The role of the specialist nurse in pelvic floor dysfunction

Helen Blackwell

Pelvic floor dysfunction can have a devastating effect on people's lives. The specialist nurse can play a vital role within the multidisciplinary team to help improve the quality of life for these patients by offering conservative management and support through surgical treatment options.

Pelvic floor dysfunction is an underappreciated problem in society, but has implications for health service costs and also for quality of life of affected individuals. This is a complex area with many different conditions appearing in affected patients. The three primary diagnoses are faecal incontinence, rectal prolapse and constipation or evacuatory disorders. The potential client group for this area is sizeable, but receives little specific government or financial support (possibly because it is not related to the achievement of specific high profile government health targets). The battle for resources is constant and practitioners can feel they are working for something of a Cinderella service. Few doctors and nurses have experience of managing such complex conditions. The work is challenging. Some patients feel that once serious pathology has been ruled out, there is a tendency for medical staff to lose interest in the problem, even though symptoms often persist for a lifetime. Patients often have considerable psychological, family and social problems.

Clinical nurse specialists in continence care are an essential part of continence services and are able to give cost effective expert care, advice and treatment to people with bowel dysfunction. Nurses play a vital role within the multidisciplinary team (MDT); this was supported by the Continence Charter (Continence Foundation, 1995), which stated that everyone with a continence problem has the right to see a specialist nurse with knowledge of incontinence. Other members of the MDT who are involved in the care of these patients include the colorectal surgeon, consultant urogynaecologist, consultant radiologist (specialist in intra-anal ultrasound, defaecating proctograms), specialist nurse, physiotherapist, dietician, physiologist and psychologist.

The success of new initiatives, i.e. nurse-led clinics, depends on the support and cooperation of other team members, particularly medical colleagues whose expertise is required to prepare and train the nurse to undertake this developed role.

FAECAL INCONTINENCE

Faecal incontinence is a distressing and disabling condition, which affects about 2.2% of the population (Nelson et al, 1995). Although not life threatening it can seriously affect quality of life and the ability to function in society. The shame and stigma of incontinence may lead to low self-esteem and social isolation. Johanson and Lafferty (1996) found that the majority of people with bowel problems do not seek professional help. People who were consulting professionals were seeing either a GP or a gastroenterologist.

Despite greater awareness of continence problems, many people are reluctant to seek medical help, making reliable data on incidence and prevalence difficult to obtain. Although most people associate faecal incontinence with the elderly, Nelson et al (1995) identified that 70% of sufferers were under 65 years of age. The causes of faecal incontinence are listed in *Table 1*.

In the majority of cases adjustment of diet and medication may enable the patient to achieve an optimal level of continence. Surgical procedures can be performed with varying degrees of success, but there will always be patients who resort to stoma formation to improve their quality of life.

The cause of faecal incontinence needs investigation. These investigations can be embarrassing so an experienced member of the MDT should carry them out sympathetically. Structural assessment of the continence muscles can be carried out by endoanal ultrasound, while anorectal physiology allows functional assessment and can confirm both sphincter function and anorectal sensation.

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CONSTIPATION AND EVACUATORY DISORDERS

Conditions that cause difficulty with evacuation of faeces from the rectum can be grouped under the term pelvic outflow obstruction.

Pelvic floor prolapses are seen in 50% of parous women (Beck, 1991), and around 10% will undergo surgical intervention at some time in their lives for the management of the problem (Olsen et al, 1997). Pelvic floor prolapse includes:

1. Rectoceles
2. Cystoceles
3. Full rectal prolapses protruding through the anus. Along with the discomfort, hygiene and social issues, rectal prolapses can damage the anal sphincters, which control anal continence. If left untreated a full rectal prolapse can cause damage to the nerves which trigger the defaecation reflex thus leading to constipation, which eventually can cause the rectum to become overstretched, thus resulting in a megarectum.

