

Mistakes in faecal incontinence management and how to avoid them

Sadé L. Assmann, Stephanie O. Breukink and Daniel Keszthelyi

People with faecal incontinence (FI) suffer from chronic involuntary loss of bowel content.¹ Oftentimes, patients with FI need to plan their day around their condition or avoid activities altogether to prevent bowel accidents from occurring. They frequently suffer from feelings of embarrassment, shame, low self-esteem and/or depression, detrimental to their quality of life.²⁻⁵ There is no 'one-size fits all' approach to treating faecal incontinence. In general, less invasive treatment options such as dietary and lifestyle adjustments, pelvic floor muscle exercises and stool bulking agents should be trialed prior to the more invasive treatment options such as sacral neuromodulation or a stoma.⁶

In daily clinical practice, the contributing factors, the preferences and experience of the physician and patient, and the availability and fitness for procedures play an essential role in selecting a treatment approach. Misconceptions due to insufficient solid evidence are common in treating faecal incontinence.

This article discusses common mistakes made when treating patients with faecal incontinence and how to avoid them. The list of mistakes and the following discussions are evidence-based where possible and based on the authors' clinical experience, where evidence is sparse.

Mistake 1 Forgetting to take a thorough medical history

Assuming patients will spontaneously provide the healthcare professional with all the necessary information to make an informed management plan is a mistake. Often FI (figure 1) causes feelings of shame resulting in hesitance to disclose information and sometimes even hesitance to seek professional help.^{2,7,8} Consequently, healthcare professionals need to ask the right questions during history taking. Suppose the patient hints at complaints suggesting faecal incontinence. In that case, this is an opening for the healthcare professional to ask relevant questions and determine if unwanted loss of faeces is present. After it has been established that the patient suffers from FI, the characteristics and severity

Definition of faecal incontinence (FI) according to ROME IV criteria

“The recurrent uncontrolled passage of faecal material for at least 3 months”

Figure 1 | Definition of faecal incontinence according to the ROME IV criteria.

of the condition should be established (e.g., changes in bowel habit, straining to empty bowels, incomplete emptying of bowel, feeling an urge or not, ability to delay defecation). Any possible contributing or causative factors should be determined, some of which are presented in figure 2. Consideration should also be given to any red flag features that may indicate a severe underlying organic cause, such as colorectal cancer or inflammatory bowel disease, as presented in figure 3. It should be further determined whether concomitant pelvic floor dysfunction or any gastrointestinal issues are present. It should clarify which treatment options have been tried before, if any, and which case-specific characteristics would suggest suitability for one treatment.⁶

Mistake 2 Seeing faecal incontinence as nothing more than an involuntary loss of faeces

Focusing merely on reducing episodes of involuntary faeces loss is often a mistake when treating FI. Faecal incontinence should be managed as the complex multi-layered anorectal problem it is. The often heterogenous and multi-factorial causes of FI should be acknowledged. The concomitant gastrointestinal



dysfunction, pelvic floor dysfunction, and psychological and social impacts should be considered and treated where possible.^{6,8} As shown in figure 4, when treating FI, other gastrointestinal symptoms such as diarrhoea, constipation, bloating, cramps, abdominal pain, or a combination of these should be considered.⁹⁻¹¹ Additionally, concomitant pelvic floor problems such as obstructive defecation disorder, pelvic organ prolapse, chronic pelvic pain, urinary incontinence, and sexual dysfunction are common in this patient group.^{2,8} Other examples of common physical problems related to suffering from FI are recurrent urinary tract infections and incontinence-associated dermatitis.²

Common disorders which can present with FI
Colorectal cancer
Colorectal trauma or surgery
Inflammatory bowel disease or proctitis
Coeliac disease
Abnormal stool consistency
Neurological disease
Cognitive disorders

Figure 2 | Examples of disorders which can present with faecal incontinence.

© UEG 2023 Assmann, Breukink and Keszthelyi

Cite this article as: Assmann S L, Breukink S O and Keszthelyi D. Mistakes in faecal incontinence management and how to avoid them. *UEG Education* 2023; 23: 1-3.

