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THE NON-SURGIC AL TREAMENT OF FAECAL INCONTIENCE

This a general document designed to provide background information. It aims to supplement verbal discussion and to be readily available as an *aide memoir*. It may not cover some areas that concern you. These can be dealt with individually. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

What is faecal incontinence?

Faecal incontinence is the involuntary passage of wind (flatus) or stool from the anus. It can range from an intermittent, minor social inconvenience to a debilitating condition that dominates the person's life, and even makes them a social recluse.

The principals that underlie the management of faecal incontinence.

Imagine a vertical tube (the bowel) that contains a mixture of solid, liquid and air. The reason this mixture does not fall out the bottom of the tube is that it is sealed with a rubber band (the anal sphincter). Provided the tightness in the rubber band is greater than the pressure in the tube, the mixture will not leak out the bottom. If the pressure in the tube rises above that of the band, the contents will start to leak out. Alternatively, if the tightness in the band falls below the pressure in the tube leakage will again occur.

The principals that underlie the treatment of faecal incontinence are to determine why there is an imbalance between the pressure in the tube and the tightness of the band. This requires a full clinical evaluation and may require special x-rays and other tests to determine the exact cause of the incontinence. Almost all patients initially require non-surgical treatment. Usually more than one treatment strategy is required. For many patients there is no role for surgery.

Causes.

In broad terms the common causes are:-

Problem	***Cause***
Weak pelvic floor or damage to the anal sphincter muscles	childbirth, anal operations or a perineal injury
Damage to the nerves of the pelvic floor muscles	childbirth, spinal injury, nervous diseases (eg multiple sclerosis), prolonged straining, diabetes
Liquid or loose stool	infection, inflammatory bowel disease, irritable bowel syndrome, previous bowel resection, diet
Rigid or irritable rectum (loss of storage)	constipation, immobility, inflammatory bowel disease

The anal sphincters.

The most common cause of faecal incontinence is damage or weakness to one or both of the anal sphincter muscles.

A weak *external* sphincter muscle typically causes urge incontinence. This is the need to rush to the toilet as soon as the need to defaecate is felt, and there is a risk of being accidentally incontinent if the toilet is not reached in time. This occurs because the weak muscle cannot squeeze hard or long enough to hold in the stool.

A damaged *internal* anal sphincter typically causes passive soiling as soft stool, or small pellets of stool, just leak out. There may be great difficulty in wiping clean after emptying the bowel. Sometimes there is damage to both the sphincter muscles, and this may lead to leakage without awareness, as well as urgency and urge incontinence.

Stool consistency.

The stool consistency is greatly influenced by what we eat and drink. If your stool is too soft it will 'break up' during defaecation. This will result in stool being smeared over the perineum and left in the anal canal. This will then leak out. Alternatively, part of the stool will be left in the lower rectum. This may later then leak out, especially of the sphincter muscles are week.

You need to carefully consider what you eat and drink. See the separate advice sheet 'Soft stools'. Experiment by excluding one type of food from your diet and monitoring the response. It should then be possible to find what affects your bowel.

Fluids	You should drink no more than 1 litre of fluid per day. Excess fluid will tend to make your stool softer. Alcohol may make the stool loose. Because of its volume and yeast, beer is often worse than other drinks.
Caffeine	Caffeine is found in coffee, tea, cola drinks and chocolate. Caffeine stimulates the bowel and as the stool then passes through faster, less fluid is absorbed and the stools are looser. Caffeine also relaxes the anal sphincter. Exclude caffeine from your diet and see if you improve.
Artificial sweeteners	Artificial sweeteners are sugars that are not absorbed by your body. Some non-absorbable sugars are used as a laxative. Not surprisingly artificial sweeteners may make the stools loose, or even cause diarrhoea. It may be worth eliminating all artificial sweeteners and seeing if this helps. Artificial sweeteners are found in most foods and drinks branded as 'low calorie', including 'Diet' drinks and low sugar chewing gum.
Fibre	Although fibre is good, it can make incontinence worse as it keeps fluid in the bowel and makes the stools loose and more likely to leak. As fibre stimulates the bowel you have to visit the toilet more often. Initially you should omit foods, which are obviously high in fibre. Soluble, or digestible fibre (eg bananas, potatoes, rice, pasta, oatmeal) is less likely to cause a problem. Spicy or hot food can simulate the bowel. Other foods, such as arrowroot biscuits, marshmallow sweets and bananas can help.
Other foods	Some people find specific foods make matters worse. Try excluding food in sequence and see how you are affected. Foods that are often implicated include smoked products, fatty and dairy foods.
Medications	Many medications influence the stool consistency.

Medications

Medicines for incontinence may be used to solidify a liquid or soft stool, to make the bowel squeeze less strongly or to ensure the rectum empties fully. Some may increase the tone of the sphincter muscles. If diarrhoea is present, treating this should lessen frequency and urgency and make incontinence less likely. If you are opening your bowels more than once each day and have soft or loose stool you may benefit from the use of medications.

Suppositories	It is important that your visit to the toilet completely empties your rectum. A suppository can be inserted as soon as you awake. You will usually be able to hold it for 20-30 minutes. This will then give a good bowel action that should not require you to linger on the toilet, nor require you to strain. The rectum will then be empty and will not contain any stool to leak out during the day. People in whom passive leakage is a major problem may choose to slow the bowel down

	so there are no bowel actions without the help of suppositories or an enema. These can be used to empty the bowel once every few days.
Loperamide (Imodium) Codeine phosphate	These drugs slow the passage of stool through the colon. More water is then absorbed and the stool becomes firmer and so less likely to leak. It is usually best to take these medicines before food rather than after. Loperamide makes the stool firmer. This may control the passive seepage of loose stool. The ideal dose needs to be individually determined as it is difficult to predict the dose that will be effective, but not cause constipation. Codeine phosphate has a similar, but more powerful effect. Some people find one or other of these drugs works best for them, or that a lower dose, but in combination, is better. You should experiment to find the regime that suits you best.
Bulking agents	If the stools are very loose, especially if there seems to be a lot of mucus, medications such as Fybogel or Metamucil can absorb excess fluid and produce a more formed stool.

Pelvic floor exercises

Sphincter exercises can help. These exercises strengthen the external anal sphincter to help you to hold both flatus and stool. Women will be familiar with these exercises from when they were pregnant. A physiotherapist will show you the exercises, but they will only work if you perform them frequency and completely. A further visit to the physiotherapist after two to three months for a check is very helpful.