Co-Management and Referral Guidelines

Management of Fecal Incontinence

Pelvic Floor Group

Phone: **503-413-5787**
Fax: **503-413-5788**

Introduction

- Fecal incontinence is a frequent and debilitating condition that can result from a multitude of different causes
- Fecal incontinence is defined as the uncontrolled passage of feces or gas over at least one month's duration, in an individual of at least 4 years of age, who had previously achieved control.
- Incontinence has a negative impact on self-esteem and quality of life, and may result in significant secondary morbidity, disability and cost
- The Mature Women's Health Study indicated that nearly 20 percent of women over 45 have fecal incontinence at least once per year, with 9.5 percent having at least one episode per month.

Treatment of fecal incontinence can be challenging and must be individualized.

Evaluation and Management

Evaluation — A careful history and physical exam should be performed to evaluate for causes contributing to fecal urgency and/or diarrhea and to assess for other symptoms including abdominal pain and concomitant urinary incontinence.

Triggers of fecal incontinence may include:

- Caffeine, sugar replacements, lactose, other dietary components (FODMAPS)
- Medications
- Infectious enteritis

Exam — Physical exam should include focused abdominal exam and digital rectal exam to evaluate for anal tone, anorectal mass or bleeding. Special attention to the perineum and perianal skin may identify other contributing issues such as prolapse or severe skin breakdown.

Diagnostic imaging/testing — Endoscopy, anorectal physiology testing and further imaging can be deferred prior to specialist evaluation. Specialist assessment will generally include the following:

Thorough history and physical including digital exam, perineal exam, anoscopy/proctoscopy. Colonoscopy should be performed if the patient is not up-to-date or if last colonoscopy predates development of symptoms. Physiologic testing and anorectal ultrasound are sometimes considered particularly in patients with history of anorectal trauma. Patients are generally asked to complete a stool diary to better characterize their symptoms prior to and during/after treatment.

Treatment

Recommended first-line therapy for fecal incontinence involves dietary and medical management and can be initiated by primary care providers:

- Limiting aggravating dietary intake
- Stool testing for infectious enteritis including *Clostridium difficile* infection: stool culture, *C. difficile* PCR test, fecal leukocytes

(continued)

- Addition of fiber supplements : 25mg or more of fiber/day, increasing soluble fiber intake
- Adsorbants such as Kaopectate to decrease excess stool fluid
- Cholestyramine for bile salt binding particularly in patients with history of cholecystectomy or ileocolonic resection
- Antidiarrheal agents such as loperamide, diphoxylate-atropine to decrease motility, may increase internal anal sphincter tone
- Skin care including barrier creams (Calmoseptine, zinc oxide etc)

Specialist treatments include:

Pelvic floor physical therapy

- Patients may benefit from pelvic floor physical therapy and biofeedback to improve sensation, coordination and strength.

Surgical treatment

- Anatomic defects, including rectovaginal fistula, rectal or hemorrhoidal prolapse, anal fistula or other anatomic deformity should be repaired as this may correct or improve incontinence
- Incontinent patients may be considered for sacral neuromodulation as a first-line surgical treatment. This procedure has been shown to be efficacious in patients with or without anal sphincter defects. This procedure involves two stages. The first stage involves temporary lead placement with assessment of response. Patients who achieve a reduction in incontinence episodes then undergo permanent lead and device implantation.
- The injection of bulking agents may help decrease incontinence episodes in patients with mild passive fecal incontinence.
- In patients with anal sphincter disruption, usually the result of obstetric injury, sphincter repair may be indicated. However, the durability of such repairs is generally understood to be poor, and sacral neuromodulation may be more effective.

Other treatments include creation of a colostomy for permanent fecal diversion.

Implantation of artificial bowel sphincter may be another option for very select patients. This procedure has been shown to have a very high rate of complications and is not performed by our specialists at this time.

When to refer

Routine referral — Patients with chronic mild symptoms refractory to initial therapies and/or rectal prolapse or other anorectal symptoms or concerns should be referred to the Pelvic Floor Group for further evaluation.

Emergent/urgent referral — Any patient with acutely worsening or severe abdominal pain or severe rectal bleeding should be referred to the nearest emergency department for assessment.

Patients with history of IBD/CRC, weight loss or bleeding should be referred to gastroenterology for urgent evaluation.

Referral process

Epic referral may be placed to "Pelvic Floor" or contact the Pelvic Floor group at 503-413-5787 for urgent referrals and/or questions regarding disposition.

November 2017

Find this and other co-management/referral guidelines online at
www.legacyhealth.org/womenshealth under Resources for Health Care Providers

LEGACY HEALTH

Fiber — Soluble vs. insoluble

Presented by Legacy Health Pelvic Floor Group

Soluble fiber helps hydrate and move waste through your intestines at the best rate .

Recommendation:
25 grams or more per day

Good sources of soluble fiber

- Oats and oat bran
- Beans — black, navy, kidney, pinto
- Lentils
- Soybeans
- Tofu
- Barley
- Flaxseed
- Brussels sprouts
- Peas
- Sweet potato
- Avocado
- Berries
- Apples
- Oranges
- Bananas

Beans, fruits and vegetables have both soluble and insoluble fiber.

Soluble fiber supplements

Full effect may take 12–24 hours

Start with 1 teaspoon per day and increase by 1 teaspoon each week. Maximum 3 teaspoons (1 tablespoon).

You also need to also drink lots of water.

- Citrucel (methycellulose) — better tolerated if bloating is an issue
- Konsyl (natural source: psyllium)
- Nature Made Fiber Adult Gummies (inulin)
- Acacia fiber
- Metamucil (natural source: psyllium)
- Benefiber (guar gum)

Good sources of insoluble fiber

- Whole wheat
- Bran
- Bulgur
- Rye
- Brown rice
- Beans — black, navy, kidney, pinto
- Skins of fruits
- Vegetables

Beans, fruits and vegetables have both soluble and insoluble fiber.

November 2017

LEGACY HEALTH