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Bradford, Seonaid started transcription

BS **Bradford, Seonaid** 0:31

Rather than a webinar, so I think it's just with the webinar we would have an option to Q&E but as we toddl along feel please feel.

Free to put things in the chat as we're going. And just from a housekeeping point of view, we're not expecting any fire alarms. Don't know if you guys are, but if you can please turn your microphones off just to keep the sort of background noise down. And while you're munching your lunches.

And we are recording the transcription of this, so I don't know if it does it visually, but just camera on or off at your own discretion. But Carlin did say that she likes seeing some faces to chat to. So Carlin. All yours.

CD **Carolyn Davie** 1:18

Thank you very much. So yeah, again, you know many, many apologies for running late and I thought this is great. I've got so much more time to do this presentation than I did two years ago at the Spfn, but possibly I don't have any more time this time.

So I think we've probably got a wide variety of levels of experience in the call, but also different.

Health professionals, so hopefully you know, as you know, it's probably difficult to cater for all that. So hopefully all of you will find one little nugget or something. And useful from today, and if you've got any questions, obviously we've got time for those or I'm happy for you to contact me directly. A wee plug for the POGP. So if anybody's not sure of the benefits of joining or want to think about becoming a full member, then please get in touch with myself and also for any of you physios that are also prescribers are going through your prescribing training and we have a non medical prescribing pelvic health group which is really active and definitely worth joining.

So.

I'm gonna hope that somebody will tell me if things slides don't move on, so please

feel free to tell me. So what? I'm going to cover in today's presentation is a little bit of the background to the service that we run in Tayside and what we do by no means this is perfect. So that would be a good thing at discussion at the end if if some of your services do things quite differently, it'd be really good to hear about that.
A little bit about patient assessment of patients with bowel problems. The two main types.
Problems that we would usually see in our clinic, which would be faecal incontinence and obstructive defecation and sometimes both together a little bit about active intervention. Obviously this is a very short talk. So really just some key pertinent things that I find really important. We're not going to have time to go through everything as you would imagine and then hopefully some take home points and some conclusions at the end.
Come on slides.
OK, so Samuel Johnson, I tend to use his quote a lot because I think it's just perfect for those of us who are a little bit obsessed with bowels and he was many things in the 1700s. He was a poet. He was an essayist. He was a critic, an editor, and also Alexa Kographer. So 10 points for somebody who puts in the chat at the end what that means. And he's got lots of great sayings to take you through life. But obviously the one that I find definitely.
Is more pertinent for us in the field of pelvic health is.
Which has been written about the pleasures of sexual intercourse. As for me, give me a solid movement of the bowel. I think we can probably all attest to that. So in NHS Tayside we would get patients, the patient journey. I guess this is so patients would usually attend their GP with a problem and that we would be expecting the GP to do certain things and then for these functional problems once they've ruled out the red flags.
These patients in Tayside would come into pelvic health physiotherapy so we would be the the mainstay of the conservative management of these patients. If they then don't improve with conservative management, we are referring to our colorectal pelvic floor clinic team which is made-up of two specialist colorectal nurses and three consultants with a specialist interest in the benign pelvic floor disorders. Usually at that point is when investigations would be implemented not before that because. Investigations would not necessarily treat your.
Change your conservative management of these patients and then usually by the time they've reached the colorectal pelvic floor clinic had their investigations, there's

they're brought to our pelvic floor MDT for discussion. So that's physios, our colorectal nurses and consultants, you're a gynaecology, The continents advisory and treatment service. And we do have some input in certain groups for these patients from dietetics pharmacy and GP.
Patient assessment. So we are working on in Teesside, some pathways again be really interested to know what others do because we get a lot of inappropriate referrals of patients of incontinence with loose stool or incontinence with overflow. So the three pathways that we're working on for GPS is management of Constipation and primary care. So this is not us managing it, it's the GP management of loose stool, chronic loose stool.
And also management of faecal incontinence of a formed stool and those are the patients that really we want to see and we are expecting our GP colleagues to start some basic lifestyle interventions. Now that might be before they refer or maybe even while they're affair. So we're you know we're asking GPS to do a little bit of work on these patients.
So again, I'm not going to go through what we do with the patient for that hour because there's no time for that and all the certainly the pelvic health physios on the call will know that. But I think these for these bowel patients, I think it's really important to explore their previous treatments and failures and this is the same for any of patients that we see, whether they're prolapse patients or bladder patients. I think it's important to acknowledge that they may have been round the houses as they say or you know gone from pillar to post and and finding out what their journey is to you and acknowledging that certain things may have failed before.
It's asking about the other compartments. I think patients that come to us with bowel problems are fairly open and honest at telling you about bladder problems, but it doesn't really go the other way around.
Perfect example was the patient I had just before the call referred with the prolapse and actually she does have faecal incontinence but has never mentioned that to anybody.
I always say when I'm doing any teaching is is just, you know, not not asking A1. You know one-size-fits-all question. Do you have faecal incontinence? Do you have bowel problems?
Because you're setting up patients to say Nope and and and move on. And so you know, I'll start the conversation around, you know, let's chat about our bowels, have a wee joke. This is our favourite subject. Get the Bristol Stool chart out. How often do

