

## FECAL INCONTINENCE

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### **What is fecal incontinence?**

Fecal incontinence is the inability to control your bowel movements, causing stool (feces) to leak unexpectedly from your rectum. Also called bowel or anal incontinence, fecal incontinence can range from occasional leakage of a small quantity of stool while passing gas to a complete loss of bowel control.

The ability to hold stool (called *continence*) requires the rectum, anus and nervous system to be working normally. Two groups of muscles in the wall of the anus and rectum are responsible for holding the stool in the rectum, the outer muscle group (external anal sphincter) and the inner muscle group (internal anal sphincter). Your ability to sense the presence of stool in the rectum (called *rectal sensation*), and the ability of the rectum to relax and store stool when having a bowel movement is not convenient (called *rectal compliance*) need to be functioning normally for continence. In addition, you need the physical and mental capabilities to recognize the urge to defecate, and go to the toilet.

### **Is it a common condition?**

Yes. More than 5.5 million Americans have fecal incontinence. It is more common in older people and in women. However, many people do not like to talk about fecal incontinence, and it may not be apparent that fecal incontinence is relatively common. If you have fecal incontinence and have not discussed the symptom with a physician or family members, you are not alone.

### **What causes fecal incontinence?**

Fecal incontinence is commonly caused by altered bowel habits (generally diarrhea, but also constipation) and conditions that affect the ability of the rectum and anus to hold stool. The sphincter muscles become weaker as you grow older. The sphincter muscles or the nerves supplying them can be damaged during vaginal delivery in women, by trauma, or during anal surgery. Nerve malfunction can also happen in people who strain excessively, in patients with diabetes or after a stroke. The rectal wall can stiffen after radiation treatment or in patients with Crohn's disease. In these patients, the rectum cannot stretch as much as it needs to, so the excess stool leaks out. Other conditions where the rectum drops down into the anus (rectal prolapse) or when the rectum protrudes into the vagina (rectocele) can also cause fecal incontinence.



## **What are the symptoms of fecal incontinence?**

Normally, ‘accidents’ or fecal leakage should not happen in adults except during episodes of severe diarrhea. People with chronic or recurring fecal incontinence may have few or frequent accidents. The symptoms may range from the inability to hold gas, “silent” leakage of stool during daily activities or exertion, or being unable to reach the toilet in time. Other intestinal symptoms such as diarrhea, constipation and abdominal discomfort may also be present.

## **What can you do if you have fecal incontinence?**

Doctors understand the emotional and social consequences of fecal incontinence, so don’t be embarrassed about talking to your doctor about this problem. Your primary care physician may be able to assist you, or you may need to see a doctor who specializes in treating conditions that affect the colon, rectum and anus, such as a gastroenterologist, proctologist or colorectal surgeon. Your doctor will talk to you about your symptoms and perform a physical examination, including a rectal examination. Depending on your symptoms, your doctor may perform one or more tests to identify the cause for incontinence. These tests include measuring pressures in the anus and rectum (anal manometry), using an anal ultrasound or MRI scan to look at the anal muscles and surrounding tissues, using barium studies to see how the rectum and anus perform during defecation (defecography) and testing to see if the nerves supplying the anal muscles are functioning normally (anal electromyography or EMG).

**Anal manometry** is conducted with a short flexible tube in the anus and rectum. This test measures the strength of the anal sphincter, and can also measure rectal sensation. An MRI (Magnetic Resonance Imaging) also is sometimes used to evaluate the sphincter.

**Anorectal ultrasonography** is performed by placing a small, balloon-tipped ultrasound probe into the rectum. Pictures of the anal sphincters are taken as the ultrasound probe is withdrawn.

**For defecography** liquid barium is placed in the colon and rectum with a small rectal tube while you lie on a table. After the rectal tube is removed, you will be asked to sit on a specially designed toilet. An x-ray video will be made while you are sitting on the toilet. You will be asked to cough, squeeze the “cheeks” of your buttocks together, and expel your rectal contents. After defecating, you will be asked to bear down as if you were having a bowel movement.

**Proctosigmoidoscopy** - Your doctor will use a long, slender tube with a tiny video camera attached to examine your rectum and sigmoid — approximately the last 2 feet of your colon. This test can identify inflammation, tumors or scar tissue that may cause fecal incontinence.



**Anal electromyography (EMG)** - Tiny needle electrodes will be inserted into muscles around your anus to identify nerve damage.

### **Is there any treatment for fecal incontinence?**

Fortunately, effective treatments are available for fecal incontinence. Treatment for fecal incontinence can help improve or restore bowel control. Depending on the cause of your incontinence, treatment may include dietary changes, medications, special exercises that help you better control your bowels, or surgery.

Foods that can cause diarrhea and worsen fecal incontinence include spicy foods, fatty and greasy foods, cured or smoked meat, and dairy products (especially if you are lactose intolerant). Caffeine-containing beverages can act as laxatives, as can products which contain artificial sweeteners (e.g., sugar-free gum and diet soda).

If you have constipation, your doctor may suggest that you eat fiber-rich foods, and prescribe fiber supplements. On the other hand, if you have diarrhea, your doctor may recommend anti-diarrheal medications (e.g., loperamide (Imodium)) or fiber supplements to help bind stool.

If fecal incontinence is due to a lack of anal sphincter control or decreased awareness of the urge to defecate, you may benefit from a bowel retraining program and exercise therapies that will help you improve muscle strength in the vicinity of your anus. In some cases, bowel training means learning to go to the toilet at a specific time of day. For example, your doctor may recommend that you make a conscious effort to have a bowel movement after eating. This helps you gain greater control by establishing with some predictability when you need to use the toilet. Most agree that use of loperamide comprises a first line treatment for fecal incontinence, before moving to biofeedback. In other cases, bowel training involves an exercise therapy called biofeedback. For fecal incontinence, biofeedback involves inserting a pressure-sensitive probe into your anus. This probe registers the strength of your anal sphincter. You can practice sphincter contractions and learn to strengthen your own muscles by viewing the scale's readout as a visual aid. These exercises can strengthen your rectal muscles. It is also possible to improve rectal sensation with biofeedback therapy.

If you leak large amounts of stool frequently, consider applying a moisture-barrier cream to prevent direct contact between irritated skin and feces. Ask your doctor to recommend a product. Be sure the area is clean and dry before you apply any cream. Nonmedicated talcum powder or cornstarch also may help relieve anal discomfort. Wear cotton underwear and loose clothing and change your soiled underwear quickly. If you use pads or adult diapers, be sure they have an absorbent wicking layer on top; this layer wicks moisture away from your skin.



Some people with fecal incontinence may require surgery. Examples where surgery may be beneficial include women who have fecal incontinence due to anal sphincter damage caused by childbirth, or in patients with rectal prolapse. A sphincteroplasty is an operation to repair a damaged or weakened anal sphincter. Other operations, such as an artificial sphincter or a muscle transplant (graciloplasty) are not done very often because they are often associated with complications. A colostomy is the last resort to treat fecal incontinence. A colostomy is an operation that diverts stool through an opening in the abdomen instead of through the rectum. A special bag is attached to this opening to collect the stool.

There are many options to help patients with fecal incontinence. Make an appointment with a gastroenterologist for an evaluation.

