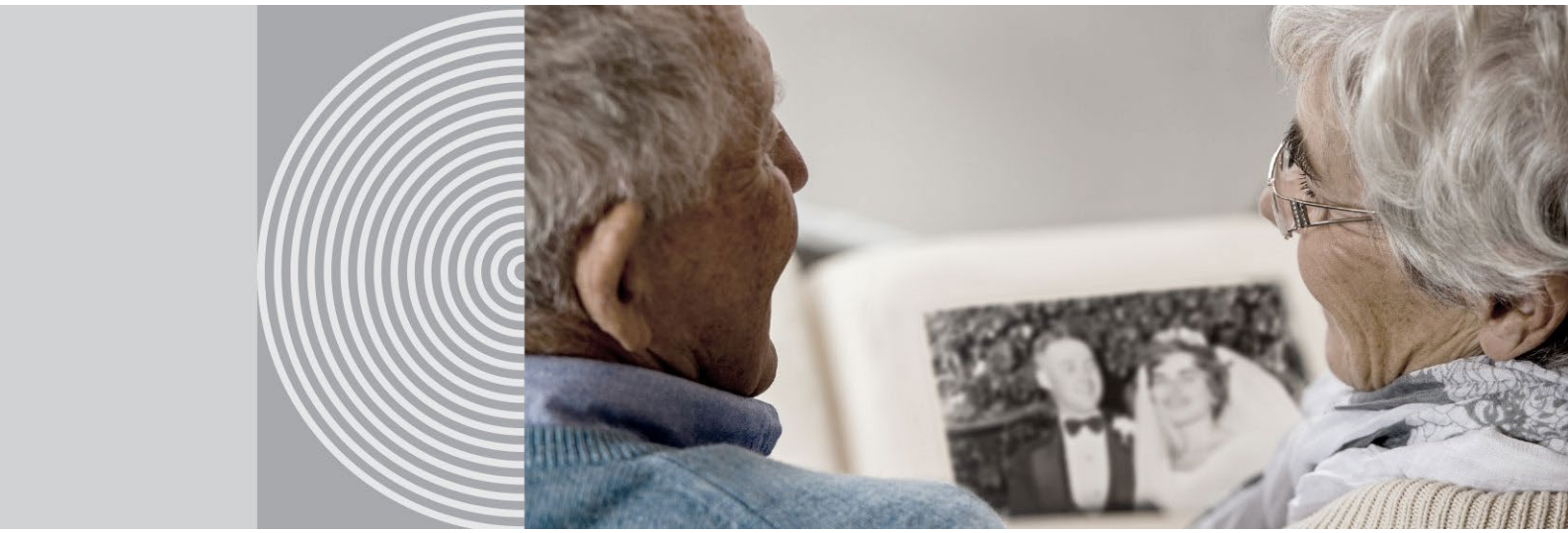
RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part A. Faecal incontinence



General principles

- Faecal incontinence is common and debilitating, but poorly assessed and managed in residential aged care facilities
- Certain risk factors (eg age) predispose a person to faecal incontinence.
- A structured approach to history, examination and relevant investigations help to identify potential causes of faecal incontinence.
- A common, reversible cause is constipation or faecal impaction that leads to overflow incontinence, which can be easily identified and treated in most cases.
- Treatment plans should involve a multidisciplinary approach as much as possible, keeping in mind the patient's goals and preferences of care.

