Community HealthPathways North Cumbria

Faecal Incontinence

This pathway is for patients aged 18 years or older.

Red flags

- Rectal pain or bleeding
- Low back pain

Background

About faecal incontinence

About faecal incontinence

Faecal incontinence is the loss of faeces that is a social or hygienic problem. It is a sign or symptom, not a diagnosis.

Prevalence increases with age, with 12% of older adults and up to 50% of nursing home residents affected. [1]

A detailed assessment and structured approach to management is needed, starting with addressing reversible factors and progressing to specialist investigations and management if needed.

Faecal incontinence can have significant effects on quality of life, such as social isolation, and long-term management should include advice on preserving dignity and independence where possible.

Assessment

1. History – Ask about:
   - symptoms in at-risk groups :

At-risk groups

People who:

- are frail or older.
- have:

- loose stools due to any cause.
- had a baby, especially after significant obstetric injury.
- a history of spinal disease or injury, e.g. spina bifida, stroke, multiple sclerosis (MS) or traumatic paraplegia.
- significant cognitive impairment.
- urinary incontinence.
- a history of colonic resection or anal surgery.
- had pelvic radiotherapy.
- rectal or vaginal prolapse.
- rectal soreness, itch, or pain.
- learning difficulties.

- Bowel habits

Bowel habits

- Frequency of faecal incontinence
- Straining, difficulty with defecation, or urgency
- History of constipation
- Frequency and consistency of motions – the Bristol Stool Chart can be useful
- Presence of blood, pain, itch, or mucus
- Rectal prolapse (a true rectal prolapse occurs when the rectum slides partially or fully out of the anal opening, turning itself inside out)

- Concomitant urinary incontinence
- Frequency of use of sanitary pads or changes of clothing

- impact on daily living, employment, or social activities and relationships.
- obstetric history .

Obstetric history

- Gravidity, parity
- Infant birth weight
- Episiotomy
- Forceps or vacuum delivery
- Perineal tear (and grade) or injury
- Shoulder dystocia
- Perineal repair and any complications of healing

- Documented obstetric anal sphincter injuries (OASIS)

- surgical history .

Surgical history

- Pelvic floor surgery
- Previous anorectal surgery, particularly:
  - incision and drainage for anorectal abscess or underlying fistula
  - sphincterotomy for anal fissure, anal dilation
  - haemorrhoidectomy
  - rectal cancer surgery
- Childhood bowel abnormalities or surgeries
- Colonic resection
- Cholecystectomy can result in malabsorption
- Injury to the muscles or nerves of the anal sphincter due to:
  - childbirth (immediately after childbirth, and second group in the perimenopause)
  - injury, including previous anal trauma or sexual abuse

- medical history .

Medical history

- Chronic constipation. impaction, and straining
- Chronic diarrhoea
- Irritable bowel syndrome (IBS)
- Inflammatory bowel disease (IBD)
- Congenital causes
- Radiotherapy, in treatment of prostate and cervical cancers
- Neurological causes, e.g.:
  - Multiple sclerosis (MS)
  - Spinal injury
  - Symptoms of cauda equina syndrome – recent onset bowel, bladder, or sexual dysfunction, low back pain or bilateral leg pain, or perianal sensory loss
  - Stroke
  - Dementia
  - Cognitive impairment

- Diabetes

- medications that may cause faecal incontinence , including herbal preparations and over-the-counter drugs.

Medications that may cause faecal incontinence

Drugs altering sphincter tone:

- Nitrates
- Calcium channel antagonists
- Beta blockers
- Sildenafil
- Selective serotonin reuptake inhibitors

Broad-spectrum antibiotics (multiple mechanisms):

- Cephalosporins
- Penicillins
- Erythromycin

Topical drugs applied to the anus (reducing pressure):

- Glyceryl trinitrate ointment
- Diltiazem cream or ointment
- Botulinum toxin A injection

Drugs causing profuse loose stools:

- Laxatives
- Metformin
- Orlistat
- Selective serotonin reuptake inhibitors
- Magnesium-containing antacids
- Digoxin
- Lithium
- Risperidone

Constipating drugs:

- Loperamide
- Opioids including codeine
- Tricyclic antidepressants
- Aluminium-containing antacids

- diet – caffeine, alcohol.

2. Examine the patient:
   - Check height, weight and calculate body mass index (BMI) .

> **Body mass index (BMI)**
>
> Body mass index = kg/m^2 (weight divided by height squared)
>
> NHS has an online calculator .
>
> - Less than 18.5 – underweight
> - 18.5 to 24.9 – healthy or normal weight
> - 25 to 29.9 – overweight
> - Over 30 – obese
>
> For black, Asian, and other ethnic minority patients:
>
> - Less than 18.5 – underweight
> - 18.5 to 22.9 – healthy or normal weight
> - 23 to 27.5 – overweight
> - Over 27.5 – obese

   - Obtain consent and perform a digital rectal examination to assess for faecal impaction, palpable masses, and blood in stool or melaena. Follow the recommended protocol .