Daniel Keszthelyi is a professor in gastroenterology and Head of the Division of Gastroenterology-Hepatology at Maastricht University Medical Centre, Maastricht, The Netherlands.

Stephanie Breukink is an associate professor and colorectal surgeon at Maastricht University Medical Centre, P. Debyeelaan 25 6229 HX Maastricht, The Netherlands.

Sadé Assmann is a PhD-candidate at NUTRIM, Maastricht University.

Illustrations: J. Shadwell

Correspondence to: s.assmann@maastrichtuniversity.nl

Conflicts of interest: SLA declares no conflicts of interest in relation to this article. SOB has received research funding from ZonMw, ESCP and UEG. DK has received research funding from Will Pharma, Allergan, Grunenthal, ZonMw, MLDS, UEG, ESCP, Horizon 2020 and the Rome Foundation.

Published online: February 9, 2023.

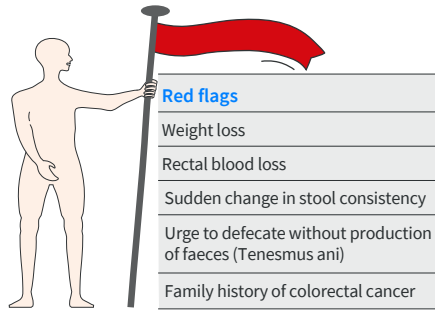


Figure 3 | Red flag symptoms to look out for which could be indicative of an underlying organic cause such as colorectal cancer or inflammatory bowel disease.

Besides the physical problems that FI causes, this condition's enormous social and psychological impact should not be forgotten.

Mistake 3 Not focusing enough on the impact faecal incontinence has on the quality of life

When treating FI, it would be a mistake to merely focus on reducing physical symptoms. Patients with FI often feel like their whole lives revolve around their symptoms, feeling the need to plan their day around their defecation needs and avoiding many 'normal' daily activities and social interaction leading to isolation and a reduction in quality of life.^{2,7,8} Activities such as shopping, exercise, sexual intercourse, going on long trips or vacations, and avoiding public transport, among others, may be avoided.^{2,8} Additionally, feelings of embarrassment, anxiety and depression are frequently described.^{12,13} Thus, the additional impact that FI carries should be determined. Understanding this may help guide which treatment options should be discussed with the patient and which suggestions can be given on dealing with the problem. If available in your region, referring to a support group for discussions with fellow patients may be beneficial.

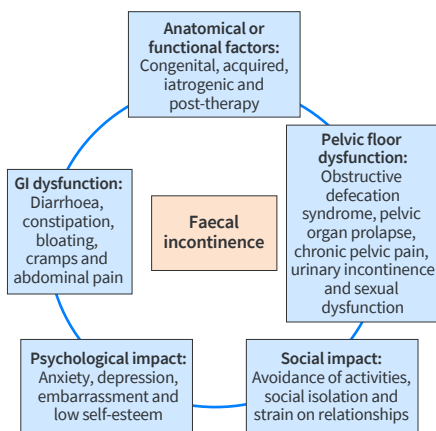


Figure 4 | Examples of health aspects related to faecal incontinence: predisposing factors, related complaints, pathophysiological mechanisms and the psychological and social impact.

Mistake 4 Not performing a digital rectal examination

Not performing a digital rectal examination (DRE) when someone presents with complaints suggestive of FI is a mistake. Although a diagnosis of FI can be made via a thorough clinical history without performing a DRE, therefore DRE may be useful for multiple other reasons.⁶ Inspection of the anorectal region and digital insertion is needed to check for any other abnormalities that may cause or contribute to the onset of FI. These abnormalities should be addressed before starting with symptomatic treatment. DRE allows you to determine (to a certain extent) the function of the anal sphincters and/or the puborectalis muscle and allows checking for the presence of faecal impaction or palpable masses (indicative of malignant neoplasm). Perianal abscesses or fistulae upon anal inspection and/or a painful DRE may suggest an underlying inflammatory bowel disorder. Additionally, we decide to proceed to a diagnostic test. In that case, DRE can help guide which test may be most suitable and decide which treatment options may be optimal for this patient.

