Faecal Incontinence

**Faecal incontinence** is the inability to control or the involuntary discharge of stool or gas. It is estimated to affect 8-9% of the population. Middle-aged women and nursing home residents are more commonly affected. Advancing age, diarrhoea, urinary incontinence and multiple childbirths, particularly vaginal delivery with sphincter tear, are independent risk factors. Faecal incontinence significantly affects quality of life[1].

**Epidemiology**

A study using data from The Health Improvement Network, a UK primary care database, reported a rate of first diagnosis per 1,000 person years of 3.1 for men and 3.6 for women aged 60-89 years. For people with dementia, these figures increased by a factor of at least 4[2].

By virtue of the nature of the condition, faecal incontinence remains largely a hidden problem. Active but sensitive case finding may be required, particularly in high-risk groups[3].

**Risk groups**

- Any patients with diarrhoea.
- Patients with anal problems:
  - Women with third- and fourth-degree obstetric injury.
  - Patients with rectal or pelvic organ prolapse.
  - Patients with pelvic radiotherapy or colonic resection.
  - Patients with perianal itching, soreness or pain, or anal surgery.
- Patients with urinary incontinence.
- Frail elderly patients.
- Patients with neurological problems or spinal disease (eg stroke, multiple sclerosis, spina bifida or spinal injury).
- Patients with severe cognitive impairment or learning difficulties.

When asking questions, always be aware of the physical and emotional impact that faecal incontinence can have on patients and carers.

**Presentation**

Be aware that faecal incontinence is a symptom or sign rather than a disease and that there are often multiple contributory factors[3]. One study found that nearly 40% of men with faecal incontinence report it in the absence of a definable functional or structural sphincter abnormality[4]. Professionals should not concentrate on one specific diagnosis to the total exclusion of all other factors.

A baseline assessment should include relevant medical history, a general examination, an anorectal examination and an assessment of cognitive function if appropriate.

**Aetiology**

Recognised associations with faecal incontinence include:

**Childbirth**

One study showed persistence of faecal incontinence many years after childbirth. One forceps birth increased the risk of faecal incontinence, whereas exclusive caesarean birth showed no association. Obesity as a risk factor[5].

**Surgery**

This is the second most common cause after obstetric trauma. Incontinence may be inevitable after complex anal fistula surgery, or may occur as an unexpected complication after haemorrhoidectomy or surgery for chronic anal fissure[6].

**Degeneration of the internal anal sphincter**

Most cases are due to primary isolated degeneration of the smooth muscle of the internal anal sphincter. Endosonography is a useful investigation to identify surgically correctable sphincter defects[7]. It often shows that the anal sphincter is fibrotic and thin and resting anal pressure is low. Degeneration is occasionally seen secondary to various conditions, such as progressive systemic sclerosis[8].

**Neurological disease[6]**

Possible central neurological deficits include focal brain defects (eg, stroke, cerebral tumours, head injury or multiple sclerosis) or more diffuse brain impairment (eg, dementia, MS, infection, drug-induced).
Congenital disorders
Spina bifida may be associated with faecal incontinence. It can also occur as a consequence of surgery for congenital disorders. Faecal incontinence is a major problem in patients treated for anal atresia and one study of 68 patients with Hirschprung’s disease identified that 82% subsequently had severe soiling\(^9\).

Miscellaneous
Children with a normal sphincter can pass stools inappropriately as part of a behavioural disorder (encopresis) or can have faecal impaction with overflow\(^{10}\). In some children the condition is due to a poorly defined neuromuscular disorder of the distal gut which can persist into adulthood\(^{11}\).

Other conditions that can be associated with faecal incontinence include rectal prolapse, inflammatory bowel disease (IBD) and unwanted anal penetration\(^{12}\).

Faecal incontinence may be caused by constipation in all age groups, not just children and the elderly\(^{10}\).

