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Original article

High-Resolution Circuit for the Diagnosis of Faecal Incontinence. Patient Satisfaction☆

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ABSTRACT

Introduction: Despite its high prevalence, faecal incontinence (FI) is still underrated and underdiagnosed. Moreover, diagnosis and subsequent treatment can be a challenge for the colorectal surgeon because of its associated social taboo and embarrassment, and the wide range of symptoms. The aim of the present study is to describe a new high-resolution circuit (HRC) for FI diagnosis, that was implemented at our centre and to evaluate patient satisfaction.

Methods: The structure and organisation of the HRC are described. Demographic and clinical data of the patients included in the HRC between February 2014 and June 2016 were collected. Moreover, patients' satisfaction was measured through a structured survey.

Results: A total of 321 patients were evaluated in our pelvic floor outpatients clinic during the study period: 65% (210) of them had FI (81% women, median age 66 years). The mean time since FI onset was 24 (range 4–540) months. A total of 79% (165) of the patients were included in the HRC. 62% of them responded to the survey. Of these, only 32% (33) had consulted for FI before coming to our centre. The majority, 88% (90) considered that performing the 2 diagnostic tests the same day of the visit was a very good option. And 94% (96) were satisfied with the information received on their FI, with a median satisfaction value of 10 (5–10).

Conclusion: With the HRC, the patient spends about 2 h in the outpatient clinic of the hospital, but leaves with the complete diagnostic process performed. The satisfaction survey confirms that most patients prefer this system.

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Circuito de alta resolución en el diagnóstico de la incontinencia fecal. Satisfacción de los pacientes

Palabras clave:
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Incontinencia anal
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Consultas externas
Satisfacción del paciente

RESUMEN

Introducción: La incontinencia fecal (IF), pese a su elevada prevalencia, sigue estando infravalorada e infradiagnosticada. La potencial afectación psicológica, el tabú asociado y el amplio abanico de síntomas hacen del diagnóstico y tratamiento un reto para el cirujano colorrectal. El objetivo de este estudio es describir un nuevo circuito de atención especializado, el circuito de alta resolución (CAR) para tratar la IF, y evaluar la satisfacción de los pacientes.

Métodos: Se realiza una descripción de la organización del CAR. Se analizan los datos demográficos y clínicos de los pacientes incluidos en el CAR entre febrero de 2014 y junio de 2016. Se reportan, además, los resultados de una encuesta de satisfacción sobre el CAR realizada a los pacientes incluidos.

Resultados: Durante el periodo de estudio se realizaron 321 primeras visitas: 65% (210) por IF (81% mujeres; mediana de edad 66 años). El tiempo mediano de evolución de la IF fue de 24 (rango 4-540) meses. El 79% de los pacientes (165) realizaron el CAR. El 62% respondieron a la encuesta. De estos, solo un 32% (33) habían consultado por este problema en otros centros. La mayoría, 88% (90) consideró preferible el hecho de que hicieran las pruebas diagnósticas el mismo día de la visita. El 94% (96) quedó satisfecho con la información recibida sobre la IF, valorando la consulta con una mediana de 10 (5-10) sobre 10.

Conclusión: Con el CAR, el paciente pasa alrededor de 2 h en las consultas externas del hospital, completando el proceso diagnóstico en el mismo día. Los resultados de satisfacción confirman que los pacientes en su mayoría prefieren este sistema.

Introduction

Until a few decades ago, there was no effective treatment for faecal incontinence (FI) except for surgical repair in cases of sphincter lesions.

In the last 20 years, there has been growing interest in treating these patients, which has led to a greater understanding of what occurs when a patient is not able to properly control faeces as well as the development of new imaging tests, study tools and therapeutic procedures.

In spite of this, the problem continues to be underestimated and underdiagnosed: some physicians are unaware of the therapeutic options, the patients themselves do not know where they should ask for help, and many medical institutions do not support or even contemplate this problem, in spite of its high prevalence.

The reported incidence is variable depending on several factors and the definition of FI,[1] but a local study has concluded that it might affect 10.8% of the adult population,[2] which is an incidence similar to diabetes mellitus.

The effect on the quality of life in patients with FI is comparable to that of patients with inflammatory bowel disease and surpasses that of other chronic patients, such as those with rheumatoid arthritis. It increases proportionately as the severity of the symptoms increases, especially in the social and emotional domains.[3] Furthermore, it has been demonstrated that chronic alterations in quality of life can involve irreversible deficits, essentially in the social dimensions.

The diagnostic-therapeutic delay in patients with FI is multifactorial, but undoubtedly one of the reasons lies in the healthcare system diagnostic circuits. Some studies indicate that the average time between the onset of the problem until the patient receives care is 55 months (9–360).[4] In the specialised healthcare system in Catalonia, the standard circuit consists of an initial visit to the hospital after having been referred from the primary care setting and several months on a waiting list, depending on the hospital. At this initial office visit, at which the specialist has 10 min to assess the patient, a series of complementary tests is usually ordered, which may take several months more to complete at most hospitals.

The primary objective of this study is to describe a new specialised care programme, the ''high-resolution circuit'' (HRC), for defecation disorders and to describe the series of patients included. The secondary objective was to evaluate the satisfaction of the patients treated in this circuit.

Methods

The HRC involves an initial office visit for all patients with defection dysfunctions of between 30 and 45 min, at which time the surgeon takes a detailed patient medical history and examines the patient as part of the protocol. In patients with FI, the HRC is completed with endoanal ultrasound and anorectal manometry that same morning.

That same week, the patient has a visit with specialised nursing staff for approximately 45 min, at which time dietary