

VIII. FAECAL INCONTINENCE IN ADULT PATIENTS

ASSESSMENT AND MANAGEMENT

1. INITIAL CLINICAL ASSESSMENT

Adult patients with faecal incontinence present with a variety of symptom complexes. As many people are reluctant to admit to having faecal incontinence, it is important to proactively enquire about it, especially in known high risk groups (such as older community-living individuals, post partum women who might have had an obstetric injury and patients with loose stools).

History will include symptoms such as loose stools and urgency, the type and severity of bowel incontinence, systemic disorders, neurological disorders, and ano-rectal surgeries (e.g., haemorrhoidectomy), obstetric history for women, medications, diet, chronic straining, cognitive status, and effects of symptoms on quality of life.

2. INITIAL INTERVENTIONS

- Assessing the type of bowel incontinence may help identify an aetiology. Types of bowel incontinence: Anal incontinence is the involuntary loss of faeces and/or flatus and/or mucus). Faecal incontinence is the involuntary loss of faeces. Flatus incontinence is the involuntary loss of rectal gas, which may indicate rectal sensory impairment and/or anal sphincter dysfunction. Mucus incontinence is the involuntary loss of mucus only (See Figure 1).
 - Some subtypes of faecal incontinence are urgency faecal incontinence, which is the involuntary loss of faeces due to an inability to defer defaecation, once the desire is perceived, for long enough to reach a toilet. Urgency faecal incontinence is often a symptom of external anal sphincter dysfunction. The symptom of urgency does not necessarily result in urgency faecal incontinence. Functional faecal incontinence is due to limitations in mobility or toileting ability or delayed assistance. Passive faecal incontinence, incontinence without forewarning, is typically related to internal anal sphincter dysfunction or poor closure of the external sphincter due to rectal prolapse or stage III/IV haemorrhoids.

- Physical examination will include anal inspection, abdominal palpitation, a brief neurological examination, digital rectal examination and usually procto-sigmoidoscopy or colonoscopy.
 - Further diagnostic testing needs to be considered if the patient has symptoms such as an unexplained change in bowel habit, weight loss, anaemia, rectal bleeding, severe or nocturnal diarrhoea, or an abdominal or pelvic mass and bowel pathology when organic conditions such as cancer, inflammatory bowel disease (IBD), a recto-vaginal fistula, full thickness rectal prolapse, or cloacal deformity are suspected. Condition specific management is indicated for these patients.
 - Reversible factors (such as inadequate access to toilets and side effects of medications resulting in loose stools) should be assessed and addressed at the outset.
- Some initial management can often be performed in primary care. After environmental factors and local or systemic pathology have been excluded, initial interventions include:
- Discussion of options and goals of management with the patient
 - Provision of patient or caregiver information and education (GoR A)
 - Adjustment of diet and fluid advice, fibre intake (GoR A)
 - Establishing a regular bowel habit (GoR C) or urgency training if relevant (GoR C)
 - Anti-diarrhoeal medication can help if stools are loose (GoR B)
 - Use of continence products including various types and sizes of absorbent pads, briefs, etc., to contain leaked faeces and prevent skin damage
 - Provide advice on practical coping skills when incontinence occurs (GoR C)

3. SECONDARY INTERVENTIONS

- If initial interventions fail to improve symptoms after 8-12 weeks, consideration should be given to referral to an incontinence specialist (e.g., gastroenterologist, continence nurse, advisor physiotherapist, or colorectal surgeon) for other interventions or further assessment.
- Pelvic floor muscle training (PFMT) – contraction of pelvic floor muscles, multiple times per day to improve strength of contraction and increase awareness of anorectal muscle function. (GoR C)
- Biofeedback therapy – behavioural treatment designed to enhance the strength of sphincter contraction and improve rectal sensation using specialised equipment. Biofeedback therapy can be combined with PFMT to improve strength. (GoR B)
- Transanal Irrigation to maximise bowel emptying and minimise faecal incontinence primarily in patients with incomplete elimination, passive faecal incontinence, or faecal incontinence with defaecation difficulty, (GoR C)