Women can present with one or more of these problems. The aetiology of pelvic organ prolapse is complex and multifactorial (*Figure 1*).

Patients complain of a variety of pelvic symptoms including pelvic heaviness, dragging sensations within the vagina, bulging, backache and sexual dysfunction. These symptoms may be directly related to the prolapsed organ, e.g. obstructed defaecation in the case of a rectocele.

The specialist nurse can play a vital role within the MDT in the treatment of these patients, the majority of whom are women. Treatment depends on the severity of the prolapse, its symptoms and the patient's general health. Options available are conservative, mechanical and surgical, but it is within the conservative remit that the nurse can play a vital role. Conservative treatment for the management of prolapses includes physical (coming under the heading of pelvic floor training) and lifestyle interventions (which include weight reduction, reducing exacerbating activities, e.g. lifting or coughing, and treatment of constipation).

QUALIFICATIONS

To be appropriately prepared for an expert role in looking after patients with bowel dysfunctional problems, the nurse should be able to demonstrate both experience and additional education in this area of practice. Clinical experience of 3–5 years in this speciality would normally be expected, together with appropriate educational preparation, e.g. a stoma care course or the bowel management course which is part of the degree pathway based at St Mark's Hospital, London. Desirable qualities include management and/or leadership skills acquired through experience and education.

THE NURSE'S ROLE WITHIN THE MDT

History taking

A full and detailed history should be taken including symptoms, current medication and past medical history, along with an assessment of how these symptoms affect their quality of life. A friendly sensitive approach helps to create an atmosphere of trust; this then helps to reduce anxiety and embarrassment. Price (1993) found that the release of tension in patients is related to satisfaction and compliance with treatment plans. Bond and Thomas (1992) found that satisfied patients are more likely to have a more favourable outcome. A friendly, informal approach can be achieved by establishing a rapport based on reciprocity of information exchange, a sense of equality, sensitivity, trust and respect.

TABLE 1.
Common causes of faecal incontinence

Sphincter	Obstetric trauma
Pelvic floor damage	Direct trauma/injury
Diarrhoea	Inflammatory bowel disease
Intestinal hurry	Irritable bowel syndrome
Iatrogenic/post surgical	Post haemorrhoidectomy
	Sphincterotomy
	Anal stretch
Anorectal pathology	Rectal prolapse
	Anal or rectovaginal fistula
Neurological disease	Spinal cord injury
	Multiple sclerosis
	Spina bifida
	Dementia
Impaction with overflow spurious diarrhoea	Institutionalized or immobile elderly
Environmental	Poor toilet facilities
	Inadequate care
Idiopathic	Unknown cause
	Possible psychological factors

From Norton (1996)

Figure 1. The aetiology of pelvic organ prolapse.

Pregnancy
Childbirth
Constipation and straining
Congenital or acquired connective tissue abnormalities
Denervation or weakness of pelvic floor muscles
Menopause
Factors associated with increased intra-abdominal pressure

Diagnosis and treatment options
Selection of treatment is influenced by factors including the cause and severity of the bowel dysfunction, its impact on the patient's life and the patient's level of comprehension and motivation for solving the problems. Patients need time and support to consider the options available.