Management\(^{3,13}\)

Person-centred care
Management should be tailored to the needs of the individual patient. Information should be provided in a format which they can understand, so that they can participate in decisions about their care. Family and carers should be involved in this process, unless the patient deems this inappropriate.

Condition-specific interventions
The following potentially reversible conditions should be excluded and, if present, treated with condition-specific interventions before other initial management is instituted:

- Faecal loading.
- Potentially treatable causes of diarrhoea - for example, infection, IBD and irritable bowel syndrome (IBS).
- Warning signs for lower gastrointestinal cancer (including unexplained weight loss, abdominal pain, change in bowel habit, rectal bleeding or iron-deficiency anaemia)\(^{14}\).
- Rectal prolapse or third-degree haemorrhoids.
- Acute anal sphincter injury, including obstetric and other trauma.
- Acute disc prolapse/cauda equina syndrome (CES).

Basic initial interventions
Interventions should promote ideal stool consistency and predictable bowel emptying.
Diet

- Existing therapeutic diets should be taken into account.
- Overall nutrient intake should be balanced.
- A food and fluid diary might be helpful.
- Advise patients to modify one food at a time.
- Patients with hard stools and/or dehydration should be encouraged to aim for intake of at least 1.5 litres of fluid per day (unless contra-indicated).
- Consider screening for malnutrition or risk of malnutrition.

Bowel and toileting habits

- Bowel emptying should be encouraged after a meal.
- Toilet facilities should be private, comfortable and used safely with sufficient time allowed.
- The patient should adopt a sitting or squatting position to avoid straining.
- Locations of toilets should be made clear and any equipment or help needed to access the toilet provided.
- Advice should be offered on easily removable clothing.
- Refer for home and mobility assessment if appropriate.

Medication

- Consider alternatives to drugs contributing to faecal incontinence.
- Antidiarrhoeal drugs should be prescribed, in accordance with the summary of product characteristics, for people with loose stools and associated incontinence once other causes have been excluded.
- Loperamide hydrochloride should be first drug of choice. Consider loperamide hydrochloride syrup for doses less than 2 mg.
- Codeine phosphate or co-phenotrope may be tried for those unable to tolerate loperamide hydrochloride.
- Loperamide hydrochloride should not be offered to people with hard or infrequent stools, acute diarrhoea without a diagnosed cause, or an acute flare-up of ulcerative colitis.
- Loperamide hydrochloride should be introduced at a very low dose and increased as tolerated until desired stool consistency is reached. Subsequent doses can be adjusted according to stool consistency and lifestyle.

Coping strategies

People with faecal incontinence should be offered advice on:

- Continence products.
- Emotional and psychological support.
- Talking to friends and family.
- Planning travel and carrying a toilet access card or RADAR key.
- Disposable body-worn pads and disposable bed pads.
- Anal plugs.
- Skin-care, odour control and laundry advice.
- Disposable gloves.
- Reusable absorbent products - these are not generally recommended.

Specific groups

People with faecal loading

- Offer a rectally administered treatment to clear the bowel satisfactorily, or a potent oral laxative if this is not appropriate. Often treatment will need to be repeated daily for a few days.
- Recommend a combination of initial management options to reduce recurrence (see 'Specialist management', below).
- Consider the use of orally administered laxatives if rectal treatments fail.
People with limited mobility

- Consider a combination of oral or rectal laxatives and/or constipating agents.
- Review toilet access.
- Advise concerning appropriate disposable products (see 'Coping strategies', above).
- Advise re timing of toileting - ie stool needs to be in the rectum at the time of the planned bowel action.

People using enteral tube feeding and reporting faecal incontinence
Modify the type and timing of feed on an individual basis to establish the most effective way to manage faecal incontinence.

People with severe cognitive impairment

- Refer for a behavioural and functional analysis to determine if there is any behavioural reason for faecal incontinence.
- If behavioural aspects are identified that contribute to faecal incontinence, offer cause-specific interventions founded on structured goal planning that aim to resolve them.
- In cases of severe cognitive impairment, further specialist management of faecal incontinence may be inappropriate.

