

Fecal Incontinence: Practical Evaluation and Management

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Disclosures

- Pelvalon-consultant; research funding, device study, non-surgical treatment FI
- Renovia-consultant
- UpToDate
- NIA-research funding
- NICHD-research funding
- No Conflict of Interest

Learning Objectives

- To appreciate that fecal incontinence (FI)/Accidental Bowel Leakage (ABL) is a reasonably prevalent pelvic floor disorder (PFD) significantly impacting quality of life
- To understand that the evaluation of FI may involve specialized tools
- First-line treatment options involve a behavioral approach
- To appreciate that the optimal treatment regimen for fecal incontinence (FI) may be a complex combination of various non-surgical and surgical approaches
- Surgery is a credible option for the treatment of FI

Definition

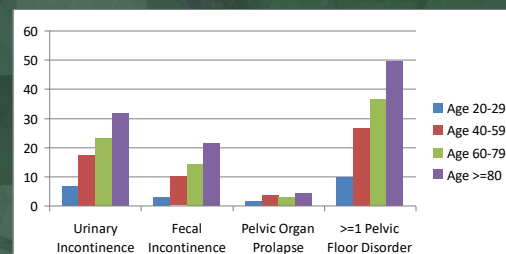
- Fecal incontinence, (also known as accidental bowel leakage ABL) is the involuntary loss of liquid or solid stool that is a social or hygienic problem¹
- Anal incontinence is the involuntary loss of flatus, liquid or solid stool that is a social or hygienic problem¹
- Accidental Bowel Leakage² (leakage in past year)
- Fecal incontinence is a symptom
- Types of FI: urgency, passive and fecal seepage³

1. Norton, 2010; 2. Brown, 2012; 3. Shah, 2011

Prevalence of FI

- A systematic review of the literature addressing community dwelling adults noted FI prevalence rates of 0.4-18%*

Prevalence Rates of Pelvic Floor Disorders in Women from the National Health and Nutrition Examination Survey (NHANES) 2005-06

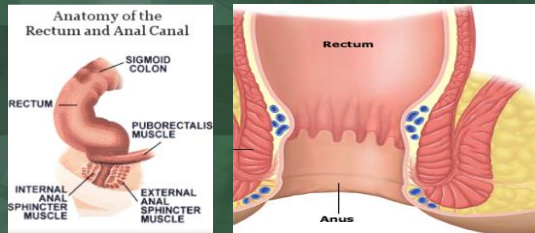


At least monthly leakage of liquid/solid stool and/or mucus

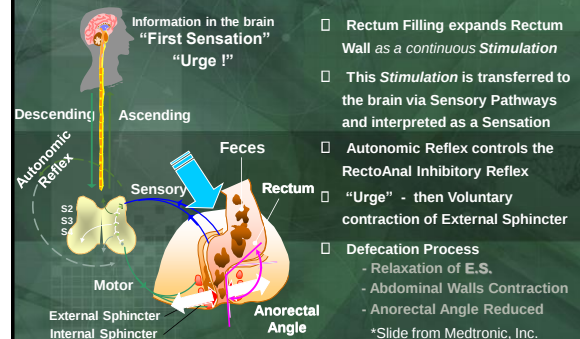
Nygaard et al, 2008

Anatomy and Physiology

- Fecal Continence depends on the integrated function of the IAS, EAS, PR, neurosensory pathway (pudendal n), volume (consistency of stool), rectal compliance, anorectal sensation and anal sphincter resting tone.



Defecation: Anatomy and Physiology



Fecal continence depends on:

- Normal mental function
- Volume and stool consistency
- Colonic transit time
- Anorectal sensation and reflexes
 - recto-anal inhibitory reflex (RAIR)
- Rectal distensibility
- Anal sphincter function

Risk Factors FI: Conceptual Framework

- Physical Status
 - Age, Gender, Race/ethnicity
 - Obesity
 - Activity/Mobility
- Genetics/Microbiome
- Trauma
 - Surgical
 - Obstetric
- Neurological/Psychiatric
 - Stroke
 - Depression
- Disease Burden
 - Medical conditions/co-morbid diseases
- Bowel Symptoms
 - Diarrhea, Urgency, Constipation



