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Fecal Incontinence (bowel control problem)

A Guide for Women

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What is fecal incontinence?
Fecal incontinence is when a person loses the ability to control their bowel movement resulting in leakage of gas or stool (feces) through the anus (back passage). It can range from difficulty with control of gas to more severe with loss of control over liquid or formed stool. It is a common problem, which can affect up to 1 in 10 people at some time in their lives. They may have bowel accidents that are caused by not being able to get to a toilet quickly enough (urge leakage), or they may experience soiling or leaking from the bowel without being aware of it (passive leakage).

Fecal incontinence can have many different causes. It can be distressing and can severely affect everyday life. Many people with fecal incontinence find it very difficult and embarrassing to talk about with doctors and nurses, or to tell their family and friends. However, once fecal incontinence has been identified there are treatments that can help manage or sometimes cure it, as well as strategies to help people cope with the condition and discuss it openly.

How does a normal bowel work?
Normal bowel frequency is between three times a day and two times a week, but most people open their bowels once a day. Normal consistency of stools should be soft and formed. Normally the bowel and rings of muscle around the back passage (anal sphincter) work together to ensure that bowel contents are not passed until we are ready. The sphincter has two main muscles which keep the anus closed: the inner (internal anal sphincter) ring, which keeps the anus closed at rest, and the outer (external anal sphincter) ring, which provides extra protection when the urge to open the bowel is felt and when we exert ourselves, cough or sneeze (Figure 1). These muscles, the nerves supplying them and the sensation felt within the bowel and sphincter all contribute to the sphincter remaining tightly closed. This balance enables us to stay in control (or 'continent').

When stool enters the rectum the internal anal sphincter muscle automatically relaxes and opens up the top of the anal canal. This allows the sensitive nerves at the top of the anal canal to detect whether it is wind, watery stool or normal stool. The external anal sphincter can be deliberately squeezed to delay bowel emptying if it is not convenient to find a toilet. Squeezing the external sphincter pushes the stool out of the anal canal and back into the rectum, where the stool is stored until a convenient time (Figure 2).

Figure 1: Internal & External Anal Sphincters

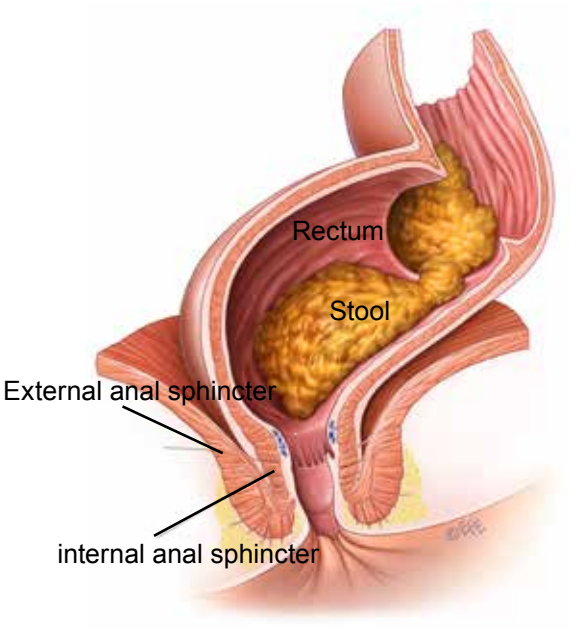
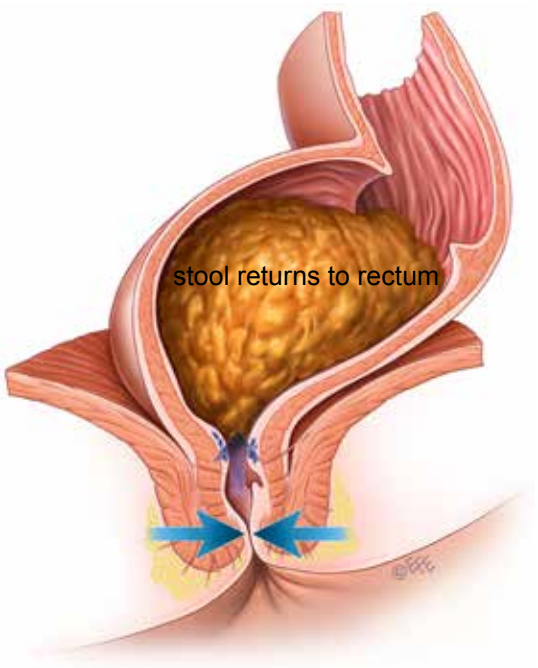


Figure 2: External anal sphincter contracting



What causes fecal incontinence?
Fecal incontinence occurs most commonly because the anal sphincter is not functioning properly. Damage to the sphincter muscles or to the nerves controlling these muscles, decreased muscle strength, excessively strong bowel contractions, or alterations to bowel sensation can all lead to this disturbance of function.