Mistake 5 Neglecting to manage treatment success expectations

Taking the time to discuss with the patient what results they can realistically expect and within which time frame is something which is often forgotten. Although in some, certain treatment options result in a complete resolution of symptoms, often treatment options merely result in a reduction in severity and not a complete cure.^{6,14} Being transparent about this may prevent disappointment later. They may find it comforting to know multiple different types of treatment options are available starting with less invasive treatment options, and in case symptom reduction is not yet sufficient, more invasive options can be chosen as shown in figure 5. This way, if initial management does not help sufficiently, patients are aware of other available options and may return to their physician to discuss further treatment plans. If a treatment has, resulted in partial symptom reduction, additional treatment options can be tried along with the initial approach. Often times, multiple different treatment options at any given time are used to manage symptoms. Alternatively, if initial treatment did not help at all, a different treatment option should be tried on its own.

Mistake 6 Treating patients with faecal incontinence according to a 'one size fits all' approach

When treating FI, it is important to remember that this is a heterogenous disorder in terms of aetiology, pathophysiology, and patient

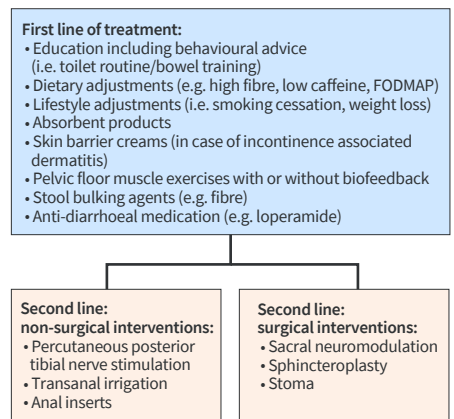


Figure 5 | Flowchart summarising current treatment options for faecal incontinence as discussed in the "guideline for the diagnosis and treatment of faecal incontinence – A UEG/ESCP/ESNM/ESPCG collaboration"⁽⁶⁾.

characteristics. Most cases do not have a single cause for their condition, and the exact aetiology may remain unclear. FI is associated with varying symptoms and complaints that may come about at different times during the day. Because aetiology and pathophysiology usually differ between persons, which specific treatment will be successful will likely also differ. This reiterates the importance of thorough medical history taking. Reports of a liquid consistency of stool may point to an optimising treatment with psyllium or loperamide. Modifying this element may be helpful if the symptoms are associated with a change in diet or medication intake.

It is essential to understand the treatment goals, the patient's preferences regarding treatment options, and what would be feasible for each case. Transanal irrigation may be a good option for a pensioner who can plan their days as they wish, but it may not be a good fit for a person with commitments early in the morning and a busier life. A stoma may sound like a last resort to most, but it may be the best approach for relief in those refractory cases severely impacted by their symptoms. The activities that had to be put on hold due to FI and would ideally be resumed may also differ between people. Whilst one person may wish to rerun a marathon without being burdened by their FI, another may wish to be able to visit a friend outside the comfort of their own home. For this reason, it is crucial to evaluate the patient's needs and goals to develop the best-individualised treatment plan.

Mistake 7 Forgetting to tackle abnormal stool consistency

It has been well established that stool consistency which may result in diarrhoea, constipation, or a combination of these is a significant contributing factor or cause of FI.¹⁵⁻¹⁷ Optimisation of stool

consistency via products such as psyllium fibre or loperamide should be the first step in the management of this pathway of faecal incontinence. The correct instructions must be followed when prescribing these products to ensure optimal results. Psyllium should ideally be taken without sweeteners such as sorbitol, which can cause diarrhoea. It is a bulking agent that, through its chemical structure, can take up large amounts of water. As it does not readily dissolve in water, it should be taken together with oatmeal, yoghurt, or custard, for reasons of palatability. Directly after ingestion, fluid intake should be limited, allowing psyllium to take up any excess fluid in the colon.

Loperamide can also be taken to firm up the stool in case of liquid stool consistency. This should be taken cautiously and at the lowest possible dose, as this can easily cause constipation.

