



UNITED GASTROENTEROLOGISTS

Patient Education Sheet

FECAL INCONTINENCE OVERVIEW

Fecal incontinence refers to the involuntary loss of gas or liquid stool (called minor incontinence) or the involuntary loss of solid stool (called major incontinence). Surveys indicate that it affects between 2 and 7 percent of the general population, although the true incidence may be much higher since many people are hesitant to discuss this problem with a healthcare provider.

Minor fecal incontinence affects men and women equally, but women are almost twice as likely as men to report major incontinence. Fecal incontinence is also more common in older adults. It is particularly common in nursing home residents: studies suggest that almost half of all residents are incontinent.

Fecal incontinence can undermine self-confidence, create anxiety, and lead to social isolation. People who suffer with fecal incontinence should learn as much as possible about their condition and discuss their symptoms honestly with their clinician. Fecal incontinence is a treatable condition; treatment can lessen symptoms in most cases and can often completely cure incontinence.

FECAL INCONTINENCE CAUSES — Continence requires the normal function of both the lower digestive tract and the nervous system. The anal sphincters, along with the pelvic muscles that surround the end of the digestive tract, ensure controlled movement of digestive tract contents. There are many possible causes of fecal incontinence; in most cases, incontinence results from some combination of these causes.

Damage to the anal sphincters — The internal and external anal sphincters are the muscles located at the end of the rectum. These muscles and the surrounding pelvic muscles create a barrier that prevents the escape of feces. Any damage to or loss of control over these sphincters can lead to incontinence. Damage most commonly occurs during vaginal childbirth and anal surgery.

Neurologic causes — Neurologic disorders such as diabetes, multiple sclerosis, and spinal cord injury can decrease sensation and control over the lower digestive tract. Nerve damage during vaginal childbirth can also decrease anal sphincter function.

Decreased distensibility of the rectum — Conditions such as inflammatory bowel disease (eg, Crohn's disease and ulcerative colitis) and radiation-induced inflammation of the rectum (radiation proctitis) can impair the rectum's ability to expand and store fecal matter.

Fecal impaction — When hardened feces accumulates in the rectum, this can cause the anal sphincters to relax and allow liquid stool to escape around the blockage. Fecal impaction is a common cause of incontinence in older adults. Factors that make impaction more likely include certain mental health conditions, immobility, and loss of rectal sensation.

Diarrhea — Diarrhea of various causes, including irritable bowel syndrome, active inflammatory bowel disease, or acute gastroenteritis, can lead to loss of liquid stool. In some cases, if the diarrhea is treated, the person will be able to control their incontinence.

Unknown causes — In some cases, the cause of fecal incontinence cannot be identified; this is called idiopathic incontinence. Idiopathic incontinence most commonly occurs in middle-aged and older women.

FECAL INCONTINENCE DIAGNOSIS — The underlying cause of fecal incontinence can often be established with a combination of a medical history, a physical examination, and diagnostic tests.

Diagnostic tests — Diagnostic tests are particularly useful in pinpointing the cause and ensuring the correct treatment. One or more tests may be recommended, based upon the suspected cause(s) of incontinence.

Direct examination — Colonoscopy (examination of the entire colon), sigmoidoscopy (examination of the terminal part of the colon), or anoscopy (examination of the anal canal) may be recommended. These tests can help identify inflammation, tumors, and other disorders that can cause fecal incontinence.

Anorectal manometry — Anorectal manometry measures the internal pressure in different areas of the lower digestive tract under different conditions. This test can identify several of the different causes of incontinence and may be especially useful in revealing poor tone of the anal sphincters. Manometry can also be used to determine if rectal sensation and rectal reflexes are impaired.

Ultrasound — An ultrasound examination of the rectum can reveal abnormalities of the anal sphincters, the rectal wall, and the pelvic muscles that help maintain continence. This test is the safest and most reliable test for identifying structural abnormalities of both anal sphincters.

Stool tests — Stool testing may be done to determine if there is an underlying reason for diarrhea (eg, infection).

FECAL INCONTINENCE TREATMENT — Three types of treatment are commonly used for fecal incontinence: medical therapy, biofeedback, and surgery. The specific treatment(s) recommended will depend upon the underlying cause of fecal incontinence.

Medical therapy — Medical therapy includes medication and certain measures that can reduce the frequency of incontinence and firm the stools, which can reduce or eliminate episodes of fecal leakage.

Often, basic measures will improve minor incontinence, but more aggressive measures may be needed to control frequent or severe episodes of leakage.

Bulking substances — Substances that promote bulkier stools may help control diarrhea by thickening the stools. [Methylcellulose](#) (a form of fiber) is one type of bulking substance that is commonly used. Increasing dietary fiber may also help to bulk stools

Medications that reduce stool frequency — The frequency of stools can be reduced with medications that are usually prescribed for diarrhea, such as [loperamide](#) (Imodium®) and [diphenoxylate](#) (Lomotil®). Loperamide can also increase the tone (tightness) of the anal sphincter muscle.

