# Assessment and Treatment of Faecal Incontinence

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# Normal bowel control

- Bowel control is a complex but poorly understood skill
- One of our first socializations as a child
- Defecation is as normal as eating but "not nice" to talk about, a taboo subject
- Defecation became privatized in Europe round about the 16th century
- Its only when something goes wrong that we realise what functions we take for granted

"The first thing I learnt was the three p's - peeing, poohing and puking."

# Prevalence of Anal Incontinence

- Prevalence of anal incontinence (AI) in adults is 7% - 15% (ICI 2017)
- Dependent on definition
- Tip of the iceberg as difficult to ascertain accurate data due to reluctance to report symptoms or seek treatment
- Women more willing to report than men (Nelson et al 1995)
- Faecal Incontinence is almost as common in men as in women (ICI 2017)
- More studies carried out on the female population due to correlation with childbirth

# Prevalence of Faeacal Incontinence

- Significant risk factors are increasing age, diarrhoea and coexisting urinary incontinence (UI)
- Faecal incontinence in care homes is estimated to range from 10% to 50% (ICI 2017)

More prevalent among individuals with

- inflammatory bowel disease
- coeliac disease
- irritable bowel syndrome
- diabetes

(Menees et al 2018)

# Cost to the patients

- Personal health
- Hygiene problems
- Restrict employment
- Educational or leisure opportunities
- Lead to embarrassment and exclusion
- It may result in abuse of adults in the workplace and older people in residential care or nursing homes
- 60% avoid going away from home
- 50% feel odd or different from others
- 45% avoid public transport
- 50% report avoiding sexual activity through fear of incontinence

Fear of not being near to a toilet!!

# Assessment

- Assessment needs to be initiated with sensitivity
- Focused medical history and condition-specific history
- Clinical examination to include Perianal and digital rectal examination
- The affects on individual’s lifestyle and quality of life
- Past surgical & obstetric history, co-morbidities and current medication, including laxatives

# Assessment

- The main symptoms and how it bothers the patient
- Bowel habit – frequency,  now and previously
- Onset and duration of the symptoms
- Differentiate the type of faecal incontinence - passive, urge, flatus or functional
- Urgency present
- Timing - such as post defecatory leakage
- Stool consistency according to Bristol Stool Form Chart
- Colour, smell, mucus, blood or undigested food
- Consider using a bowel diary to assist in the assessment

# Use of questionnaires to enhance assessment

- Faecal Incontinence Quality of Life Scale (FIQL) (Rockwood, 2000)
- Modified Manchester Health Questionnaire (Kwon et al 2005)
- Bowel version of the International Consultation on Incontinence questionnaire(ICIQ-B) (Cotterill et al 2011)
- Symptom severity scores

# St. Mark's Score

*Vaisey CJ et al 1999*

| | *Never* | *Rarely* | *Sometimes* | *Weekly* | *Daily* |
|---|---|---|---|---|---|
| Incontinence for solid stool | 0 | 1 | 2 | 3 | 4 |
| Incontinence for liquid stool | 0 | 1 | 2 | 3 | 4 |
| Incontinence for gas | 0 | 1 | 2 | 3 | 4 |
| Alteration in lifestyle | 0 | 1 | 2 | 3 | 4 |
| | | | | *No* | *Yes* |
| Need to wear a pad or plug | | | | 0 | 2 |
| Taking constipating medicines | | | | 0 | 2 |
| Lack of ability to defer defecation for 15 minutes | | | | 0 | 4 |

Never, no episodes in the past four weeks; rarely, 1 episode in the past four weeks; sometimes, >1 episode in the past four weeks but <1 a week; weekly, 1 or more episodes a week but <1 a day; daily, 1 or more episodes a day.

Add one score from each row: minimum score = 0 = perfect continence; maximum score = 24 = totally incontinent.