People with neurological or spinal disease/injury

- Offer, until satisfactory bowel habit is established, a bowel management programme which:
  - Ascertains the person's preferences and premorbid bowel habit.
  - Maximises the person's understanding of normal bowel function and how it has been altered.
  - Modifies diet and/or administers rectal evacuants and/or oral laxatives, adjusted to individual response, to establish a predictable pattern of bowel evacuation.
  - Considers digital anorectal stimulation for people with spinal cord injuries or other neurogenic bowel disorders.
  - Manual removal of faeces may be needed, particularly for people with a lower spinal injury.
  - For those unable to achieve reliable bowel continence after a neurological bowel management programme, offer:
    - Coping and long-term management strategies (see 'Coping strategies', above and 'Long-term strategies', below).
    - Rectal irrigation.
    - Electrical stimulation of the sacral roots has been used with some success in patients with partial cauda equina syndrome[^15].
    - Other surgical options (including stoma) if faecal incontinence or the time taken for bowel emptying imposes major limits on their lifestyle.

People with learning disabilities
It is essential that these people follow the same initial care pathway as other people with faecal incontinence, regardless of when their faecal incontinence started.

Severely or terminally ill people
Consider a faecal collection device.

Specialist management
This should be considered for people who continue to have episodes of faecal incontinence despite initial management. Such management may include:

- Pelvic floor muscle training.
- Bowel retraining.
- Specialist dietary assessment and management.
- Biofeedback.
- Electrical stimulation.
- Rectal irrigation.
- The use of anal bulking agent injections, which has met with variable success. A review found that the use of silicone or ceramic microspheres of calcium hydroxyapatite achieved the best results[^16].
- Surgery - the benefits and limitations should be discussed, as follows:
  - Sphincter repair should be considered for people with a full-length external anal sphincter defect that is 90° or greater and faecal incontinence that restricts quality of life. The effectiveness of the procedure decreased in people with internal sphincter defects, pudendal nerve neuropathy, multiple defects, external sphincter atrophy, loose stools or IBS.
  - One ten-year follow-up study found a gradual deterioration in continence, especially people who were older at the time of surgery or who had more than two births[^17].
  - People undergoing anal sphincter repair should not:
    - Routinely receive a temporary defunctioning stoma.
    - Receive constipating agents in the postoperative period.
  - Consider a trial of temporary sacral nerve stimulation if sphincter surgery is inappropriate and proceed to implantation if successful.
• Consider a neosphincter (stimulated graciloplasty or an artificial anal sphincter) if a trial of sacral nerve stimulation is unsuccessful[18, 19, 20]. Advise patients that they may experience evacuatory disorders and/or serious infection, which may necessitate removal of the device.

• Antegrade irrigation via appendicostomy, neo-appendicostomy or continent colonic conduit should be offered to selected people with constipation and colonic motility disorders associated with faecal incontinence[21].

• A stoma for people with faecal incontinence severely restricting lifestyle should only be considered once all appropriate non-surgical and surgical options, including those at specialist centres, have been considered. Refer to a stoma care service.

Long-term strategies
Symptomatic people, who do not want to persevere with active treatment or who have intractable faecal incontinence, should be offered:

• Advice on preservation of dignity and, where possible, independence.
• At least six-monthly review of symptoms.
• Discussion of other management options (including specialist referral).
• Contact details for relevant support groups.
• Advice on coping strategies and skin care.

Further reading & references
• Faecal incontinence, NICE Quality Standards (Feb 2014)

17. Stimulated graciloplasty for faecal incontinence; NICE Interventional Procedure Guidance, March 2006
18. Sacral nerve stimulation for faecal incontinence; NICE Interventional Procedure Guidance, November 2004
19. Artificial anal sphincter implantation; NICE Interventional Procedure Guidance, June 2004

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