Modified from Landefeld et al. 2008

FI Evaluation: History

- Onset and duration of symptoms
- Severity, frequency
- Impact on quality of life
- Precipitating events
- *Medical History (diabetes/neurologic disease), Surgical History (anorectal surgery), Obstetric History
- Prior treatments
- Bowel habits/Stool consistency
- Dietary intake
- Adaptive Behaviors
- Medications

Patient Reported Symptoms

- Bowel Diary
- Fecal incontinence Severity*
 - FISI (Grade C)
 - Vaizey/St. Mark's Score (Grade C)
 - ICIQ-B (Grade B)
- Impact on Quality of Life
 - Fecal Incontinence QOL (FIQOL)
 - Modified Manchester Health Questionnaire
 - ICIQ-B

Norton C et al, ICI, 2016

Evaluating Fecal Incontinence

- Stool consistency (Bristol Stool Scale-Lewis and Heaton, 1997)

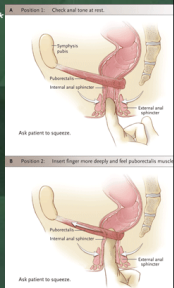
Stool Form Correlates to Intestinal Transit Time

The Bristol Stool Form Scale

Slow Transit  Fast Transit	Type 1		Separate hard lumps, like nuts
	Type 2		Sausage-like but lumpy
	Type 3		Like a sausage but with cracks in the surface
	Type 4		Like a sausage or snake, smooth and soft
	Type 5		Soft blobs with clear-cut edges
	Type 6		Fluffy pieces with ragged edges, a mushy stool
	Type 7		Watery, no solid pieces

FI: Evaluation

- Physical Examination: abdominal and pelvic
- Neurologic Reflexes (sensory and motor): anal wink, bulbocavernosus
- Digital Rectal Exam (anal sphincter and PR): tone* voluntary squeeze strength (strong, moderate, weak), and appropriate relaxation with valsalva; paradoxical contractions; rectal masses, fecal impaction (no std measure rectal tone, Brink)
- Skin changes: erythema, rash, scarring, ulcerations, fissures
- Anal patulence, perianal dimpling/dovetail sign
- Vaginal exam: pelvic organ prolapse (especially rectocele), perineal descent
- Rectovaginal fistula
- Rectal prolapse/rectal mucosal prolapse



Wald A, 2007

Anorectal Physiology Testing*

- Definitely needed
 - Endoscopic evaluation (anoscopy, proctoscopy): visualization of the rectal cavity to rule out tumors, inflammatory causes, or impaction.
- Probably helpful (especially if failed initial therapy)
 - Anal manometry and compliance testing
- Possibly needed
 - Defecography – Ultrasound
 - Electromyography – MRI
 - Pudendal nerve terminal latency

Choose treatments based on:

- Severity of FI
- Structural integrity of sphincter
- Conservative
 - Mild cases of FI
 - Biofeedback can be used for any cause
 - Painless and risk-free
- Treat underlying medical and surgical causes:
 - Cancer, IBS, rectal prolapse, impactions
- Start with simplest and least invasive **FIRST-mainstay of treatment for FI is behavioral therapy**

An Evidence-Based Look at Dietary and Medication Treatments for Fecal Incontinence

Dietary Considerations

- Malabsorption syndromes
 - Lactose
 - Gluten
- Sorbitol
- Natural laxatives
- Spicy foods
- Dietary fiber intake
 - Soluble and insoluble



Supplemental Fiber Intake

- Stool bulking vs side-effects

Trade name	Active Ingredient	Form	Natural or Synthetic	Amount of fiber/dose	Bulks stool
Metamucil	Psyllium husk	Powder	Natural	3.4 gm/tsp.	Yes
Metamucil capsules	Psyllium husk	Capsules	Natural	0.525 gm/capsule	Yes
Citrucel	Methylcellulose	Powder	Semi-synthetic	2 gm/tsp.	Yes
Citrucel caplets	Methylcellulose	Caplets	Semi-synthetic	0.5 gm/caplet	Yes
Konsyl	Psyllium husk	Powder	Natural	6 gm/tsp.	Yes
Benefiber	Wheat dextrin	Powder	Natural	3 gm/tsp	No
Fibersure*	Inulin	Powder	Natural	5 gm/tsp	No
Fibercon caplets	Calcium polycarbophil	Caplet	Synthetic	0.5gm/caplet	Yes
Fiberchoice	Inulin	Capsule	Natural	2 gm/tablet	No

