LET'S TALK…. ABOUT FECAL INCONTINENCE

Nicole Cook, PhD, MPA
Angela Garcia, PharmD, MPH

Defining the condition

- Fecal incontinence is defined as accidental solid and/or liquid leakage of stool or mucus
- Chronic and unpredictable
- More common than we likely think it is
  - – 2-13% among community dwelling adults
- Most cases of fecal incontinence are unreported, undiagnosed and untreated

Risk factors

- Childbirth, constipation, diarrhea, irritable bowel syndrome, inflammatory bowel disease, pelvic or anal surgery that resulted in damage to anal sphincter muscles (result of disease or malformation; hemorrhoid surgery), neurological disorders of injuries (multiple sclerosis, diabetes mellitus, spinal cord injury, Parkinson's disease), radiation treatments for certain cancers,
- Associated with increase in age

Quantifying the condition

Population	Prevalence Range from Literature
Community-dwelling	2.0-13.2%
Prevalence by age group[a]	
- 20-29	2.91%
- 30-39	1.7-4.86%
- 40-49	1.5-3.4%
- 50-59	2.2-5.6%
- 60-69	2.3-6.3%
- 70-79	2.6-6.7%
- >=80	7.5-13.2%
Patients with Diabetes Mellitus	11.8-18.1%
Morbid Obesity (>=35 m/kg^2)	63%

Why we need to talk about it

- Patients are embarrassed to discuss the condition with their doctors
- Few doctors screen for fecal incontinence
- Many people do not seek care and suffer with the condition alone
- Fecal incontinence can result in reduced quality of life, financial burden and it is a primary reason for nursing home institutionalization

Why we need to talk about it

"Out of the blue at age 58 I started having fecal incontinence and would wake up in the middle of the night in a large puddle of diarrhea. This went on for 6 years. I lost a lot of weight and saw a lot of doctors and was treated for SIBO. I was on antibiotics for 4 years. I then upped my probiotics and the diarrhea stopped, but then I started getting considerable pain after a bowel movement. Now I have to stay at home because of the pain and if I eat something (never really know what - keeping a food journal) then I have a day of what I call "never trust a fart."

I am now retired and would LOVE to have the life I worked so hard to attain, but am stuck close to home for fear of incontinence. It still strikes. It is not an easy thing to explain to people, so I have lost a lot of friends. I have never felt more alone and sad. Thank you all for being here. I hope there is more healing ahead.

- *– Name withheld by request*

Source: http://www.aboutincontinence.org/site/living-with-incontinence/personal-stories

Why we need to talk about it

“It doesn't seem to matter what I eat. If I eat a sandwich or more, I may have an urge for a bowel movement while eating or very shortly after. I usually need at least 3-4 more bowel movements within the next hour after the first movement. This makes traveling - even locally - very awkward. I take meds for seizures and for heart problems, but the GI problems started years before any of this. Fiber does nothing special for me. I've had some blood tests and a colonoscopy and so far all is ok. I am going to have a stool sample test, and may do an upper GI test next. Does anyone share my torture?

- Louis

Source: http://www.aboutincontinence.org/site/living-with-incontinence/personal-stories

Why we need to talk about it

"It gives some sort of comfort to know I am not alone in what is sometimes a living nightmare. I have suffered from bowel incontinence for 15 years now. The tests revealed a very damaged sphincter muscle, of which I had a repair done with the promise of complete success. Unfortunately it was quite the opposite and was completely unsuccessful. How do you live with this? I really have not worked it out yet, or even know whether I can live like this..... I have tried to separate the "problem" from myself and who I am. This works to some degree, but is still a problem never the less. I feel for you all so very much and wish I could give you all a hug in person."