# Cleveland Clinic Fecal Incontinence Score

Jorge & Wexner 1993

| Type of incontinence | Frequency<br>Never | Rarely | Some-times | Usually | Always |
|---|---|---|---|---|---|
| Solid | 0 | 1 | 2 | 3 | 4 |
| Liquid | 0 | 1 | 2 | 3 | 4 |
| Gas | 0 | 1 | 2 | 3 | 4 |
| Wears Pad | 0 | 1 | 2 | 3 | 4 |
| Lifestyle Alteration | 0 | 1 | 2 | 3 | 4 |

*Never: 0 Rarely: <1month*
*Sometimes: <1/week, ≥1/month Usually: <1/day, ≥1/week*
*Always: ≥1/day 0= perfect continence*
*20=complete incontinence*

# Baseline bowel diary

**Patients name** **Hospital number** **Date started / /**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Controlled bowel movements(no incontinence)** | | | | | | | | | | | | | | |
| How many times did you go to the toilet (controlled) | | | | | | | | | | | | | | |
| How many times did you go **in a rush** to reach the toilet | | | | | | | | | | | | | | |
| **Uncontrolled bowel movements (incontinence)** | | | | | | | | | | | | | | |
| How many times did you **NOT** make it in time to the toilet? | | | | | | | | | | | | | | |
| How many times did you not feel the bowel movement but only afterwards (leakage without being aware) | | | | | | | | | | | | | | |
| **Staining / minor soiling of underwear** | | | | | | | | | | | | | | |
| Did you stain/soil your underwear pants or pad today? | | | | | | | | | | | | | | |
| **Pad/enema/suppository usage** | | | | | | | | | | | | | | |
| Pad used for incontinence? (yes or no) | | | | | | | | | | | | | | |
| Enema/suppository administered? (yes/no) | | | | | | | | | | | | | | |
| **Social functioning** | | | | | | | | | | | | | | |
| Did your faecal incontinence limit you in your daily activities (eg leaving the house shopping etc)? | | | | | | | | | | | | | | |
| Stool consistency what was your stool consistency today (circle one) | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid | Solid Mushy Liquid |

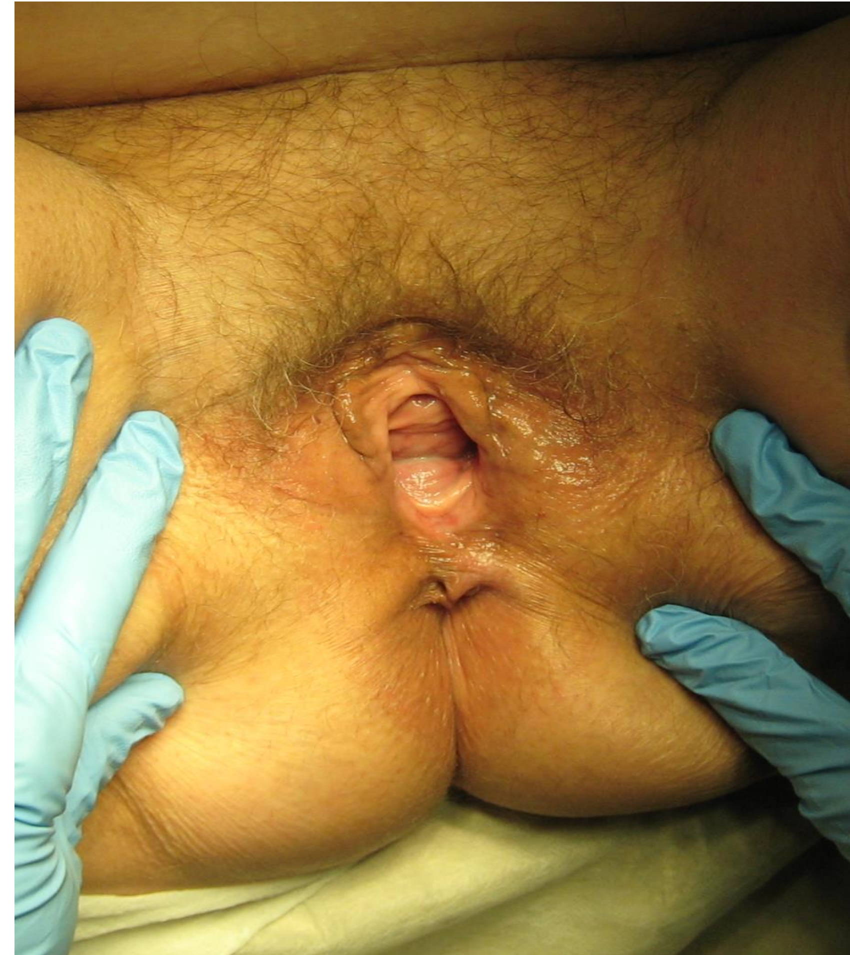
Please also answer these questions as will help in pre operative assessment