Evidence for Fiber Treatment

- Fiber: placebo-controlled pilot study¹
- Pilot study, n=27
 - Comparing psyllium, guar gum, and placebo
 - Significant improvement in the proportion of incontinence stools on a 7-day diary for both types of fiber compared to placebo

1.Bliss. Nurs Res, 2001

Fiber, cont

- Dietary supplements used to manage FI
- Little known regarding fiber type where effectiveness appears to be related to fermentability of the fiber resulting in increased bulking, water-holding and gelling
- Single-blind RCT* to compare effects of carboxymethylcellulose (CMC), gum arabic (GA) and psyllium to placebo in community dwelling individuals with loose stools and FI
- 1°outcome: FI frequency; 2°outcomes: FI amt and consistency, supplement tolerance and QOL

*Bliss et al, Res Nurs Health, 2014

Results

- 14 day baseline diary
- N=189 subjects consumed placebo or 16 g total fiber/d for 32 days
- Baseline: approx 6.2 FIE/w in placebo, 4.7 CMC, 5.3 GA, 5.0 psyllium
- Post supplementation ITT: 5.5 FIW/w placebo, 6.2 CMC, 4.3 GA and 2.5 psyllium (51% decrease)
- Consistency and amt of FI-no difference

QOL

- No significant differences in FIQoL, including lifestyle, coping, depression and embarrassment scores baseline or post supplementation (ITT or PP)

Pharmacologic Treatment of FI

- 16 trials, 558 participants
- 11 trials included treatment for liquid stools
- Loperamide* (synthetic opioid inhibiting peristalsis and increases anal sphincter tone) - 3 placebo-controlled trials¹
 - Loperamide superior to placebo in all studies
 - Side effects greater than placebo
 - Less CNS side-effects noted on loperamide compared to lomotil®

¹Omar and Alexander Cochrane Database Syst Rev. 2013

Other Pharmacologic Treatments

- Loperamide ± Fiber¹: placebo-controlled trial
 - No additional improvement in FI severity by adding fiber
- Loperamide vs Psyllium Fiber²: RCT, double-blind, placebo-controlled cross-over trial comparing loperamide (followed by psyllium) to psyllium (followed by loperamide)
- N=80, at least 1 FIE/7-day bowel diary; 1st outcome FIE/7-day bowel diary
- Participants received either daily loperamide+placebo psyllium or psyllium+loperamide placebo for 4 weeks; 2-week washout, participants crossed over to alternative treatment
- Mean age 60.7±10.1 years, 68% men; combined analyses showed no differences between loperamide and psyllium groups for reducing FIE: loperamide: 7.9 to 4.2, p=0.001, psyllium: 7.3 to 4.8, p=0.008; no difference in symptom severity or QoL; all p>0.05
- Constipation 29% loperamide, 10% psyllium

¹Lauti et al, Dis Colon Rectum 2008; ²Markland et al, Dis Colon Rectum, 2015;

Other Pharmacologic Treatments

- Cholestyramine : case series reported²
 - Improved FI episodes and number of bowel movements in addition to biofeedback
- Diphenoxylate HCl (Lomotil)
- Hyocymamine (helps in postprandial leakage)
- Amitriptyline- small uncontrolled study
 - Anticholinergic effect decreasing motor complexes
- *Low-dose clonidine (α adrenergic agent): reduces rectal sensation and urgency²
- Phenylephrine gel-increases IAS tone³

¹Remes-Troches, 2008; 2. Costilla, 2013, 3. Omar, 2013

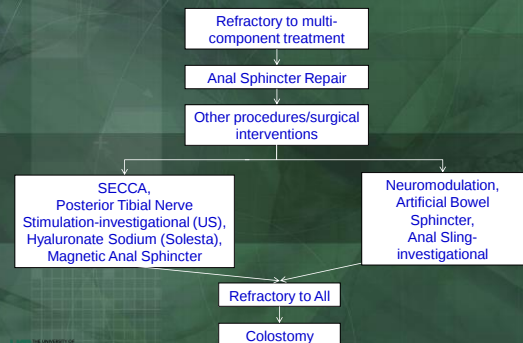
Cochrane Review 2013 Surgery for Fecal Incontinence

The review is striking for the lack of high quality randomized controlled trials with any fecal incontinence surgeries that have been carried out in the last 10 years.....

