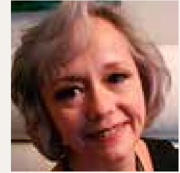
# ask the SPIN DOCTOR



Q: "I've been dreading an upcoming colonoscopy because of how hard the preparation is. I'm afraid of getting a pressure sore from sitting on the toilet that long and I don't have enough caregiver time to help me with it. Is it really necessary?" asks Simran in Kamloops. We asked Dr. Karen Smith, Physiatrist and Emeritus Professor in Physical Medicine and Rehabilitation at Queens University, and co-author of the *Actionable Nuggets* (www.actionnuggets.ca).

Simran, you are not alone in feeling this way as preparing for a colonoscopy can be challenging. It is important to discuss the medical reasons for colonoscopy with your physician and how bowel preparation could be adjusted to make it practical and safe for you.

There are some conditions where a colonoscopy for colon cancer screening might be unavoidable, such as a family history of colon cancer (cancer in a first-degree relative, such as a parent, brother, sister, or child), a personal history of precancerous polyps, or inflammatory bowel disease.

In our brief clinical guidance resource on primary care for people with SCI, the *Actionable Nuggets* (4th Ed.), we advised, "Initiate colorectal cancer screening for patients with SCI using the same principles as those for the general population."

Colorectal cancer is about as common in individuals with SCI as the general population but harder to screen for and often diagnosed at a more advanced stage. Decreased sensation and mobility can prevent individuals with SCI from recognizing symptoms that would be evident to someone without SCI. Because symptoms of colorectal cancer relied on for screening, such as rectal bleeding, are seen more often in people living with SCI due to neurogenic bowel, routine screening for colorectal cancer is essential.

As with the general population, individuals with SCI between the ages of 50 and 74 years with no family history should be screened for colorectal cancer according to current Canadian guidelines, which have been updated with the availability of the fecal immunochemical (FIT) test.

People are considered to be at average risk of colorectal cancer if they are aged 50 to 74 years with no first-degree relatives who have been diagnosed with colorectal cancer, and who have no personal history of pre-cancerous colorectal polyps or inflammatory bowel disease.

People at average risk and asymptomatic for colorectal cancer should be screened with a FIT test every 2 years (abnormal FIT results should be followed up with colonoscopy within 8 weeks). Those who choose to be screened with flexible sigmoidoscopy (FS) rather than a FIT test should be screened every 10 years.

FIT tests are at-home test kits provided by a clinician that check stool for very small signs of blood and do not require any special bowel preparation. However, because rectal bleeding is both a symptom of colorectal cancer and very common after SCI, flexible sigmoidoscopy is the screening test recommended for people with SCI if they have a history of rectal bleeding. Flexible sigmoidoscopy is performed by a trained medical professional who uses a narrow, flexible tube fitted with a light and camera to look inside the lower part of your colon. It is a less invasive test that involves less bowel preparation than a colonoscopy.

Colonoscopy is not recommended to screen for colorectal cancer in individuals at average risk. Preparation for colonoscopy, which permits direct visualization of the large bowel in its entirety, is a significant ordeal for someone with neurogenic bowel, to the extent that it is often incomplete and produces compromised results. It is recommended only in the case of a positive screening test. In some cases, colonoscopy for individuals with SCI is done in an inpatient setting; however, inpatient admission for elective procedures can be difficult to access. A consultation with a gastroenterologist may also be required, but this is often not available in many regions. Given this, a physiatrist can be a good starting point for planning the procedure.

When colonoscopy is recommended, how can it be accomplished with the least risk to skin and autonomic dysreflexia (AD), without increased caregiver support, and with the greatest chance of successful screening? Preparation for a colonoscopy typically involves changing to a clear liquid diet. However, alternatives suggested for colonoscopy bowel prep indicate that a more prolonged period of clear fluid diet of three days, in addition to magnesium citrate, polyethylene glycol (PEG) 3350 and/or electrolyte lavage solution orally had 89 percent adequate colon preparation. I recommend to my patients with SCI to prolong the period of clear fluid diet to three days but otherwise follow the recommendations of the colonoscopy unit, usually involving a combination of oral laxatives.

I encourage my patients to work with their care team to explore the possibility of additional care in the home, using measures to reduce the time needed on the commode, such as briefs or blue pads for the first few hours, or the possibility of respite care in your area. If you are at high risk of AD, I strongly recommend that you speak with your doctor or physiatrist about completing the later portions of the bowel preparation under some supervision or with a clear plan in the event you experience autonomic dysreflexia.

Everyone's situation is unique but I hope this gives you some reassurance and information to work with your healthcare provider to do what is best for you.