Liberate Yourself from Constipation

A guide for patients with long-term constipation, anismus, slow-transit and rectal prolapse

By JOSEPH PATRICK
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Introduction

This report aims to outline the possible reasons for your constipation, and outlines the options that are available to you. ‘Chronic idiopathic constipation’ is the scientific shorthand for the following:

“You can’t crap, and there doesn’t seem to be a good reason why”.

If you’re reading this report, then it is likely that you are suffering from what is medically termed ‘Chronic idiopathic constipation’.

If you’re not fully satisfied with your current treatment and are looking for a better solution.

There is a lot of detail in this e-book, but in Section 3 you will find what I call “The E and D Solution”, which offers the practical and extremely effective treatment that I discovered for myself. Constipation is a strange phenomenon: for a condition that is reportedly benign, it can feel horrendous, usually producing sensations of bloating and over-fullness, fatigue, moodiness and nausea. Needing to evacuate but being unable to do so is frustrating and painful. It is a horrible sensation of fullness - I honestly believe it is one of the most unpleasant problems your body can endure.

The True Effects of Constipation

If it has become a continuous problem for you as it once was for me, you know that constipation can significantly affect your life. A quick look at online communities and forums on the topic is all it takes to see that the collective suffering is immense. Chronic constipation can make people a little uncomfortable and less mobile - or it can ruin their career, affect their personal life, send them into depression and provoke anger and frustration.

In fact, many people actually prefer chronic pain in other areas of the body to the pain of constipation: some patients suffering from other pain issues will stop taking pain-killers, because the constipation as a side-effect of the medication is worse than the original pain itself! Codeine, for example, causes constipation, as it acts on receptors in the bowel and also the central nervous system and slows down peristalsis, which is the passage of waste through the bowel. This leads to slow moving stools, which become extremely dry and painful to pass. Many pain patients will stop taking codeine after a few weeks as they find that the constipation symptoms are worse than the pain they are experiencing. If there is anything that illustrates how serious constipation is and how much it reduces your quality of life it is that comparison: people prefer severe pain to constipation.
In online forums I have seen many posts that emphasise how severe constipation can be. Take this example which I have cut and pasted with no editing from an online forum:

“As a cancer sufferer I used to be on many drugs, most containing codeine. Constipation caused by this drug was even worse than the cancer itself”

Wow....

But you already know this! And the solution is not that you can just stop taking codeine to clear up the constipation, because you’re not even taking it in the first place....

**Constipation Isn’t Considered Sexy**

As a long-term patient you may be tearing your hair out because the problem is relentless – it doesn’t go away, simply because you cannot stop eating and digesting. In many cases, this problem will take over your life. Beyond the physical suffering, which is significant, there is also the social stigma attached to faeces, defecating, gas and so on, that makes your problem somewhat taboo to share. The more I have thought about this the, more I believe our culture has developed a collective insanity towards our rear ends. Louise Hay, founder of Hay House publications writes:

> "Every organ in our body is a magnificent expression of life with its own special functions. We do not choose to think of our livers or our eyes as dirty or sinful. Why do we then choose to believe our genitals are? The anus is as beautiful as the ear...”

My intellect agrees with Louise Hay, but I have also discovered that I experienced a good deal of resistance and embarrassment about my constipation condition. This was mainly due to my social conditioning and, frankly, to absorbing the embarrassment of other people - even doctors - around this issue.

I have great empathy for anybody dealing with bowel conditions. You are not only dealing with a tricky bastard of a medical problem with limited medical help, but you are also dealing with your own and other people’s misplaced and backwards prejudices about all things colonic and anorectal. The more quickly you begin to realise that this is purely social conditioning, the better you can approach the physical condition and the more objectively you can deal with the symptoms.

In some cases, the resistance people have to talking about their own colon, rectum and bowel habits results in late detection of bowel cancer - and death. This discussion in its entirety, however, is for another book. This report is designed to offer a quick help to get your life back on track, but I feel the need to point out that the shame, embarrassment and even guilt that people feel are a big part of why so many people suffer this horrendous problem in silence.
The Quest for a Solution

I have found that there is very little clear information available to patients who are suffering from chronic constipation severe enough to lower their quality of life. Over years of looking for a solution for this problem I have discovered, or rather re-discovered, two solutions that have worked wonders for me and many other patients – so much so that constipation, which once dominated and ruined my life, is no longer an issue for me at all!

I had to scour medical journals, subscribe to medical and nursing websites, seek help from numerous consultants, speak to endless nurses, try many variations in diet and various techniques and, ultimately, I even underwent an operation. I was amazed at how such a simple problem was so poorly treated and seemed so difficult to address within the current treatment paradigms. After two long years of suffering, I finally found the two solutions that worked best for me. I came across these solutions through a combination of research and trial and error, and I haven’t looked back.

This report aims to lay out the known causes for chronic constipation, and to inform people of the various solutions offered in medicine, surgery, nursing and alternative practices. I’ll also offer the two secret weapons that have given me my life back.

Easy, Accessible, Effective Solutions

One of the reasons I have bothered to write this E-book is that these solutions are astonishingly effective, and yet they are not advocated by most doctors, gastroenterologists and surgeons and therefore many people suffering from constipation will never learn about them. The medical profession does its best to help patients, but in many cases severe and chronic constipation is not treated effectively. Also, for reasons I can't fathom, the most effective and simple solutions which I offer here are usually overlooked, even maligned, even though there have been studies that clearly demonstrate how effective they are!

This is the information I wish I had had years ago; my aim is to lay all of the possible causes and treatments out in front of you to help you with your own condition. Most importantly, I will lay out the two silver bullets for constipation that have completely restored my life. A few years ago, I would have given all my worldly possessions for this information, when the problem of chronic constipation was making my life a living hell. In a sense, I’m writing this to my former self: it maps out the known territory in the tangled mess of constipation and shows you a route out.

I offer you this information with sincere understanding for the problem you are dealing with and great compassion and love for you as a fellow human being. I hope you will benefit from this information and find relief soon.
Disclaimer

This e-book does not constitute medical advice. I am a fellow patient simply laying out information, giving my own opinion, and offering an account of how I have dealt with the problem of chronic constipation. Many of the conditions that cause chronic constipation are benign (that is to say, they won’t kill you even if they can make your life miserable), but there are several life-threatening conditions - such as bowel and prostate cancer - that can cause severe constipation and so it is essential that you seek proper medical attention for your symptoms.

Constipation can also be a symptom of many medical problems, from Hirschbrungs disease to Multiple Sclerosis and even depression, so it’s sensible to get a full-work up if you’ve been experiencing severe constipation for a while. It’s also worth remembering that for ‘ordinary’, that is to say occasional, mild constipation, the medical paradigm usually offers an effective treatment.
Section 1: Causes of Chronic Constipation.

If you have got as far as reading this, then no doubt you will have worked on all the most common causes of constipation: dehydration, dietary issues, exercise, stress etc. You will have also likely had tests to rule out things like tumours and Crohn's Disease. Broadly speaking, there are three basic possibilities for chronic constipation that does not go away and is not effectively treated by addressing the above issues.

1. **Lack of motility in the bowel** – the stool just doesn’t move around. There are various classifications of this: *Spastic colon; IBS – type C; Colonic Inertia*. In essence though, the problem is a sluggish, in some cases almost inert, colon.

2. **Anismus** - which is a problem with the muscles involved in defecation – this is sometimes known as spastic pelvic floor.

3. **Rectal prolapses** – both internal and external. A prolapse is when the tissue around the rectum collapses inwards causing blockage in the rectum.

Let’s take a look at each of these little blighters in more detail....

1. **Causes – Lack of Motility in the Bowel**

This is also described as *colonic inertia, functional constipation, or IBS type C*. This is a common problem, although exactly how common is unclear as it may go underreported. "Lack of motility" basically happens when, for some reason, the colon stops pushing your poop through and it pretty much just sits there without moving along as it should.

Normally, the colon pushes the poop through by contracting in powerful waves in the morning and after meals. In the case of colonic inertia, this doesn’t happen correctly: the poop just shuffles along incredibly slowly, causing the colon to fill up with a great deal of stool and making the patient feel bloated, sluggish and generally pretty grim.

These patients will feel the urge to open their bowels far less, in some cases virtually never. Occasionally they will be able to open their bowels as there is nothing actually stopping the act of defecation itself, though the stool may be very large, hard and painful to pass.

