



Faecal incontinence is a considerable but probably very much under-reported problem. It particularly prevalent in post-menopausal women but can affect any age in both sexes. A significant proportion of individuals suffer with faecal incontinence as a result of neurological, muscular as well as psychiatric disorders, the diagnosis of which is usually well established and managed by specialists in the field. Underlying serious bowel disorders (colitis and colorectal cancer) may occasionally manifest themselves as faecal incontinence and necessitate appropriate treatment but in the majority of sufferers attending a specialist clinic, a sphincter or pelvic floor disorder is diagnosed.

Faecal incontinence or soiling (of the skin and underclothes) includes the involuntary release of wind and liquid or solid stools from the anus. This may be an event that the individual is aware of (urge incontinence) or unaware of (passive incontinence).

Introduction

Normal bowel continence is achieved by the action of two rings of muscle (one within the other) which make up the wall of the anal canal or sphincter. The inner layer of muscle (internal sphincter) is not under voluntary control by the patient and is kept contracted at all times except when the bowels are opening.

The nerve supply to this muscle runs across the wall of the pelvis and is particularly prone to stretching or crushing especially during pregnancy and childbirth. This may result in poor function of the muscle and passive incontinence, the unexpected finding of faecal material around the anal canal and within the underclothes. A small number of patients may in the past, have had anal surgery or conditions that have injured the sphincter muscles.

The outer layer of muscle (external sphincter) is a different type of muscle which has some degree of control by the individual. It is normally relaxed and only contracts under stimulus from the nerves that supply it when the mechanism controlling continence is put under stress for example when the rectum has become full and begins to involuntarily contract or when coughing or straining. The external sphincter (along with the internal component) may be injured during childbirth particularly if difficult requiring forceps or when tearing occurs. The effects may not become apparent until many years later when, as with many muscles weakening occurs with age.

Damage to any part of the mechanism of continence, or excessive strong contraction of the rectum when inflamed, (with gastroenteritis, colitis or

a tumour) results in incontinence. In some patients with severe constipation the rectum and anal may fill with stool and become abnormally distended allowing liquid faeces from above to trickle past and lead to incontinence. Rectal prolapse deforms the sphincter mechanism making it less efficient and prone to failure.

Investigation

In a specialist clinic a full history and examination of the anal canal and rectum will be undertaken which usually identifies the likely cause of the problem. Evaluation of the anal canal, rectum and left side of the colon with endoscopy may be arranged to exclude serious bowel pathology. The anal sphincter is usually evaluated by means of an ultrasound scan probe that is inserted into the anal canal. This may identify any defects within the muscles which might benefit from surgical repair. The strength of these muscles and the ability of the pelvic nerves to send impulses to the sphincter muscles can be evaluated by a different device similarly inserted, with safety and with comfort.

Treatment

Once significant bowel disease has been excluded or treated the poor function of the sphincter mechanism can be addressed.

The majority of patients do not have a sphincter injury that is significant or amenable to surgical correction and are treated with conservative measures. For those with a sizeable defect of both the internal and external sphincter an operation (sphincter repair) is performed through the skin in front of the anal canal to overlap

the torn ends of the muscles in the hope that this will improve function. Unfortunately nerve injury is not amenable to surgical correction.

Conservative measures

Most patients in specialist clinics will have their symptoms relieved or significantly improved using the techniques below.

- 1 Weight loss programmes where appropriate
- 2 Pelvic floor exercises supervised by specialist physiotherapists (Kegel's exercises)
- 3 Constipating drugs (Imodium)
- 4 Sphincter plugging (cotton wool ball, continence aids)
- 5 Antispasmodic drugs
- 6 High fibre diet
- 7 Biofeedback. Devices are inserted in the anal canal which give visual feedback upon squeezing using the sphincter muscles. This helps patients retrain their pelvic floor and sphincter muscles.

Continence advisors are usually on hand to assist with the successful adoption of these techniques.