One of the most common causes of fecal incontinence in women is injury during childbirth. The anal muscle may be torn during delivery or there may be damage to the nerves that help the anal muscle function. Some of these injuries

can be recognised at the time of delivery, but others may not be as obvious and not become a problem until later in life.

Some individuals experience loss of strength of the anal muscles as they age. So it may become more of a problem later in life. Anal operations or injury to the area around the anal muscle can also lead to loss of bowel control. Loose stools or diarrhea may be associated with loss of bowel control or a feeling of urgency due to the frequent passage of stool through the anal opening. If associated with bleeding there may be an inflammation in the colon (colitis), a rectal mass (growth) or a rectal prolapse. This requires prompt evaluation by a doctor.

Who is at risk of fecal incontinence?

There are certain groups of people who are more likely to have fecal incontinence than others. Healthcare professionals should ask people (or their carers) whether they experience fecal incontinence if they are in one of the following groups:

- Following childbirth – usually due to a tear (hidden or obvious) in the sphincter muscles
- People of any age who experience an injury or infection of the sphincter: they may be affected immediately or later in life
- People suffering from Inflammatory Bowel Disease (colitis) or Irritable Bowel Syndrome (alternating diarrhea and constipation together with abdominal pain) because the bowel is very overactive and squeezes strongly
- People who have had an operation on their colon (part of the bowel) or anus
- People who have had radiotherapy to their pelvic area
- People who have had a prolapse of their rectum or organs in their pelvis (this means that these organs have slipped down from their usual position in the body)
- People who have injury to or disease of their nervous system or spinal cord e.g. multiple sclerosis
- People with learning disabilities or memory problems
- Children and teenagers – if they are born with an abnormal sphincter or if they have persistent constipation
- Frail elderly people
- People with urinary incontinence

How is fecal incontinence assessed?

An initial discussion with your doctor will help establish the degree of control difficulty and how it is affecting your lifestyle. By reviewing your history the doctor may be able to identify the cause of the incontinence. For example, childbirth history is very important in determining possible causes if there is a history of many births, large birth weight, forceps or vacuum assisted deliveries, or large episiotomies and tears. In some cases, bowel conditions, medical illnesses, and medications can play a role in loss of bowel control. If you are taking any medicines, your healthcare professional should consider whether this is making your incontinence worse, and if so offer a different treatment if possible.

Initially, a physical examination of the anal area should be performed. An obvious defect (gap) or injury can be readily assessed. Tests of sphincter function are relatively simple to perform and are usually pain-free. The strength of the muscles, sensation and nerve function, for example, can all be tested using simple pressure measuring devices. An ultrasound using a thin probe in the anal canal can provide a picture of the anal sphincter muscle rings and look for any disruption, thinning, damage, or defect (gap) in the anal muscles. Further tests may be needed depending on your situation.

As part of your assessment, you should be given help and advice to help you deal with your incontinence. Your healthcare professional should tell you about continence products available and how to use them, including disposable pads. They will give you advice about how to clean and protect your skin, to stop it getting sore as well as advice on odour control and how to deal with your laundry.

What are the treatment options?

Your bowels are a part of your body and it is possible to get back in control of them. This may seem difficult at times, especially when you feel under stress. You may need advice from a specialist who has expert knowledge about fecal incontinence. These problems are common so you need not feel embarrassed about discussing them. Most of the treatments are simple and effective, so do not hesitate to seek advice. The following measures will help you towards regaining control.

Simple self-help measures

Diet / bowel habit

Changes to diet and bowel habit can be helpful for many people because the type of food you eat and the amount of fluid you drink can help with regular bowel movements and the firmness of your stools. You may be asked to keep a diary of your food and fluid intake so that any changes can take into account your current diet. Any changes should also consider particular dietary needs that you may have. You should eat a healthy balanced diet and drink between 1.5-2 litres of fluid per day (6-8 cups full). Water and squash are best and caffeinated drinks should be kept to a minimum. It is worth experimenting with your diet to see if certain foods worsen the situation. In particular, an excessive high fibre diet (too much bran, cereal, fruit, etc.), too much caffeine or alcohol and a lot of artificial sweeteners can worsen fecal incontinence.