Practice points

Practice points	References	Grade
Assess the type of incontinence using an objective grading system (eg Bristol Stool Chart)	1	Consensus-based recommendation
Include a seven-day bowel chart to provide information about frequency, timing, episodes of incontinence and stool consistency during history-taking	1	Grade of Recommendation: C
Examination should include a digital rectal examination, assessment of skin integrity and primary neurological conditions	2, 5	Consensus-based recommendation
Establish a regular bowel pattern by encouraging (and assisting if necessary) the patient to open their bowels soon after a meal, at the same time each day	1, 2	Consensus-based recommendation
Encourage adequate dietary fibre and fluid intake	1	Fibre: Level of Evidence: 1;

		Grade of Recommendation: B Fluid: Level of Evidence: 2
Promote easy access to toilet or provide a commode next to the bed	1, 2	Consensus-based recommendation
Advise regular exercise within the context of the patient's comorbidities and physical abilities	1, 2	Consensus-based recommendation
Regularly review the use of laxatives, as overuse can lead to diarrhoea and faecal incontinence	8	Consensus-based recommendation
Consider that transanal irrigation may be suitable for those with intact cognition and high motivation levels to comply with treatment	9	Consensus-based recommendation
The mainstay of treatment of faecal incontinence is often containment strategies (eg pads, bed protection)	10	Consensus-based recommendation

Introduction

Faecal incontinence is the involuntary loss of liquid or solid faeces[1] at an inappropriate time and/or place. Anal incontinence includes these events as well as the involuntary loss of flatus.[1]

Clinical context

The prevalence of faecal incontinence is estimated to be 12–13% in older people, and up to 50% for those in residential aged care facilities (RACFs), with a higher prevalence rate among men.[2] There are few prevalence studies of faecal incontinence in RACFs, but a prevalence of 54% was reported in one study, and another found an incidence of 20% during a 10-month period after admission.[1]

In comparison with urinary incontinence (refer to Part A. Urinary incontinence), all the challenges of underreporting and undertreating are magnified in faecal incontinence. There is a low rate of referral to primary care physicians and/or nurse continence specialists for further assessment, with a tendency toward containment only (eg use of pads without further evaluation). Older people themselves are often reluctant to volunteer symptoms of faecal incontinence for social or cultural reasons. They may also be reluctant due to a popular misperception that the condition is part of the ageing process and therefore 'nothing can be done about it'.[1]

Only half of geriatricians in one study reported screening for faecal incontinence, and only a third believed that RACFs provide good care for faecal incontinence.[1] A standardised approach for screening with the help of validated tools (eg Revised Faecal Incontinence Scale)[3] may help with early and accurate identification of faecal incontinence.

Changes in ageing (eg reduction in sphincter tone at rest, squeeze) make older people more susceptible to faecal incontinence. Other associated risk factors include female gender, co-existing urinary incontinence, high body mass index (BMI), loose stool consistency and prior colorectal surgery.[1]

Common causes

Common causes of faecal incontinence in older people include:[4]

- faecal impaction – this may result from chronic constipation associated with immobility, delayed response to the urge to defecate, decreased fluid and fibre intake or the use of certain medications (eg opioids, anticholinergics)
- reduced bowel emptying secondary to defaecatory dysfunction – poor defaecation technique due to inadequate external sphincter relaxation and/or insufficient expulsive effort leads to retention of stool in the rectum and often passive faecal incontinence post attempted defaecation
- neurogenic incontinence – higher central nervous system damage from severe stroke or advanced dementia (however, mild or even moderate dementia is not a cause of faecal incontinence itself), and other neurological conditions (eg autonomic neuropathy or spinal cord disease). The faecal incontinence associated with these conditions is usually the result of a combination of the direct neurological insult and functional causes
- anal sphincter or pelvic muscle weakness (eg obstetric trauma, prior surgery)

- loose bowel motions – diarrhoeal illness, change in dietary habits, medications (eg antibiotics, laxatives)
- colorectal disease (eg carcinoma, villous polyps, rectal prolapse, inflammatory bowel conditions or haemorrhoids)
- functional causes – secondary to either severe cognitive impairment, physical disability affecting ability to reach toilet quickly, reduced dexterity impeding the ability to disrobe appropriately, poor toilet access, among others
- others – causes amenable to surgical intervention in younger patients (eg anal sphincter tears) are rarely the sole cause of faecal incontinence in frail older patients.

