

Specialty Clinic Referral for Faecal Incontinence

Wesley Lai, MB, ChB, MRCS

Specialist Surgical Registrar

National Health Service School of General Surgery, South West Deanery, U.K.

Nicholas J. Kenefick, BChir, MB, MA, MD, FRCS

Member, International Neuromodulation Society

Consultant Colorectal Surgeon, Torbay Hospital, U.K.

Faecal incontinence is an inability to control bowel movements that results in the involuntary passage of faecal material. It is one of the most devastating conditions as it can have a serious impact on one's quality of life, self-esteem and image, and even lead to social isolation.

How common is it?

Faecal incontinence is common. In the U.K., one study showed major faecal incontinence affects about 1.4 % of the community population over 40 years old¹, while a U.S. survey found faecal soiling occurred in 7 % of households². The prevalence of faecal incontinence is likely to be underestimated, as many affected individuals are reluctant to report or discuss it. Also it is more common in the elderly population, with one study reporting faecal incontinence affecting 15 % of people 70 years old or older³, and nearly half of the nursing home resident population⁴. It is also the second leading cause of nursing home placement in the U.S.

Causes of Faecal incontinence

Continence is maintained by a complex process involving the lower digestive tract and the nervous system; as such the cause of faecal incontinence is often mixed. It is dependent on a number of factors including mental function decline with aging, stool volume and consistency, and also on colonic, rectal and anal sphincter function. Any dysfunction involving the factors above can potentially lead to incontinence. Common causes include nerve or muscle damage incurred during childbirth (such as a sphincter tear), injury during surgery, faecal impaction (particularly among the elderly) and medical conditions such as

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diabetes and inflammatory bowel disease. When a cause is not identified, the condition is termed idiopathic faecal incontinence.

Assessment of Faecal Incontinence

Assessment requires a detailed medical history and thorough physical examination, followed by appropriate specific investigations. First, serious colorectal problems must be excluded, normally by direct visualisation of the colon with colonoscopy.

Once other pathology has been excluded the clinician determines the severity of symptoms and the impact on the patient's quality of life.

It is essential that the clinician receive an accurate history of childbirth, details of any previous pelvic or anal surgery or radiotherapy, and a complete list of past and current medicines and drugs. Next, follow-up examination may be undertaken in order to pinpoint the underlying cause of faecal incontinence and

lead to appropriate management. These focused diagnostic procedures are normally arranged by a specialist clinic, and may include such measures as anorectal manometry (to test pressure and stretch capacity), endoanal ultrasound (to visualize muscle walls of the anus and sphincter), proctography (X-ray of the rectum) and/or a colonic transit study.

Treatment Options

There are two main treatment options for faecal incontinence: conservative medical management with exercises that may involve biofeedback therapy, or surgery. It is important to remember that incontinence is a serious symptom but not a life-threatening disease and as such a balance between the severity of symptoms and potential benefit and risks of the treatment needs to be carefully considered in each individual case.

Conservative treatment includes medical treatment with drugs, physiotherapy and lifestyle modification. This includes the use of medication to improve stool consistency and reduce frequency. Biofeedback therapy may involve the use of an expandable balloon in the rectum to help improve perception of rectal distension, and sensors on the skin, linked to a visual display, to provide feedback about adequately contracting the external sphincter.

While there are various techniques, perhaps most important element is having a dedicated trained specialist with the appropriate time to treat patients. Conservative treatment and biofeedback will improve 70-80% of patients to a level where they do not wish any further treatment⁵. This approach is recommended by the American College of Gastroenterology as a safe and effective treatment for faecal incontinence⁶.

Referral to Specialist Clinic

If conservative measures and biofeedback are unsuccessful, then referral to a specialist clinic for further investigation and treatment is indicated. Further investigations aim to identify the underlying cause of the incontinence so that other treatment options can be explored. Often more courses of biofeedback may be appropriate. However if symptoms are severe and persistent, surgery may be recommended.

Surgical Treatments

There are several surgical procedures available for treatment of faecal incontinence. In all cases the potential benefit must be balanced against the risk of the procedure. The current option with the highest chance of success (70%) and with the lowest risk of complications is sacral nerve stimulation (SNS). Hence in the vast majority of cases this technique will be trialled first.

Sacral nerve stimulation is a minimally invasive surgical technique. It involves delivering low-level electrical pulses using thin implanted leads and a small portable pulse generator to stimulate the sacral nerves and produce the desirable physiological effects. The technique involves an initial trial with a

temporary sacral nerve stimulation device, normally performed without an overnight stay, and then if successful a permanent implant. In 2005 U.K. NICE issued guidelines confirming the safety and efficacy of SNS for faecal incontinence. Economic evaluation had also demonstrated SNS as a cost-effective treatment in the U.K. NHS⁷. Several studies have shown a long-term success rate of 41-75%⁸.

Other surgical options include an overlapping sphincter repair, transposition of inner thigh or lower buttock muscle to the anus, and a variety of synthetic anal sphincter devices and injection of various sphincter-bulking materials. These techniques have varying success rates and also varying levels of risk^{9,10,11}. They tend to be used either after SNS has failed or in specific situations. When all other treatment fails or as a primary treatment in certain situations a colostomy is the treatment of choice. This will cure incontinence and in some situations is an excellent treatment; however it is often declined due to social reasons.

Conclusion

Faecal incontinence is common and can have a devastating effect physically, psychologically and socially. In the majority of cases it is well treated by conservative measures and biofeedback therapy. If symptoms then persist referral to a specialist clinic is indicated for specific investigations and specialist treatment. For the majority of cases of faecal incontinence referred for further treatment, sacral nerve stimulation is currently a treatment of choice.

Please note: *This information should not be used as a substitute for medical treatment and advice. Always consult a medical professional about any health-related questions or concerns.*

References

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Resources

National Digestive Diseases Information Clearinghouse
<http://digestive.niddk.nih.gov/ddiseases/pubs/fecal/incontinence/>

National Association for Continence
<http://www.nafc.org/bladder-bowel-health/types-of-incontinence/fecal-incontinence/>