Mistake 8 Not opting for referral when you can't help the patient (any further)

The overall lack of solid evidence in FI research, in combination with the heterogeneous and multi-layered nature of the condition, can make it challenging to decide the best treatment pathway for each case. Most healthcare professionals will feel comfortable starting any first-line treatment options as described in figure 5. However, a multidisciplinary approach is preferred when these options fail or do not lead to a sufficient reduction in symptoms. If you do not have a multidisciplinary- or expert team available in your vicinity, it is important to find out where a team like this is available in your region. This way, any cases can be discussed and referred to when necessary to ensure the best help possible is given.

Mistake 9 Seeing sacral neuromodulation as the holy grail treatment

Since its introduction in 1995 in the faecal incontinence field, many patients have benefitted from sacral neuromodulation (SNM).^{6,18} Often a decrease in FI symptoms is seen, in some cases even to the extent that no more symptoms are present. In either event, this results in a significant improvement in quality of life. For optimal use, the settings on the device should be changed depending on the symptoms experienced. The upside is that individuals are in control of their devices. However, some could also see this as a downside or difficulty.

Although SNM is the perfect solution for several people, for others, it works only for a short period or not at all. The sustained efficacy of SNM is between 43.9 and 86%, generally showing a decrease over time.¹⁹⁻²¹

Furthermore, possible side effects include general surgical risks and pain or discomfort from the implant.

Moreover, lead migration and eventual battery replacement should be noticed as both require reoperation.^{6,21}

It is essential to assess whether SNM would suit each individual and discuss the possible risks with patients whilst stressing that. In contrast, SNM can be an effective treatment option for some but lacks efficacy for others.

References

- Rao SS, Bharucha AE, Chiarioni G, Felt-Bersma R, Knowles C, Malcolm A, et al. Anorectal disorders. *Gastroenterology*. 2016; 150 (6): 1430-42. e4.
- Olsson F, Berterö C. Living with faecal incontinence: trying to control the daily life that is out of control. *Journal of Clinical Nursing*. 2015; 24 (1-2): 141-50.
- Bartlett L, Nowak M, Ho Y-H. Impact of fecal incontinence on quality of life. *World journal of gastroenterology: WJG*. 2009; 15 (26): 3276.
- Deutekom M, Terra M, Dobben A, Dijkgraaf M, Baeten C, Stoker J, et al. Impact of faecal incontinence severity on health domains. *Colorectal Disease*. 2005;7(3):263-9.
- Wilson M. The impact of faecal incontinence on the quality of life. *British Journal of Nursing*. 2007; 16 (4): 204-7.
- Assmann SL, Keszhelyi D, Kleijnen J, Anastasiou F, Bradshaw E, Brannigan AE, et al. Guideline for the diagnosis and treatment of Faecal Incontinence—A UEG/ESCP/ESNM/ESPCG collaboration. *United European gastroenterology journal*. 2022; 10(3): 251-86.
- Bharucha AE, Zinsmeister AR, Locke GR, Seide BM, McKeon K, Schleck CD, et al. Prevalence and burden of fecal incontinence: a population-based study in women. *Gastroenterology*. 2005; 129(1): 42-9.
- Madoff RD, Parker SC, Varma MG, Lowry AC. Faecal incontinence in adults. *The Lancet*. 2004; 364(9434): 621-32.
- Mowatt G, Glazener CM, Jarrett M. Sacral nerve stimulation for faecal incontinence and constipation in adults. *Cochrane Database of Systematic Reviews*. 2007(3).
- Brochard C, Chambaz M, Ropert A, l'Héritier AM, Wallenhorst T, Bouguen G, et al. Quality of life in 1870 patients with constipation and/or fecal incontinence: constipation should not be underestimated. *Clinics and Research in Hepatology and Gastroenterology*. 2019; 43(6): 682-7.
- Ng KS, Nassar N, Hamd K, Nagarajah A, Gladman M. Prevalence of functional bowel disorders and faecal incontinence: an Australian primary care survey. *Colorectal Disease*. 2015; 17(2): 150-9.
- Cotterill N, Norton C, Avery KN, Abrams P, Donovan JL. A patient-centered approach to developing a comprehensive symptom and quality of life assessment of anal incontinence. *Diseases of the colon & rectum*. 2008; 51(1): 82-7.
- Maeda Y, Vaizey C, Hollington P, Stern J, Kamm M. Physiological, psychological and behavioural characteristics of men and women with faecal incontinence. *Colorectal Disease*. 2009; 11(9): 927-32.
- Riemsma R, Hagen S, Kirschner-Hermanns R, Norton C, Wijk H, Andersson K-E, et al. Can incontinence be cured? A systematic review of cure rates. *BMC medicine*. 2017; 15(1): 1-11.
- Bharucha AE, Zinsmeister AR, Locke GR, Seide BM, McKeon K, Schleck CD, et al. Risk factors for fecal incontinence: a population-based study in women. *Am J Gastroenterol*. 2006;101(6):1305-12.
- Whitehead WE, Borrud L, Goode PS, Meikle S, Mueller ER, Tuteja A, et al. Fecal incontinence in US adults: epidemiology and risk factors. *Gastroenterology*. 2009; 137(2): 512-7. e2.
- Rey E, Schleck CD, Zinsmeister AR, Locke III GR, Talley NJ. Onset and risk factors for fecal incontinence in a US community. *The American journal of gastroenterology*. 2010;105(2): 412.
- Matzel K, Stadelmaier U, Gall F, Hohenfellner M. Electrical stimulation of sacral spinal nerves for treatment of faecal incontinence. *The Lancet*. 1995;346(8983):1124-7.
- Brochard C, Mege D, Bridoux V, Meurette G, Damon H, Lambrescak E, et al. Is Sacral nerve modulation a good option for fecal incontinence in men? Neuromodulation: *Technology at the Neural Interface*. 2019; 22(6): 745-50.
- Mellgren A, Wexner SD, Collier JA, Devroede G, Lerew DR, Madoff RD, et al. Long-term efficacy and safety of sacral nerve stimulation for fecal incontinence. *Diseases of the colon & rectum*. 2011; 54(9): 1065-75.
- Janssen PT, Kuiper SZ, Stassen LP, Bouvy ND, Breukink SO, Melenhorst J. Fecal incontinence treated by sacral neuromodulation: long-term follow-up of 325 patients. *Surgery*. 2017; 161(4): 1040-8.

