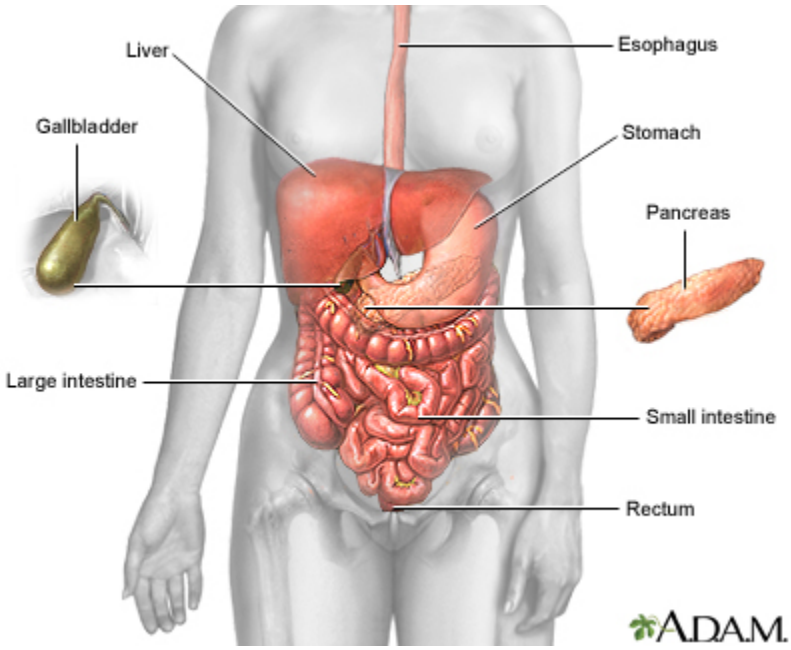
Bowel incontinence



The esophagus, stomach, large and small intestine, aided by the liver, gallbladder and pancreas convert the nutritive components of food into energy and break down the non-nutritive components into waste to be excreted.

Also known as: *Uncontrollable passage of feces, Loss of bowel control, Fecal incontinence or Incontinence - bowel*

Definition

Bowel incontinence is the loss of bowel control, leading to an involuntary passage of stool. This can range from occasionally leaking a small amount of stool and passing gas, to completely losing control of bowel movements.

Urinary incontinence, a separate topic, is the inability to control the passage of urine.

Considerations

Among people over age 65, most surveys find that women experience bowel incontinence more often than men. One to three out of every 1,000 women report a loss of bowel control at least once per month.

To hold stool and maintain continence, the rectum, anus, pelvic muscles, and nervous system must function normally. You must also have the physical and mental ability to recognize and respond to the urge to have a bowel movement.

Common Causes

- Chronic constipation, causing the muscles of the anus and intestines to stretch and weaken, and leading to diarrhea and stool leakage (see: encopresis)
- Chronic laxative use
- Colectomy or bowel surgery
- Decreased awareness of sensation of rectal fullness
- Emotional problems
- Gynecological, prostate, or rectal surgery
- Injury to the anal muscles due to childbirth (in women)
- Nerve or muscle damage (from trauma, tumor, or radiation)
- Severe diarrhea that overwhelms the ability to control passage of stool
- Severe hemorrhoids or rectal prolapse
- Stress of unfamiliar environment

Home Care

Incontinence is not a hopeless situation. Proper treatment can help most people, and can often eliminate the problem.

Treating bowel incontinence should begin by identifying the cause of the incontinence. There are several ways to strengthen the anal and pelvic muscles and promote normal bowel function.

FECAL IMPACTION

Fecal impaction is usually caused by chronic constipation. It leads to a mass of stool that partially blocks the large intestine. If constipation or fecal impaction contributes to fecal incontinence, usually laxatives and enemas are of little help. A health care provider may need to insert one or two fingers into the rectum and break the mass into smaller pieces that can pass more easily.

Take measures to prevent further fecal impaction. Add fiber to your diet to help form normal stool. Use other medications your health care provider recommends. In addition, drink enough fluids and get enough exercise to enhance normal stool consistency.

DIET

Bowel incontinence often occurs because the rectal sphincter is less able to handle large amounts of liquid stool. Often, simply changing the diet may reduce the occurrence of bowel incontinence.

Take alcohol and caffeine out of your diet, because they may cause diarrhea and incontinence in some people. Certain people develop diarrhea after eating dairy foods because they are unable to digest lactose, a sugar found in most dairy products. Some food additives such as nutmeg and sorbitol may cause diarrhea in certain people.

Adding bulk to the diet may thicken loose stool and decrease its amount. Increasing fiber (30 grams daily) from whole-wheat grains and bran adds bulk to the diet. Psyllium-containing products such as Metamucil can also add bulk to the stools.