In practice

Assessment

There are three steps in the assessment of faecal incontinence:

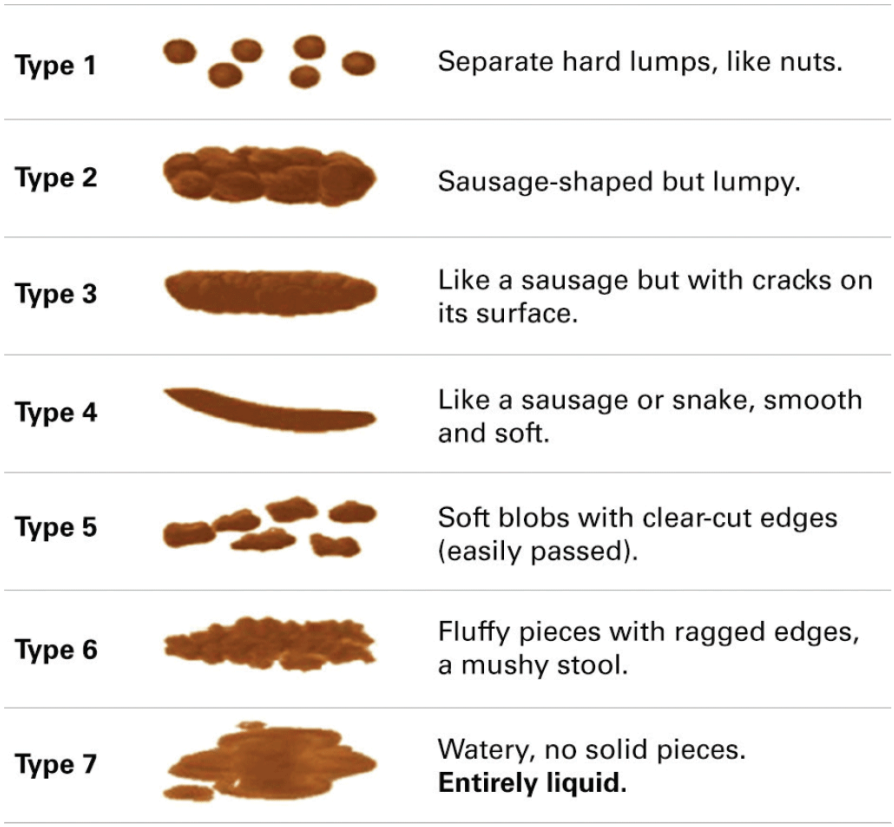
- History
- Examination
- Investigations

History

History-taking is an important component of assessing faecal incontinence, and should include assessing:[1]

- type of incontinence (eg solid, liquid or gas)
  - Bristol Stool Chart (Figure 1) provides an objective grading system.
  - Include a seven-day bowel chart to provide information about frequency, timing, episodes of incontinence and stool consistency (Grade of Recommendation: C).
  - Loose bowel motions can be seen in faecal incontinence because of diarrhoea or ‘overflow incontinence’ secondary to constipation.
- frequency of bowel actions and usual bowel habit
  - Urgency is closely associated with diarrhoeal illness, or any cause of loose bowel motions.
  - Constant passive leakage is more characteristic of overflow incontinence because of faecal impaction or faecal incontinence because of impaired rectal emptying secondary to defaecatory dysfunction.
- timing of bowel actions
  - Incontinence from severe dementia may result in postprandial bowel actions because of the gastrocolic reflex (stool consistency often normal).
- associated symptoms
- constipation, pain or straining, local symptoms (eg rectal bleeding)
- effect on lifestyle (eg avoiding going out) and hygiene (personal and domestic)
- dietary history and appetite, including intake of fruit and fibre
- comorbidities, past history and medications (including use of laxatives and enemas)
- cognitive status, mobility, visual acuity, manual dexterity, access to toilet and carer assistance.