– Name withheld by request

Source: http://www.aboutincontinence.org/site/living-with-incontinence/personal-stories

Seeking treatment

- Survey conducted by International Foundation for Functional Gastrointestinal Disorders (IFFGD) among 142 individual with fecal incontinence, also called bowel incontinence.
  - 68% responders said they had never been diagnosed by a physician
  - In general, most people waited 3 years after symptoms first appeared to speak with a physician
  - Most people speak first with a primary are physicians or OB/GYN
  - Responders who have a diagnosis by a physician self-report more frequent symptoms
  - 99% of people diagnosed with FI reported that the condition interferes with their daily activities (often -40%; always- 29%, sometimes – 31%)

Source: http://www.aboutincontinence.org/site/living-with-incontinence/personal-stories

Seeking treatment

- Reasons given for not speaking with a physicians:
  - Too embarrassed to bring it up
  - Feel they can manage it on their own
  - Social stigma
  - Not aware that potential treatments are available

Source: http://www.aboutincontinence.org/site/living-with-incontinence/personal-stories

Providers

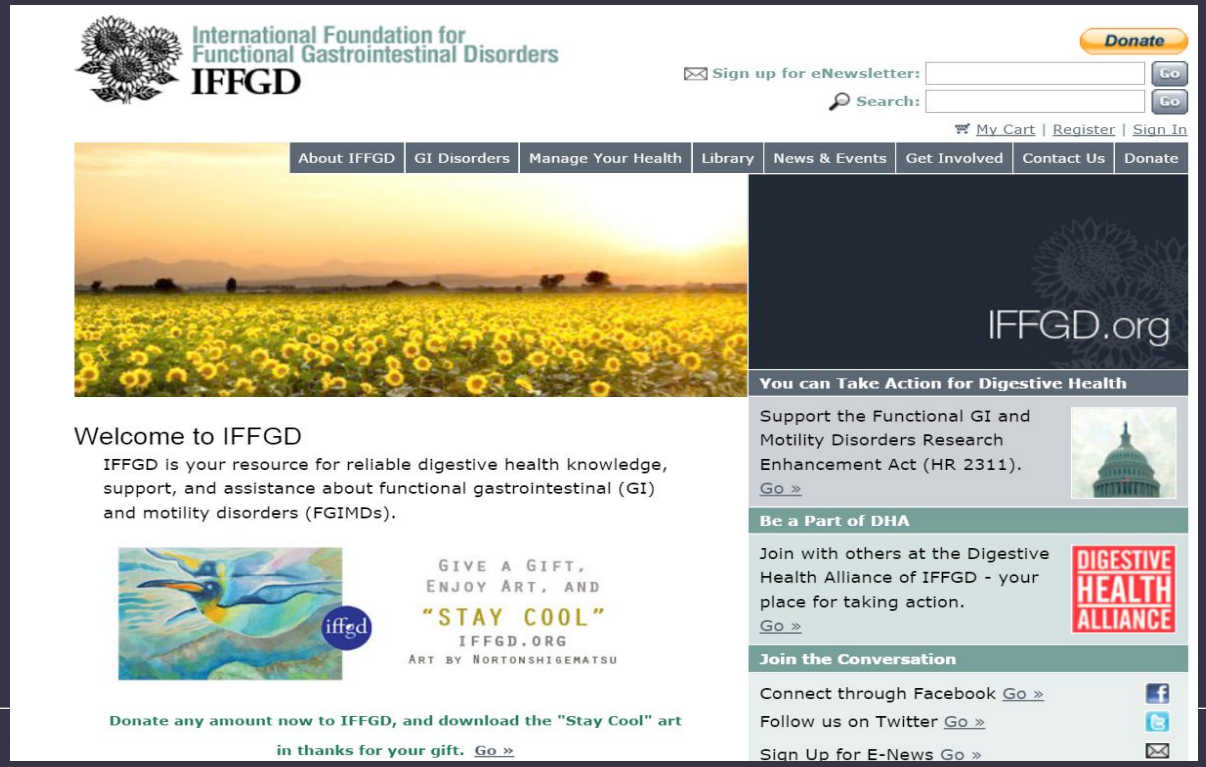
- 23% of patients reported that they mentioned the condition to the doctor but the doctor implied that their there is not much that can be done or that it is a normal part of aging
- Patients prefer that providers ask them about symptoms (rather than patients initiating the conversation)

Treatment

- First line treatments:
  - Dietary modification including fiber supplements
  - Minimization of foods that induce incontinence (identified through food journal)
  - Behavior modification including fiber supplements
  - Supportive measures including skin are

Support for people living with fecal incontinence

- For more information and support
- http://www.aboutincontinence.org/



Incontinence Treatment: Lifestyle Modifications

- Being prepared is the first step to being actively engaged in treatment
  - Balancing the fear of an accident and how to handle an accident are key
  - Having 'clean up supplies' and extra clothes as well as knowing the restroom locations is a good plan for active living
  - Considerations for protective undergarments is a conversation that is difficult yet important to have