Patients may also experience soiling when the stool suddenly comes down without warning. If you suffer from a lack of motility then you’re in good company: it is a relatively common problem, and seems to affect a lot people as they get older. Indeed the King himself, Elvis, suffered severe colonic inertia and couldn’t take a crap for weeks on end. We all know how the side-burned genius looked in his latter
days: bloated, clammy and, frankly, extremely constipated. The poor guy: it is well known that he died of heart failure while struggling to take a crap. His heart gave out during the almighty frustrated push: the *valsava manoeuvre*, otherwise known as "straining until your eye-balls pop out".

Prolonged, intense straining can actually contribute to death in patients with existing circulatory issues, causing a drop in blood pressure due to the pressure on the abdominal aorta, which in turn causes arrhythmia of the heart and, ultimately, can cause heart-failure. It has been suggested that this is exactly how Elvis died. It’s amazing how many senior citizens die of heart failure on the toilet. Paramedics will often say to families that a loved one died in the shower when in fact they died while taking, or trying to take, their last dump. For some reason, it seems that dying in the shower seems more dignified (which isn’t to say that people *don’t* also legitimately die in the shower, but I’m getting off-topic here). Anyway –if there’s a lesson we can take from Elvis, it’s that constipation is potentially a cause of death, or at least it may lead to heart failure that causes death - a curious but underreported fact!

Some people experience varying levels of constipation with Irritable Bowel Syndrome with Constipation (IBS-C), which is basically a version of IBS that tends towards constipation. Patients suffering from IBS-D (IBS with Diarrhoea) can also experience periods of constipation. As I have mentioned, with lack of motility/slow transit constipation the colon is slower than it should be at transporting stool to the rectum, and the result is often a dry stool. As stool enters the colon from the small intestine it is liquid in texture. As it passes through the bowel, the walls of the colon absorb water. If the stool passes through the bowel very slowly, more and more water is absorbed from the stool and this leads to some pretty unpleasant rock-like faeces – steel pellets that can be damned difficult and unpleasant to pass.

If you are suffering from slow transit constipation you may get the urge to poop very infrequently, and when you do often the stool may be harder than normal. It is also possible that only one part of the colon is inert or sluggish and that the rest is actually functioning normally.

**Diagnosis**

*OK, you say, this is all very fascinating, but how do I know if I have colonic inertia, IBS C or slow transit constipation or whatever it’s called...?*

In addition to the description above, your symptoms would typically be that the poop comes out when it gets to the rectum – ie. You can take a crap like a champ – it’s just that you rarely get the normal urge, and you feel bloated, uncomfortable and unpleasant going many days and even weeks (or - dare I say it – months, in some cases) without taking a proper crap.

This should be fairly straightforward to diagnose – the doctors will give you a weeks’ worth of radioactive pills to take and then scan you to see how they have progressed through your colon. This should give a decent picture of how stool is
moving through your colon. From this it should be straightforward to see if the colon is generally working correctly or if it has decided just to take a chill pill and not bother doing much. It should even be possible to identify if there is a certain length of the colon that isn’t working as it should be.

 Causes

What is the root cause of these this problem?

Good question! Assuming you’re not taking any drugs that reduce motility and are able to move around most of the time, there doesn’t seem to be an easy answer. There are numerous theories, from problems with the cells in the colon, to more general ideas about neurological problems. One experienced surgeon I spoke to told me that, frankly, they still didn’t understand what causes the problems of slow transit. He suspects that it might be neurological. I have also spoken to a very experienced neurologist who said that he didn’t see evidence to support this. I wonder if there are inter-disciplinary studies going on...

Anyway, there are all sorts of theories about the cause but there doesn’t seem much agreement on it so I have found it best just to focus on solutions instead.

 Treatments

OK - So what are my options?

Regular western medicine will offer you a) laxatives, and eventually, b) surgery. My E and D solution, described in Section 3, offers you a highly effective alternative to both.

 Laxatives

Naturally, you will be offered a number of different laxatives (see Section 2 for more information on laxatives). These are worth a try, but in my experience very few of them worked well enough to use long-term.

 Surgery – Your Options: Partial Removal of the Colon, or Stoma in the Bowel

For Colonic Inertia, when high doses of laxatives, dietary measurements and lifestyle improvements (such as drinking more water and getting more exercise) produce no results, then surgery may be recommended. The operation offered will usually be to remove 80% of the colon and to attach the end of the small intestine to the rectum: the procedure is called a 'total abdominal colectomy and ileorectal anastomosis'. If a certain part of the colon has been identified as being sluggish then the surgeon may remove only a certain length of the colon.

There is also the ACE operation – The antegrade colonic enema operation. In this operation a stoma is created in the large bowel. To put it simply, this is a little tube that goes from the surface of the skin into the bowel.
Constipation is then treated by taking a water enema through the stoma which floods the bowel with water and encourages stool to pass through. I personally find this operation baffling. I don’t understand the reasoning behind surgically creating a hole in your intestine in order to take a water enema when you could simply take the enema through the anus. Obviously a stoma is a huge, life-altering adjustment, and I find it strange that this treatment, which works on the same principle as a normal enema, would be recommended to somebody rather than a regular enema program.

**ACE Procedure Results**

What are the results like, you wonder? Studies differ but for the removal of the colon, generally, if slow transit is the only problem and you’re not also suffering from anismus, then the results tend to bear out that about two-thirds of patients no longer suffering from constipation. Diarrhoea is a very common result of this operation. This is no surprise, really, as the colon absorbs water from the stool coming from the small intestine and without the colon, it’s logical that the stool is often liquid. A vastly increased frequency in going to the bathroom is reported, with patients needing to open their bowels up to eight times a day being a common result of this surgery. One surgeon mentioned off-hand to me that, although diarrhoea is a common issue afterwards, most patients say that this is far better than being completely constipated as they were before. In some patients this diarrhoea will settle down after a while.

With respect to the ACE procedure, the results are also a mixed bag. About half of the patients who undergo the treatment report an improvement in constipation symptoms. Some studies report that up to 80% of the patients have needed further surgery after the initial operation. Other problems such as soiling can arise, as well as difficulties with the intestinal catheter.

The statistics are important, but they’re not necessarily that useful for the individual patient: If an operation improves the lives of 2/3 of people but doesn’t help 1/3, then it is considered a good procedure. Even if it harms 10% of people and makes their life worse it will still be considered a good surgical option. That’s fine if you’re one of the lucky ones, but *what if you’re not?* The doctor/surgeon sees many patients and if he helps a lot of them he is a good doctor or surgeon. However, you only have one body - you either see improvement, stay the same or get worse. The fact that other people have improved from the operation is no consolation if it doesn’t work for you; you don’t get another chance with the next patient who walks through the door in the same way that the doctor does. In my understanding, there is a great chasm between your experience and the perspective of the doctor for this reason – psychologically, it’s easy to distance yourself from the unlucky few who have not benefited from the procedure by the success of the many
who have, but no matter how it goes, you can’t just start over in a new body – you only have the one and you’ve got to work with it.

These are very serious operations - particularly the first option, the full removal of the colon. There are potential complications in the operation itself and it’s never clear sailing afterwards. You may well find yourself going from one bowel movement a week to one every hour or so after the operation. As with any surgery, the results vary and it is a question of looking at the potential improvements in quality of life that will come after the operation.

Across studies, about two thirds of patients do report an increased quality of life from their previous condition of slow transit constipation. But once your colon is gone, there’s no going back and you will have to get on with whatever the outcome. Naturally, this is an operation that should be considered with a great deal of care. It really ought to be a last effort operation. I would strongly advise doing your research by looking at a number of medical papers as well as patient forums before taking on this option. If your colon is so sluggish you are considering surgery for slow transit constipation, it is certainly worth giving the E and D procedure – outlined in Section 3 of this report – a good try first.
2. Causes – Anismus or Tight Pelvic Floor

Also known as a *tight pelvic floor*, anismus is basically a problem with the act of defecation itself. When enough stool arrives at the rectum, you get the urge to open your bowels. During normal defecation, the pelvic floor relaxes and the stool can slide out of the rectum and through the anus. Often people will increase the pressure in the abdomen, pushing down on the stool slightly by breathing in and bearing down. The push downwards happens as the abdominal muscles contract slightly, but the pelvic floor remains relaxed so the stool can come through. We also, under normal circumstances, have control of our external sphincter and have the ability to hold the stool in until there is a convenient place, usually a toilet, or an enemy’s doorstep, to defecate. I say we have control over this process, but for most people it is barely conscious, an instinct that happens pretty much like this: Need to poop – sit on toilet – relax pelvic floor – push a little if necessary – out comes poop – wipe bum – wash hands – feel light and wonderful – go back to life.

