CSSANZ
COLORECTAL SURGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

Faecal Incontinence

What is Faecal Incontinence?

Faecal incontinence is the inability to control the passage of faeces or flatus from the anus. This can be severe with major accidents or minor with streaking or smearing of the underwear.

Incontinence may occur everyday or at irregular intervals. There may be difficulty with cleaning and sufferers may routinely have to wear a pad. Faecal urgency is the inability to wait or "hang on" to go to the toilet to use the bowels. Accidents may not happen but faecal urgency is disabling.

Faecal incontinence or urgency may lead a person to be house bound or only go to places where they feel they can cope with an accident. Work, social and sex life can all be affected.

Normal Continence

This is the ability to recognise the need to go to the toilet and to "hang on" until a socially appropriate time to go. It relies on a healthy bowel and healthy anal sphincters. These are the muscles of the anus that we can contract or relax.

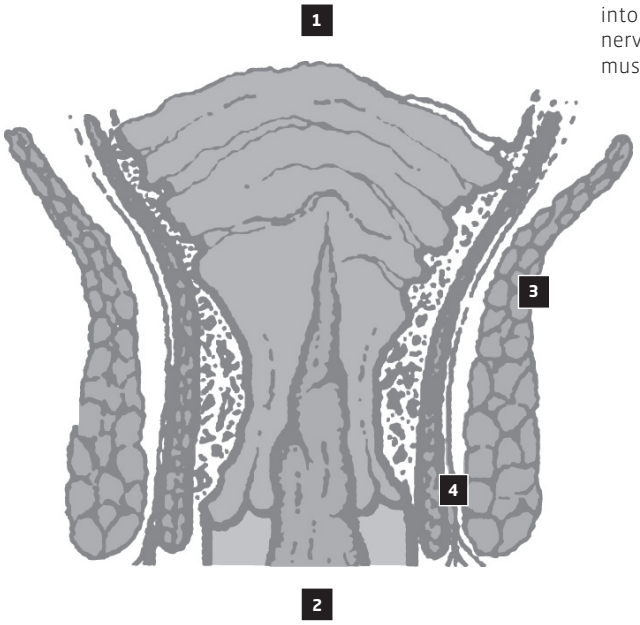
What Causes Faecal Incontinence?

There are many causes of faecal incontinence:

1. Childbirth injury to the muscles or nerves of the anal sphincter. This is the commonest cause of faecal incontinence.
2. Chronic constipation with repeated straining to defaecate may cause injury to the nerves of the anal sphincter muscle.
3. Faecal impaction and rectal prolapse (protrusion of the lower bowel through the anus) may be associated with incontinence.
4. Injury to the anal sphincter from an accident or surgery (fistula, fissure, haemorrhoids).
5. Diseases of the bowel such as irritable bowel syndrome and inflammatory bowel disease.
6. Congenital causes where babies may be born with a problem of the bowel or anal sphincter such as imperforate anus.
7. Miscellaneous causes such as diabetes, multiple sclerosis, spinal injury and dementia.

How Common is Faecal Incontinence?

It is estimated that in Australia up to 10% of the population suffer faecal incontinence. It is more common in the elderly and people in nursing homes.



1. Rectum
2. Anus
3. External Anal Sphincter
4. Internal Anal Sphincter

Diagnosis

The diagnosis is established by the history of the incontinence and a rectal examination. Tests on the bowel such as a colonoscopy or barium enema may be performed to exclude diseases of the bowel. Further tests on the anal sphincters will help establish the cause and how to manage the problem.

1. Anal manometry involves the insertion of a slender catheter into the anus. This test measures the strength of the anal sphincter muscles.
2. Anal ultrasound involves the insertion of a probe into the anus. It is simply performed and not painful. It gives an accurate picture of the anatomy of the anal sphincter muscles. Injuries that are suitable for repair may be detected.
3. Nerve tests are used to detect if a nerve injury is present. This may influence management.

Treatment

Symptoms of faecal incontinence are readily improved. Alteration of diet, thickening of the faeces (medication and bulking agents), pelvic floor exercises and physiotherapy are often helpful in regaining control. Surgery can be offered to repair or tighten the anal sphincter muscle when this is damaged.

For selected conditions causing incontinence, newer procedures are available to enhance sphincter closing by injecting inert materials into the muscle or by implanting a nerve stimulator to facilitate muscle contraction.

Occasionally, a colostomy will be recommended. Modern appliances make this a very reasonable option which may be preferable to continued soiling or accidents.

The major reason for not seeking medical attention for faecal incontinence is embarrassment. If you suffer or know someone who suffers from faecal incontinence, talk to your doctor. A colorectal surgeon can give specific advice upon the cause and potential remedies for the problem.

Faecal incontinence is a difficult and frustrating condition for a patient, and it can have a significant impact on your mood and your ability to carry out your normal daily activities. Please discuss any concerns around this with your surgeon. Treatment outcomes are variable, and there may be the need for several surgeries in complex situations. As a patient, it is important that you receive a clear description of the likelihood of treatment success from your surgeon.

Colorectal Surgical Society of Australia and New Zealand (CSSANZ)

Members of the Society are surgical specialists practising exclusively in colorectal surgery - the management of diseases of the large bowel (colon), rectum, anus and small bowel. After completing general surgery training they have completed a further period of training and research in colorectal surgery. The Society's mission is the maintenance of high standards in colorectal surgery and colonoscopy in Australia and New Zealand through the training of colorectal surgeons and the education of its members, and to promote awareness, prevention and early detection of colorectal diseases in the community.

The CSSANZ Foundation is a trust with a board of governors whose objective is to support high quality research projects for colorectal surgeons in training and our members. Donations to the CSSANZ Foundation are fully tax deductible in Australia and can be sent to:

CSSANZ Foundation Pty Ltd
79 Church St, Hawthorn, VIC 3122, Australia

79 Church Street, Hawthorn VIC 3122 **Tel:** (+61 3) 9853 8013 **Email** secretariat@cssanz.org **www.cssanz.org**