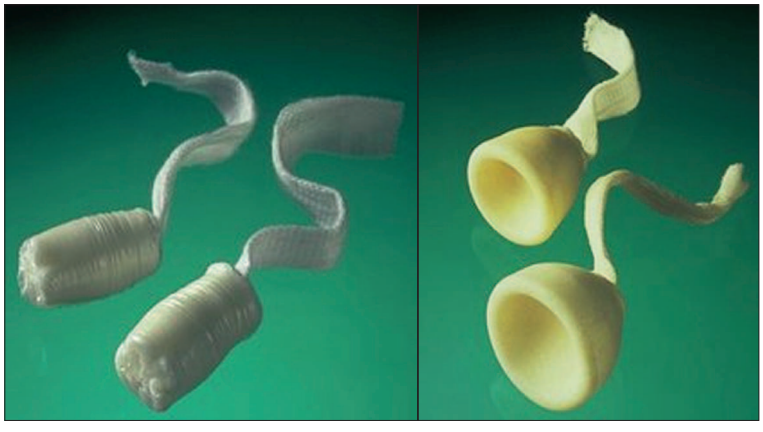
Pelvic floor assessment
It is vital that the patient strengthens the pelvic floor muscles. Wells (1990) showed the effectiveness of pelvic floor exercises in restoring strength and power to these muscles. Once they have been taught the exercises patients can carry these out at home. Vaginal cones can also be used to strengthen the muscles (Herbert, 1999). Patients may need biofeedback and electrical stimulation to help retrain these muscles.

The role of nutrition in chronic disorders
Reduction of the fibre content of the diet is the single most important dietary factor. Fibre causes bulky stools, which tends to exacerbate the urgency of defaecation and thus incontinence. Fybogel is best avoided in these circumstances.

Lifestyle advice
Weight reduction should be encouraged if appropriate for patients with prolapses. These patients should also be encouraged to avoid exacerbating activities, e.g. heavy lifting, and to stop smoking to avoid coughing.

Use of products to manage incontinence
The number of products available for the management of faecal incontinence is limited. Apart from pads that can be rather bulky, there is an anal plug similar to a tampon (e.g. Coloplast, Denmark; *Figure 2*). These tend to be more successful with patients who have relatively insensitive anal canals. The anal plug may give patients the extra confidence to go out and about (Mortensen and Humphreys, 1991).

Figure 2. Anal plugs.



Odour and perianal care
A patient with faecal incontinence requires especially diligent nursing care of the perineal skin. Control of stool consistency by the use of medication such as loperamide is the most important measure, as liquid faeces can break down the skin barrier and produce a raw perineum in a matter of hours. Lessening the contact time of a stool with the skin is important for the same reason. The skin should be cleansed gently with warm water after each bowel action. The patient should avoid using soap on the area. Barrier creams are useful. If there is continuous mucus or the skin is broken and wet a powder barrier can be of some benefit.

Medication
Constipating agents, e.g. loperamide or codeine phosphate, can help faecally incontinent patients, and the dose can be individually titrated. For some patients use of a daily glycerine suppository to aid evacuation and ensure an empty rectum prevents leakage. Rectal washouts are another option.

Biofeedback and exercises
Patients with weak but intact anal sphincters and those with problems coordinating evacuation may benefit from biofeedback to improve control and/or sphincter exercises (similar to pelvic floor) to strengthen the voluntary component of the muscles. While there has been some research into this and results are generally good, more work needs to be done to enable it to be understood more fully and to identify which patients are most likely to benefit (Enck, 1993).

Social support
In the UK some continence products are available on prescription. The cost of laundering clothes and bed linen may be considerable. For patients on low income financial help is available from the Department of Social Security.

Follow up and telephone support
Patients can be followed up for conservative management of continence problems as well as postoperatively according to local protocols. The nurse can provide additional support by giving patients his/her contact phone number to help with queries between official clinic appointments.

Counselling about possible surgical options
Patients need to be fully prepared for surgery, with full explanation of the aim of the surgery together with the risks involved and the benefits aimed for. The surgeon and the nurse specialist should fully counsel the patient, giving them time to consider the options. This is particularly

important as surgery is for quality of life problems rather than life-threatening problems. Patients can attend nurse-led clinics for additional support before making their final decision.

Information leaflets or videos and support from other patients may well help; this can be arranged by the nurse. Salter (1990) stressed the importance of preoperative counselling to prepare the patient psychologically to cope with a variable functional outcome. Brumfield et al (1996) showed that a well-informed patient is less anxious, more confident, and a more active participant, and experiences a more positive surgical outcome.