Larger rigorous RCTs (including the use of sham treatments) are needed, however, it should be recognized that the optimal treatment regime may be a complex combination of various surgical and non-surgical therapies

Brown et al 2013

Surgical/Other Procedural Treatments for Fecal Incontinence

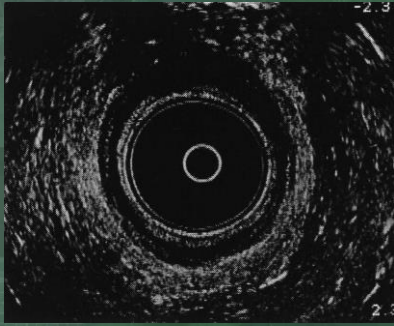


Case 1

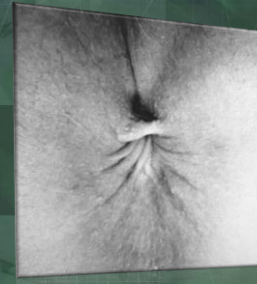
- 55 yo female P3013 with 5 year history of FI and ano-rectal urgency
- FI of liquid/solid stool and gas despite a credible attempt at management with behavioral therapy
- Spontaneous vaginal delivery (SVD) X 3 with largest infant weighing 3700 g
- Forceps delivery and a lot of "stitches" with first SVD
- Alternating constipation & diarrhea
- PMH: obesity
- PSH: cholecystectomy

Physical Examination and Diagnostic Testing

- Examination: decreased anal tone, intact reflexes, dove tail appearance, 1.5 cm thickness
- Surface Electrode EMG: reasonable isolation with decreased squeeze pressure activity, good relaxation, no evidence of dysynergia
- Anal Manometry: anal resting tone of 25 mm Hg, squeeze to 55 mmHg, normal sensation, compliance 200 cc, normal RAIR
- Endoanal Ultrasound:



Fecal Incontinence with Abnormal Sphincter



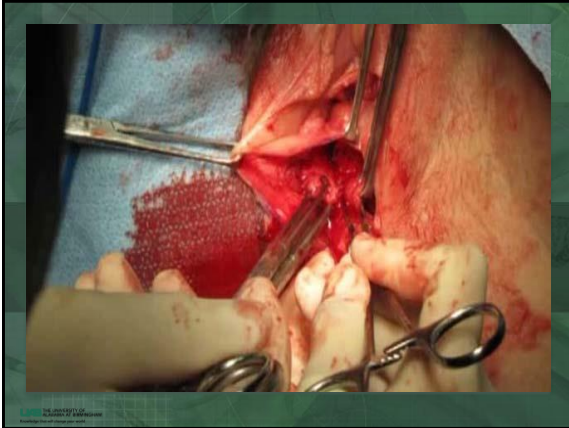
- Direct sphincter injury
 - Obstetric (majority)
 - Surgical (anal or rectal)
 - Trauma
- Congenital anomalies

Sphincteroplasty

- The term sphincteroplasty is used to describe secondary or delayed reconstruction of the anal sphincter musculature, injury to which has either not been recognized or the outcome of the repair unsatisfactory
- Among women who had a sphincter tear repaired at the time of delivery, 35% continued to have IAS gaps and of those women, the majority had concomitant EAS disruptions at 6 and 12-months*

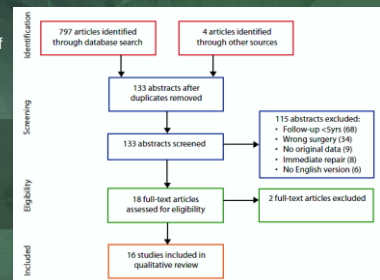
*Bradley, Richter, Gutman et al. Am J Obstet Gynecol, 2007





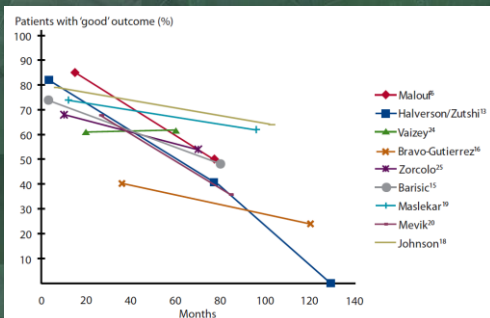
Evidence for efficacy?