However, in the case of anismus, the pelvic floor doesn't relax properly and may even tense up as a person pushes - meaning that the stool hits a wall. The person feels the urge to defecate and goes to the toilet, but either nothing happens, or they push and cannot open their bowels. Naturally, this causes a great deal of frustration and confusion. The patient feels the urge but they just can’t crap because their pelvic floor is either tensing when it should be relaxing, or is in a permanent state of tension – *spasticity*. This is a tricky problem. Some test subjects with anismus don’t experience any constipation, but many other patients suffer terrible ‘outlet obstruction’ because of anismus: meaning they can’t crap for love nor money.

**Diagnosis**

*How do I know if I have anismus?*

The diagnosis is difficult. There are several techniques that surgeons and gastroenterologists use to try to detect anismus. One technique is for the practitioner simply to insert a latexed finger into the patient’s anus and ask the patient to push as if they were pushing out a stool. The physician can sometimes feel the tensing or relaxation of the pelvic muscles and make a diagnosis from this.

Another technique involves putting a medically adapted balloon into the patient’s anus which is then pushed up into the rectum and inflated before the patient is asked to expel the balloon as if it were a normal stool. From this test the gastroenterologist can get readings of the pressures of the pelvic floor muscles when the patient attempts to push the stool out, as well as seeing how much the balloon needs to be inflated before the patient feels the urge to defecate – this is basically the holding capacity of your rectum. If this test sounds uncomfortable and slightly ridiculous, that’s because it is.
There is also a “paste test” known as a *defecating proctogram*, used in the UK, in which a patient has a paste squirted up inside the rectum. After this the patient either has to lie down in a scanner and basically poop into a bowl placed under the anus – or the scanner is designed so that the patient can sit down while poop into a basin. From the images of this scanner, the physician can analyse the rectum and the movement of the pelvic floor.

Anyone reading these description can probably imagine the difficulties involved with such a test, and anyone who has experienced them – and I have experienced every single one - will tell you that there is a very obvious problem with them all: the environment in which the test takes place is beyond UNNATURAL - it’s the last place on earth you could ever take a crap! How can you ever expect to relax and defecate normally when you’ve either got a physician’s finger, a balloon, or paste in your ass…and an audience?

All of these scenarios are about as far from the normal bathroom procedure as is imaginable. I mean, who has ever taken a crap while being monitored by four people! Of course you can’t relax! I was told by the imaging consultant in the lie-down scanner that practically nobody can relax enough to poop in that position, while inside a scanner with several people watching them. They could at least give you a newspaper.

As a lay person and not a medical person, I suspect that although these tests do have value they might also produce some false positives due to the tension created by all the metal, fingers, paste, balloons and onlookers. This seems to be borne out by the observation that pseudoanismus is often observed – meaning that the tests produce false-positives. I imagine that the patient’s description is probably the best place to start. If somebody feels a great urge to defecate but when they go to the bathroom things just don’t come out despite all efforts, then there is a reasonable chance that anismus might be a factor.

Ian Lindsey of the Oxford colorectal partnership in the UK has written a paper suggesting that the best way to diagnose anismus is to give the patient a botox injection into the pelvic floor, which immediately and completely relaxes the muscle. If the constipation resolves with a totally relaxed pelvic floor then anismus was the cause. If the constipation continues then anismus was not the cause.

**Causes**

*What causes anismus in the first place? Where does the spasticity of the pelvic floor come from?*

These are interesting questions and there have been numerous answers: from injury, neurological and muscular problems, to stress, abuse and trauma. Again the root cause isn’t exactly known and so...you guess it, it's better just to focus on alleviating the symptoms. Are you beginning to see a pattern emerge here?
Treatment

OK – So what are my options here?

Typically you will be prescribed laxatives as a first line of treatment for your constipation (see Section 2 for more information on laxatives). If this doesn’t work and anismus is diagnosed, there are various treatments available.

**The Health–Step** is a step which you put underneath your feet while you are on the toilet. It raises your feet so that your legs and your pelvis make more of a squatting angle. The squat is the optimum position for defecation as in this position the pelvic floor muscles are able to relax more easily, and the position also opens the angle of the rectum to allow defecation to happen with less effort. This step can help to make the process of defecating easier.

It makes sense if you think about it: in our evolutionary past and up until relatively recently (the mid-nineteenth century) we have always squatted to defecate, and the Health-Step allows us to recreate this position. If you can’t get hold of a Health-Step, then a couple of hefty books will do the trick.

**Bio-feedback** is a type of training involving a biofeedback sensor which is inserted into the anorectum and which monitors the pressure of the internal sphincter. The patient is trained to relax the internal sphincter while bearing down, as occurs in normal/optimum defecation. This brings a level of conscious control to the process and can prove helpful for patients suffering from anismus. This retraining of the internal sphincter and the pelvic floor can take a long period of time.

**Botox injection into the pelvic floor** – One treatment protocol is the injection of botox into the pelvic floor. If the pelvic floor is in spasticity, an injection of botox into the pelvic floor will cause the pelvic floor to relax. Botox - short for **Botulium toxin** - is the most potent neurotoxin that we have available. Botox prevents all the contractility of a muscle making it go completely soft and motionless. This is why people inject it into their faces as, by paralysing the muscles of the forehead, it decreases stress and age lines. It was developed by opticians to help ease uncontrollable blinking that was believed to be linked to spasticity in the muscles surrounding the eye.

In the treatment of anismus, botox is injected into the pelvic floor. The pelvic floor goes from being in a state of spasticity to relaxation. If the patient is suffering from anismus, the botox injection can allow defecation to take place by relaxing the pelvic floor. This has had variable results across studies. The centre in Oxford the UK has had the best results for treating anismus by using a higher dose of botox and by ensuring that the patient is not also suffering from rectal prolapse. My E and D Solution, outlined in Section 3, may also be highly beneficial for patients with anismus.
3. Causes – Rectal Prolapse

The rectum is the final part of the large intestine. It varies between about 4 to 7 inches long and descends from the area around the middle of the tail bone down to the anus. When a large amount of stool reaches the rectum, usually in the morning or after a heavy meal, it triggers powerful waves of contraction in the colon and the nerves in the rectum give you the sense that you’ve got to go poop - the rectum then empties (hopefully in an appropriate location) through the process of defecation. The rectum is a kind of storage tank held in place by the surrounding tissues.

Rectal prolapse occurs when the rectal tissues lose their shape and collapse inwards. This collapse can have varying degrees of severity. In an internal prolapse, the prolapsed tissue may be quite severe but still does not protrude from the anus. However, with a full thickness prolapse, the prolapsed tissue protrudes out from the anus. If you think of the rectum as the end of a pipe, a rectal prolapse is like the walls of a pipe collapsing in – naturally, this causes a blockage. This is why sudden onset and severe constipation will often occur when a rectal prolapse happens, or when it reaches a certain level of severity.

A patient with an external prolapse will certainly feel a measure of pain, discomfort and distress. Equally so, a patient with an internal prolapse may have an uncomfortable sensation in the rectum and have severe symptoms of constipation. There is often a feeling of fullness even after passing a bowel movement, which is the internal rectal tissue squashed together. The blocked or collapsed pipe analogy fits well with how some patients will respond to laxatives to treat constipation: you can pump more water through the pipes at a faster rate, but if the end is collapsed or blocked, it might not get through and will simply create a build-up of pressure. Believe me, this is extremely uncomfortable. Some patients will also experience a lack of control over opening their bowels (incontinence) due to the rectal prolapse.

I personally found the condition to be very distressing: I had this a diabolical sense of constipation and blockage, which didn’t respond at all to laxatives and only infrequently to saline enemas.

Diagnosis

How do I know if I have rectal prolapse?

The main symptoms described above are constipation or strange evacuation problems, a weird pain in affected areas and, possibly, protruding tissue. If you have a full thickness prolapse, this should be very straightforward to diagnose as the protruding tissue will be visible on a physical examination. The internal prolapse is more tricky to diagnose, as it often won’t be seen or felt in an examination. It won’t usually be apparent in a colonoscopy, either, as the rectum is to some extent inflated and restored to its natural shape so physicians won’t see
the prolapse. It can also be assessed with a barium X-ray, but even this doesn’t
always produce a positive.

The gold standard for detecting a rectal prolapse is the CAD device. This is basically
a fairly large anal dilation device that is inserted while the patient is under
anaesthetic (thank God you’re out cold for this one) which allows physicians to look
for a prolapse. This device is a great advance in the detection of rectal prolapse.

