

# How I deal with faecal incontinence

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Faecal incontinence is more common than many doctors expect. This month, Dr Tony Eyers outlines his approach for helping patients with this potentially distressing problem.

## Remember

- Minor forms of faecal incontinence are very common and not always reported by patients.
- A loss of anal sphincter function will ultimately manifest itself as uncontrolled bowel motions or urgency. The patient's regularity and ability to cope often determine which symptom dominates.
- Patients who have faecal soiling but are confident about their ability to hold on to a bowel motion or flatus tend to have simple anal pathology (such as haemorrhoids) rather than a deficient anal sphincter.
- Most idiopathic faecal incontinence is due to pudendal neuropathy, which is often believed to have been acquired during childbirth.
- Incontinent patients know every toilet in their environment. They carry clothing changes everywhere they go and usually wear some sort of incontinence pad.
- Major faecal incontinence can be identified when patients will not leave home until after their morning bowel motion and will not eat or drink anything until they get home.

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- Profuse watery diarrhoea can test the competence of even the best anal sphincter. However, incontinence with a purge (such as a bowel preparation for colonoscopy or surgery) is not normal.

## Assessment

- During the examination, the patient should be asked to bear down while the anus is on view so that the doctor can identify abnormal perineal descent, rectocele and either mucosal or full-thickness prolapse.
- In patients with faecal incontinence, the anal sphincter often feels thin or hypotonic and the anal canal looks lax or patulous. Alternatively, the resting posture and tone can appear normal, but the ability to mount a prompt and brisk voluntary squeeze is missing. In either case, anal physiology testing is indicated to define the underlying problem.

## Management

- In most cases, faecal incontinence is not easy to correct and so management is directed at minimising the problem.
- Simple measures such as improving stool consistency by dietary means or using antidiarrhoeal medications are often effective if symptoms are mild. Pelvic floor exercises and biofeedback programs are worthwhile.
- Surgery involving either direct sphincter repair or levatorplasty often

provides short term improvement, but long term follow up has revealed increasingly disappointing results. The results of surgical repairs are best when the anal sphincter has been injured without any associated nerve damage.

- There are some newer developments that offer some hope for the future, including dynamic graciloplasty (Figure) and the artificial bowel sphincter:
  - Dynamic graciloplasty involves transposing a muscle from the leg to form a new anal sphincter. To make the muscle contract constantly, electrical stimulation with an instrument like a cardiac pacemaker is required – the contraction is turned on and off with a telemetric device to control defaecation.
  - The artificial bowel sphincter is a mechanical prosthetic device using a saline filled cuff that is implanted and can be emptied and filled from a reservoir by means of a pump valve to achieve defaecation.

Neither dynamic graciloplasty nor the artificial bowel sphincter, however, appears to be the panacea that was initially anticipated. Sacral nerve stimulation is being explored as a further possible aid to incontinence.

- A colostomy often represents the best chance that a patient with advanced faecal incontinence has of returning to a full and active life.

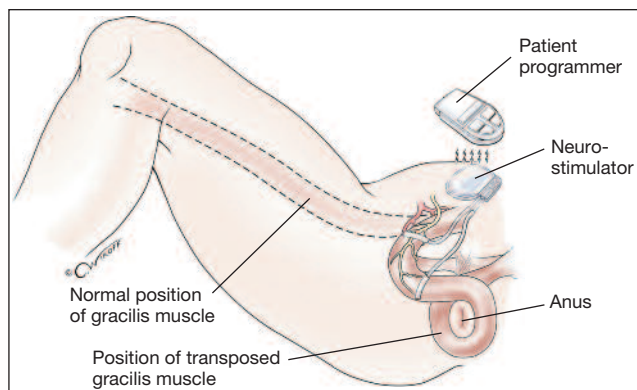


Figure. Dynamic graciloplasty, a surgical option for patients with major faecal incontinence. The gracilis muscle is transposed around the anal canal and connected to a neurostimulator. A hand-held device is used to control defaecation by turning the muscle contraction on and off.

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