you go do you strain? How do you sit on the toilet and then moving into do you have any urgency? Do you have any near misses? Are you having accidents? Do you have problems wiping clean? Have you got any soiling? So I think when you can you can break it down. I think you're giving patient permission at that point to see.
Yes, I do. And if they're being referred to you with a bowel problem, we would expect that you know your GP to do the red flag questions, ruling out things. But remember, we may not get the GP may not be aware that they have these symptoms. So we need to be aware of these red flags. So if you are seeing these patients who haven't seen AGP, you know, is there any other investigations that they may need had a really interesting conversation with Yvonne from Grampian the other day about? Whether we accept referrals from other healthcare professionals or our MSK colleagues and I was like, well, it's a really good question, but I tend to fall down on the line of no because.
They don't know that necessarily the right questions to ask for our patients to, you know, and if they're sitting on a 20-30 week waiting list, somebody needs to have assessed these patients, done an abdominal examination, ruled out a mass, asked the right question. So although it seems a bit backward when everybody's moving to self referrals, I'm very much at the moment saying I think these patients need to come via their GP.
Asking our patients what bothers them the most? Sometimes these complex patients can be really overwhelming because you know your problem plan list is in double figures. Where do you start?
It's a bit overwhelming for you. It's overwhelming for your patient, but just breaking it down to what bothers them the most and you know what, that's what we're going to spend time on and you know, try and get a quick win, get these symptoms a bit better and then you can circle back to address some of their other issues.
And any previous investigations, whether that's just even qfit any scopes that they've had or if in the past they've had manometry or proctagrams, sometimes it's good to get those results and go through that with your patient and that could be part of your education as well.
Exploring their motivation and goals, I think is very, very important. I think we're very good, certainly as physios is doing that you know and and getting their patient patient set goals along with your outcome measures in tasks, I'd only one that we use for our bowel patients at present is the ICIQ Bowel Questionnaire, which tends to be really well completed because it's Tiki box and there's a nice little Bristol Stool

chart on there. So that's the one that we use.
Comorbidities that might affect your treatment or how you would start to manage patients symptoms.
Their mobility, their access to toilet. We know that's really important.
And medication, I think it's definitely worth as a working in this field having a prescribing qualification because it's not just about prescribing, it's about deprescribing medicines. It's about medicines, reconciliation.
It's about looking at medication that they're on for, other things that could affect their pelvic floor that could affect their bowel symptoms, but also the other way. If you're thinking about medication for loose stool, whether that's a bulking agent or loperamide, you need to know about the interactions with other medications, spend a bit of time with bowel patients talking about their diet and their fluids. That's really important for these patients.
Previous surgery that might impact on them.
And again, I don't need to tell Granny to suck eggs, but it's about giving these patients time.
It's about giving them privacy, so we should be all in individual rooms, not behind curtains, you know, and just having that sympathetic and empathetic ear quite often, these patients become very tearful and open up to you.
I've got this little video which I think is quite a powerful one, and it's about a midwife who suffered an obstetric anoshctar injury and about the bowel symptoms that she had. And this is where I hope to goodness that this link works, but we will try.
Will somebody shout out if you don't see the video please?
So it's on my screen. Is it on everybody else's screen?

JM **Jenny Munro (NHS Highland)** 12:06
Don't have it, love.

CD **Carolyn Davie** 12:08
Don't have it.
Do I need to if I bring that over to that screen? Does that work now?

CC **Charczuk, Claire** 12:11
Hello.

Jenny Munro (NHS Highland) 12:15
I can see your mouse, but nothing else.

Carolyn Davie 12:19
OK, so I will stop sharing and then I will share again.
Oh, technology, right? That should be it. Now, though, is it? Yeah.

