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
• It’s only when something goes wrong that we realise what functions we take for granted
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 Faecal 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*

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Weekly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence for solid stool</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Incontinence for liquid stool</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Incontinence for gas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Alteration in lifestyle</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Need to wear a pad or plug**
No | Yes

**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**

<table>
<thead>
<tr>
<th>Type of incontinence</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>Solid</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Liquid</td>
<td>0</td>
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<tr>
<td>Gas</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>Wears Pad</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Lifestyle Alteration</td>
<td>0</td>
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<td>2</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Patients name</th>
<th>Hospital number</th>
<th>Date started</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td><strong>Controlled bowel movements (no incontinence)</strong></td>
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<tr>
<td>How many times did you go to the toilet (controlled)</td>
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<tr>
<td>How many times did you go in a rush to reach the toilet</td>
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<td><strong>Uncontrolled bowel movements (incontinence)</strong></td>
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<tr>
<td>How many times did you NOT make it in time to the toilet?</td>
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<td>How many times did you not feel the bowel movement but only afterwards (leakage without being aware)</td>
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<td><strong>Staining / minor soiling of underwear</strong></td>
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<tr>
<td>Did you stain/soil your underwear pants or pad today?</td>
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<td><strong>Pad/enema/suppository usage</strong></td>
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<tr>
<td>Pad used for incontinence? (yes or no)</td>
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<tr>
<td>Enema/suppository administered? (yes/no)</td>
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<td><strong>Social functioning</strong></td>
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<tr>
<td>Did your faecal incontinence limit you in your daily activities (eg leaving the house shopping etc)?</td>
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<tr>
<td>Stool consistency what was your stool consistency today (circle one)</td>
<td>Solid</td>
<td>Mushy</td>
<td>Liquid</td>
<td>Solid</td>
<td>Mushy</td>
<td>Liquid</td>
<td>Solid</td>
<td>Mushy</td>
<td>Liquid</td>
<td>Solid</td>
<td>Mushy</td>
<td>Liquid</td>
<td>Solid</td>
<td>Mushy</td>
<td>Liquid</td>
<td>Solid</td>
</tr>
</tbody>
</table>

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 at 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
REFERENCES


• Vaizey CJ, Carapeti E, Cahill JA, Kamm MA. Prospective comparison of faecal incontinence grading systems. Gut 1999;44:77-80.


• Young CJ; Zahid A; Koh CE; Young JM; Byrne CM; Solomon MJ; Rex J; Candido JA. A randomized controlled trial of four different regimes of biofeedback programme in the treatment of faecal incontinence. The official journal of the Association of Coloproctology of Great Britain and Ireland; Apr 2018; vol. 20 (no. 4); p. 312-320 Outcomes for entire group