1. When you get the urge how long can you defer going to the toilet (circle one) **not al all <1min 1-5min 5-15min more**
2. Do you have to strain to empty your bowel? (circle one) **Never sometimes frequently always**
3. Are you able to empty your bowel completely? (circle one) **Never sometimes frequently always**
4. Do you experience urinary incontinence? (circle one) **Never sometimes frequently always**
5. If yes (urinary incontinence) how many pads do you use per day? (circle one) **0 1-3 4-7 >7**
6. Please rate the degree of urinary urgency prior to voiding? (circle one) **none mild moderate severe**

# Perianal Inspection

Observation of perineum for:-

- Scars from previous surgery or obstetric injury
- Perianal disease - prolapsing haemorrhoids, prolapse fistula, anal warts etc
- Presence of sensory deficits
- Absence of perineal body - suggestive of obstetric trauma
- Faecal soiling

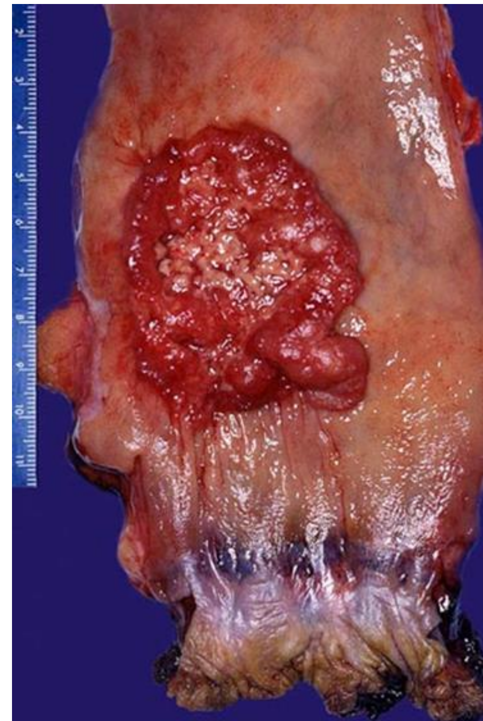


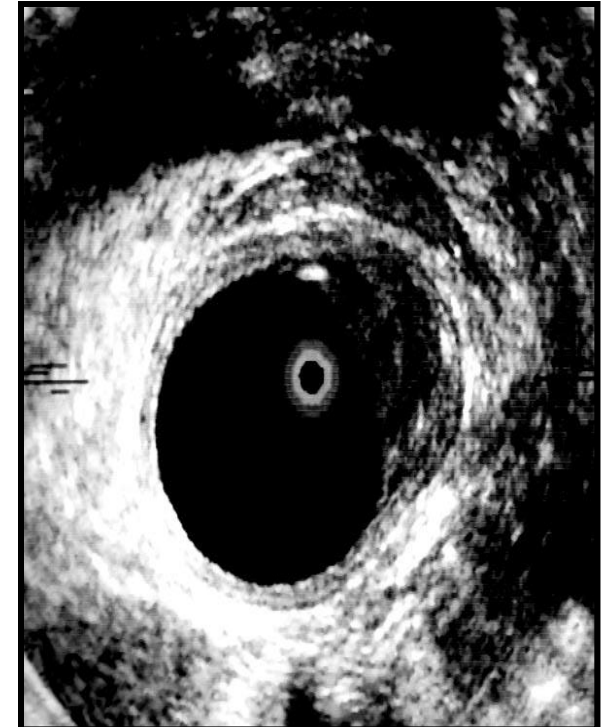
# Digital Rectal Examination

- Rectal contents
- Rectal tumour or mass
- Resting tone - indicative of internal anal sphincter function
- Voluntary and reflex squeeze pressure - indicative of external anal sphincter function
- Function of the puborectalis muscle
- Regional sphincter defects - detected as asymmetry.
- Paradoxical puborectalis contraction

Rectal carcinoma

- 20% present with sole symptom of faecal incontinence





# Conservative treatment for faecal incontinence

Address co existing conditions before progressing to initial management of faecal incontinence (NICE CG49, 2007)