**Causes**

**OK – so what the hell causes rectal prolapse?**

I’ve researched this question a great deal and also asked a couple of surgeons and
a registrar: the answer is that – drum roll please – they’re still not sure. Repeated
straining to take a crap is one cause that has been identified and speculated about.
It seems pretty obvious to me that this can cause a prolapse. The strain puts the
tissues of the rectum and those surrounding ligaments under pressure and, over
time, this can lead to a prolapse. Again, imagine the pipe analogy: if you keep
squeezing on the outside or pushing down on the pipe, eventually it may collapse
inwards.

I have heard some nurses discussing a case of a full-thickness rectal prolapse of a
patient who had come to Accident and Emergency after suffering a very large and
unpleasant prolapse after straining: over a foot of the rectum and the large
intestine came out through the anus. The nurses were having drinks and this
episode had obviously traumatised them as they were telling their friends,
“Whatever you do, don’t push too hard – you don’t want a rectal prolapse!” It
shows how distressing the condition can be when nurses - who see some pretty
unpleasant stuff in A and E - were actually shocked by it.

So there you have it: **Don’t push too hard!** Pregnancy and birth have been
identified as possible factors in rectal prolapse. The strain on the pelvic organs is
obviously a potential cause for rectal prolapse. Women generally are more likely to
get it than men are. It has also been observed that patients will often complain of
symptoms of a rectal prolapse after a bout of gastro-enteritis. This is something
that is seen commonly, so there is some speculation that a bout of gastro-enteritis
may somehow affect the rectal tissues in these patients – but as far as I know why
and how this happens is unknown. There is also the possibility that a very low
sphincter-tone might also leave a patient more likely to suffer from rectal prolapse
as straining the tissue may cause it to lose its shape. There is even a little
speculation that patients who are double jointed with hyper flexibility are also more
prone to rectal prolapse.

Rectal prolapse is a problem that also typically affects older people more than
younger people. There may be several reasons for this: The rectal tissues may have
been affected by many more years of straining to pass a stool, and/or it may also
be related to a natural loss in tone of the rectal tissues and sphincter as a result of
ageing. The reasons why older patients are affected more is unknown but it is seen in numerous studies.

**Treatments**

OK – so what are my options if I am suffering from a rectal prolapse? First of all, it’s worth noting that not everyone suffers symptoms from a low-grade rectal prolapse. However, if you have made your way to this guide then it is probable that your prolapse is bad and is causing symptoms. For both the full thickness rectal prolapse and internal rectal prolapse, surgery is the most obvious, and indeed possibly the only, way to correct the prolapse. However, there is a resource for people wishing to heal rectal prolapse by Alyce Adams, who advocates a series of **specific daily kegel exercises in order to reverse prolapse**. For a low-grade internal prolapse that isn’t causing much in the way of symptoms, perhaps pelvic floor exercises would be tried in order to stop the prolapse from progressing.

If the symptoms are bad and or the prolapse is quite large or even full-thickness, then surgery can be undertaken. Historically, there have been several operations on offer for rectal prolapse.

**Surgery: Laporoscopic Ventral Rectopexy**

The main operation you may be offered these days is *Laporoscopic Ventral Rectopexy*. This is keyhole surgery (this means they only make small incisions rather than cutting your belly right open) in which the collapsed rectum is restored to its natural anatomical position (or as close to as possible) by a mesh which is stitched to the top of the rectum.

In the past this operation used to be an open procedure – meaning that you were fully cut open in order for the operation to be carried out. As well as being more likely to cause complications after the operation it also damaged the nerves on the top of the rectum making constipation and evacuation even more difficult than they had been before. The new procedure restores the rectum to its natural position in the pelvis through a keyhole procedure. This is the operation that I underwent and, overall, I was pretty happy with it. It didn’t take care of the severe constipation, which was the main reason I had the operation and I still had evacuation difficulty, but I could actually feel that the prolapse was gone.

Although the results weren’t satisfactory in my case as I still had pretty bad symptoms of outlet obstruction and constipation, I’m still happy that I had the surgery and the prolapse, which was quite large, has now gone. I have had periods of pain after the operation at times and I still had to go on to find and refine solutions for the ongoing constipation.

Having looked at the various operations available, this seemed to me to be the best one on offer for various reasons:

1. The bowel isn’t removed – this can only be a good thing.
2. The nerves on the front of the rectum are left intact because of the keyhole method which didn’t used to be the case.
3. Complications are quite low and hospital stay is relatively short - again this is because the keyhole method is used.

After my operation, I had some intense pain where the mini camera had been inserted through the belly button – it felt like I had a needle inside me for a couple of days. There are three main incision sites through which the surgery is performed: two a couple of inches to the right of the bellybutton and one a few inches to the left. You need to take care of these for a few weeks afterwards until they heal up, but the scars are tiny and practically disappear after a year.

Although my results from the surgery were only so-so, generally this operation has quite good success rates and low complication rates.

**Surgery: Stapled Transanal Rectal Resection (STARR)**

There is also the, to my mind rather deceptively named, STARR operation (Stapled Transanal Rectal Resection) in which a probe is inserted into the rectum and the parts of the tissue which are loose are cut out before the rectum is stapled back together. Some papers are quite positive about this operation, but he prolapse is statistically more likely to return with the STARR operation than with the rectopexy. If you look through online forums, tons of people complain that the staples cause pain when they leave the rectum. In fact if you look in the forums you will probably be put off having this operation at all as there are some truly horrifying posts from people who have undergone STARR and had terrible experiences of post-operative bleeding and pain.

Personally, I find the idea of having staples in my rectum pretty unpleasant. With this operation in particular, there seems to be a mismatch between the delicate and sensitive area that is undergoing surgery and the brutality of the operation itself. It’s definitely worth checking out the forums if you have been offered this operation – actually it’s essential to do so!

**Other Options**

Bear in mind there are other operations you can have. I was advised by an excellent MD before my own Lap-Ventral-Rectopexy operation that with surgery the skill and experience of the surgeon is of paramount importance – on a par with the general success of the operation itself. Just remember what will be happening to you on the table: your body will be cut open and bits will be either taken out or put in. The cuts are of great precision and they are undertaken by a surgeon who has great knowledge of physiology and is doing their very best to help you but, nevertheless, it is still an act of violence towards the body. It is not something you should undertake lightly.
Fortunately, the procedure is a non-urgent one, which means that you’re not in the accident and emergency ward, and you have the chance to do your research and to pick an experienced surgeon at a good centre. I found the best centre in my country and had the operation with a highly experienced surgeon who had also published a number of papers on the operations and the question of rectal prolapse and constipation. The centre was the Oxford Colorectal Partnership and my surgeon was Ian Lindsey. I would strongly advice that you seek out a similar surgical team if you decide to explore the surgical approach.
Section 2: Laxatives, Suppositories, Chemical Enemas & Dietary Measures

Laxatives

For patients of slow-transit constipation, anismus and rectal prolapse, laxatives are usually prescribed as a measure to treat the constipation. There are a few different types of laxatives. You may have tried most, if not all, of the laxatives mentioned here, but I'll run through the list anyway.

- **Lactulose**: Probably one of the first laxatives that you’ll be prescribed. It’s got a sweet taste with the texture of honey. It works by increasing the water content of the lower bowel, thus making your stool softer and easier to pass. It also stimulates peristalsis by increasing the acid content of the bowel. Its side-effects are minimal and it can be taken every day.
- **Movicol**: This is also a laxative that works by drawing more water into the bowel (osmotic) so that your stools become softer, bulkier and should pass more easily. It is quite a strong laxative and it shouldn’t be taken by everyone. It also has a number of side-effects.
- **Senocot**: This laxative works by stimulating contractions of the bowel – peristalsis – hence its classification as a stimulant laxative. It is a pretty gentle laxative but it can cause stomach cramps, which can be painful, as well as other side-effects.
- **Dulco-ease**: This works by stimulating peristalsis and also by drawing more water into the stool making stools softer and easier to pass.
- **Prucalopride**: This works on producing mass movements of stool through the bowel by stimulating a serotonin receptor in the bowel. It is approved for use in Europe and Canada but not yet the United States. For some reason it has only been tested on women and is therefore not supposed to be prescribed to male patients at the moment. It seems to be quite a promising laxative.

In the conditions we are dealing with – colonic inertia, rectal prolapse and anismus - laxatives are notoriously ineffective. For people who suffer outlet obstruction due to a rectal prolapse or anismus, these laxatives may or may not help for the obvious reason that the problem isn’t in the transit of the stool, which is what these laxatives treat, but in the outlet mechanics.