Figure 1. Bristol Stool Chart



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Examination

After taking the patient's history, an examination should be conducted, including:[2,5]

- digital rectal examination, to exclude faecal impaction or rectal mass, and assess anal sphincter tone (ie resting and squeeze pressure), rectal prolapse and pelvic muscle tone
- assessment of anal sphincter and pelvic muscle tone may be difficult or impossible in older people with cognitive impairment or in those who are unable to squeeze on demand. Reduced anal sphincter tone can occur with long-standing constipation – this is due to continued activation of the recto-anal inhibitory reflex, anal sphincter damage (eg post-childbirth) and lower spinal cord or cauda equina lesions (the latter would also usually be associated with reduced perineal sensation)
- assessment of skin integrity is important given faecal incontinence can lead to the development of dermatitis or pressure ulcers, especially in those with impaired mobility[1]
- primary neurological assessment, although not a common cause of faecal incontinence, primary neurological conditions such as spinal cord injury should be considered, and a lower-limb neurological examination should be conducted along with testing perineal sensation, and observing for the anal reflex (contraction of the external anal sphincter upon stroking perianal skin or 'anal wink').

Investigation

Investigations are not necessary in all cases, but can be useful for more severe cases of faecal incontinence, especially if the cause is not clear. This could include:[2]

- a plain abdominal X-ray to exclude faecal loading, although interpretation of lesser degrees of faecal loading is subjective
- stool microscopy, culture and sensitivity, including testing for *Clostridium difficile* toxin for persistent or severe diarrhoea if there is no other clear cause for the faecal incontinence

- a colonoscopy to rule out sinister pathology; however, in the RACF context, a holistic view needs to be adopted to ensure benefits outweigh risks, and decisions are made in line with the patient's values, preferences and long-term prognosis
  - features that suggest underlying malignancy include change in bowel habit, appetite and weight loss, anaemia, rectal pain or bleeding and faecal incontinence.
- screening for malabsorption syndromes (eg lactose intolerance, gluten sensitivity, fat-malabsorption, carbohydrate malabsorption) in selected older people only, especially if there appears to be a relation to diet.

Management

The management and treatment of faecal incontinence depends on the underlying cause. Multiple interventions may be required and, ideally, a multidisciplinary approach is advised where simple measures have been ineffective. However, there is currently limited high-quality evidence in this setting to guide management.

Faecal incontinence in RACFs is commonly due to constipation with colonic loading and overflow. Thus, efforts to prevent this should be part of the care plan for all residents. Behavioural and non-pharmacological measures include the following:[1,2]

- Try to stimulate the patient's usual bowel pattern and establish a regular bowel pattern by encouraging (and assisting if necessary) the patient to open their bowels soon after a meal, at the same time each day. Stool transit can also be stimulated by appropriately trained professionals with abdominal massage in the direction of colonic transit.
- Encourage adequate dietary fibre (Level of Evidence: 1; Grade of Recommendation: B) and fluid intake (Level of Evidence: 2; plus consider dietitian referral).
- Promote optimisation of toilet access or provide a commode next to the bed.
- Advise regular exercise within the context of the patient's comorbidities and physical abilities.

Regular prompted toileting and structured exercise programs administered separately have not been found to reduce faecal incontinence. However, the combination of both in one randomised controlled trial found a reduction in faecal incontinence, albeit with the need for increased staff-to-resident ratios in RACFs (1:5), challenging the feasibility of these interventions in everyday clinical practice.[6]

Simple patient and carer education on proper bowel habits includes the following points:[7]

- Respond promptly on urge to defaecate.
- Provide privacy to defaecate wherever feasibly possible.
- Adjust/modify position of toilet to facilitate rectal evacuation (eg back support, footstool to achieve squat position).
- Engage in regular exercise to promote bowel actions.

Bulking agents (eg psyllium found in oats, cereals, commercial preparations) may help reduce the incidence of faecal incontinence, although these should not be given to older people who are frail with poor oral intake as constipation can be worsened.