Management of your fecal incontinence can be helped by ensuring that you have bowel movements at regular time(s) during the day. If possible you should use the toilet after a meal and make sure you have access to a private, comfortable and safe toilet facility that you can use for as long as you need. You should be advised about correct positioning when emptying your bowel and how to empty your bowel without straining (Figure 3).

Access to the toilet

A very important way of managing your incontinence is to make sure you can use the toilet as easily as possible. You should be given advice about clothing that is easy to remove so that you can use the toilet more quickly. A healthcare professional may assess your home and your mobility to see what extra help or equipment you might need to help you get to the toilet. If you are in a hospital or a care home, toilets should be easy to find and help to use the toilet should be available if you need it. Your privacy and dignity should always be respected.

Figure 3

Skin Care

Anyone who has frequent bowel motions, diarrhea or accidental fecal leakage may get sore skin around the back passage. This can be very uncomfortable and distressing. Occasionally, the skin may become so inflamed that it breaks into open sores. These sores can be difficult to heal. Taking good care of the skin around your back passage can help to prevent these problems from developing. Tips to prevent soreness:

- After a bowel action, wipe gently with soft toilet paper
- Whenever possible, wash around the anus after a bowel action. Use warm water only, disinfectants and antiseptics can sting if you have sores
- After washing, pat your bottom dry gently with a soft towel (or soft toilet paper), do not rub
- Avoid using products with a perfume such as scented soap, talcum powder, or deodorants on your bottom. Use a non-scented soap. Many baby wipes contain alcohol, so should be avoided
- Wear cotton underwear to allow the skin to breathe. Avoid tight jeans and other clothes which might rub the area
- Use non-biological washing powder for underwear and towels
- Avoid using any creams or lotions on the area, unless advised to do so
- If you need to wear a pad because of incontinence, use a pad with a soft surface

Pelvic Floor / Anal Sphincter Exercises

The pelvic floor is a sheet of muscles that extend from your tail bone (coccyx) to your pubic bone at the front, forming a "platform" between your legs. They support the bladder, bowel and uterus (in women). The pelvic floor muscles help to control when you pass urine and open your bowels. Pelvic floor muscle exercises to improve the coordination and strength of the pelvic muscles can improve or stop any leakage from your bowels. If you opt for pelvic floor muscle exercises, a trained healthcare professional should plan a programme with you, including regular assessment of your symptoms to see how well the exercises are going.

Special exercises to strengthen the anal sphincter muscles help many people. Techniques such as biofeedback are now available to re-train the bowel to be more sensitive to the presence of stool, so that the sphincter contracts when necessary and they are used in conjunction with physical treatments to improve bowel and pelvic floor coordination. In addition, electrical stimulation involving the application of tiny, safe electric currents to the anus in order to improve coordination and strength may also be added to the treatment.

Medication

Drugs may be helpful when:

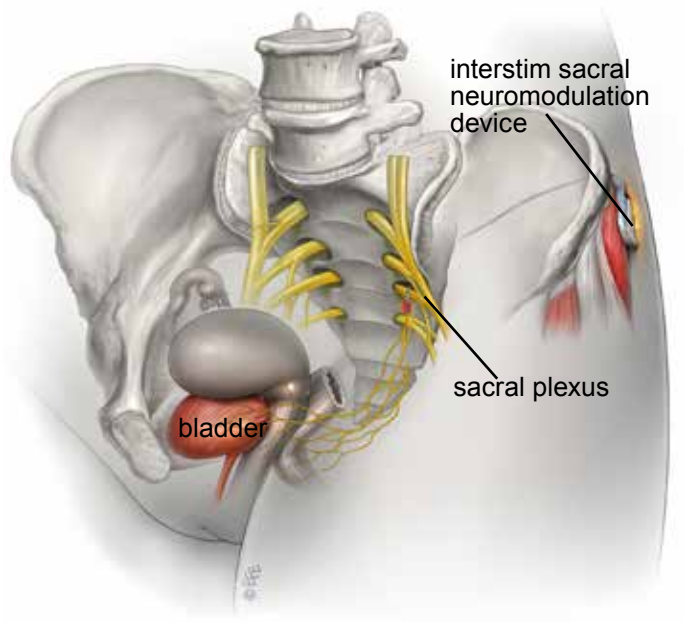
- The bowel is squeezing too strongly (urgency to get to the toilet quickly)
- The stool is very loose
- The sphincter muscles are weak. Drugs can decrease movement in the bowel, make the stool more formed, and make the sphincter muscle tighter.
- Occasionally fecal incontinence is due to not emptying the bowel completely, and then use of suppositories or laxatives might be helpful.