Figure 3 illustrates a patient's journey through a bowel dysfunction service, showing how the nurse-led service coordinates with the colorectal clinics. The service assesses, investigates, offers treatment options and finally discharges the patient back to the primary health-care team.

CONCLUSION

The specialist nurse can play a vital role within the MDT. They provide specialist advice and information for patients with bowel dysfunction and ensure that the patient has enough time to discuss and revisit problems. As many patients are seen in colorectal clinics these clinics become heavily populated with patients who need time to fully assess them and discuss treatment options. If they were seen by a specialist nurse this would free up clinic slots for other patients thus reducing clinic waiting and referral times. GPs benefit as their patients have a reduced waiting time when they are referred, and hospital consultants gain as a nurse provides them with a full assessment before they see the patient. This has the ongoing benefit of fewer appointments and also ensures appropriate referrals. The specialist nurse can provide seamless care with follow up for patients after treatment and promote discharge back to the nurse and finally back to the primary health-care team.

Koefman (1995) states that it is no longer about what is a doctor's role and what is a nurse's, but who is the right person in the right place at the right time to provide the most appropriate and effective service to meet the patient's needs. The expanding role of the nurse has relieved some of the clinical burden of increasing patient demand but it has much more important consequences. The nurse has a different relationship with the patient and can offer skills and support to patients which doctors cannot supply. HM

Figure 3 *is reproduced by kind permission of Coloplast Ltd. Conflict of interest: none.*

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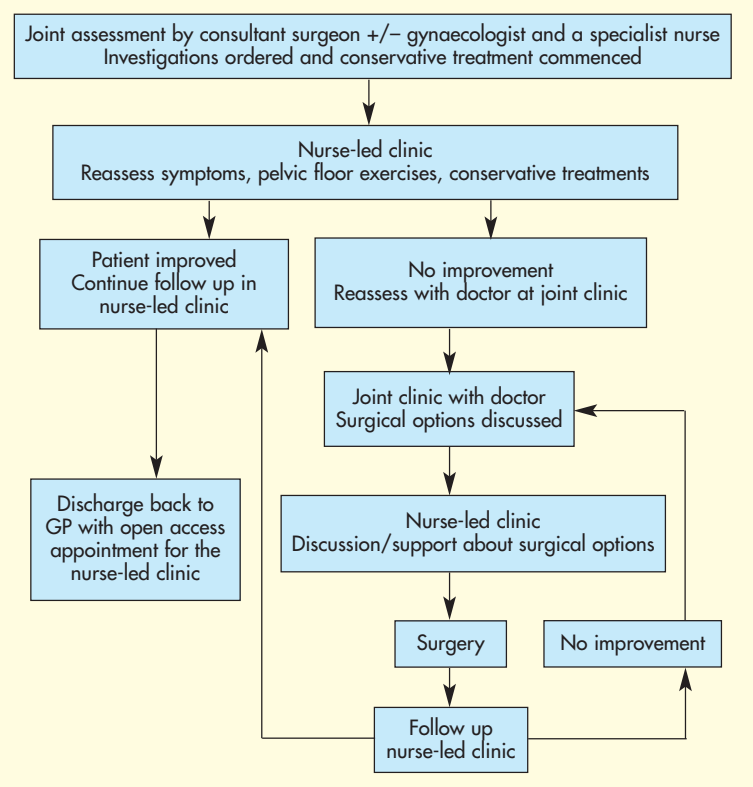
Figure 3. Example of a patient's journey through a bowel dysfunction clinic.



KEY POINTS

- The specialist nurse plays a vital role within the multidisciplinary team in the treatment of patients with pelvic floor dysfunction.
- Specialist nurses can give cost-effective expert care.
- Nurse-led clinics benefit patients, GPs and hospital consultants by reducing clinic waiting and referral times.
- The specialist nurse can provide seamless care by assessing, treating and promoting discharge back to the primary health-care team.