- Body Liners (Butterfly, Tena, Poise)
- Protective Underwear for Men and Women (Prevail, Tena, Tranquility, Depends)
- Overnight and Daytime Disposable Underwear
- Disposable Swim Diaper (Swimmates, SOSecure)

Incontinence Treatment: Dietary Changes

- Keeping a food diary can assist with patterns in the diet that increase or trigger incontinence or unwanted reactions
- Referrals to dieticians or providers with extensive nutrition knowledge and training can help identify healthy meals and snacks to ensure nutritional needs are met
- Foods that can stimulate gut reactions are important to identify and may need modifications based on the reactions caused (leakage, cramps diarrhea, etc.)
    - High fat foods or Large meals (over eating) or Fried foods
    - Stimulants (caffeine in drinks) or Alcohol
    - Sorbitol and fructose (sugar used as a sweetener, diabetic foods, candies, gums)
    - Gas producing foods (beans, cabbage, legumes, cruciferous vegetables, onions, etc.)
    - Dairy and some fruits (raisins, prunes)

Incontinence Treatment: Medications

- Antidiarrheals: decreasing bowel movement frequency, improved formation of stool, increasing sphincter tone at rest
  - Loperamide (Imodium A-D)
  - Diphenoxylate and atropine sulfate (Lomotil)

- Do not relieve abdominal pain and often lead to constipation; may cause drowsiness; very important to maintain fluid and electrolyte balance

Incontinence Treatment: Medications

- Laxatives: increases bowel function (fiber*, osmotic, stimulant, emollient*)
  - Fiber**: psyllium (Metamucil), polycarbophil (FiberCon), methylcellulose (Citrucel)
  - Stimulant: bisacodyl (Dulcolax), sennosides (Senokot)
  - Osmotic: polyethylene glycol (Miralax), magnesium hydroxide (Milk of Magnesia)
  - Emollient**: docusate (Colace)
  - Lubricant: glycerin suppositories , mineral oil

- May increase abdominal pain, interferes with many medications, may lead to electrolyte imbalances, dehydration issues, may interfere with normal colon function

Incontinence Treatment: Medications

- Fiber Supplements: soluble (in water) or insoluble; soluble dissolves and forms a gel; insoluble absorbs liquid and acts like a bulking agent and often increases gas and bloating (also classified as a type of laxative)
  - Methylcellulose (Citrucel)
  - Psyllium (Metamucil)
  - Polycarbophil (FiberCon)

- Add slowly to the diet over a period of weeks to decrease complications, watch for binding with medications, try to incorporate high fiber foods if possible and increase water intake to balance fiber intake

Incontinence Treatment: Medications

- Stool Softeners: provide moisture to the stool and prevent dehydration; prevent hardening of the feces
  - Docusate (Colace)
  - Polyethylene glycol (Miralax)

- Gentle and effective, do not produce immediate results, must be use with caution to prevent dependence and interference with normal bowel function

When Fecal Incontinence is a side effect of a Primary Disease

- Irritable Bowel Disease, Inflamed Bowel Disease, Crohn's or Colitis, etc.
- Prescription medications may be used to target the inflammation or other complications of the bowels and as a result decrease fecal incontinence but are not targeting fecal incontinence itself
- Addressing issues early on may increase adherence to medications and improve transitions between therapies as well as functional status

Alternatives to Medications

- Biofeedback to train the muscles, sphincter, nerves, etc.
- Bowel training to teach the body when to have a bowel movement or to establish more regular bowel movements
- Sacral Nerve Stimulation (SNS) which is an implanted device
- Osteopathic treatments to improve bowel function, motility, sacral dysfunction, gastrointestinal function, parasympathetic nerve normalization, and muscle tone

Losing the Fear and Regaining Quality of Life

- Working with an interprofessional health care team increases safety during medication use and decreased side effects
- There are phases of options depending on the level of incontinence and clearly communicating about the issue is the first step to determining what options will fit the needs of the patient
- Communication is critical; there are many opportunities to screen patients and initiate the conversation to prevent the silence from the fear and stigma