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PATIENT INFORMATION

Faecal Incontinence

What is Faecal Incontinence?
What causes Faecal Incontinence?
What tests will I need?
What treatment is available?

Rectum
Exterior sphincter
Exterior sphincter
Interior sphincter

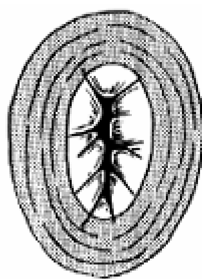
What is Faecal Incontinence?

Incontinence is the impaired ability to control gas or stool. Its severity ranges from mild difficulty with gas control to severe loss of control over liquid and formed stools. Incontinence to stool is a common problem, but often it is not discussed due to embarrassment. Both bladder and bowel incontinence are problems that tend to increase with age.

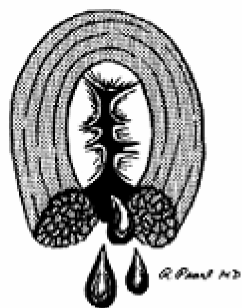
The loss of bowel control, also known as *faecal incontinence*, can be a devastating problem. There can be few things more embarrassing than a bowel accident that other people notice, and few conditions that create so much anxiety.

What causes Faecal Incontinence?

- Damage to the sphincter muscle (childbirth/forceps, surgery)



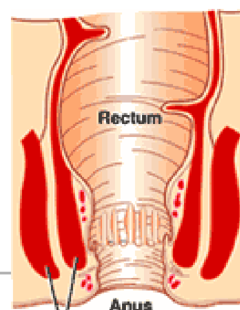
Normal anal sphincter muscle

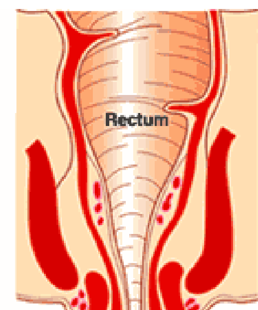


Severed anal sphincter muscle

- Damage to the nerves (aging, stretching-childbirth/perineal descent)
- Stool consistency-diarrhoea/constipation
- Reduced capacity of Rectum-inflammatory bowel disease, cancer, radiation damage
- Rectal prolapse- where the inside of the rectum comes out or partially out through the sphincter muscle

Diag: Rectal prolapse





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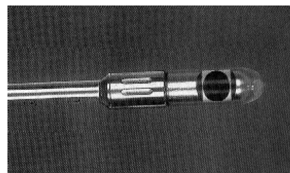
What tests will I need?

A thorough history and examination are essential to start with. In the rooms a simple procedure such as rigid sigmoidoscopy can be performed. This allows direct visual inspection of the mucosa (internal lining of the bowel). Depending on your symptoms further tests may be necessary.

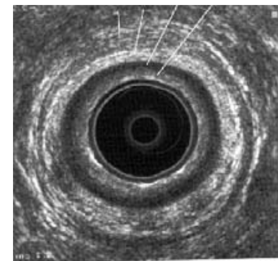
- Colonoscopy- direct inspection of the whole large bowel
- Ano-rectal Physiology- pressure measurements of the sphincter and the rectum. In a test called manometry, a small catheter is placed into the anus to record pressure as patients relax and tighten the anal muscles.
- Nerve Studies-measurement of the function of the pudendal nerves 9Important in sphincter function

Special electrode for nerve studies

- Ultrasound scan- a probe is placed in the anus and images of the sphincter can be obtained. This may show obstetric damage and can guide repair.



USS probe and scan picture



- Defaecating proctogram (defaecogram). In this X-ray a mixture of barium and porridge is placed in the rectum and X-rays obtained as you pass a bowel motion. This gives very important information on function and internal prolapse.

DPG showing internal prolapse

What treatment is available?

