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CLINICAL ARTICLE

Anal incontinence severity assessment tools used worldwide

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ABSTRACT

Objective: To conduct an international survey of anal incontinence assessment tools and the need to evaluate frequency of occurrence of fecal urgency. **Methods:** A questionnaire on the use of anal incontinence assessment tools was distributed between May and December 2012 among clinicians and researchers dealing with anal incontinence, primarily in North America, Europe, and Asia. **Results:** A total of 143 responses were collected from 56 (39.2%) obstetricians, gynecologists, and urogynecologists; 71 (49.7%) colorectal surgeons, proctologists, and general surgeons; and 16 (11.2%) physiotherapists, theoretical scientists, and gastroenterologists. Fourteen different tools were reported—most commonly Wexner score (n = 78; 48.8%) and St Mark's score (n = 29; 18.1%). No scoring system was used by 24 (16.8%) respondents. Thirty-four (28.6%) used multiple tools. There was variation in the reasons given for scoring the frequency of fecal urgency as 4 points when using St Mark's score. Of 96 respondents responding to a query about modifying the St Mark's score, 88 (91.7%) agreed that fecal urgency should be scored according to the frequency of occurrence. **Conclusion:** Although the Wexner score neglects fecal urgency, it is the most commonly used scoring system. The study contributes to the standardization of terminology and reproducibility of results in research and clinical management of anal incontinence.

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1. Introduction

Anal incontinence is the involuntary loss of flatus, or liquid or solid stool through the anal sphincter, and is a serious and distressing condition. It can have a devastating effect on quality of life, including occupational, social, and sexual aspects [1]. Childbirth is an important risk factor for the development of anal incontinence. Brincat et al. [2] reported that fecal incontinence was experienced by 6.4% of women 6 weeks after delivery and 5.3% of women 1 year after delivery. The cumulative incidence rate of anal incontinence during pregnancy and after delivery in previously continent nulliparous women was 10.3% in Europe [3]. In a study from South Africa, 6-week postpartum incidence of anal incontinence was reported in 61.1% of women, with a 6-month persistence of 6.4% [4]. Some 54% of women with urinary incontinence, pelvic organ prolapse, or both, reported anal incontinence, suggesting a significant relationship between anal incontinence and other pelvic floor disorders [5]. Diagnosis of anal incontinence requires a symptom-based approach rather than a traditional disease-based approach, making subjective assessment of the severity of anal incontinence superior to objective examinations [6]. Fecal urgency is the inability to suppress the sensation

to defecate. It is a particularly important and bothersome aspect of anal incontinence, which may be as limiting to an individual as frank incontinence. For this reason, the evaluation of fecal urgency has been incorporated into numerous tools for the assessment of anal incontinence [7–13].

Designing and evaluating the most effective scoring systems for anal incontinence are continuing goals. One of the first evaluation systems ever described used a scale from 1 to 4 to differentiate a normal condition, gas incontinence, liquid fecal incontinence, and solid fecal incontinence [14]. Pescatori et al. [15] included a scoring system to account for the frequency of episodes of anal incontinence. This system was further elaborated, and weightings were introduced into the anal incontinence severity evaluation in the Anal Incontinence Severity Score [16]. Subsequently, the Cleveland research group developed the Wexner score—a point system ranging from 0 to 20—that considers other relevant factors such as change in quality of life and use of incontinence pads [17]. This system has been widely accepted by specialists despite the omission of fecal urgency. More recently, Vaizey et al. [7] devised a modification to the scoring system (St Mark's score) that takes into consideration fecal urgency and coping behavior such as taking constipating medicines. In this system, fecal urgency is defined as the inability to defer defecation for 15 minutes; however, the frequency of fecal urgency episodes is not considered—absence of fecal urgency is scored as 0 points and any sign of fecal urgency is scored as 4 points [7]. The St Mark's score is recommended for the follow-up of women with obstetric anal sphincter injury [18].

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Although fecal urgency has been neglected in many scoring systems, it can affect quality of life considerably—by its frequency as well as its presence. Quality of life may be unaffected by rare urgency episodes, and yet the final score would be altered considerably. This may be why the Wexner score was found to be more reliable despite the lack of fecal urgency assessment [19]. Similarly, the Fecal Incontinence Severity Index (FISI), as a weighted score, was recommended in cases of high-frequency incontinence; however, its applicability may be limited owing to the lack of fecal urgency assessment [6].

Under the aegis of the International Urogynecological Association (IUGA) we conducted an international survey of anal incontinence severity scoring systems and evaluation tools used by specialists. The primary objective of the survey was to determine which scoring systems are used most frequently. In addition, we proposed a modification to the St Mark's scoring system by dividing the scores for fecal urgency according to the frequency of occurrence (0 = never, 1 = rarely, 2 = sometimes, 3 = weekly, 4 = daily). We sought the opinions of the surveyed experts on this modification to assess the need to evaluate the frequency of occurrence of fecal urgency.

2. Materials and methods

A simple questionnaire was distributed between May and December 2012 among international experts who conduct research or clinically manage anal incontinence, primarily in North America, Europe, and Asia (obstetricians, gynecologists, urogynecologists, colorectal surgeons, proctologists, general surgeons, physiotherapists, theoretical scientists, and gastroenterologists). The questionnaire provided a brief introduction to the topic, an explanation of the reasoning behind the proposed modification to the St Mark's score, and three simple questions. The experts were asked which scoring system they used to assess the severity of anal incontinence in their hospital. The respondents using the St Mark's score were asked to record the frequency of fecal urgency episodes they scored as 4 points for fecal urgency. All experts were then asked for their opinion of the modification to the St Mark's score to assess the frequency of occurrence of fecal urgency.

