincter function and coordination.</p> <p>Comprehensive training of the patient is central to safe long-term use of TAI. Hands-on training should be supported by locally-written instructions, which may be supplemented by commercial information. Audio-visual resources may be helpful in preparing the patient and for their later reference. Information should also include explanation of risks and benefits; informed consent to TAI should be obtained prior to its use.</p> <p>An individual should be taught how to self-administer the treatment when possible. Where an individual cannot undertake the procedure independently, a carer can be trained to perform all or part of the procedure.</p> <p>Most patients will be taught how to perform irrigation as outpatients. The first irrigation should be undertaken under clinical supervision. This allows the trainer to evaluate the patient/carer’s understanding and abilities, reinforce safety, and for the patient/carer to ask the questions.</p> <p>Many individuals will empty their rectum with TAI without further intervention, which is the goal. However, some individuals will need to use additional interventions such as abdominal massage, bracing abdominal muscles, digital rectal stimulation, or digital evacuation of faeces. The need for these interventions may decrease as an effective routine is established. If the patient is using laxatives when starting TAI, these should be continued until TAI is well established; gradual reduction can then be attempted. Patient should understand that it may take 4- 12 weeks and adjustments in technique to establish a reliable and effective routine to achieve their individualised goals.</p> <p>The aims of the practical session are to introduce the technique of TAI in the management of lower bowel dysfunction and to practice with different TAI systems.</p> <p>References Christensen P, Krogh K, Buntzen S, Payandeh F, Laurberg S. Long-term outcome and safety of transanal irrigation for constipation and fecal incontinence. <i>Dis Colon Rectum</i> 2009;52(2):286-92.</p> <p>Crawshaw AP, Pigott L, Potter MA, Bartolo DC. A retrospective evaluation of rectal irrigation in the treatment of disorders of faecal continence. <i>Colorectal Dis</i> 2004; 6: 185-190.</p> <p>Emmanuel A, Kumar G, Christensen P, et al. Long-term cost-effectiveness of transanal irrigation in patients with neurogenic bowel dysfunction. <i>PLoS One</i>. 2016;11(8):e0159394.</p>
<p>Speaker Julia Herbert</p>	<p>Overview of the management of evacuation difficulties and Rectal Balloon Training</p> <p>Conservative management usually involves correcting the underlying pelvic floor dyssynergia by teaching patient to defecate effectively using bracing of the abdominal wall muscles and effective relaxation of the pelvic floor muscles with or without attempts to improve rectal sensory perception. There are three main methods of monitoring the function of the anus and providing biofeedback to patients. These methods include electromyography (EMG) biofeedback, manometry biofeedback and rectal balloon training (RBT). The principles of Rectal Balloon Training (RBT) and when to use it as part of the management of lower bowel dysfunction</p> <p>The aims of this session are to 1) familiarise delegates with ‘healthy’ values for rectal sensation, 2) introduce the technique of RBT to down-train hypersensitivity of the rectum (1), and 3) discuss the RBT technique for dysfunctional defaecation. The session will include practical time with balloon catheters.</p> <p>Assessment An initial assessment will be conducted by introducing a deflated rectal balloon catheter into the rectum. The rectum should be digitally assessed to check that it is empty prior to conducting this assessment.</p>

Three key values will be recorded: 1) threshold volume of rectal distension required to elicit the first sensation of distension – (normal range 40-50 mls); 2) threshold volume of rectal distension required to elicit a sustained feeling of urgency to defecate or 'call to stool' (normal range 80 – 100 mls); and 3) the maximum tolerable volume (normal range 120 – 150 mls).

Assessment of patients with faecal urgency will typically demonstrate reduced rectal sensation levels, which may be as severe as patients describing maximum tolerable with only 10 mls of air in a rectal balloon. In patients with difficult defaecation a further assessment may include balloon expulsion assessment. Noetling et al.(2) describe this as the time required for subjects to expel a rectal balloon filled with 50 cc of warm water while seated in privacy on a commode. The balloon is removed if the subject is not able to expel the balloon in 3 minutes. However, this assessment may also be performed with an air-filled balloon and the patient in left side lying.

Training

RBT consists of introducing a deflated balloon into the rectum and inflating the balloon with air or warm water via a syringe to simulate rectal filling.

Difficult defaecation

In patients with bowel evacuation difficulties RBT may be utilized to correct the dyssynergia or incoordination of the abdominal, rectal, puborectalis and anal sphincter muscles in order to achieve a normal and complete bowel evacuation, to facilitate normal evacuation by simulated defecation training and to enhance rectal sensory perception in patients with rectal hyposensitivity. This technique may be called 'balloon expulsion training'.

Anal incontinence

RBT is also used to correct the physiological deficits that contribute to faecal /anal incontinence, in particular faecal urge incontinence, by improving the ability to sense smaller volumes of stool in the rectum and contract pelvic floor muscles in response to these volumes and/or improving the ability to tolerate larger rectal volumes.(3)

References

1. Bols E., Berghmans B., deBie R. et al. Rectal balloon training as add-on therapy to pelvic floor muscle training in adults with fecal incontinence: A randomized controlled trial. *Neurourol and Urodyn* 2012;32(1);132-138.
2. Noetling J., Ratuapli S.K., Bharucha A.E.. et al. Normal values for high-resolution anorectal manometry in healthy women: Effects of age and significance of rectoanal gradient. *Am J Gastroenterol.* 2012;107(10);1530–1536.
3. Rao S. C. Bharucha, A.E., Chiarioni G. et al. Anorectal disorders. *Gastroenterol.* 2016;150;1430–1442.