- Systematic Review of FI studies 1991-2010
- 16 studies selected with 900 patients



Glasgow, Lowry
DCR 2012

Long Term Data



Glasgow, Lowry DCR 2012

Outcome Data

- Data reflects effectiveness in the short-term where 70-80% of patients report symptom improvement
- Long-term success deteriorates over time: 20-67% by 5 years, 0-40% at 10 years

Anandam 2014; Sung et al 2007; Tjandra et al 2003; Garcia et al 2005

Sphincteroplasty-Summary

- Approximately 2/3 of patients report improvement
 - Based on patient recall, little prospective data
 - Defined by "good", no standardized outcomes used until recently
 - No factor significantly associated with a worse outcome (age, severity, duration, previous repair and pudendal nerve delay implicated)
- Still an appropriate first line therapy for women with major sphincter defects
 - Restore sphincter to circumferential configuration- although MRI data may dispute this
 - Build up perineal body

Most common complication: wound infection (2.2-35%)

Case 2

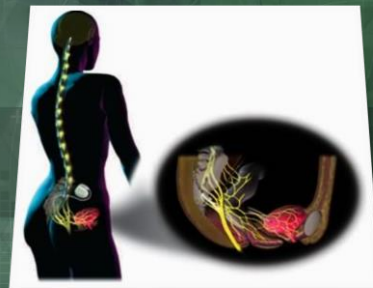
- 67 yo female with a 7-year history of FI
- FI of liquid/solid stool, 3-times per week necessitating constant pad use and scared to leave her home
- Has had a sphincter repair, tried behavioral therapy including pelvic muscle exercises, other PT strategies, attention to diet, and use of medications with some improvement, but still room for improvement
- Recent 2 week diary revealed nearly daily bowel movements with leakage 2 times the first week and 3 times week 2
- PMH: hypertension
- PSH: hysterectomy

Physical Examination & Diagnostic Testing

- Examination: decreased rectal tone, intact reflexes
- Surface Electrode EMG: reasonable isolation with good subjective squeeze pressure activity, good relaxation, no evidence of dysynergia
- Anal Manometry: anal resting tone of 40 mm Hg, squeeze to 70 mmHg, normal sensation, compliance 100 cc, normal RAIR
- Endoanal Ultrasound: intact external and internal anal sphincters

She is considering colostomy-
what surgical options are available?

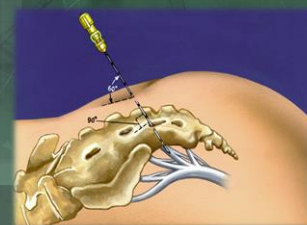
Sacral Nerve Stimulation



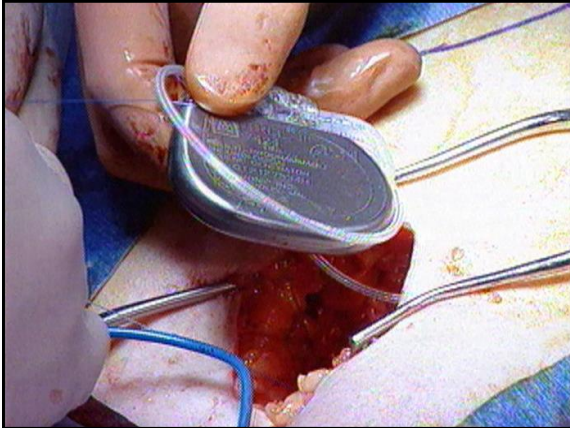
How Does It Work?

- Many potential neurologic targets
 - Voluntary somatic
 - Afferent sensory
 - Efferent autonomic
- Rectal blood flow increased with stimulation as measured by doppler flowmetry-effect was reversible¹
- Decreased episodes of spontaneous sphincter relaxation²
- Electrical stimulation of the sacral nerves causes:
 - Modulation of neural reflexes
 - Interrupts constant sensory input from rectum

¹Kenefick, Br J Surg 2003; ²Vaizey, Gut 1999



- Staged testing
- Simple outpatient procedure done under local anesthesia with IV sedation
- 2-4 week bowel diary prior to placement, then 2-4 week stimulation trial with diary



SNS Data Summary Short, Medium, Long-term

- When reviewing short (<12 months), medium (12-36 months) and long-term (>36 months) success (success defined as a 50% reduction in FI episodes):
 - ITT median (range) rates of 63% (33-66%), 58% (52-81%), 54% (50-58%), respectively
 - Per protocol median (range) rates of 79% (69-83%), 80% (65-88%) and 84% (75-100%), respectively

