



Fecal Incontinence

Fecal incontinence is the inability to defer the passage of stool or gas to an appropriate time and place. It may be a profoundly embarrassing and debilitating condition that can compromise social, professional and personal function and alter one's way of life. Fecal incontinence results from a variety of causes and may be simple or complex in nature.

Fecal continence (control of bowel movements) is dependent on several different and interrelated functions including:

- the amount, frequency and consistency of stool
- a compliant and functioning rectum that will expand to hold stool and contract appropriately to empty
- intact internal and external anal sphincter muscles to control the outlet
- proper sensation in the rectum and anal areas
- an awake and responsive individual

Compromise of any of these components may lead to incontinence. Some people have one problem among those listed and some have many. In addition, fecal incontinence may be related to other disease processes that affect the factors listed above. For example, neurologic disorders such as spinal injuries, diabetic neuropathy, and multiple sclerosis may lead to incontinence. Thus, evaluation of persons with fecal incontinence requires a medical history and careful physical examination. Other tests may be needed such as colonoscopy, anorectal manometry, anal ultrasound or pudendal nerve terminal motor latency studies. Some or all of these studies may be needed to identify the cause of your symptoms and to choose the best therapy.

Some Causes of Fecal Incontinence

- Vaginal childbirth with injury to the anus or rectum
- Trauma to the anus or rectum from other causes
- Anorectal surgery
- Spine or pelvic trauma or surgery
- Radiation and chemotherapy
- Diabetes mellitus
- Neurologic diseases
- Tumors of the colon, rectum, pelvis, spine
- Inflammatory bowel disease – ulcerative colitis or Crohn's disease

Approach to Fecal Incontinence

Since fecal incontinence is both symptom and a diagnosis, it is important to objectively assess how bad it is. You may be asked by your doctor to determine the frequency of accidents (daily, weekly, monthly, occasionally, never), if and how often you wear pads, and if or how often fecal incontinence forces you to modify your lifestyle. This information contributes to a scoring system that may be used to understand the severity of your problem. Your description of your symptoms, the scoring system, the physical



findings and the test results are all used to help the doctor determine which type of therapy is best for you. It is important to match the type of intervention with the severity and impact of symptoms. This is a complex assessment can only be achieved with active patient participation.

Fecal incontinence is treatable and controllable. However, successful therapy requires active patient participation both for diagnosis and for therapy. Only you can determine just how bad the symptoms are and its impact on your quality of life. It is up to you to monitor your progress and your response to management.

Stage I – The Bowel Management Program

Initial therapy of fecal incontinence is designed to be empowering and to help you understand your condition better. You will be asked to follow a bowel management program. Although this will vary somewhat with your individual situation, the program generally is as follows.

1. Eat regular meals at the same times each day with similar foods. It is best to start with a boiled, broiled and bland diet. Remember BRAT (bananas, rice, applesauce, toast) and BBB (Boiled, Broiled and Bland) as foods that help to thicken and slow bowel movements.
2. Certain foods increase bowel function and secretion and should therefore be avoided. These include caffeine, alcohol, licorice, chocolate, greasy fried foods, high-fat foods, milk and ice cream, citrus fruits, leafy green vegetables, and heavily spiced foods.
3. Drink 4-6 glasses of water and other fluids per day. Beverages with alcohol or caffeine increase urination and dehydration and do not count.
4. Consume 3-6 grams of fiber products (Metamucil, Konsyl, Citrucel, or Benefiber) 2-3x per day. Although some of these products are labeled “laxatives,” they actually absorb water, make liquid stools more solid, and hard stools more soft, and overall promote regularity.
5. Keep a careful journal of meals, fiber products, frequency of bowel movements and episodes of incontinence.

A 4 to 6 week trial of this regimen usually restores regularity to bowel movements and make them more predictable. Most people with stable health on an established regiment of medications and diet will develop some degree of regularity. It is importantly to remember that illness, changes in medications, surgery, radiation and chemotherapy, travel or other alterations in your routine can disrupt regular bowel habits.

Adherence to this regiment does not mean that one cannot eat fried or spicy foods ever again. Such indulgences, known as “dietary indiscretions,” are acceptable and enjoyable parts of life. However, if you know that they will cause problems, plan ahead. Stay at home or in close proximity to a bathroom, and keep a change of clothing on hand. Just as excessive alcohol consumption can leave one with a hangover the next morning, so too can dietary excess lead to loss of bowel predictability and control.



For some people with mild incontinence, bowel management may be all that is necessary. These are individuals who retain some sphincter function and sensation and can therefore plan their day around predictable, regular bowel function.

Stage II - Stimulated Defecation

For many people, bowel management will restore predictability, but not control of bowel movements. Such individuals may benefit from *stimulated defecation*. This regimen involves the regular use of enemas or suppositories, along with Imodium or Lomotil. Enemas may be used to stimulate a bowel movement at specific times during the day, particularly after a meal. A bowel-slowing agent such as Imodium may then be taken to keep stool from coming down into the rectum until the next scheduled bowel movement. This regimen must be undertaken along with the bowel management program, and not merely alone, to avoid excessive constipation.

This regimen is for those who have no control of bowel movements but who can achieve regularity with scheduled meals and fiber. Rather than waiting for a bowel movement, you can stimulate one with a suppository or enema at a given time. Some trial and error is often necessary to achieve reasonable balance predictability. The use of a journal to monitor both frequency of bowel movements, meal times, use of fiber and use of these agents is helpful.

Stage III – Pelvic Floor Rehabilitation

Pelvic floor rehabilitation is method of anal sphincter exercise and sensation training designed to improve the function of weakened muscles and nerves. Using pressure and electrical sensors in the anal canal and rectum, activity at rest, with squeezing and with bearing down is shown on a computer screen. In this way you can see the effect of your efforts. Under the direction of a therapist, this feedback may be used to learn to exercise the muscles or to improve awareness of rectal filling. Pelvic floor rehabilitation therapy generally requires several sessions with the therapist and regular exercise at home.

Stage IV - Surgical Intervention

Most people with fecal incontinence will not be candidates for surgical correction. Yet, selected individuals may benefit. Surgery is not for everyone as it involved varying degrees of risk and complications.

A variety of surgical procedures and techniques exist for the treatment of fecal incontinence. The type of procedure must match the symptoms and clinical condition and is determined on an individual basis. Procedures include:

- Sphincteroplasty - direct repair of a muscle defect
- Artificial bowel sphincter – an implanted inflatable donut placed around the anal muscles
- Sacral nerve stimulation – electrodes placed to stimulate spinal nerves
- Colostomy or ileostomy



The results of these interventions vary and perfect continence is difficult to achieve in many people. It is important to understand that fecal incontinence can be cured with a colostomy or ileostomy. Properly placed and constructed, a stoma will restore control over bowel function. However, this requires a surgical procedure, general anesthesia, and introduces a major change in body image and way of life. Stomas are also associated with their own complications.

Fecal incontinence is a complex and varied problem, ranging from occasional mild soiling and irritation to complete loss of bowel control. Treatment is based on symptoms and the results of evaluation. Our goal is to help you regain the ability to control bowel activity and to function as normally as possible.