Jenny Munro (NHS Highland) 12:32
Got it.

Carolyn Davie 12:34
You got the audio, the video, the washing machine.

Jenny Munro (NHS Highland) 12:39
No audio.

Charczuk, Claire 12:41
Audio.

Carolyn Davie 12:45
I wonder if there's subtitles.
You'll just have to read it. Sorry.
That the audio didn't work because I think it's a little bit more powerful when you hear the audio, but that was from you can get that link on the mesic.
Website So it's worth having a wee look at that. Now let's see if I can go back to share my presentation.
Right. Are we back? Yes, hopefully.

Heather Scott 15:07
Perfect. Perfect.

Carolyn Davie 15:11
Unshamed eyes when stories are told in safe places, and I think that's quite a powerful quote as well, that these patients, you know, we're giving them the

permission to, you know, tell us, tell us what's going on. And that alone is really, really powerful for some of these patients. And when I was preparing for this presentation, I had a look at some statistics on the mesic website and a couple of them really shocked me. And I'm just going to share them with you now. So the first one was the 85% of women.
With severe birth injury, said impacted on their relationship with their child.
And when I first started to read that statistic, I thought it was going to say with their partner, but it kind of shocked me that it said with their child and probably what's even worse is that 24% of women affected regretted having a child because of their injuries sustained. So this this can be a big group of your patients with bowel issues.
And the incidence of OEC is in the literature varies from 0.1% to 10.9%. So the reality is it's probably somewhere in the middle.
And.
So faecal incontinence, typically iceberg, lots of patients are out there and they you know they don't divulge that they have an issue, but remembering you know that somewhere between one and 10% of the population will have an issue with bowel control and 2/3 of these will also have urinary incontinence. So we're probably picking up a lot of them. They are being referred to them, refer to us for their bladder symptoms as you can well imagine, there's a huge impact on quality of life and mental health with these bowel problems.
Incontinence is a symptom, not a diagnosis, and our main types of faecal incontinence would be urgent continents. When you've got that sudden urge to move your bowel and you don't make it in time, so it could be a near miss or it could be an episode of incontinence that would make you think that there's an issue with their external **** sphincter, which is part of the **** sphincter complex. That will allow you to defer the urge. So when something drops down.
You get the sampling. It's not socially convenient time or place to do your poo so that external **** sphincter will contract, and that urge will wear off. So if they've had a, you know, sphincter injury for one, that's why they tend to have problems related to urgency.
Passive faecal incontinence is when patients are unaware, completely unaware that they've had an accident, which could range from a bit of post defecation, soiling or smearing up to passive leakage of a fully formed stool.
You're starting to think there might be an issue with their resting tones, their internal **** sphincter is usually affected if they have passive incontinence overflow, so we've

got these constipated patients that then produce all this mucus that gets stained. It bypasses the hard stool and they have what they think is incontinence of a loose stool. And the functional patients who maybe just don't have the dexterity or the mobility.
To toilet properly, these patients are patients are complex. They're multifactorial. It, you know, it is about trying to identify the.
Individual contributory factors and some of those are modifiable. Sometimes they're not, and finding that combination of interventions that that work and are acceptable to that patient obstructive defecation always consider Constipation. The way I describe it to my patients is a Constipation is a getting it around problem whereas obstructive defecation is a getting it out problem and they may very well have both. These patients are coming to you with straining but with unsuccessful attempts to defecate.
They're not empty.
Spending a lot of time on the toilet pain when they're going to the toilet and they can often get this soiling because they're never, you know, they can never wipe clean because something's in their ****** and it's, you know, it's like trying to get a dog's nose dry. It just will not happen. It just keeps going. They may have fragmented stools. And they're also often having to digitate or splint. And you may have to ask the question because they may not divulge that. So I usually say, do you have to help yourself?
To to move your bowels, and they might say yes. OK, So what does that look like for you? And I might say something like lots of people do it and they do it in different ways. Do you have to press on the outside? Is that the front? The back? Do you have to put your finger in your vagina? Do you ever have to go into put your finger to the back passage and and giving them those options again so it's easier for them to say? Yeah, that's me. That's what I do. Why do we get obstructive defecation? Probably one of the most common ones that we'll see in our clinics isn't it is a wreck to seal. And that's relatively easy to diagnose.
And they may have pelvic floor.
Muscle, dys, synergia.
You know that can be picked up on proctogram, but you know it can relatively easily be picked up by your finger as well. When you're examining these patients.
They may have interception or rectal prolapse which, unless it's severe, you're unlikely to uncover an examination, but you would probably be starting to think