Your faecal incontinence management briefing

UEG Week

- 'Faecal incontinence' session at UEG Week 2022 [https://ueg.eu/library/faecal-incontinence/252689]
- 'Faecal microbiota transplant: An essential tool to explore microbiome host interactions' session at UEG Week 2022 [https://ueg.eu/library/risign-star-faecal-microbiota-transplant-an-essential-tool-to-explore-microbiome-host-interactions/252903]
- 'Faecal transplantation in IBS: Does it help?' session at UEG Week 2022 [https://ueg.eu/library/faecal-transplantation-in-ibs-does-it-help/252854]

Standards and Guidelines

- "NICE Quality Standard Irritable bowel syndrome in adults (QS114)" [https://ueg.eu/library/nice-quality-standard-irritable-bowel-syndrome-in-adults/141817]
- Assmann SL, Keszhelyi D, Kleijnen J, Anastasiou F, Bradshaw E, Brannigan AE, et al. Guideline for the

diagnosis and treatment of Faecal Incontinence—A UEG/ESCP/ESNM/ESPCG collaboration. *United European Gastroenterology Journal* 2022;10(3):251-86. [https://ueg.eu/library/guideline-for-the-diagnosis-and-treatment-of-faecal-incontinence-a-ueg-escp-esnm-espcg-collaboration/248750]

- Savarino E, Zingone F, Barberio B, Marasco G, Akyuz F, Akinar H, et al. Functional bowel disorders with diarrhoea: Clinical guidelines of the United European Gastroenterology and European Society for Neurogastroenterology and Motility. *United European Gastroenterology Journal* 2022;10(6):556-84. [https://ueg.eu/library/functional-bowel-disorders-with-diarrhoea-clinical-guidelines-of-the-united-european-gastroenterology-and-european-society-for-neurogastroenterology-and-motility/248752]