Anal Incontinence

BIRMINGHAM PELVIC FLOOR CLINIC

Anal, or faecal incontinence is the inability to control bowel movements, leading to an unexpected or unpreventable leakage faeces. This can mean an inability to control, solid stools, liquid stools or wind.

Anal incontinence affects more women than men. It does however affect both sexes more equally with increasing age. Women can be affected by anal incontinence after childbirth, particularly as a result of a difficult delivery which may have required the use of forceps or an episiotomy.

In the elderly anal incontinence can develop when muscles become gradually weaker.

Incontinence can also occur as a result of muscle damage from anal and rectal surgery. Muscles can be damaged occasionally during relatively simple surgery to treat haemorrhoids, a fistula or a fissure. Patients who have undergone major surgical operations on the rectum or after treatment with radiotherapy may also develop problems with bowel control.

Damage to the nerves controlling anal muscle function and rectal can lead to incontinence. Childbirth can also be responsible for nerve damage as well as with certain chronic diseases such as diabetes or multiple sclerosis. A spinal cord injury or a stroke may also result in anal incontinent symptoms.

Symptoms of Anal Incontinence

Symptoms of anal incontinence can vary from soiling i.e. stains on underwear, loss of control of gas through to total loss of control of liquid or solid stools.

We tend to break down the symptoms into two categories:

- **Urge bowel incontinence** - an individual may have a sudden or urgent need to go to the toilet but not be able reach the lavatory every time. This usually indicates a problem with voluntary control of our sphincter muscles.
- **Passive incontinence** – an individual has a lack of any sensation that a stool or gas is being passed. This usually indicates a problem with the involuntary part of our sphincter muscle or with sensation in that area.

How Anal Incontinence is Investigated

When you are seen in clinic the consultant will take a full history and carry out a clinical examination. Usually this will involve a rigid sigmoidoscopy and sometimes a proctoscopy as well.

If you are over the age of 40 the consultant will normally recommend endoscopic examination of the bowel either by flexible sigmoidoscopy or colonoscopy to ensure that the bowel is otherwise healthy.

Anorectal physiological testing will usually be performed together with an endoanal ultrasound scan to look specifically at the structure and function of the anal sphincter muscles. Sometimes an MRI scan can be helpful to examine all the pelvic floor muscles and is also useful to the way that the bowel empties. A videoproctogram may be requested If there any symptoms of rectocele or prolapse.

Anal Incontinence Treatment

As continence is affected by a whole host of factors, not just the sphincter muscle function, it is important that we try to address as many of these as we can to control the problem.

In most cases we aim to manage this with 'conservative' treatments i.e. without the need for surgery. Conservative treatments include change in diet, the use of bulking agents, anal plugs, anti-diarrhoeals, suppositories, enemas, and physiotherapy / biofeedback.

Diet is a really important factor in controlling bowel function. Dietary help can often be helpful in improving the symptoms.

The use of a 'bulking agent" such as ispaghula husk often sold as Fybogel can bulk up the stools and regularize bowel habits.

Cutting out caffeinated drinks and reducing alcohol intake are also useful in improving symptoms.

Losing weight may be beneficial for some patients as well as undertaking regular exercise.

Pelvic floor physiotherapy and biofeedback techniques aim to strengthen the sphincter muscles to give more control over bowel movements.

Biofeedback treatments can also help with sensations of urgency

Sometimes medications may cause changes in bowel function leading to incontinence or make existing symptoms worse. You should never stop any prescribed medication without speaking to your doctor first.

The use of an anti-diarrhoeal medications such as loperamide is very helpful for many patients. Loperamide reduces bowel frequency and makes the stools firmer. Loperamide can be taken in as capsule by mouth, in a 'melt' placed under the tongue, or as a syrup. The syrup form is only available on prescription.

Patients may choose to take a small dose regularly or just use it on an as required basis.

The use of suppositories or an irrigation device to help empty the rectum may stop leakage resulting from incomplete passage or evacuation of stools.

Anal plugs are small devices that can be placed inside the bottom to prevent small amounts of leakage.

Sacral nerve stimulation - (also known as sacral neuromodulation) is a procedure whereby a device is implanted in the lower back. This stimulates the nerves in the pelvis and has been shown to be beneficial in some patients with anal incontinence. The procedure is usually carried out in two stages. In the first stage involves placement of a temporary implant to gauge the effect on symptoms over 2-3 weeks. If it is beneficial then a permanent implant is inserted..

Sphincter repair - this surgery aims to repair damaged sphincter muscles. A cut is made in the skin around the bottom and the damaged muscle can then be repaired usually by overlapping the ends. .

Colostomy - this procedure is only recommended when other surgical treatments have been unsuccessful. The procedure involves dividing the colon and bringing the end to the body surface. Waste then empties into a bag attached to the skin.