> **Recommended protocol**
>
> - Only perform a rectal examination if there is a specific and clear clinical indication.
> - Always seek voluntary consent. Consider the capacity to consent of patients who are physically, mentally, or intellectually impaired, and those of culturally or linguistically diverse backgrounds (among others).
> - Always consider:
> - the presence of a chaperone in the room.
> - the patient's specific needs, e.g. if disabled or culturally or linguistically diverse.
> - If relevant, discuss and explain the limits of confidentiality.

   - Assess for:
     - localised complications, e.g. perianal dermatitis.
     - blood and stool consistency.
     - anal tone.
     - perineal sensation, if cauda equina syndrome is suspected.

    - rectal prolapse (a true rectal prolapse occurs when the rectum slides partially or fully out of the anal opening, turning itself inside out).
  - In a female patient, assess for uterine descent, presence of rectocele or cystocele, and pelvic floor competence.
3. Be aware of:
  - colorectal cancer risk factors .

    Colorectal cancer risk factors

    - Smoking
    - Human papilloma virus (HPV) exposure (anal sex increases anal cancer risk)
    - Personal or family history of colorectal cancer
    - Personal history of inflammatory bowel disease, adenoma
    - Older age

    Not an exhaustive list.

  - signs or symptoms suggestive of colorectal cancer .

    Signs or symptoms suggestive of colorectal cancer

    - Rectal bleeding or melaena
    - Altered bowel habit for at least 6 weeks
    - Unexplained weight loss
    - New abdominal pain not otherwise explained by a more likely differential
    - Unexplained iron deficiency anaemia

    Not an exhaustive list.

  See also NICE Clinical Knowledge Summaries (CKS) – Symptoms Suggestive of Gastrointestinal Tract (Lower) Cancers

4. Consider performing cognitive assessment, if indicated.
5. If present, consider causes of chronic diarrhoea .

    Causes of chronic diarrhoea

    - Exclude infective causes in chronic diarrhoea
    - Consider foods or additives which may worsen diarrhoeal symptoms:
      - Lactose
      - Artificial sweeteners
      - Caffeine

- Alcohol
- Consider other causes of chronic diarrhoea:
  - Lactose intolerance
  - Medications
  - Coeliac Disease in Adults
  - Inflammatory Bowel Disease (IBD)
  - Irritable Bowel Syndrome (IBS)

6. Arrange investigations:
   - Arrange FBC, ferritin, urea and electrolytes, TFT, coeliac serology, tissue transglutaminase (tTG) antibodies, and immunoglobulin A (IgA).

Tissue transglutaminase (tTG) antibodies

Advise the patient to include gluten in their diet for 4 to 6 weeks for the test results to be accurate, e.g. at least 4 slices of gluten-containing bread or equivalent each day.

A patient with a co-existing IgA deficiency will have a false-negative IgA tTG result. The laboratory will automatically check for IgA deficiency. If the patient is IgA deficient, then IgG tTG will be measured.

Urea and electrolytes

When requesting urea and electrolytes, the laboratory will automatically test:

- Sodium
- Potassium – blood sample must be spun down or analysed within 6 hours of collecting, or the lab will omit potassium analysis
- Urea
- Creatinine
- eGFR

- If constipation is a predominant symptom, add bone profile.
- If diarrhoea or loose motions are predominant symptoms, arrange faecal microbial investigation (molecular enterics) and *Clostridium difficile* PCR (if recent antibiotics), CRP, B12, folate.
- Use faecal calprotectin only in patients younger than 50 years with chronic diarrhoea. It is helpful in distinguishing functional from organic causes of diarrhoea.

Faecal calprotectin

- Faecal calprotectin is a useful but expensive stool test.

- For diarrhoea, it is now seen as a first line test to help exclude inflammatory bowel disease (IBD): [2]
  - Faecal calprotectin is a marker of intestinal mucosal inflammation that can be useful in differentiating between inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS) in symptomatic patients.
  - In IBD, levels correlate with disease activity, and a concentration less than 50 microgram/g is considered to be a good negative predictor (published negative predictive values 70 to 90%). The best value of this test in general practice is a negative result, which effectively excludes a diagnosis of IBD in young patients presenting with diarrhoea.
  - For patients with known inflammatory bowel disease in remission, faecal calprotectin greater than 50 microgram/g is associated with an increased risk of relapse over the next 12 months.

- If iron deficiency anaemia, arrange tissue transglutaminase antibodies and IgA level. Check a urine dipstick to exclude microscopic haematuria – see Haematuria in Adults.
- If indicated, arrange a faecal immunochemical test (FIT).

Management

1. Manage according to presentation. If:
   - suspected cauda equina syndrome, request acute orthopaedic assessment.
   - the patient meets 2-week wait criteria for colorectal cancer, request 2-week wait colorectal surgery assessment.