Matzel et al, 2009

SNS Adverse Events

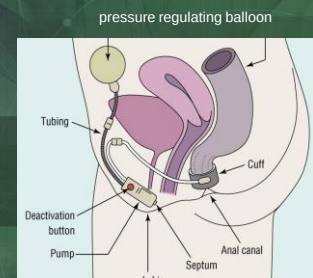
- Most AEs occur within 1st year of implantation
- Common events include: device pain (28%) and paresthesia (15%)
- Meta-analysis reported lower rate of implant site pain (6%)*
- With advancements in lead design and techniques, explantation rarely necessary (3-4%)*
- Infection rate 3-11%**

*Tan et al 2011; **Wexner et al, 2010; Mellgren et al, 2011

Other Procedural/Surgical Treatment Approaches for Treatment of Fecal Incontinence

Artificial Bowel Sphincter (ABS)

- Severe, refractory FI
- Efficacious
- High morbidity



ABS Results

Success Rates 50-77%



Results of Artificial Bowel Sphincter

Study	No. of Patients	Follow-Up (mo)	Preoperative Score	Postoperative Score	P Value
Cleveland Clinic Score*					
Altomare <i>et al.</i> ¹²⁰	28	19	14.9	2.6	<0.001
Devesa <i>et al.</i> ¹²¹	53	26.5	17	4	0.001
Lehur <i>et al.</i> ¹²²	13	30	17	4.5	<0.001
O'Brien <i>et al.</i> ¹²³	14	6	19	4.8	0.002
Ortiz <i>et al.</i> ¹²⁴	22	28	18	4	<0.001
Vaizey <i>et al.</i> ¹²⁵	6	10	19.5	4.5	0.001
American Medical Systems Score†					
Altomare <i>et al.</i> ¹²⁰	28	19	98.5	5.5	<0.001
Casal <i>et al.</i> ¹²⁶	10	29	99.9	28.4	<0.001
Dodi <i>et al.</i> ¹²⁷	8	10.5	95	19.4	<0.004
Lehur <i>et al.</i> ¹²⁸	24	20	106	25	<0.001
Lehur <i>et al.</i> ¹²⁹	16	25	105	23	<0.05
Wong <i>et al.</i> ¹³⁰	112	12	106	48	<0.001
Williams Score‡					
Christiansen <i>et al.</i> ¹³¹	17	60	5	2.5	<0.001
Fecal Incontinence Scoring System§					
Parker <i>et al.</i> ¹³²	35	24	103	24	<0.001

* Cleveland Clinic Score – scale of 0 to 20; 0 = complete continence and 20 = complete incontinence.¹¹⁹
 † American Medical Systems Score – scale of 0 to 120; 0 = complete continence and 120 = complete incontinence.¹¹⁹
 ‡ Williams Score – scale of 1 to 5; 1 = complete continence and 5 = complete incontinence.¹¹⁹
 § Fecal Incontinence Scoring System – scale of 0 to 120; 0 = complete continence and 120 = complete incontinence.¹³⁰

ABS Complications

Complications of Artificial Bowel Sphincter

Study	Explants (%)	Revision (%)	Erosion (%)	Infection (%)
Altomare <i>et al.</i> ¹²⁰	18	25	11	18
Casal <i>et al.</i> ¹²⁶	30	10	10	60
Christiansen <i>et al.</i> ¹³¹	41	35	6	18
Devesa <i>et al.</i> ¹²¹	23	30	21	21
Dodi <i>et al.</i> ¹²⁷	25	Not stated	25	25
Lehur <i>et al.</i> ¹²²	31	62	8	7
Lehur <i>et al.</i> ¹²⁸	33	38	13	4
Lehur <i>et al.</i> ¹²⁹	31	13	6	Not stated
O'Brien <i>et al.</i> ¹²³	23	31	8	23
Ortiz <i>et al.</i> ¹²⁴	41	27	23	9
Parker <i>et al.</i> ¹³²	40	64	11	31
Vaizey <i>et al.</i> ¹²⁵	17	17	17	33
Wong <i>et al.</i> ¹³⁰	37	65	25	38

Anal Slings-investigational, TOPAS® System

- Self-affixing Type-I Polypropylene Sling
- Minimally invasive trans-obturator post-anal sling