In my case, they made me feel a lot worse. This is hardly surprising when you think about it: the end of the pipe is blocked (rectal prolapse or anismus) and you are pumping more and more water into it at a faster rate. This just causes more pressure and makes the blockage more difficult to deal with. In my case taking laxatives just made not being able to crap (outlet obstruction) more unpleasant and more frustrating; I imagine this is the same for many patients. The majority of GPs
and even many gastroenterologists don’t have the expertise to diagnose rectal prolapse, so they may just end up prescribing more and more laxatives.

As well as the discomfort, bloating and increased sense of pressure I experienced, the quantity of laxatives I took also made me feel systemically unwell: my skin was grey, I’d lost weight and when I saw myself in photos I almost didn’t recognise myself. I’m pretty sure that the laxatives were dehydrating me and maybe even stopping my body from absorbing some nutrients.

For people with outlet obstruction, it seems logical to me that laxatives can actually make your symptoms even worse as they create a greater build-up of pressure. This was certainly my experience.

Suppositories

Again, if you have purchased this guide then there’s a chance you’ve become an unwilling connoisseur of all these options by now, but here is some information anyway. Glycerine suppositories are small white waxy pellets that you insert into your anus. They are sucked up into the rectum where they pull water down into the lower bowel and rectum to soften up hardened stool in the lower colon and rectum. They also irritate the tissues of the rectum, causing contractions and making the expulsion of stool easier. This is the theory and, while for many people they may be effective, in my experience the Glycerin suppositories were very hit and miss...but mainly miss. Often I would just expel liquid and a bit of the remains of the suppository if anything came out at all. I tried these for a while and had next to no success with them. Another issue is that they can cause irritation – I found that I experienced a stinging sensation with these laxatives after only a couple of uses.

Chemical Enemas

Saline enemas – Micralax enemas: These little bad-boys come usually come in small disposable tubes. You take the end of the cap off, insert the nozzle into the anus and then squeeze the contents of the tube. They work by drawing water into the lower bowel and rectum and also by irritating the lining of the rectum and bowel causing it to contract. It’s best to pick up the disposable small ones as you can just empty out the content into your butt and throw the tube away. I found these to be the only thing that medical doctors gave me that had a reasonable degree of effectiveness. They didn’t always work satisfactorily – but they did get me passing stools sometimes, which is more than I can say for all the other medicines put together.

Chemical enemas cause quite a lot of irritation and can cause dehydration. They also become less effective over time and have been reported to be habit forming. In comparison to my E and D Solution (coming up in the next section), they are practically useless. That said, they are worth a try if you think you need them. Again if you have a rectal prolapse, anismus, or slow transit, this may not be enough for you.
Dietary Measures

Again, most of you will have tried all of the conventional dietary measures to increase bulk through insoluble fibre such as bran, the skins of fruit, wholegrain products like bread and cereals. In theory, all of these things are advisable with patients who have a very low level of constipation which is quickly resolved by adding more bulk to the stool. However, in patients with the types of constipation we’re discussing here I doubt these will help much, and in my experience they made life more unpleasant. Adding more bulk can create the same feeling of pressure and bloating as the laxatives do, when the problem is the mechanics of pooping due to anismus or rectal prolapse. It’s the end of the pipe that has mechanical problems, so speeding up or increasing the quantity of the stool flowing through the pipe can actually make things worse at the outlet end.

The Problem With Fibre

Insoluble fibre also causes a small amount of irritation to intestinal wall and also causes gas. This only adds to the sense of feeling sluggish and bloated. The only increase in fibre that has been useful for me has been in the form of porridge (oatmeal), which contains quite a lot of soluble fibre. This type of fibre moves through the bowel in a thick paste as it dissolves with water and makes the stools bulkier and smoother without causing excess gas contributing towards bloating. Overall, I actually find that consuming less insoluble fibre makes me feel less bloated, which therefore eliminates on symptom of the constipation. This goes directly against what doctors and surgeons would tell you, but it makes sense if you think about it: if you have outlet obstruction problems, the effects become more unpleasant and distressing when you have the urge to go to the bathroom but can’t.

Most Gastroenterologists would recommend that you take more fibre and laxatives: this is what they are trained to say. Can you see the problem here? If you can’t poop because of outlet mechanics, then adding more bulk and stimulating movement just makes things worse. There is more stool pushing into your lower bowel and down in the rectum but you are still unable to open your bowels – it is horrible and makes you feel worse.

My Dietary Suggestions

This was the negative pattern I was in: I couldn’t open my bowels without enemas because there was a prolapse, and so pushing a load of laxatives and fibre in there just made the blockage feel worse. I now find that taking no laxatives and not eating too much fibre is actually the best way to avoid excess gas and bloating! This dietary modification is radical in the sense that it goes against conventional medical wisdom – but it’s obvious that outlet obstruction and more usual constipation are completely different types of constipation.

My own experience over several years of dealing with these symptoms and experimenting with every dietary modification, herbal supplement and laxative has
lead me to adopt a diet that includes **no laxatives and includes no extra fibre intake** outside of my everyday diet. When I look at the science behind fibre, laxatives and what they are doing it seems obvious to me that increasing them too much will be unhelpful if you suffer from outlet obstruction.

This dietary approach combined with my E and D Solution (yes, coming up in the next section!) has brought me to the stage I’m at now – I rarely, if ever, think about my bowels and certainly don’t experience any problems with them. It’s incredible to think this after years of extreme difficulty and I’m extremely grateful that I have found the solution.

**Think For Yourself**

Having looked at some of the treatment protocols and operations on offer it is worth asking overall, "**how effective are these methods, and how big are the side-effects and risks?**" These are important questions, and I’m not sure how straightforward it is to answer them. I would say that, in my case, the medical treatments were not effective to any satisfactory level and the side-effects – particularly those of the laxatives – were unpleasant. I would go as far to say they made me systemically unwell. The surgery was necessary but even with a good operation in a good centre with a reputable and experienced surgeon, the results still weren’t even close to a return to ‘normal’ – which was the ultimate goal of the surgery.

As I have expressed before, even if a treatment is effective for three out of four people, then for at least one person that treatment is a waste of time, and could even be causing unnecessary harm. That one patient’s needs are just as important as those of the other three patients. In my experience as a patient – which was extensive, and involved hundreds, perhaps even thousands of hours of research to find the best treatments and many trips to see multiple specialists – the overall picture is that the field of proctology and treatment of constipation is much more complex than I could ever have imagined. I find it incredible that, in this age of iPhones and Hadron Colliders, we are still in the dark about many aspects of the functionality of the bowel and are often at a loss to treat chronic idiopathic constipation. I mean you’d think: **it’s just crap, how hard can it be to get it out of your body effectively?**

There is so much that is unknown and even in the best centres of treatment and study they admit that there is a lot they don’t know. One option I did not fully explore before my operation was Kegel exercises to restore the rectum to its natural position. This is an approach which I believe may prove beneficial for some people, and since the operation I have begun to undertake some kegel exercises to add strength and suppleness to my pelvic floor. It’s also worth noting that for conditions such as rectocele, bladder and uterine prolapse these exercises can be effective. I would suggest taking a look at Alyce Adams (The Kegel Queen)’s
website as she has some very sensible advice about exercises and which activities to avoid with prolapse. She deals mainly with women's physiology and will say openly that her expertise is with women rather than men, but I found some of her tips to be beneficial and much of her advice about exercising with prolapse to be sensible.

So now that we've covered your many (rather unsatisfying) options, or at least everything that I unearthed in my own research into my condition, I'd like to share with you the protocols I developed that helped me the most, and will hopefully change your life for the better as they did mine.
Section 3: The E and D Solution

It is definitely worth trying all your options before choosing an operation. Even if you have undergone an operation and were not fully satisfied with the outcome, there are still things you can try. This is where the E and D Solution comes into play. I hope you get the most out of it. It is one hundred per cent natural: it doesn’t involve surgery or laxatives and I have found it to be highly effective. By that I mean far more effective than any other dietary, medical or surgical approaches I have undertaken. I’m so grateful that I have found out about this procedure as it has made my life so much easier, and I am really hoping that it can help you as much as it has helped me.

The E and D Solution – Discovery and Wonder!

I discovered this method in two parts, as much through pure chance as anything else. I was just about going crazy with the prolapse symptoms. It had taken over my life: the infernal constipation, the bloating, and the discomfort of the prolapse were difficult to deal with. My primary doctor was a complete waste of space – I went back to him seven times and he just kept telling me it was in my head and to stop coming in! Without doubt he was negligent. This made me angry in itself, and at the time I also didn’t fully understand how referrals are funded by the NHS and that GPs are sometimes paid more to cut specialist referrals –effectively being paid to withhold treatment from patients. However, that is for another book...