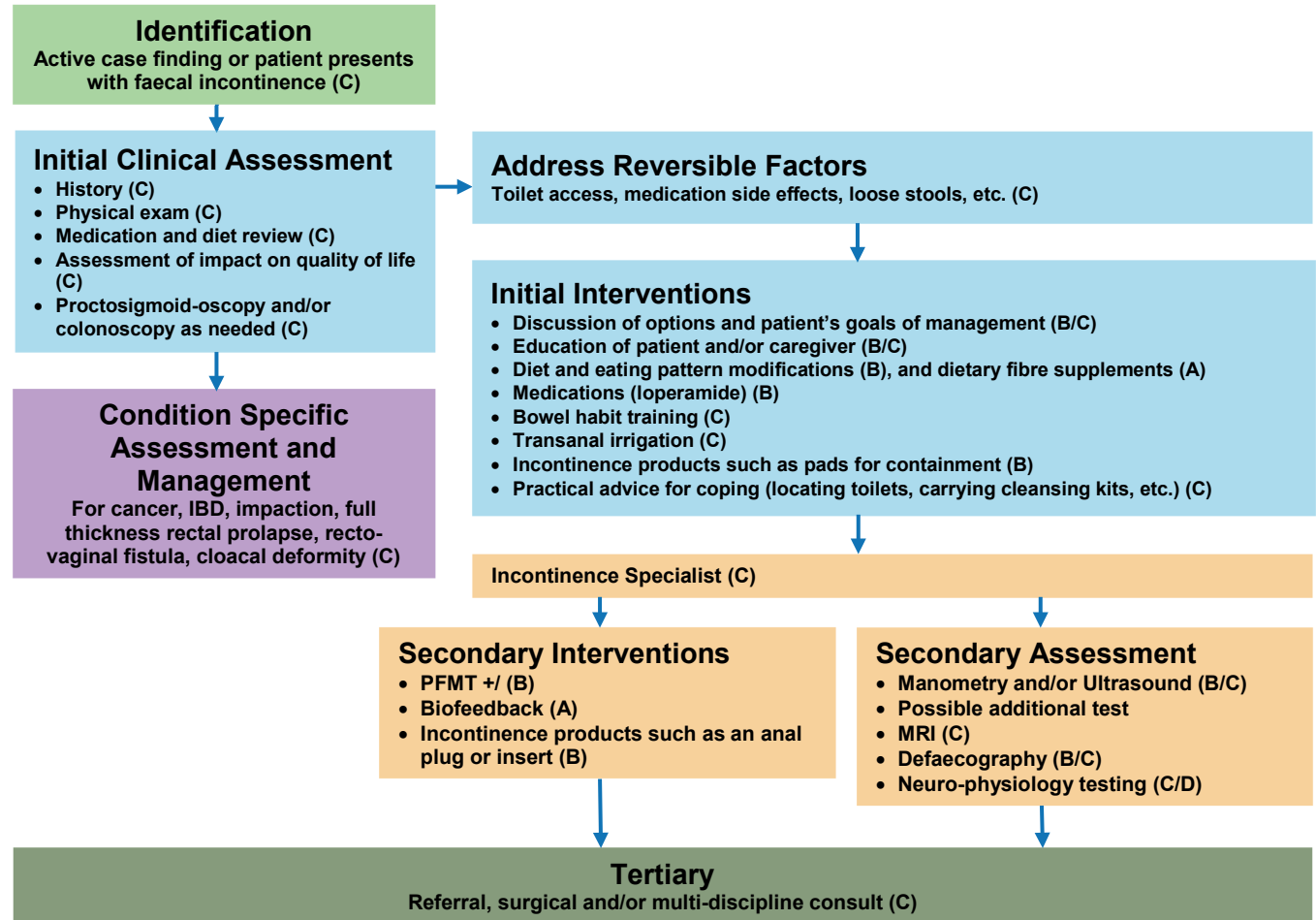
4. SECONDARY ASSESSMENT

- A variety of anorectal investigations, including manometry, anal ultrasound, and possibly MRI, defaecography, and neurophysiological testing can help to define structural or functional abnormalities of anorectal function and guide management if initial and/or secondary interventions are ineffective

