

Faecal incontinence: common and treatable

Overcoming embarrassment about this problem is the first step towards a solution

THE ABILITY TO REMAIN CONTINENT is fundamental to our functioning as socially capable individuals. Loss of faecal continence leads to physical, psychological and social disability. Contrary to common belief, the condition is not confined to the disabled elderly. Rather, it affects people of all ages.

The greatest contribution to improving the care of people with faecal incontinence would come from improved recognition by doctors. If those who experience faecal incontinence are able to overcome embarrassment, they will seek help from a doctor, usually their general practitioner. To be told that there is nothing to be done (still a common response) is disheartening — and incorrect.

In this issue of the *Journal* (page 54), Kalantar and colleagues have published important data about the prevalence of faecal incontinence in the Australian community.¹ They used a postal questionnaire to determine the prevalence of faecal incontinence over the previous 12 months. Incontinence for solid stool occurred in 2% of respondents, and of liquid stool in 9%.

These figures are similar to, or somewhat higher than, data published from the USA and Europe over the last 10 years. All recent studies demonstrate that faecal incontinence is common. Current figures are much higher than estimates from the 1980s and earlier, which appear to have markedly underestimated the true prevalence, probably because of the methods of case ascertainment used and the unwillingness of sufferers to disclose the presence of such a stigmatised symptom.

In the study by Kalantar et al, men and women were affected in approximately equal proportion. A perineal tear or surgical trauma were identified as associated factors, as were feelings of impaired rectal emptying, loose bowel actions, and a sense of bowel urgency.

Only one in eight of those with incontinence had sought medical care. This was despite impaired quality of life and perception of poorer health.

In a specialist centre, the commonest cause of faecal incontinence is structural anal sphincter damage associated with childbirth.² The most important risk factor is instrumental delivery; other risk factors are a large baby, occipitoposterior position, and a long second stage of labour.³ Anal endosonography, a painless, quick and non-invasive test, has demonstrated that such damage occurs in up to a third of first vaginal deliveries.³ A third of those with damage will have new bowel symptoms after their delivery. The vast majority of these women have not had a recognised third-degree tear. It is therefore perhaps not surprising that 31% of female obstetricians, when asked about their preferred mode of delivery for their first uncomplicated pregnancy, said they would opt for a caesarean section.⁴ The main reason given was to prevent perineal trauma.

The second-commonest cause of incontinence in a specialist referral unit is postsurgical sphincter damage.² Some patients have anal sphincter damage as an unavoidable consequence of a necessary treatment (eg, in the care of anal fistula). Others sustain irreversible sphincter damage as a consequence of procedures which are now outdated, such as manual dilatation performed for chronic anal fissure, constipation and non-specific anal symptoms.

When there is no structural damage present, the commonest cause of faecal incontinence appears to be a degenerative disorder affecting the delicate smooth muscle which keeps the anal canal closed, the internal anal sphincter.²

In patients with congenital anorectal abnormalities, it has only recently been appreciated that, despite corrective surgery in infancy or childhood, impaired continence can persist into adult life.⁵ Encopresis, often related to behavioural issues, can also severely affect a child's development.

In the elderly, many factors can contribute to impaired continence, including comorbidity, medications, and social circumstances. Faecal impaction is an important factor in some.

Patients with a range of primary disorders, such as neurological disease, inflammatory bowel disease, and connective tissue disorders, can experience severe faecal incontinence. For many this hidden symptom causes them the greatest uncertainty and substantially impairs their quality of life.

Is it worth making a diagnosis? Can anything useful be done? Emphatically, yes. Many individuals can be helped substantially, often by a combination of careful history taking, examination for sphincter damage or impaction, and correction of predisposing factors.

A broad range of therapies have been applied to this condition. Selection of an appropriate therapy, after correcting simple contributory factors, should be based on the aetiology and severity of a patient's incontinence. The least invasive and safest treatments should be used first.

Many patients with excessively strong bowel contractions, or sphincter weakness, can have their well-being transformed by a small dose of an antidiarrhoeal medication such as loperamide. This drug is extremely effective and safe in adults. If patients become constipated, the dose can be reduced.

Behavioural techniques, such as "biofeedback" (teaching patients to improve sphincter function using physiological feedback, such as anal electromyography or pressure measurement) and sphincter exercises, help about two-thirds of patients, including some with structural sphincter damage.⁶ Such behavioural techniques are not simply "exercises"; rather, they involve a complex package of care that includes dietary advice, proper use of constipating drugs, teaching

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patients to resist urgency, decreasing their sense of panic, sphincter training and counselling.

Topical pharmacological therapies have radically altered the management of anal fissure, thereby preventing the need for surgical sphincterotomy (one of the causes of incontinence). The first such topical therapy was glyceryl trinitrate (GTN), which lowers anal tone, thereby allowing fissures to heal. Topical GTN is associated with headache in two-thirds of patients, limiting compliance.⁷ The use of calcium-channel blockers such as diltiazem offers the same therapeutic benefit but without the side effects.⁸ Injectable botulinum toxin also lowers anal pressure and allows healing.

Topical preparations which raise sphincter tone and prevent leakage, such as phenylephrine, are also under development.⁹

Only a very small proportion of patients require surgical treatment. Sphincter repair for major obstetric structural damage produces a good short term outcome, but the longer-term results are less satisfactory.¹⁰ New surgical techniques include:

- The artificial bowel sphincter (a circular cuff implanted around the anal canal and inflated to maintain sphincter closure).¹¹
- Sacral nerve stimulation by means of a fine electrode implanted through a sacral foramen.¹² This is connected to a battery to provide continuous low level stimulation, resulting in altered rectal and sphincter motor function.
- Dynamic graciloplasty. The gracilis muscle is mobilised from the inner thigh and wrapped around the anal canal. Battery stimulation produces muscle contraction, which increases anal pressure.¹³ This procedure has limited application owing to its complexity and associated morbidity.

When all else has failed, a tiny proportion of patients will be well served by a colostomy.

Data such as those published in the Journal today should serve to remind doctors that faecal incontinence is a common and treatable condition. A range of treatments is required if patients with different types and severities of incontinence are to be successfully managed. Such a range of expertise is not readily available in many centres. These data should therefore also remind healthcare planners that this is a health issue which requires action in the community, in addition to multiskilled centres of expertise for the minority of patients who need more intense treatment.

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