about that with their subjective history. You can see when you examine these patients if they've got a very short perineum, if they've got a descending perineum. Other causes of ODS could be mega, ****** and slow transit hyposensitivity of the ****** pain around that area and haemorrhoids.
So what do we do about it? I think for those of you that have been around Pre 2014 when the mesh stuff started to to to come in, I think that that queue of people has certainly shifted more to the right and it's not just physiotherapy. I'd say it's conservative management. There are a lot less patients coming in saying they want that surgical option now, which for us is really positive because it it just makes your job a little bit easier, doesn't it?
Huge part of treating the bowel patients I feel as education, so I can't you know, I can't stress that enough.
They need to understand what is going on, why it's going on and I have a whole drawer stacked to the gunnels full of lots of different bits of anatomy and Physiology, or laminated, and they usually come out so you can, you know, just take time to explain things to your patient. It is complex. It is multi compartment.
And with a lot of our complex patients generally, we're having to disentangle the challenges that their symptoms or their home circumstances are or their comorbidities or their medication. There's going to be a lots of challenges with with these patients setting their goals and expectations is really important. But making sure they're realistic.

HS **Heather Scott** 22:15
Yeah.

CD **Carolyn Davie** 22:16
And if they're not realistic, it's just, you know, putting that back to the patient and having that open and honest discussion with them compliance and concordance, it's all about getting that therapeutic relationship early on, isn't it? And then I think your compliance and concordance with treatment will automatically increase.
But I'll also you know, just for the experience, put it back to patients if they're, you know, if they're telling you on their first visit, you know, they're 10 out of 10, life is terrible. But you know, they they're they're poor tenders or they're, you know, repeatedly, you're having to ask them to do the same things again.
You know, I'll put it back to the patient and say, you know, you know, I'm noticing

that, you know, you're struggling to do XY and Z, but yet you're, you know, you're really symptomatic with this and you're, you know, what's happening. And I think again, that opens the doors to.
Then be able to trust you and say, well, actually I'm not doing that because of this. OK, let's address it.
The brain is a really good acronym for everything really to do with medicine and treating patients. So that's, you know, discussing the benefits of a particular treatment, the risks, what are the alternatives, giving them information and also that you know they can do nothing that is an option. So nice have a good quote and they say that the specific management of intervention should be offered based on the findings from the baseline assessment.
Tailored to your individual circumstances and adjusted to personal response and preference, and I think we probably are pretty good at doing that anyway.
So last few slides, that's quite a scary statistic, isn't it? So 40 to 80% of medical information is forgotten and 50% is remembered incorrectly. However, it can increase and it can reach up to 80% of retention if it's giving in pictographs. Hence why you know, clinic rooms, we've got lots of lovely.
You know, pictures of stool charts, pictures of bowels, pictures of prolapses.
It's also good because then out of hours really don't like using these rooms because they leave them very untidily because they don't like all the pictures of bowels and poos everywhere. But I think it's really important that we have a whole variety of different educational tools that we can use for our patients.
Can't do talk about bowels without the Bristol Stool chart.
You know Irene Puller, who's my various still missed predecessor.
To always talk about the Goldilocks poo. So it's, you know, not too hard, not too soft, just right. But like the slippy slips in and out in one movement and requires no wiping. So that's the Holy Grail of poos, that ourselves and our patients want to achieve. And if you have a patient coming in, which I couldn't believe find this so it's a New York Times recent article about different Squatty Potties. So I did have a patient once who said to me, I'm not putting that, you know, God awful ugly plastic. You know, stool footstool in my toilet. So now we can signpost them. You can have a beautiful perspex one. You can have a bamboo Bristol Stool chart. The choice is yours.
So keep it simple, is my mantra in life, but also my mantra at work.
And definitely something to consider with our bowel patients. So strip it right down,