5. TERTIARY REFERRAL, SURGICAL OR MULTI-DISCIPLINARY CONSULTATION

- Faecal incontinence that fails to respond to initial and secondary management requires specialised consultation by a gastroenterologist, colorectal surgeon, urogynaecologist, and/or a multi-disciplinary team

ASSESSMENT AND CONSERVATIVE MANAGEMENT OF FAECAL INCONTINENCE



* Consider CONTINENCE PRODUCTS for temporary support during treatment

VIII. FAECAL INCONTINENCE IN ADULT PATIENTS

SURGERY FOR FAECAL INCONTINENCE

1. PATIENT ASSESSMENT

- The reader is referred to the relevant chapter sections in “Dynamic Testing” and “Conservative Treatment for Faecal Incontinence.” In general, patients referred for surgical management of faecal incontinence must either have failed conservative therapy or not be candidates for conservative therapy due to severe anatomic or neurological dysfunction.
- Prior to surgical management of faecal incontinence, the integrity of the anal sphincter complex should be assessed. This assessment is best performed with endoanal ultrasound, though pelvic MRI may also be useful. Ancillary tests include anal manometry, electromyography, and defaecography.
- If the patient has persisting faecal incontinence, he or she should undergo repeat assessment, including endoanal ultrasound.

2. SPECIALISED MANAGEMENT

- The surgical approach is influenced by the presence and magnitude of an anatomical anal sphincter defect. If no defect is present, or if the sphincter defect is minimal, options include SNS and biomaterial injection therapy.
- Acute anal sphincter repair is usually required following obstetric or direct trauma. End to end or overlapping repair may be performed. When possible the internal anal sphincter should be separately repaired. (GoR C)
- Patients with rectal prolapse, rectovaginal fistula or cloacal deformity often have associated faecal incontinence. Initial therapy should be directed at correction of the anatomical abnormality. (GoR C)
- For patients with moderate sphincter defects, sphincteroplasty, SNS or biomaterial injection therapy can each be considered. For patients with large sphincter defects (>120 degrees), sphincteroplasty is likely to be the best option, though a PNE trial for SNS can be considered. (GoR C)

- Patients with sphincter defects of greater than 180° or major perineal tissue loss require individualised treatment. In some cases, initial reconstruction can be performed. Should incontinence persist, alternatives include stimulated muscle transposition (usually graciloplasty) artificial anal sphincter implantation, or SNS. (GoR C)

3. SALVAGE MANAGEMENT

- For patients who remain incontinent following sphincteroplasty, repeat endoanal ultrasound should be undertaken to reassess the status of the repair. If no defect is present, or if the sphincter defect is minimal, options include SNS and biomaterial injection therapy. If there is a large persisting sphincter defect, repeat sphincteroplasty can be considered. (GoR C)
- Patients who have failed SNS can be considered for biomaterial injection therapy or sphincteroplasty if a sphincter defect is present. Other alternatives include stimulated graciloplasty and implantation of an artificial anal sphincter. (GoR C)
- Patients who fail surgical therapy for faecal incontinence, or who do not wish to undergo extensive pelvic reconstruction, should consider placement of an end sigmoid colectomy. (GoR C) While this procedure does not restore continence, it does restore substantial bowel control and appears to improve social function and quality of life. Novel therapies can also be considered under protocol: PTNS, the magnetic anal sphincter, SECCATM, vaginal pessary (EclipseTM) and sling procedures. (GoR D)

4. SPECIAL SITUATIONS

- Individuals with congenital abnormalities may be amenable to surgical repair. Often this will involve both laparoscopic abdominal and perineal approached. Poor functional outcomes may be treated by an Antegrade Continence Enema (ACE) procedure or colectomy. Patients with cauda equina type neurological disorders, either congenital or acquired, should be considered for an ACE procedure or colectomy. (GoR C)

SURGICAL MANAGEMENT OF FAECAL INCONTINENCE