The questionnaire was disseminated via email, the IUGA weekly newsletter, and in print format. Email addresses were obtained from published studies on anal incontinence. PubMed, Medline, and Google scholar databases were used to search for the publications. The following keywords were used: anal, ano-rectal, fecal, incontinence, fecal urgency, anal sphincter tear, injury, trauma, and OASIS. In addition, a web-based survey was created, and a link was sent to IUGA members via the IUGA weekly newsletter. The responses were compiled, analyzed separately, and are expressed as numbers and percentages. No statistical significance calculations were necessary because the study was a survey and purely descriptive. No ethical committee approval or informed consent was necessary owing to the nature of the study.

3. Results

A total of 143 responses were received. The composition of participants was 56 (39.2%) obstetricians, gynecologists, and urogynecologists; 71 (49.7%) colorectal surgeons, proctologists, and general surgeons; and 16 (11.2%) physiotherapists, theoretical scientists, and gastroenterologists. The geographical distribution of the responses is presented in Fig. 1. According to the survey, 24 (16.8%) respondents did not use any scoring system for the evaluation of anal incontinence and these were excluded from the analysis. Responses from the remaining 119 participants on the spectrum of evaluation tools used are presented in Table 1. A total of 34 (28.8%) respondents used multiple tools for the evaluation of anal incontinence. Respondents reported using 14 different tools for assessing anal incontinence, totaling 161 responses. The most commonly used tools were the Wexner score used by 79 (49.1%) respondents, the St Mark's (Vaizey) score used by 29 (18.0%) respondents, and the Fecal Incontinence Quality of Life (FIQL, Rockwood)

score used by 21 (13.0%) respondents. Common tools for assessing anal incontinence were distributed evenly among experts, except for the FIQL, which was used less frequently by obstetricians and gynecologists. The FIQL scale is a tool for assessing quality of life rather than the severity of anal incontinence, and was used predominantly in combination with an anal incontinence severity scoring system. The FIQL alone was used by only one respondent.

Specific aspects of anal incontinence covered by the assessment tools are presented in Table 2. A subanalysis of the responses of specialists who used the most common scoring systems (Wexner, St Mark's score, or both) was then carried out to consider the combination of scoring systems with quality-of-life assessment tools (Table 3). A total of 19 (19.6%) responders used a quality-of-life assessment tool in addition to an anal incontinence severity scoring system, and this was highest among surgeons ($n = 15$; 24.6%). Most obstetricians and gynecologists used a severity scoring system alone ($n = 25$; 96.2%).

The responses of participants who reported using the St Mark's score to record frequency of fecal urgency episodes as 4 points are presented in Table 4. No unequivocal answer was given to this question; 4 points was scored for occurrence of regular episodes by 11 (37.9%) respondents, as well as for any recent episode irrespective of frequency by 10 (34.5%) respondents. Inconsistent responses were given by individual specialties on the frequency of fecal urgency episodes (Table 4). The answer "when it affects quality of life" was given five times and always in association with frequency of fecal urgency episodes (three times with regular episodes, once with a recent episode of urgency regardless of frequency, and once with daily occurrence). We assumed that effect on quality of life was superior to frequency here and assigned these answers to this specific response (Table 4).

Ninety-six (67.1%) respondents commented on the modification proposed to the St Mark's tool to score fecal urgency based on the frequency of occurrence. Most respondents ($n = 88$; 91.7%) agreed with the suggested modification (Table 5).

4. Discussion

Anal incontinence is a severe condition that can have a substantial impact on the quality of life of affected individuals. Despite increased scientific interest in developing a reliable and widely used instrument to evaluate anal incontinence, significant variability exists in the way these patients are assessed. Owing to its nature, anal incontinence is frequently neglected by physicians who are not directly involved in its treatment. Despite its potential association with pregnancy and delivery, gynecologists and even urogynecologists often tend to neglect anal incontinence in the follow-up of patients post partum.

Fecal urgency was proven to be closely associated with external anal sphincter dysfunction irrespective of rectal sensitivity and internal anal sphincter dysfunction [20]. Its evaluation is therefore particularly important in the follow-up of individuals with obstetric anal sphincter injury. The St Mark's score has been recommended for this purpose [18]. In the present study, use of the St Mark's score was not higher among obstetricians and gynecologists compared with colorectal surgeons, proctologists, and general surgeons. Other anal incontinence assessment tools that take fecal urgency into account include the FIQL (Rockwood), Manchester Health Questionnaire, Birmingham Bowel and Urinary Symptoms Questionnaire, Australian Pelvic Floor Questionnaire, Colorectal-Anal Distress Inventory, and Rintala score [8–13]. All of these are more complex tools for assessing quality of life with anal incontinence. According to the results of the present study, 24.6% of surgeons used a tool for quality-of-life assessment in conjunction with the Wexner or St Mark's score, whereas this practice was rare among obstetricians and gynecologists (3.8%), including urogynecologists.

A survey conducted among surgeons and gastroenterologists in Spain also showed the dominance of the use of the Wexner score in both groups [21]. The present study was designed to assess the scoring of anal incontinence among obstetricians and gynecologists. As patients

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