Formula tube feedings often cause diarrhea and bowel incontinence. For diarrhea or bowel incontinence caused by tube feedings, talk to your health care provider or dietitian. The rate of the feedings may need to be changed, or bulk agents may need to be added to the formula.

MEDICATIONS

In people with bowel incontinence due to diarrhea, medications such as loperamide (Imodium) may be used to control the diarrhea and improve bowel incontinence.

Other antidiarrheal medications include anti-cholinergic medications (belladonna or atropine), which reduce intestinal secretions and movement of the bowel. Opium derivatives (paregoric or codeine) or diphenoxylate (lomotil), as well as loperamide (Imodium) increase intestinal tone and decrease movement of the bowel.

Other medications used to control bowel incontinence include drugs that reduce water content in the stools (activated charcoal or Kaopectate) or that absorb fluid and add bulk to the stools (Metamucil).

MEDICATION EVALUATION

With your health care provider, review all the medications you take. Certain medications can cause or increase bowel incontinence, especially in older people. These medications include:

- Antacids
- Laxatives

OTHER THERAPY

If you often have bowel incontinence, you can use special fecal collection devices to contain the stool and protect your skin from breakdown. These devices consist of a drainable pouch attached to an adhesive wafer. The wafer has a hole cut through the center, which fits over the opening to the anus.

Most people who have bowel incontinence due to a lack of sphincter control, or decreased awareness of the urge to defecate, may benefit from a bowel retraining program and exercise therapies to help restore normal muscle tone.

Special care must be taken to maintain bowel control in people who have a decreased ability to recognize the urge to defecate, or who have impaired mobility that prevents them from independently and safely using the toilet. Such people should be assisted to use the toilet after meals, and promptly helped to the toilet if they have the urge to defecate.

If toileting needs are often unanswered, a pattern of negative reinforcement may develop. In this case people no longer take the correct actions when they feel the urge to have a bowel movement

See also: Toileting safety

SURGERY

People who have bowel incontinence that continues even with medical treatment may benefit from surgery to correct the problem. Several different options exist. The choice of surgery is based on the cause of the bowel incontinence and the person's general health.

RECTAL SPHINCTER REPAIR

Sphincter repair is performed on people whose anal muscle ring (sphincter) isn't working well due to injury or aging. The procedure consists of re-attaching the anal muscles to tighten the sphincter and helping the anus close more completely.

GRACILIS MUSCLE TRANSPLANT

In people who have a loss of nerve function in the anal sphincter, gracilis muscle transplants may be performed to restore bowel control. The gracilis muscle is taken from the inner thigh. It is put around the sphincter to provide sphincter muscle tone.

ARTIFICIAL BOWEL SPHINCTER

Some patients may be treated with an artificial bowel sphincter. The artificial sphincter consists of three parts: a cuff that fits around the anus, a pressure-regulating balloon, and a pump that inflates the cuff.

The artificial sphincter is surgically implanted around the rectal sphincter. The cuff remains inflated to maintain continence. You have a bowel movement by deflating the cuff. The cuff will automatically re-inflate in 10 minutes.

FECAL DIVERSION

Sometimes a fecal diversion is performed for people who are not helped by other therapies. The large intestine is attached to an opening in the abdominal wall called a colostomy. Stool passes through this opening to a special bag. You will need to use a colostomy bag to collect the stool most of the time.

Call your health care provider if

Report any problems with incontinence to your health care provider. Call your health care provider if:

- A child who has been toilet trained has any stool incontinence

- An adult has stool incontinence
- You have skin irritation or sores as a result of bowel incontinence

What to expect at your health care provider's office

The health care provider will perform a physical examination, focusing on the stomach area and rectum. A finger exam of the rectum and anus will be performed. The health care provider will insert a lubricated finger into the rectum to evaluate sphincter tone, anal reflexes, and to check for any abnormalities of the rectal area.

The health care provider may ask the following medical history questions:

- Describe the problem. When does it occur?
- For how long has incontinence been a problem?
- How many times does this happen each day?
- Are you aware of the need to defecate before you leak?
- What is the consistency of the stool? Is it hard or soft liquid?
- Describe the amount of stool leakage (discharge with gas, a large amount of stool)?
- Has anything happened recently to cause emotional upset?
- Is the patient confused or disoriented?
- Was the child toilet trained? Did he or she have trouble with toilet training?
- What other symptoms are present?
- What surgeries have you had?
- What injuries have you had? Did you have a complicated delivery?
- What medications do you take?
- Do you drink coffee? How much?
- Do you drink alcohol? How much?
- Describe your usual diet.

Diagnostic tests may include:

- Barium enema
- Blood tests
- Electromyography (EMG)
- Rectal or pelvic ultrasound
- Stool culture
- Test of anal sphincter tone (anal manometry)
- X-ray procedure using a special dye to evaluate how well the sphincter contracts (balloon sphincterogram)
- X-ray procedure using a special dye to see the bowel while you have a bowel movement (defecography)

References

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