Although I should have received better treatment by my primary GP, I eventually came to realise that, even with more specialist care, treatment for chronic constipation is hit-and-miss. I also learned a huge amount for myself during this time through studying medical papers, subscribing to journals, and looking through medical text books and nursing publications.

D is for Digitation

It was within the field of nursing that I found the first part of the puzzle. I eventually came across the practice of rectal stimulation – or Digitation: D – in a nursing manual. Apparently this has been used in nursing for a long time to treat patients with fecal impaction due to medication, spinal and nerve injuries, or multiple sclerosis. Reading more about it, I thought it looked relatively simple to do and was probably worth a try myself. I tried it – and it worked better than anything else I had tried before. I was surprised later to find that when I did eventually get to see a gastroenterologist, he was horrified that I had to resort to Digitation to open my bowels. I was also later surprised to find out just how common place this practice is in nursing, and to this day I don’t fully understand why my gastroenterologist got so squeamish about it! The nurses are the ones who have to do it, after all...
I honestly think that Digitation is one of the great unspoken truths of medicine and bowel conditions. I have conferred with a consultant who has worked in the NHS (British National Health System) for forty years, and he told me that he’s perfectly aware of the technique, that it is used by a lot of people, and that it’s perfectly safe for all but a few patients with spinal problems (as it can occasionally cause Autonomic Dysreflexia). I’ll go into more details on the technique, how it works and how best to use it if you need to in the next section.

In my case, Digitation was a life saver in terms of offering me something that got me through for a while. Even though it could be time consuming and unpleasant, it was reasonably effective, particularly in comparison to the use of laxatives and saline enemas.

E is for Enema

The technique alone, though, isn’t enough – hence the letter E, for Enema...but a very specific type of enema! I found out about the beauty that is the **High-Volume Enema** after trying my first session of colonic irrigation. Colonics is an effective treatment for constipation and many of the symptoms of rectal prolapse. For the uninitiated: warm, purified water is streamed into the bowel where it absorbs impacted and sluggish faeces before flowing back out of the bowel like a normal poop. It is a magical process and has really no negative side-effects. However, you don’t need to see a colon hydrotherapist, which is highly expensive, to do it effectively.

There are a number of technical things to consider when you use colonics, or more specifically, the high-volume enema. I have been refining my home technique for a while, and explaining the process of how to use the high-volume enema effectively and comfortably is one of the reasons that I have written this guide.

Enema and Digitation were, together, the **silver bullet** for my condition and have changed my life incredibly. I am so grateful for these processes – I mean I’m beyond grateful. They are incredible! I’m in love with my high-water enema and the E and D process! Let’s let the magic begin...

**The Digitation Process**

You will need:

- A latex glove.
- A small amount of lubricant.

OK – don’t get squeamish about this – it’s all done hygienically and is perfectly comfortable. Let’s go through the technique:

- Put on your latex glove.
• Sit down on the toilet.
• Squeeze a small amount of lubricant onto the index finger of your hand. I would recommend using one of the following: KY Jelly, Durex Internal Massage Lubricant, or Vaseline.
• Lean forward slightly and, placing the gloved hand under your bottom, insert the tip of your index finger about 1-2 cm into your anus. Inside the anal canal, you will feel a band-like muscle around the opening of the anus. This is your external sphincter. Further inside you will also feel another area of muscular tissue – this is the internal sphincter.
• Move your lubricated finger around the inside of the anal canal in a circular motion. Try this palpitation for around 10 seconds – then stop. Often stool will come through very quickly after you do the first digitation.
• Repeat – do a further 10 seconds of circular movements followed by 10 seconds of resting. Repeat this process up to six times or until the stool comes out.

This series alone will normally be enough to produce a bowel motion in constipated patients. If this series of six is not enough, try another series of six – this time increasing the circular motion to fifteen seconds. If you feel that a poop is coming but you have finished the two sets of six, continue to massage the internal sphincter – you will be the best judge of whether it is worthwhile continuing this process. Once you get the hang of the technique you will be able to palpitate the sphincter for longer if that is necessary for you to empty your bowels.

In most cases, you will find this technique of Digitation extremely, even shockingly, effective. If you can’t actually feel the internal sphincter muscle don’t worry about it – it’s there doing its job and you are massaging it when you do the Digitation technique.

The technique is effective for two reasons.

1. It acts as an anal gag reflex – stimulating the walls of the rectum and the lower bowel to contract, to empty out stool.
2. The internal sphincter is in a state of permanent tension throughout the day. This is a good thing, but sometimes this internal sphincter does not relax as it should when you wish to open your bowels – this is anismus. By palpating the internal sphincter you cause it to relax so that stool can come through.

So you can see that Digitation works both by stimulating stool to come through, and also by relaxing the internal sphincter and allowing for evacuation of the stool. It is an amazing technique and can help people with both transit problems and anismus.

If this technique doesn’t work on its own, don’t panic. Combine digitation with the type of enema in the next section and you will see results, I promise.
The High-Volume Enema Process

The High-Volume Enema is the most effective way, in my experience, to treat constipation problems of any kind. I even used it when I still had an unfixed prolapse and it was effective.

Saline and chemical enemas prescribed by doctors work by drawing water down into the lower bowel and irritating the tissues of the bowel/rectum to stimulate a bowel movement.

The **High-Volume Enema** works in exactly the opposite way – you filter water through the anus into the rectum and then up around the bowel. The increased volume in the bowel causes contractions and any sluggish or even impacted stool is pushed back out. You can also use Digitation to complement this process.

**The Technique:**

In my experience, technique is very important when taking a High-Volume Enema. A good set-up and correct technique will make the whole experience more pleasant and efficient for you.

You will need:

- An enema bag
- Lubrication
- Towels
- Optional: a health-step (or books to raise your legs into a squat shape while you sit on the toilet)

With respect to the enema bag, I have tried many different ones and, at the moment by far the best I have found is the **Artsana Bag**. It is manufactured in Italy and sold by Manifest Health in the UK. It can easily be folded up and stored. It’s pretty cool-looking and you actually see the water going down against the half-litre measurements so you can easily tell how much has gone into the bowel, which is very important. I would say it is worth doing an international shipment to get this bag – although, if this is not possible, any other bag which allows you to see the quantity of water going into the bowel would also work well.

The methodology is as follows:

- In almost all bathrooms there is both a bathtub and a toilet. This is the perfect set up for the high-volume enema.
- Fill the bag with pure water at a pleasant temperature (details on controlling water temperature and purity to come in the following FAQs)
- Hang the bag at a height of around five feet in the air. You can use whatever type of stand you need to do this. Fortunately the Artsana enema bag is designed so that it can easily be hooked over a stand of some kind, or a hung on a coat-hanger, or a bath-rail, or even a purposely installed hook in the bathroom wall. Hang the bag on whatever suitable point you have installed next to the bath-tub. If you have nothing at all to hang the enema
bag on then you can always attach it to the tap in the bath but I find that hooking it over a stand makes the process easier.

- Take your clothes off and lie down in the bath. You may want to keep the top half of your body covered just for warmth and comfort.
- Take out your lubricant and lubricate the anus. Then, lubricate the enema tip.
- Insert the enema tip gently and carefully into the anus. Don’t insert it very far – read the instructions on whichever enema bag you purchase for the exact insertion length.
- Hold the enema tip gently in place and turn the tap on the nozzle so that the water begins to flow through. Allow the water to flow into your bowel.
- The first time through, allow half a litre to flow into the bowel before turning the tap and pausing the water.
- Hold the enema for about thirty seconds, or as long as you can, and then go over to the toilet and release. If you find it helpful. put the Health-Step (or other squatting aid) in front of the toilet.
- After the first enema, repeat the process for a second enema, but this time, take a full litre into the bowel if possible. The water moving around the colon can feel uncomfortable. If you find that you have to open your bowels urgently and aren’t able to take in more water or hold it, that’s fine – in fact, it’s more than fine, it’s fantastic: it’s the whole point of the this process! Just go and release the water and stool into the toilet.

**Enema Tips and Pointers**

**Discomfort:** The sense of discomfort you feel during the enema process will be a general sense of bloatedness or fullness. This is most notable when you are taking the water into your bowel, and will pass immediately as soon as you release the water. This discomfort lasts only a matter of seconds and is nothing to worry about. It’s just your central nervous system responding to having a full bowel, and basically strongly encouraging you to find a toilet.

**Holding the water in:** You may also find that you will need to hold a little bit to make sure that the water doesn’t flow back out before you are ready – this is quite easy and is something that you get a feel for, but initially you will want to be aware that you may need to hold the enema at a certain point for a few seconds while you get correctly positioned on the toilet.