Anticholinergic medications — When taken before meals, anticholinergic medications (such as the prescription drug [hyoscyamine](#)) can decrease the incontinence that occurs after meals in some people. The medications work by reducing contractions in the colon.

Solesta- A gel that is given through 4 injections into the wall of the anal canal. It helps give you more control by bulking up the tissue in the anal canal. Since the injections are well tolerated by most patients, anesthesia is not necessary.

Visit the web site: Solestainfo.com for more information

Treatment of impaction — People who have become impacted (when the rectum is full of hard stool) may need to have this stool removed in the office. After disimpaction, the person will be given one or more medications to keep the bowels moving on a regular basis.

Defecation programs — When incontinence is related to a disability or mental health condition, a clinician will often recommend a scheduled toileting program. This usually involves sitting on the toilet at a regular time every day, after a meal. Incontinence is less likely to occur if the person empties their bowels regularly.

Biofeedback — Biofeedback is a safe and noninvasive way of retraining muscles. During biofeedback training, sensors are used to help the person to identify and contract the anal sphincter muscles, which help maintain continence. This is usually done in a healthcare provider or physical therapist's office.

Biofeedback can be successful, although not all studies have confirmed a benefit. The people most likely to benefit from this type of therapy are people who can contract the anal sphincter muscle and have some sensation when they need to have a bowel movement. The effects of biofeedback may begin to decline six months after the initial training, and retraining may be helpful.

Sacral nerve stimulation — Electrical stimulation can eliminate leakage in 40 to 75 percent of people whose anal sphincter muscles are intact [1]. An electrode is surgically inserted near a nerve in the sacrum (low back).

It is not entirely clear how sacral nerve stimulation works. Experience with this approach is limited. Some people develop complications of the surgery, including pain, device malfunction, or infection, which may require that the device is removed or replaced. At present, this treatment is generally reserved for people with an intact or repaired anal sphincter who have not improved with other treatments.

Anal electrical stimulation — Electrical stimulation involves using a mild electrical current to stimulate the anal sphincter muscles to contract, which can strengthen the muscles over time. The electrical current is applied using a small probe, which the patient inserts inside the rectum for a few minutes every day for 8 to 12 weeks.

A controlled trial suggested that electrical stimulation has only a modest benefit, possibly from increasing sensation in the anal area. However, this treatment is inexpensive, non-invasive, and has few to no side effects.

Surgery — Several different surgical procedures can help alleviate fecal incontinence. Surgical repair can reduce or resolve incontinence, particularly for women who develop a tear in the external anal sphincter during childbirth and in people with injury of the sphincter due to surgery or other causes. Surgery cures fecal incontinence in 80 percent of women with childbirth-related sphincter tears.

In people who have irreparable damage of the sphincters, muscles can be transferred from other areas of the body, usually the leg or buttock, and surgically placed around the anal canal. These muscles mimic the action of the damaged sphincters. Muscle transfer surgery can restore continence in up to 73 percent of people.

An alternative to a transferred muscle is a synthetic anal cuff that can be inflated to hold back feces and deflated to allow bowel movements. However, this type of procedure is only performed in specialized centers. Complications can occur even in when these surgeries are performed by experts.

Colostomy — Colostomy is a surgical procedure in which the colon is surgically attached to the abdominal wall. Stool is collected in a bag that fits snugly against the skin. This eliminates leakage of stool from the rectum. Variations on the procedure may allow the person to control bowel emptying.

Colostomy is usually a last resort, after other treatments have failed. It may also be considered for people with intolerable symptoms who are not candidates for any other therapy.

REDUCING FECAL INCONTINENCE — There are some steps that patients can take to help minimize leakage of stool.

- Avoid foods and drinks that may cause loose or more frequent stools, which can worsen fecal incontinence. These can include dairy products (for people who are lactose intolerant), spicy foods, fatty or greasy foods, caffeinated beverages, diet foods or drinks, sugar-free gum or candy, and alcohol.
- Eat smaller more frequent meals. In some people, eating a large meal triggers the urge to have a bowel movement, and sometimes cause diarrhea. Eating smaller and more frequent meals can reduce the frequency of bowel movements.
- Increase fiber in the diet. Fiber increases stool bulk and often improves the consistency of stool. The recommend daily intake of fiber is 25 to 30 grams. The amount of fiber should be increased gradually over a few weeks to reduce the possibility of bloating and gas.

WHERE TO GET MORE INFORMATION — Your healthcare provider is the best source of information for questions and concerns related to your medical problem. For more information visit www.uptodate.com/patients