Caution - Investigational device. Limited by Federal (United States) law to investigational use

TRANSFORM Study

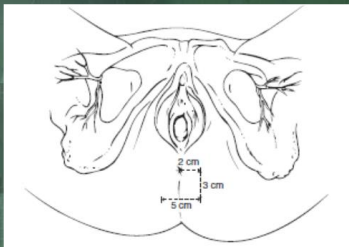
ClinicalTrials.gov Identifier:
NCT01090739

- TOPAS (AMS) sling for FI
- Prospective, multi-center(12 sites)
- Single-arm, open-label, two-stage, adaptive study with one planned interim analysis
- N=152
- The mesh sling placed via the transobturator approach

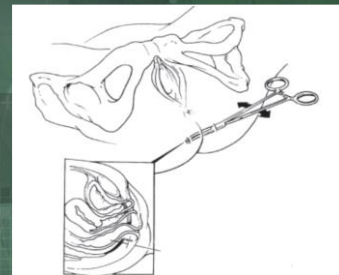


Mellgren A *et al*, Am J Obstet Gynecol 2015

Surgery



Surgery



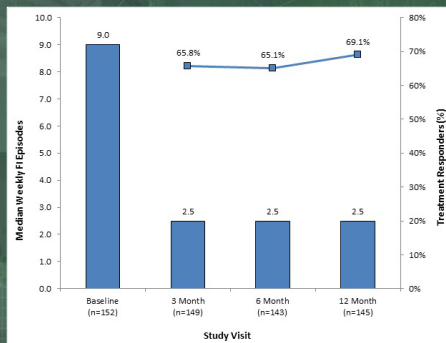
Surgery



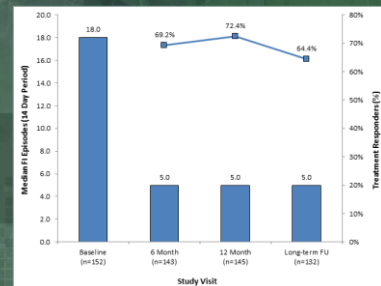
Surgery

- Mean surgical time = 33 minutes (range 11-71)
- Mean EBL = 13 cc (range 0-50)
- Mean hospital stay = 11 hours (2-57)
- NO visceral injuries or perforations

Primary Outcome-12 months (ITT)



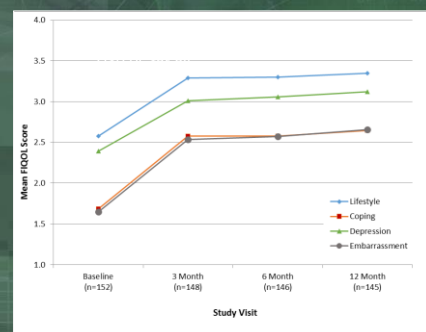
Sustained Outcomes-34 months per protocol



Secondary Outcomes

	Baseline Median (range)	12 mos. Median (range)	P value
CCIS (Wexner)	13.9 (mean)	9.6 (mean)	< 0.001
FI Episodes per week	9.0 (2-40.5)	2.0 (0-40)	< 0.001
FI Incontinent Days	5.0 (1.5-7)	2.0 (0-7)	< 0.001
FI with Urgency	2.0 (0-7)	0 (0-26)	< 0.001

Improvement in FIQOL



Treatment Related Adverse Events

Adverse Event Category	Number of Events	Number of Patients (% Patients)
Pelvic pain	47	41 (27.0%)
Infection	26	22 (14.5%)
Incision site infection	9	9 (5.9%)

17 no treatment
29 treated with medical therapy
1 sciatica surgery
10 persistent at 1 year
None classified as SAEs by FDA standards

NO mesh erosions or extrusions

Radiofrequency Therapy: SECCA®



SECCA® Efficacy Data

- Long-term* (5 year) study, mean Wexner incontinence score improved from 14 to 8, $p < 0.0003$
- 80% subjects had 50% improvement
- N=19
- Other studies limited by short-term follow-up and small sample sizes (N=8-50)
- No comparative data
- Main AEs rectal bleeding and pain

*Takahashi-Monroy et al 2008

PTNS-targets sacral plexus



Posterior Tibial Nerve Stimulation

- Peripheral neuromodulation directed to L4-S3 nerve roots
- Spleen 6 point in Chinese acupuncture
 - OAB, UUI, pelvic/bladder pain, impotence
- RCT with sham effective for OAB/Urges UI



