Protocol on management of faecal incontinence

Faecal incontinence is a sign or a symptom and is defined as involuntary leakage of gas, fluid and stool leakage thru anus.(1) Around 1-10% of adults are affected and around 0.5%-1% experience FI regularly affecting their quality of life (2)

Classification of FI-

1. Based on symptoms: a. Urge before leakage (Urge faecal incontinence) b. No sensation (passive soiling)
2. Based on the character of leakage : solid, liquid, mucus or gas (the term anal incontinence is used to include gas incontinence)
3. Based on type of patients : Neurological, frail older people, women with OASIS
4. Based on underlying cause: Faecal loading, neurological motor or sensory impairment, damage or weakness of internal or external sphincter, problems with rectal capacity, cognitive impairment, gut motility and problem with toilet access

<u>High risk Group for faecal incontinence</u>

- frail older people
- People with loose stools or diarrhea from any cause
- Women following childbirth (especially following third and fourth degree obstetric injury)
- People with neurological or spinal disease/injury (for example, spina bifida, stroke, multiple sclerosis, spinal cord injury)
- People with severe cognitive impairment

- People with urinary incontinence (see what NICE says on urinary incontinence in women and urinary incontinence in neurological disease)
- People with pelvic organ prolapse and/or rectal prolapse
- People who have had colonic resection or anal surgery
- People who have undergone pelvic radiotherapy
- People with perianal soreness, itching or pain
- People with learning disabilities.

Assessment-

- Relevant Medical history
- General examination
- Abdominal examination
- Vaginal examination – to r/o prolapse and to assess oxford score
- Anorectal examination
- Cognitive assessment if possible

Address potential reversible causes

- faecal loading
- potentially treatable causes of diarrhoea (for example, infective, inflammatory bowel disease, irritable bowel syndrome)
- Warning signs for lower gastrointestinal cancer
- rectal prolapse or third-degree haemorrhoids
- Acute anal sphincter injury including obstetric and other trauma
- Acute disc prolapse/cauda equina syndrome.

Investigations-

1. Defaecating proctogram – if history is suggestive of obstructed defaecatory symptom
2. Endoanal scan
3. Anal manometry- Refer to colorectal nurse

4. Colonoscopy- If red flag sign suggestive of cancer or inflammatory bowel disease. Refer to colorectal

Management-

1. **Life style modification**- Advice on dietary and fluid intervention to maintain an appropriate stool consistency and timing of defaecation. Foods (for example, prunes, figs and rhubarb) contain naturally occurring laxative compounds. Artificial sweeteners such as sorbitol and other non-absorbable sugars also have laxative properties. There is a growing interest in the possible value of probiotics ('good bowel bacteria') and prebiotics (the foodstuffs that allow these bacteria to multiply in the bowel): these are currently classified as foods (rather than drugs) in the UK.
2. **PFMT and Biofeed back**
3. **Drugs –**
    1. Anti-diarrhoeal medication- Loperamide 0.5mgm-16mgm/day) po .can be used as tablet or syrup form (for FI with loose stools) (Contraindication- hard or infrequent stools, acute diarrhoea without a diagnosis, acute flare up of ulcerative colitis)
    2. Laxatives- to promote bowel emptying
    3. Rectal irrigation- to promote emptying and reduce constipation and hence FI

Life style modification, PFMT and drugs can be used on its own or in combination

TREAT VAGINAL OR RECTAL PROLAPSE IF PRESENT

PERIPHERAL TIBIAL NERVE STIMULATION (PTNS) – to Sally colorectal nurse

(If no response with conservative strategies and surgical treatment of vaginal /rectal prolapse)

Refer to colorectal surgeons- to consider options-

1. Sacral Nerve stimulation-
2. Sphincter repair- consider repair if full length external or internal sphincter defect i.e. 90 degrees or more (patients with pudendal nerve neuropathy, IBS, multiple defects and external sphincter atrophy decrease the effectiveness of repair)
3. Antegrade Irrigation (in selected patients with constipation and colonic motility disorder with faecal incontinence via appendicostomy, neo- appendicostomy or colonic conduit)

Reference-

1. See NICE guidance CG49- 2007 https//www nice.org.uk/guidance/cg49
2. Perry S, Shaw C, McGrother C, Matthews RJ, Assassa RP, Dallosso H *et al*. Prevalence of faecal incontinence in adults aged 40 years or more living in the community. *Gut* 2002, **50**(4):480-4.

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