get them eating regularly. A nice balanced diet.
Good fluid intake, making sure these patients are exercising adequately.
You can signpost them to, you know, physical activity guidelines. There may be exercise groups in your area active for life type programmes that you can refer patients to and getting them to use their gastrocolic reflex. So the common one, you know, I ask about somebody's routine. OK, I get up and, you know, I shower, I do my hair, do my makeup, blah, blah, blah blah walk the dog. And then I come and eat my breakfast. OK well, actually, if we flip that around.
Get up. Have a hot drink. Eat your breakfast, then do your activity and there's a good chance you're going to get your gastrocolic reflex to kick in. You can do your poo before you leave the house. Then you're not caught short on the journey to work or you're not further constipating yourself by resisting that urge. And I would describe it to my patients. It's like an escalator going in reverse. If you keep resisting that urge, your body will stop sending you those signals. And we need to retrain that. So don't rush. Don't strain.
Having privacy and time really difficult sometimes.
Your you know, you know, young Mum at home to have privacy and time to do a poo. That's always the time somebody's wanting you and you know, you think somebody's dying. And actually it's just kind of have a snack, please.
So trying to encourage your patients to take their time, good defecation dynamics can be life changing. If you get it right.
And avoid prolonged sitting.
And very much encouraging our patients to stop manual evacuation. How we doing for time? Right another 5 minutes.

HS **Heather Scott** 27:16
Of course.

CD **Carolyn Davie** 27:18
So very whistle stop tour of, you know, other interventions, pelvic floor. It's not about the strength, it's about their function. It's about their coordination.
Lifestyle, so weight loss, smoking exercise. We've talked about stool modification which goes along with the dietary modification. You may need to introduce some medication there. Teach the defecation process. You know get your squatty potty or other toilet stool out in the clinic and get your patients in that position.

Get them to relax, get them to do their deep breathing.
I don't use much now of, you know, rectal sensitivity or capacity training or EMG biofeedback. I tend to use transperinail ultrasound and if you for those of you that do that, if you move your probe horizontally, I'm terrible with my planes, but tip it back, you can actually see the **** sphincter complex and for a lot of patients, you can see they're both are external and internal **** sphincters, which is a really great form of biofeedback.
Encourage digitation women don't like doing it. They think they're doing something wrong. If they've got a wreck to seal. But you know, encourage them to do it or splint their perineum. You can signpost them to families if they need a bit of extra support in tayside, within physiotherapy, we will introduce low volume rectal irrigation to patients that have obstructive deficiency or rectoceals. But if we feel they need something and beyond that, then we will always refer into our colorectal nurse colleagues to do the high volume TTNS.
Used occasionally do acupuncture with some faecal urgency patients, but that's very, you know, heavy on time for you and the patient. So TTNS is fantastic for some of these patients. You get them in once they bring, they buy their own 10s machine, set them up and they can go off and do that and there's some good evidence for that now and don't forget.
That these patients don't always need investigations, they're useful if they've been done because it kind of can go with what your assessment is, and often you'll find. Yeah. That's what I thought.
But you don't need the interventions to treat your patients again, sometimes stripping it back. These patients can be very anxious and stressed. You know it's a chicken and the egg what came first, but maybe giving them some pelvic stretches, talking to them about mindfulness and breathing techniques.
Containment. I'm going to use your phrase, Jenny. So it's continents, not containment, which should be at the forefront of our mind.
You know, we've got to treat these patients and the aim is is to get them continent, but containment might be appropriate for some patients.
You might need to involve your occupational therapy colleagues if there's some environmental factors that's influencing things. Be mindful of religion and beliefs, particularly with bowel and bladder symptoms. We can't give emotional and psychological support to our patients. I think we've got some therapeutic support there, but they may need. They may need other healthcare professionals to help

them as well. You've got the bladder, bowel UK. Just can't wait. Card, which can be helpful for some patients as well as the radar key that they can and they don't need to be referred for these. They can just go and request them.
And obviously, being mindful, particularly with bowel leakage, because no.
Things going to absorb that, just be mindful of skin care and cleaning for these patients.
So final slides to the future. So the future in NHS Tayside, we are still working on trying to get some joint perineal injury clinics with our Uruguayan colleague and hopefully going to have some trans **** ultrasound there as well our pathways that we talked about that we're hoping to introduce in the next few months for GPS to get them to start some lifestyle changes and to reduce an appropriate referrals. And then we are working on some online.
Our website.
She's under construction. It's very slow because it's just me that's doing it and my IT skills, as today is a prime example, are not brilliant. So we're going to work on that so patients can be signposted to information before referral while they're waiting to be seen while they're on treatment. And for those, when you discharge the patient that they, they've got this resource that they can go back to.
And finally, I think it would be it would be sort of the Holy Grail if we could get some sort of psychological input, not for staff. Maybe we need that, but certainly for our MD TS, because I think I find the bowel patients, certainly there's a big overlap.
Of psychology with these patients.

Bradford, Seonaid stopped transcription