2-week wait criteria

- Abdominal, rectal, anal mass or ulceration.
- Rectal bleeding in association with unexplained:
  - abdominal pain.
  - change in bowel habit.
  - weight loss.
  - iron deficiency anaemia. IDA is defined as haemoglobin less than 130 g/L for men or less than 115 g/L for women and low MCV, low MCH, or low ferritin. [3] Consider iron deficiency may also be present if ferritin is between 23 to 75 microgram/L in the presence of systemic inflammation, e.g. elevated CRP.
- Rectal bleeding in a patient older than 50 years.
- A patient:
  - older than 40 years with unexplained weight loss with abdominal pain.
  - with high-risk iron deficiency anaemia (IDA) – Defined as all men with IDA, women older than 50 years, or women who are older than 40 years and are non-menstruating.

> - a positive FIT test.

- the patient has constipation with overflow faecal incontinence, follow the Constipation in Adults pathway.
- rectovaginal fistula or rectal prolapse, request routine colorectal surgery assessment.

2. Seek non-acute colorectal surgery advice if the patient has a:
   - history of sphincter injury.
   - sacral nerve stimulator and ongoing issues.
3. Manage causes of chronic diarrhoea .

> **Causes of chronic diarrhoea**
>
> - Lactose intolerance
> - Coeliac Disease in Adults
> - Inflammatory Bowel Disease (IBD)
> - Irritable Bowel Syndrome (IBS)

4. Offer anti-diarrhoeal medication once treatable causes of faecal incontinence have been excluded.

> **Anti-diarrhoeal medication**
>
> First-line – loperamide 0.5 mg to 16 mg daily as needed:
>
> - Start on a very low dose and up-titrate according to the response.
> - If doses of less than 2 mg are needed, use loperamide oral solution (1 mg in 5 mL).
> - Advise the patient to use the medication as needed to manage symptoms.
>
> Second-line (if loperamide is not tolerated or ineffective) – codeine phosphate.

5. For all patients, provide patient advice:
   - Diet and weight

> **Diet and weight**
>
> - Make dietary recommendations, including fibre supplementation:
> - Reduce alcohol and caffeine.
> - Ensure adequate intake of fluid and fibre – good sources of fibre include fruits, oats, beans, peas, and green leafy vegetables.
> - Give advice on maintaining a healthy weight. Obesity is well-documented as a risk factor for faecal incontinence.

- Maintaining dignity and independence where possible, offer:
  - details of the National Key Scheme (NKS)

    > **National Key Scheme (NKS)**
    >
    > Radar keys offer disabled people independent access to more than 9000 locked public toilets around the country. Toilets fitted with NKS locks can now be found in shopping centres, pubs, cafés, department stores, bus and train stations, and many other locations in most parts of the country.

  - details of the Bladder & Bowel Community support group for advice on continence products, how to talk to family and friends, and planning travel.
  - advice on skin care, e.g. barrier cream.

6. If needed, consider requesting adult continence assessment from the Community Bladder and Bowel Service.
7. Consider proactive bowel management for patients who are in an at-risk group for faecal incontinence.
8. Provide specific treatment and advice for an older or frail patient .

> **Specific treatment and advice for an older or frail patient**
>
> - Ensure adequate fluid and fibre intake or use aperients to avoid constipation or diarrhoea.
> - Advise regular toileting and changes of continence aids.
> - Consider access to toileting facilities, including:
> - difficult-to-manipulate clothing.
> - inaccessibility or lack of equipment, e.g. toilet rails or commode.
> - waiting for required assistance.
> - lack of privacy or other adverse environmental factors.
> - Encourage structured daily exercise.
> - Ensure pressure area cares.
> - Advise the patient to use soap-free washes and emollients to promote skin integrity.

9. If the patient has a known neurological cause, e.g. MS, or symptoms are exacerbated by an existing neurological condition, request routine neurology assessment.
10. If further evaluation of cognitive impairment is indicated, consider requesting cognitive impairment specialised assessment.
11. If conservative treatment by the Community Bladder and Bowel Service has been unsuccessful, consider requesting routine colorectal surgery assessment.

Request

- If suspected cauda equina syndrome, request acute orthopaedic assessment.
- If the patient meets 2-week wait criteria for colorectal cancer, request 2-week wait colorectal surgery assessment.
- If needed, consider requesting adult continence assessment from the Community Bladder and Bowel Service.
- Request routine colorectal surgery assessment if the patient has:
  - rectal prolapse.
  - rectovaginal fistula.
- Consider requesting routine colorectal surgery assessment if conservative treatment by the Community Bladder and Bowel Service has been unsuccessful.
- Request non-acute colorectal surgery advice if the patient has a:
  - history of sphincter injury.
  - sacral nerve stimulator and ongoing issues.
- If the patient has a suspected neurological cause, or symptoms are exacerbated by an existing neurological condition, request routine neurology assessment.
- Consider requesting cognitive impairment specialised assessment.

Information

For health professionals

Education

North Cumbria HealthPathways – Continuing Professional Development

Further information

NICE Guidance – Faecal Incontinence in Adults: Management

For patients

Bladder & Bowel Community – Website

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SOURCES

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