

As mentioned above, longstanding spinal conditions, especially spinal injuries, can cause neurogenic bowel problems. The type of problem will depend on the location of the injury.

For example, a complete injury at the sacral level (the Cauda Equina) (LMN) results in an areflexic bowel in which no reflex peristalsis occurs. Nerves within the colon wall coordinate slow stool propulsion and the denervated external anal sphincter has low tone.

This results in a sluggish stool movement, a dryer, rounder stool and a greater risk of faecal incontinence through the flaccid anal sphincter.

A reflexic bowel by contrast, resulting from an injury above the sacral spinal segments (UMN), involves a sphincter which is spastic (increased tone). Defaecation cannot be initiated by voluntary relaxation of the sphincter.

However, nerve connections between the spine and the gut are intact and there remains reflexic coordination of stool propulsion.

Patients with SCI experience the following GI problems:

- haemorrhoids
- abdominal distension
- autonomic dysreflexia (sweating, fainting etc. ) related to GI tract (e.g. on defaecation)
- difficulty with bowel evacuation
- poorly localised abdominal pain

- faecal impaction (Right colonic with UMN, left with LMN lesions)
- rectal bleeding
- problems depend on pre-injury bowel problems such as IBS or IBD
- Constipation is a common problem following SCI, occurring as a consequence of several factors including: alteration of large bowel motor activity, loss of rectal sensation, loss of voluntary control of defaecation, inactivity and change of routine.

Those with a lesser degree of nerve damage may find that they have some loss of rectal sensation, perhaps coupled with a visceral hyperpathia (see above under chronic abdominal pain) : this means that there is a delayed perception of the full rectum, and that once the threshold for perception of distension is reached, there is sudden, painful (often burning) urge to defaecate, which may result in incontinence.