- Impaction
- Treatable causes of diarrhoea
- Warning signs of lower gastrointestinal cancer
- Rectal prolapse
- Ano rectal injury
- Acute disc prolapse

# Conservative treatment for faecal incontinence

- Educating and empowering the patient
- A personalised treatment plan
- Explanations on defecatory dynamics

Specialist treatment could include (NICE, 2007)

- Specialist dietary assessment and management
- Pelvic floor muscle training (PFMT)
- Bowel retraining
- Biofeedback
- Rectal irrigation

# Foods and fluids which may aggravate the bowel and alter stool consistency

- Eat regular meals – timing
- Increase water intake
- Soluble dietary fibre with moderate fermentability
- Probiotic drink or bio yogurt daily
- Reduce or increase fibre
- Avoid vegetables such as onions, garlic, mushrooms, beans and brassica
- Avoid liquorice, chocolate and dried fruit
- Avoid sugar free products especially if they have sorbitol in them
- Peel fruits such as pears and apples

# Biofeedback and PFMT

- Its about building a relationship of trust and care with the patient so they feel safe, enabling them to talk about their problem
- Biofeedback augmented by PFMT with experienced therapist more effective than PFMT alone (Sjodahl et al 2015, Damon et al 2014)
- Biofeedback treatment programmes improves faecal incontinence, quality of life, anxiety and depression
- Biofeedback regimes with less face-to-face treatment are just as effective as face to face regimes (Young et al, 2018)
- Urgency resistance training for defaecation urgency (ICI, 2017)

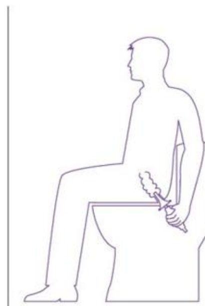
# The use of medication

- The most useful medication is Loperamide syrup (NICE 2007, ICI 2017)
- ½ - 1 tsp (1mg per tsp) is often enough
- 0.5 -16mg can be used in a day
- Psyllium fibre (ICI 2017)

# Use of Products

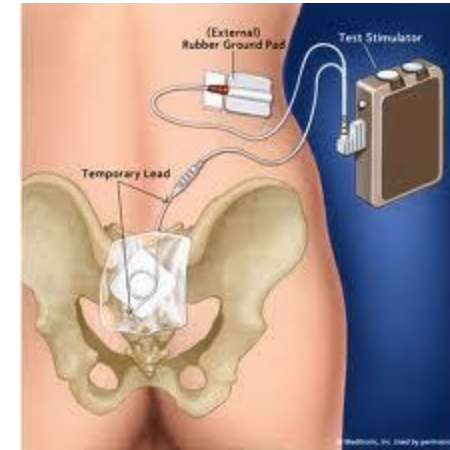
Advice on products such as

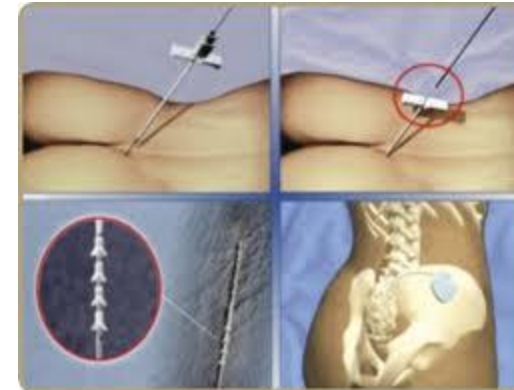
- Anal inserts/plugs
- Suppositories
- Trans anal irrigation (NICE 2018)
- Skin care products



# Sacral nerve stimulation

- Sacral nerve stimulation (SNS) recommended trial if sphincter repair fails or inappropriate
- Potential benefits and limitations of this procedure should be explained.
- A trial stimulation period of at least 2 weeks to determine if they are likely to benefit.
- If improvement shown then permanent implant implanted
- Patients being considered for SNS should be assessed and managed in a specialist centre with experience
- Expensive £13,000 needs to be commissioned



# Combined pelvic floor clinic

If no improvement with conservative treatment consider onward referral

- Consultant Urogynaecologist
- Consultant Colorectal Surgeon
- Colorectal Nurse Specialist
- MDT Discussion

# Thank You For Listening

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