**Self-massage to stimulate flow:** After you have taken the enema and before you go to the toilet, self-massage around the abdomen is an excellent way to stimulate the water to flow back out. You can do this self-massage either when you are lying down in the bath, standing up, walking around or sitting on the toilet seat. Start by massaging the lower right side of the abdomen, then move up the right side of the abdomen, across the top of the abdomen below the rib-cage and then move down the left side of your abdomen, down into the left side of the pelvis. This movement
traces several areas of the ascending, transverse, descending and sigmoid colon. This is not an exact trace, but you will massage several important areas of the colon stimulating water and stool to come through.

**If the water doesn't flow from the bag:** Sometimes the water does not flow down from the enema bag immediately. The tip of the enema tube is in the anus, everything is set up and the water just doesn’t flow in. This happens sometimes and it is nothing to worry about. All you need to do is give the enema bag a few nudges and the water will soon come down. You can use the tubing to swing the enema bag a few centimetres from side to side, which will cause the water to flow quickly. Once it is in full-flow, all you need to do to start and stop it is turn the nozzle on or off. After the first and second enemas or wash-outs, you may well feel very satisfied with the result and be happy to end the process there.

Indeed, if you have moved your bowels after severe constipation then you will probably be very happy with the results of one or two wash-outs. If you feel there is more stool to come through, you may try three, four or even five wash-outs of up to one and a half litres to fully empty the colon.

**It is not recommended to do an excessive number of wash-outs:** The reinsertion of the enema tip can cause some irritation to the anus. It is important to take care that you re-insert the tip of the enema bag each time you take some more water, as careless insertion can cause pain. Re-lube the tip and your anus a little each time and be gentle with the insertion.

**Empty the water from the bowel:** It’s also important to try to ensure that the water that goes into the bowel from the enema bag comes back out each time you go back to the toilet. This is mainly for your own comfort as you don’t want to stretch the bowel too much by refilling it before it has emptied. A little water being left in the bowel is absolutely fine, but you don’t want the majority of the enema to still be swilling around in there as it’s uncomfortable. One thing that may happen with people suffering from outlet obstruction is that they may find that the water doesn’t come back out very easily. If this happens there are several things you can do to make the water come through.

1. Stand up and walk around the bathroom a little – this movement almost always stimulates the bowel to push through the liquid and often you will quickly open your bowels.
2. Self-massage. Massage around the bowl – start by massaging the lower right side of the abdomen, then move up the right side of the abdomen, across the top of the abdomen below the rib-cage and then move down the left side of your abdomen, down into the left side of the pelvis. This movement traces several areas of the ascending, transverse, descending and sigmoid colon. This is not an exact trace, but you will massage several important areas of the colon stimulating water and stool to come through.
3. Digitation – The E and D Solution, using Enema and Digitation together. This is, as I have said, the silver bullet for constipation. Even if you have anismus,
or slow transit constipation, the combination of using both the **High-Volume Enema** and then donning the latex glove for the **Digitation** technique is so powerful that the stool must come through. Thanks to the High-Volume Enema, you have a great volume of liquid in the bowel which flows easily. This volume stimulates the bowel on its own. By adding Difitation, you are also providing stimulation and effectively activating the rectal gag reflex from the other side. You are also palpitating your pelvic floor and helping the anal side of the pelvic floor to relax. In effect, you are causing a bowel motion powerfully from both inside the bowel and outside it – it is a great combination.

**Finishing up:** Ending on a 300ml-to-half a litre wash out is a great way to ensure that there is no more residue left in the rectum. It’s delightful, beautiful, time-effective and allows you to get on with your life!

**Side Effects:** In my experience of this procedure, there have been NO side-effects. There is the possibility that a small amount of water will remain in the bowel, but this need not be the case thanks to self-massage and Digitation. Should this happen, however, and a little splash of water remains, there is no danger. As we have noted, one of the functions of the lower bowel is to absorb water into your body, so you are actually just hydrating yourself a little more.

This is one of the great things about this approach – it is in harmony with your body's processes. You may find that you also need to urinate after the enema – this is perfectly normal and very common. Your bowel has absorbed water and any extra water that you don’t need passes out of the system in your urine.

As stated, you can occasionally get a minimal level of irritation to the anus from the nozzle of the enema bag, but even this will not occur if you are gentle each time you insert the nozzle and take care to put a little lubricant on the nozzle each time you re-insert it. The very few times I’ve experienced this, it has been due to my own carelessness upon inserting the nozzle when going for a third or fourth wash-out.
FAQs for the E and D Solution

*Is it messy?*

Occasionally little splashes might leak out while you are lying down in the bath, or on the few steps that you take from the bath/floor to the toilet. This happens to me every so often but, frankly, it’s not a big deal and is easily dealt with. If you have a marble or laminate floor you can just mop it up – it’s only a bit of liquid. If you have a carpeted bathroom you can simply put a few towels down. I usually have one in the bath – more because it’s comfortable to lie on than anything else. I put down another towel en route from the bath to the toilet and one just in front of the toilet. You can keep these towels as your enema towels and just wash them afterwards if there are any little stains.

*How long does it take?*

I used to like to set aside an hour for the process of taking the enemas, and then half an hour to have a relaxing bath afterwards. However, as time has gone on I have found that I can do the process at a relaxed place in about half-an hour. You really only need one or two wash-outs with the High-Volume Enema to pass enough stool to allow you to be very comfortable for a couple of days.

Overall, now I’d say that I spend 30-40 minutes on this procedure every couple of days. This is such a trivial amount of time that the E and D process just slots into my routine with little effort or forward planning these days.

*What water source should I use?*

Water will be flowing from your enema bag into your bowel. You will want to control both the purity and the temperature of the water. Most people advocate bottled water such as Evian or Volvic to be sure of its purity.

If you are in a country or city where the water supply is of questionable purity, then it is certainly essential to use good quality bottled water. In my city I am perfectly happy to drink cold tap water, so I assume it is pure enough to go into my bowel. It would be weird to drink water and then say that I wasn’t happy with it going into my body from the other end!

Some practitioners insist on using purified water even when your water source is already clean – I’m not sure I see the point in doing this if you’re one hundred per cent sure that your water source is clean enough to drink. I’m happy to use the tap water in my area – I have researched its purity and I’m completely comfortable using it. I would suggest doing this to ensure that the water you use is equally purified.

As to the question of temperature control: For getting the temperature right, one option is to mix your cold water with water from the hot tap and check the temperature with a thermometer before inserting it into the bowel. I find a
temperature around 25-27 degrees is pleasant. This is the most simple way of doing things.

The most effective, quick and easy way to control both the temperature and the purity of the water is to stream water from a colonic irrigation unit, which you can have installed in your bathroom. I had a colonic irrigation unit installed in my bathroom because I wanted to try it as an alternative to the high-volume enema. I found that the stream from the colonic irrigation unit was far too powerful and uncomfortable, and I found the tip caused a lot of irritation. When I decided to go back to the High-Volume Enema, however, which was much more comfortable than using the colonic irrigation unit, I now had the perfect means of getting pure water through at the right temperature! I select the temperature I want with my Superstream B colonic irrigation unit and then fill up the enema bag with the water from the colonic irrigation unit. The water goes through an extra purification process in the Superstream so I can be perfectly happy that it is coming through pure.

*What? You use a colonic irrigation unit and an enema bag...?*

I used to! It may seem strange to use a more expensive piece of equipment as a water purifier but that really didn’t concern me at all, especially because I’d already purchased the unit. What truly concerned me was crapping comfortably. All that said, over time I continued to test the process and I have concluded that simply using the Artsana enema kit alone with a clean water supply is all you actually need. The water-purification process taking place in the colonic irrigation unit obviously wasn’t really necessary as I live in a country with a clean water supply. I have also travelled around Europe (Italy and France) using nothing but the Artsana enema kit and tap water. I have had no problems whatsoever with this. As long as you have access to clean water, this technique works without side-effects.

*Should I try the Enema or Digitation first?*

I would personally advocate using the High-Volume Enema first. The Digitation procedure is immediately accessible, so by all means try it if it’s all you can do right now. I do believe that using the enema is the most effective solution, and the combination – the E and D Solution – will serve even more effectively if it is required.

You have the option of trialling High-Volume Enemas alone, Digitation alone, and/or the E and D Solution. When you find an approach that works best for you, you will know without a doubt which one it is.

It wasn’t until I started using the High-Volume Enema that I gained complete control over my constipation.

