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## YOUR BOWEL HABIT AFTER LARGE BOWEL SURGERY

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

### Your post-operative bowel habit.

It is inevitable that your bowel habit will be disrupted in the post-operative period. Indeed, the only predicable feature of your post-operative bowel habit is that it will be unpredictable.

Your operation removed some of the colon, and may be some of the rectum. Because the large bowel has been shortened, less water will be absorbed, faeces will pass through the shorter colon quicker, and the stool presenting in the remaining rectum will be softer. As the colon does not have the ability to store faeces like the rectum, the ability to defer defaecation is greatly reduced. You will therefore wish to pass stool more frequently (up to six times per day and again at night) and there may be urgency and occasional episodes of incontinence of either flatus (wind) or faeces. These problems can be distressing, but they do improve enormously over the first three months and even further over the next six months. Some patients notice an ongoing improvement for up to two years.

Some patients have a temporary, defunctioning loop ileostomy that is closed after three to six months. After closure, the defunctioned bowel has to recover in terms of its muscle function, regeneration of the bowel lining and re-colonisation of normal bacteria flora. This also takes several months and will add to the changes in the short term post-operative bowel function.

### What can be done?

Much can be done to help by paying close attention to what you eat and drink. The table below give you an idea as to what you can do to help yourself. Experiment by excluding one type of food from your diet and monitoring the response. It should then be possible to find what affects your bowel.

Fluids	You should drink no more than 1 to 1.5 litre of fluid per day. Excess fluid will tend to make your stool softer.
Caffeine	Caffeine stimulates the bowel and as the stool then passes through faster, less fluid is absorbed and the stools are looser. Caffeine also relaxes the anal sphincter. Caffeine is found in coffee, tea, cola drinks and chocolate. Exclude caffeine from your diet and see if you improve.
Artificial sweeteners	Artificial sweeteners are sugars that are not absorbed by your body. Some non-absorbable sugars are used as a laxative. Some non-absorbable sugars, such as sorbitol or mannitol, are used in sugar free foods. Not surprisingly artificial sweeteners may make the stools loose, or even cause diarrhoea. Eliminate artificial sweeteners and seeing if this helps. Artificial sweeteners are found in most foods and drinks branded as 'low calorie', including 'Diet' drinks and low sugar chewing gum.
Fibre	<p>Although fibre is good, it can make incontinence worse as it keeps fluid in the bowel and makes the stools loose and more likely to leak. As fibre stimulates the bowel you have to visit the toilet more often. All vegetables tend to make motions softer, more frequent and make gas. Initially you should omit foods, which are obviously high in fibre. Capsicum, cabbage, brussel sprouts, onions, beans and broccoli have the most potent effect. Stone (apricots, plums, peaches) and dried (prunes and sultanas) fruits may also have a bad effect.</p> <p>Potato and pumpkin appear to have the least effect. Soluble, or digestible fibre (eg bananas, potatoes, rice, pasta, oatmeal) is less likely to cause a problem.</p>
Medications	Many medications influence the stool consistency (see below).
Alcohol	Alcohol may make the stool loose. Because of its volume and yeast, beer is often worse than other drinks.
Spicy foods	Spicy or hot food can simulate the bowel.
Other foods	Some people find specific foods make matters worse. Try excluding food in sequence and see how you are affected. Foods that are often implicated include smoked products, fatty and dairy foods. Other foods, such as arrowroot biscuits, marshmallow sweets and bananas can help.

## Medications

Some medications will make your bowel habit worse. Examples include antibiotics, non-steroidal anti-inflammatories for arthritis, and some anti-depressants. Other drugs essential to well being, such as metformin for diabetics, also make the stool softer.

Other medicines can be used to solidify a liquid or soft stool, to make the bowel squeeze less strongly or to ensure the rectum empties fully. Some may increase the tone of the sphincter muscles. Some medications may be need for a prolonged period, often years.

Suppositories	It is important that your visit to the toilet completely empties your rectum. A suppository can be inserted as soon as you awake. You will usually be able to hold it for 20-30 minutes. This will then give a good bowel action that should not require you to linger on the toilet, nor require you to strain. The rectum will then be empty and will not contain any stool to leak out during the day. People in whom passive leakage is a major problem may choose to slow the bowel down so there are no bowel actions without the help of suppositories or an enema. These can be used to empty the bowel once every few days.
Loperamide (Imodium)	These drugs slow the passage of stool through the colon. More water is then absorbed and the stool becomes firmer and so less likely to leak. It is usually best to take these medicines before food rather than after.
Codeine phosphate	<p>Loperamide (Imodium or Gastrostop) makes the stool firmer and has a potent effect, but is barely absorbed into the bloodstream. There is no tendency to develop tolerance or addiction. The ideal dose needs to be individually determined as it is difficult to predict the dose that will be effective, but not cause constipation.</p> <p>Codeine phosphate has a similar, but more powerful effect. It may produce sedation and is not usually first choice.</p> <p>Some people find one or other of these drugs works best for them, or that a lower dose, but in combination, is better. You should experiment to find the regime that suits you best.</p>
Bulking agents	If the stools are very loose, especially if there seems to be a lot of mucus, medications such as Fybogel or Metamucil can absorb excess fluid and produce a more formed stool.