Evidence-Based Update on Treatments of Fecal Incontinence in Women

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KEYWORDS

• Accidental bowel leakage • Anal incontinence • Anal sphincter
• Defecatory disorders • Fecal incontinence • Treatment • Surgical treatment

KEY POINTS

- Fecal incontinence (FI), defined as the complaint of involuntary loss of liquid and/or solid stool, is caused by disruption of the multicomponent continence mechanism.
- FI is a physically and psychosocially debilitating condition. Many women are reluctant to report their symptoms and seek care.
- Management options for FI consist of conservative and/or surgical approaches, and more-invasive therapies should be reserved for patients with a refractory condition.
- Traditionally, options were limited once patients had failed conservative therapies. Surgical management of FI was considered invasive and provided only short-term success with high complication rates.
- Recent research has demonstrated not only the long-term safety and efficacy data on existing modalities but also the development of less-invasive options and investigational devices.

INTRODUCTION

FI, defined as the complaint of involuntary loss of liquid and/or solid stool, is a highly prevalent condition. In community-dwelling women, the reported prevalence of FI varies widely from 2.2% to 24% and rises with advancing age.[1–8] Epidemiologic studies suggest that up to 70% of patients with FI have not reported their symptoms to health care professionals.[9,10] Thus, the prevalence of FI is often underestimated. The negative

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consequences of FI include not only the physical debilitation but also the social isolation, embarrassment, loss of employment, and effect on intimate relationships and self-esteem. To reduce the burden of FI, eliminate stigma, and promote care-seeking, it is important to raise public awareness of the condition and various treatment options available to those who suffer in silence. Another obstacle to help-seeking is that many providers fail to screen for FI because of the complexity in evaluation as well as a lack of clinical experience and knowledge on the current management approaches.

The etiology of FI is multifactorial and caused by the disruption of the continence mechanism dependent on anal sphincter function, intact rectal sensation, adequate rectal capacity, compliance, colonic transit time, stool consistency, and cognitive and neurologic factors. It was reported that 80% of patients with FI had more than 1 continence factor compromised.[11] This article reviews the evidence-based approach in the management of FI.

MANAGEMENT

The goal of treatment should focus on restoring continence and improving quality of life (QOL). Health care providers should routinely ask patients about the presence of FI directly, rather than relying on voluntary reporting, and identify conditions and risk factors that may predispose to FI. To provide proper treatment, clinicians should determine symptom severity and characterize stool type, frequency, amount of leakage, and the presence of urgency. It is helpful to obtain bowel diaries because they are shown superior to self-reports for characterizing bowel habits and can better predict colonic transit.[12,13] Recognizing the type of FI based on the awareness of the desire to defecate before leakage can provide clues to underlying pathology: (1) urgency incontinence, or inability to postpone defecation on urgency, can be related to external anal sphincter (EAS) dysfunction; (2) passive incontinence, or the loss of stool without the urge to defecate, is often attributed to internal anal sphincter (IAS) dysfunction and peripheral neuropathy; and (3) fecal seepage is related to incomplete evacuation and impaired rectal sensation.

Management of FI consists of conservative and surgical approaches. Conservative treatment includes lifestyle changes, medications, pelvic floor muscle exercises, physical therapy with or without biofeedback. Unfortunately, no single option has been shown to provide consistent, long-term effectiveness with low complication rates, making FI extremely difficult to manage. However, symptoms may be alleviated by simple measures.

Dietary Considerations

Avoid offending foods

The frequency and consistency of stool can greatly affect symptom severity. Patients should be educated on factors contributing to bowel disturbances and loose stool consistency, including foods containing incompletely digested sugars (fructose and lactose), sweeteners (sorbitol, xylitol, and mannitol), carbonated beverages, caffeine, alcohol, cured or smoked meat (sausage, ham, and turkey), spicy foods, and fatty/greasy foods. Bowel and food diaries can help identify an individual's offending food items that cause loose stools and incontinence. In cases of diarrhea, patients should be evaluated and treated for any underlying cause. Fecal impaction should be treated and prevent further constipation to avoid overflow incontinence.

Fiber supplementation

Fiber supplementation along with dietary modification is one of the first-line treatment options for FI, which is helpful particularly in women with low-volume,

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