PTNS

- The largest prospective study including 115 patients with a median follow-up of 26 months (range, 12 – 42) reported 52% of patients achieving a $\geq 50\%$ reduction in FI episodes as well as improving QOL*
- First multi-center RCT (the CONtrol of Faecal Incontinence using Distal Neuromodulation [CONFIDeNT]) in the United Kingdom was recently published
- This trial included 227 patients to evaluate the efficacy and cost-effectiveness of PTNS (n=115) comparing to sham electrical stimulation (n=112)
- Interestingly, the study reported no difference between the PTNS and sham groups in efficacy at 12 weeks: 38% in PTNS versus 31% in sham achieving a $\geq 50\%$ reduction in the number of FI episodes per week, adjusted ratio 1.28 (95%CI 0.72-2.28; $p=0.40$)**

*Hoturas et al 2014; **Knowles 2015

Non-Animal Sodium Hyaluronate-NASHA Dx

- Dextranomer microspheres and sodium hyaluronic acid
 - Identical to Deflux
- Administered via anoscope to the proximal anal canal
 - Out-patient setting
 - No anesthesia
 - Four 1ml blebs of Solesta



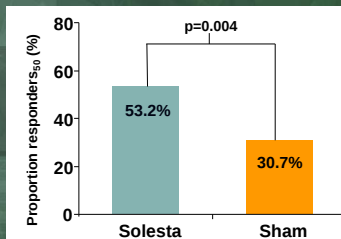
Pivotal Trial

- Only large scale trial in the literature – injectable bulking agent vs. sham
- 206 patients
 - 13 sites in U.S. and EU
 - 80% female
- Three part primary endpoint
 - Superiority over sham at 6 months
 - Threshold responder rate at 6 months
 - Durability of effect to 12 months

Graf et al, Lancet 2011

Pivotal Trial: Results

- All 3 success criteria were met
 - Responder rates superior to sham at 6 months
 - Above the predetermined threshold
 - Durability of effect out to 12 months: 57.4% Responder₅₀



Most Common Related AEs - Solesta Patients Pivotal Study Through 18 Months

Preferred term	Events	% patients
Proctalgia	41	17.3
Injection site hemorrhage	18	8.1
Rectal hemorrhage	15	7.6
Pyrexia	14	6.6
Injection site pain	10	5.1
Diarrhea	10	4.1
Anal hemorrhage	9	4.1
Anorectal discomfort	8	4.1
Rectal discharge	7	3.6
Proctitis	5	2.5

Majority of AE's were mild and self limited

Final Consideration

- Fecal Diversion



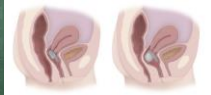
Fecal Diversion

- Considered "last resort"
- One case-control and two cohort studies
- Results in improved QOL
- More cost effective at 5 years than artificial AS and dynamic graciloplasty
- Usually an end sigmoid colostomy without proctectomy (rectal stump)
- Laparoscopic approach, safe and effective

Colquhoun et al 2006; Norton et al 2005; Ludwig et al 1996

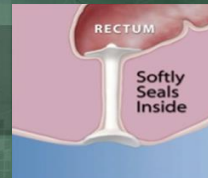
New Paradigm: Vaginal Bowel Control (VBC) System

- A non-surgical treatment option consisting of a vaginal insert and pressure-regulated pump
- Designed to offer a low-risk and easily reversible treatment for FI
- Dynamically controls bowels under user control by reversibly deflecting the RVS and interrupt stool passage



RENEW ANAL INSERT

Renew Medical, Inc

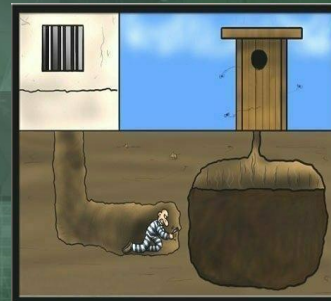


Conclusions

- Cause of fecal incontinence (a lecture unto itself) is often multi-factorial
- 1st line treatment is...
 - Education
 - Pelvic Floor Muscle Exercises
 - Medications
 - Normalization Of Stool Consistency
 - Bowel Habits
 - Devices*
- Surgery helpful for many women
- Need to be able to discuss all options with patients and individualize care



Things could always be worse.....



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