*What about caffeine enemas and other herbal enemas?*

I don’t really know of any research into this area. I think this may be more of a health fad for people looking for a ‘well-being’ kick than a treatment for patients
with long-term, serious constipation. Caffeine is a relatively strong chemical and I don’t really see the logic of introducing caffeine into the bowel through a coffee enema, or introducing any other herbs for that matter, when pure water is perfectly adequate. The bowel is designed to deal with water, so why complicate matters. I personally won’t be trying either of these options, but I’m open to hearing other’s people’s experiences on the effects.

What does the E and D Solution cost?

The enema bag, plastic gloves and lubrication can be ordered online. Alternatively, the plastic gloves and lubrication can be bought in most health or pharmaceutical supply shops, including Boots in the UK.

The Artsana enema bags can be bought on Amazon and also from www.ManifestHealth.co.uk.

You can buy different enema bags, and I have tried many, but this is the one that I recommend. They need to be cleaned and replaced every few months if you are using them as a life-style aid.

The most expensive piece of kit – which is completely optional, and as I explained, largely unnecessary for effectiveness, but allows for very precise temperature control – is the Superstream B colonic irrigation unit which comes at about £1100. It is expensive but gives you water at exactly the right temperature and purity. I used my Superstream B for about a year and found it to be a valuable investment. These days, however, I simply stick with the Artsana enema bag. When compared to the price of going to see a colon-hydrotherapist the Unit will pay for itself within three months. Personally, I used the enema bag with cold water alone for a year before investing in a colonic irrigation unit.

It’s incredible that the most effective way of dealing with chronic constipation is also extremely cheap.

The estimated cost is the following:

4-8 enema bags + lubrication + gloves over a year = £120 - £240

Cleaning materials - £30

Total cost for the year = £150 - £270

This works out at around £1-£2 per enema session.

In my view, the process is almost miraculous. It’s incredibly cheap compared to laxatives and even more so compared to operations – and yet in my experience it is far more effective than either and causes far fewer (in my case, zero) side-effects. Beautiful! Even if you decide to invest in your own colonic irrigation unit to control water temperature and purity, this will only put the cost of the enema up to about £12 per enema over the first year. After that, the irrigation unit is paid for.
E and D as a Lifestyle Choice

I use High-Volume Enemas now as the only means of dealing with constipation. I use my High-Volume Enema every second day, so that's three to four times per week. I usually like to make the time as enjoyable as possible – in a way I consider it ‘me’ time in which I can just relax my mind. I’ll often take a magazine or a book to read while I’m going through the process. Once you’ve done the process for a few weeks it becomes very easy and really requires no effort, so you can take some reading material in without a problem.

I also like to make sure that the bathroom is at a very comfortable warm temperature for the process.

I like the enema to be the beginning of a few hours of relaxation, but equally I have used it before work or a social engagement if it feels necessary.

In the past I always took a warm bath straight after the enema to relax all my muscles. Then I would usually lie around for half an hour or so reading, and then take twenty minutes to do some mindful meditation before either going to sleep or getting on with whatever plans I have. These days, though, I’m busier and I will often do the enema, have a shower, relax for 5 minutes and then get straight on with my day. The entire process including showering and a short relaxation takes about 50 minutes. However much time you choose to spend on the process, it is time well invested. Feeling healthy and constipation-free is most certainly worth it – you are certainly worth it!

If you have been dealing with chronic constipation for while, it is a very difficult problem and it’s important to have compassion for yourself throughout the whole process. Be kind to yourself. Relax. Enjoy your new-found freedom from constipation.

Other Notes

Exercise

Generally, moderate amounts of exercise are good for constipation, as well as your general health. For prolapse patients, activities which put the pelvic floor under a large amount of pressure are generally to be avoided, as this can push the prolapsed tissue further through.

The main exercises to avoid are abdominal crunches or sit-ups. These are terrible for both rectal prolapse and vaginal/pelvic prolapse in women. The abdominal muscles are hugely powerful muscles and doing crunches makes them push down on the pelvic organs. I personally believe that they are one cause of
prolapse. From a fitness point of view, they aren’t even the best exercises for the abdominal muscles. You can still exercise the abdomen effectively without sit-ups – I personally advocate planks and other core exercises, which you can find online or in many fitness guides.

Also check out the “Kegel Queen” online if you are dealing with prolapse. She goes over tips on exercising and is a great resource for women with rectal and vaginal prolapse.

I personally think that patients who have suffered rectal prolapse should also avoid doing heavy weights. This is because when you lift weights to your maximum capacity, you may put strain through your abdominals and pelvis in the same way that you would if you were straining to take a poop. This is particularly the case for squats or bench presses. I only include light, manageable weights in my own programme anymore as I just don’t see that it is worth taking the risk. There are yoga poses that you can do which work your arms and back isometrically and build up strength without putting a huge amount of strain through the abdominals and pelvis.

It’s also essential to build up very slowly to the more demanding strength work so that you put the force through your muscles and don’t over-strain into your abdominals and pelvis. After my surgery I did three months of very little exercise, followed by a year of yoga and tai chi, followed by three months of more demanding yoga poses and isometrics, followed by three months of isometric poses with free weights. It is only in the last three months that I have begun to introduce selected dynamic weight lifting movements.

There is no rush with fitness and strength – it is far more important to be consistent. Work a programme of three or four sessions into your week if you do decide to work on your strength and fitness.

**Pelvic Floor Exercises**

If you have anismus, this is a spasticity of the pelvic floor, so your pelvic floor is already in a state of contraction. Pelvic floor exercises are likely to make your pelvic floor tighter still, so are probably best avoided for patients of anismus or at least if they are undertaken they should also be done alongside relaxation exercises to try to introduce some suppleness into the pelvic floor.

For patients who are suffering from rectal prolapse, pelvic floor exercises can be a helpful way to reduce the prolapse, or at least reduce the symptoms of the prolapse.

For patients who have already undergone surgery for prolapse, pelvic floor exercises are often recommended. I found these to sometimes be quite painful when done after my operation.

I personally do daily kegel workouts as good musculature in the pelvic floor should help prevent further prolapse and the need for surgery. For patients with slow
transit constipation, it is unlikely that pelvic floor exercises will make a great deal of difference, good or bad, to your symptoms.
Final Thoughts

Why did I share this guide?

For about 12 months after I’d been using E and D process as a life-style solution, I had wanted to tell people about it. The reason that I didn’t go about writing this guide for a while is because the last few years have been extremely testing and at times traumatic. Rectal prolapse and problems of extreme constipation basically ruined my life for a couple of years, and it is uncomfortable and unpleasant to think back to those times. This is why I put off writing this guide because in a way it has brought back up unpleasant memories.

However, in the end I took the attitude: _fuck it, it’s better to face these memories and let go of that pain_. I also realize that it was this suffering and experience that prompted me to do my own research and which has eventually led me to where I am today, with a pretty refined E and D system. I’m very happy about the impact of the E and D Solution on my own life, and I would like to offer useful information to people who may be struggling with severe constipation.

I still haven’t seen much useful information out there for people suffering colonic inertia, rectal prolapse and anismus so it has got to the point where I feel it’s important to put this information out there in a clear structure, jargon-free. If this product can help people who are affected by long-term, severe constipation then it will have served its purpose. The process is simple, inexpensive and beautifully effective, and I hope you enjoy it!

If you have any questions, please feel free to email me directly:

marquezjoseph1@gmail.com
Useful References

Here is a list of useful references that you may want to have a look at regarding the material contained in this report. I have referred often to my own extensive experience and research. I subscribe to a number of sites aimed at gastroenterologists and proctologists, and frequently purchase medical papers to ensure that I am aware of all new developments in the field.

As I mention in the beginning of this paper, unfortunately the treatment offered in most GPs and specialists' offices lags far behind the needs of patients. The method I outline is far more gentle, user-friendly and cost-effective than any other treatments I have tried.

For your interest as a reader and confidence in this method, I can point you in the direction of a few easily available online resources which are individually quite useful:

**Products**

www.manifesthealth.co.uk - Artisana Enema kit. In Europe thus is certainly the best on the market – it’s easy to use, transport and store.

The Superstream colonic irrigation Unit can be purchased from: www.colontherapysupplies.co.uk

**Papers**

Botox treatment for anismus:

http://xa.yimg.com/kq/groups/19365734/1389170111/name/anismus.pdf

Medline Plus:


In depth guide for nurses in the UK (this is also worth reading if you are a patient treating yourself):


Good general resource:

http://www.ddc.musc.edu/public/symptomsDiseases/diseases/colon/colonicInertia.cfm