Non-Operative

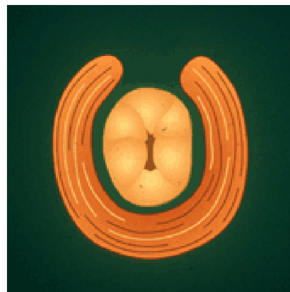
- Improve stool consistency- bulk laxative (Metamucil), loperamide
- Pelvic floor physiotherapy and improved toilet posture and practice
- Diet: Food affects the consistency of stool and how quickly it passes through the digestive system. One way to help control faecal incontinence in some patients is to eat foods that add bulk to stool, making it less watery and easier to control. Also, avoid foods that contribute to the problem. They include foods and drinks containing caffeine, like coffee, tea, and chocolate, which relax the internal anal sphincter muscle.
- Trial Suppositories. If you can fully empty your rectum then there won't be as much stool to leak out. (eg: glycerine suppositories or microlax enemas)

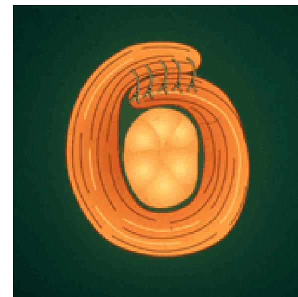
Operative treatment

There are many different surgical options and these are individualised. Some people may require more than 1 type of operation to control their symptoms.

1. Overlapping Sphincter Repair

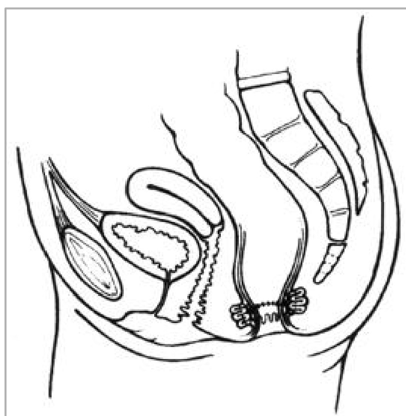
Usually in patients with childbirth injuries.

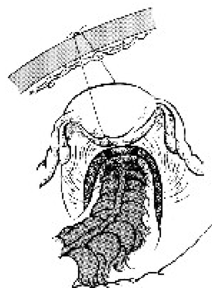




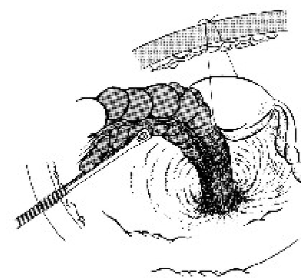
2. Prolapse procedures

As a result of the prolapse the sphincter muscle is stretched. Repairing the prolapse will help restore this muscle. Secondly, the prolapse may stimulate a reflex that relaxes the internal sphincter muscle. Options here are a Delorme's Procedure or a Laparoscopic Resection Rectopexy (fixing the rectum up internally).



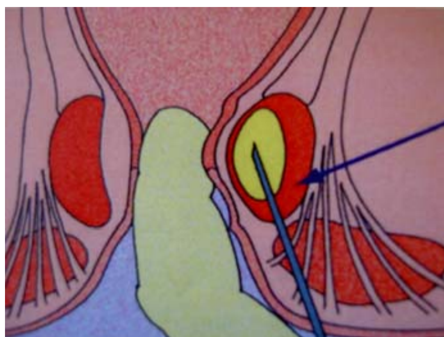


Delorme's Procedure

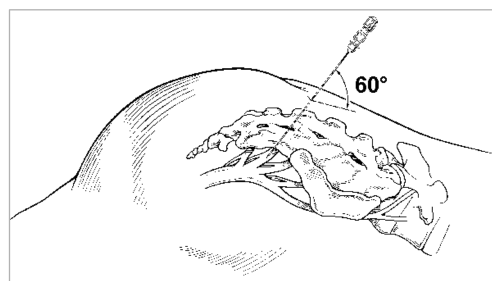


Rectopexy

3. PTQ Implants. A silicon based material is injected into the sphincter muscle to bulk it up. This is good if there is generalised weakness of the muscles.



4. Sacral Nerve Stimulation. This is a very new technique where an electrode is inserted next to one of the nerves supplying the sphincter muscle and the rectum. Stimulation improves continence, urgency and constipation.
   A test lead is placed before the permanent stimulator is implanted.



5. Colostomy. This is usually as a last resort but is a good option for some patients.