Medications to treat constipation include:[8]

- stool softeners (eg docusate)
- osmotic laxatives
- stimulants (eg senna, bisacodyl) may work better than other agents for those with poor oral intake or fluid restrictions
- suppositories (ie glycerine, bisacodyl or microenema [eg docusate 5 mL]), generally for more severe constipation where the patient is unresponsive to other laxatives. This should be used according to response, but usually these are only required second or third daily.

All laxatives need to be regularly reviewed as overuse can lead to diarrhoea and faecal incontinence.

Transanal irrigation may be suitable for those with intact cognition and high motivation levels to comply with treatment. It can reduce the severity of constipation and incontinence, improve quality of life and promote independence.[9] It requires nurse continence specialists to provide patient and carer support via training and education.

For severe constipation with impaction, consider the following:

- If a rectal examination shows the patient is rectally impacted, suppositories or a microenema should be administered, with a result expected within 30–60 minutes.
- If the rectal examination does not confirm rectal impaction, but the patient has not opened their bowels for some days +/– the abdominal X-ray showed faecal loading, oral macrogol can be given (up to eight sachets over a six-hour period for not longer than three days).
- Occasionally, impaction may require manual evacuation with premedication for pain if the faecal impaction has not been responsive to the above measures, although this is not commonly needed.

For faecal incontinence related to persistent diarrhoea, not clearly due to an infectious cause (eg acute gastroenteritis, *C. difficile*), loperamide can be used in an attempt to reduce the frequency of faecal incontinence. However, infection and other causes should be excluded prior to regular use. Rare adverse cardiac events have been reported with loperamide (although usually with higher doses), and it may also lead to constipation, especially if taken regularly.[8]

The treatment of faecal incontinence associated with neurological conditions (eg cerebrovascular disease, Parkinson's disease) follows the same principles outlined above. Patients with spinal cord disease often have faecal incontinence associated with constipation, which is therefore the primary management target. Management principles such as a regular toileting program and non-pharmacological measures are also applicable in this patient group. A common laxative regime used in patients with spinal cord disease includes docusate and senna (given separately) in the evening, followed by glycerine +/– bisacodyl suppositories after breakfast in the morning. Anal stimulation may also be required to facilitate relaxation of the anal sphincter. Management can often be difficult and should be guided by specialist advice wherever possible.

Pelvic floor muscle retraining has few adverse effects; however, there is little evidence for its effectiveness in frail, disabled older people. It is also rarely practical in the residential care setting because of patient factors (eg cognitive impairment) and lack of resources to instruct in the technique and to monitor progress.

Containment strategies are often the mainstay of treatment, and include pads and bed protection. Anal plugs can be effective for achieving control of faecal incontinence in certain cases; however, these are often poorly tolerated. Input from nurse continence specialists can be invaluable in determining the best containment methods. Governmental subsidies such as the Continence Aids Payment Scheme (CAPS) may be available for eligible parties, although most patients in RACFs are ineligible.[10] State and territory specific programs such as the State-wide Equipment Program (SWEP) in Victoria may provide further financial assistance.

Skin care is crucial in the management of incontinence, and includes:[11]

- regular checks to ensure the skin is clean and dry
- washing skin with soap-free cleanser or soap alternative
- regular pad changes
- application of barrier cream.

A small minority of patients with troublesome faecal incontinence that is unresponsive to conservative measures who are willing, and are medically fit, to undergo invasive testing and surgical intervention can be referred for specialised investigations to assess for surgical treatments. These can include surgical sphincter repair or considerations of other strategies such as peri-anal bulking agents, sacral neuromodulation or percutaneous tibial nerve stimulation.[5]

Many regional aged-care service providers offer a specialised continence service with access to a geriatrician, nurse continence specialist and continence physiotherapist. The National Continence Helpline (1800 330 066) can provide details of these clinics and services.

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