The rectum is designed to hold solid stools; watery stools are more likely to leak and cause fecal incontinence. In most cases the first drug you are offered is Loperamide, as long as the problem isn't caused by your diet or by laxatives. Loperamide is an anti-diarrheal medication designed to thicken the stools and reduce diarrhea. It is well-established, relatively free of side-effects, safe to use and you can take it for as long as you need. Loperamide works by slowing the passage of food through the colon, allowing more water to be absorbed and creating a formed stool. Different people need varying doses to achieve a formed stool, please follow the advice of your doctor to avoid becoming constipated. It is usual to start on a low dose and increase it slowly over several days to judge how your body is responding. You can change the dose, stop and start taking Loperamide as needed, depending on the consistency of your stools and on your lifestyle. If you are taking a low dose of Loperamide, you may be offered Loperamide syrup instead of tablets. However, you should not be offered Loperamide if you have hard or infrequent stools, acute diarrhea without a known cause, or an acute flare-up of ulcerative colitis (inflammation of the colon and rectum).

Sacral nerve stimulation

This is a way of using electrical pulses to keep the anal sphincter closed. It is only suitable for people who have a weak but intact sphincter. It involves inserting electrodes under the skin in the lower back and connecting them to a pulse generator (Figure 4). This system produces pulses of electricity that are thought to affect the nerves controlling the lower part of the bowel and the anal sphincter, with the result that a person does not pass feces until he or she is ready to do so. There have been reports of good success with this method, 2 to 3 out of 4 people (50 - 75%) improved or had no leakage. There was also evidence that people's quality of life was improved once the sacral nerve stimulation system was in place.

Figure 4



Surgery

If your doctor thinks surgery might help you, he or she should refer you to a specialist surgeon. The surgeon should discuss the possible options with you, explaining the risks and benefits and how likely the operation is to work. The type of operation offered will depend on what is causing your incontinence. For example, if you have a gap in your anal sphincter you may be offered an operation to repair it. When there is nerve damage to sphincter muscles a different operation to tighten the sphincter will sometimes help. Depending on your condition, the specialist will discuss the various surgical options with you. If you decide to have one of the operations, you should be offered ongoing support to help you. Types of operation available include:

- Stimulated graciloplasty involves making a new anal sphincter from muscle taken from the thigh. Electrical stimulation is applied to this new sphincter to strengthen it.
- Artificial anal sphincter implantation involves placing a circular cuff under the skin around the anus, to allow you to control when you open your bowel.
- Endoscopic radiofrequency (heat) therapy involves using heat energy to cause a degree of fibrosis (similar to scar tissue), thereby tightening the ring of muscle that forms the anal sphincter and helping to control bowel movements. It is intended to be less invasive than other surgical treatments and is usually done under sedation and local anaesthetic.
- Antegrade irrigation involves washing out the colon with water, using a tube going through the wall of the abdomen into the appendix.
- If there are no suitable treatments, your surgeon may consider offering you a stoma if you have incontinence that severely affects your everyday life. A stoma is an opening from your bowel through your abdomen, created by a surgeon. If this is the case, you will first be seen by a specialist stoma care service to explain all the risks, benefits and long-term effects to you.

Review and long-term management

After each stage of your treatment, your healthcare professional should ask whether the treatment has helped you. If it hasn't helped, you should be able to discuss and receive advice about other treatment options, including referral to a specialist. If you decide not to have any more treatment for your incontinence, or if it doesn't improve, you should be given practical and emotional help. In the very unusual situation that nothing can be done to decrease incontinence, appliances and advice are available which can make life much more comfortable. You may be offered anal plugs (to insert in the anus to prevent leakage of feces) if they are suitable for you. Advice should be sought from a local continence advisor; your doctor can help with finding who this is. You should also be offered regular check-ups and given advice about how to maintain your dignity and independence. Your healthcare professional may suggest that you see a therapist or counselor if this might help you to cope with your condition better.

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