ANAL INCONTINENCE: The silent Drama

Anal incontinence can have a devastating effect on women's quality of life. It affects between 1% and 16% of women, with prevalence increasing with age. Community based studies found a rate of between 2.2% of adults to a rate of 7% in healthy adults over the age of 65. The prevalence rises to reach 50% in institutionalized populations.

Anal incontinence is defined as an involuntary passage of stools through the anus. People with fecal incontinence differ widely from one another but they share a common difficulty. Their disorder affects nearly every aspect of their daily lives. It dramatically reduces their quality of life. The personal cost is a loss of confidence, self- respect, and sometimes isolation. It may change their profession, their hobbies, their social life and functions. Many people become almost homebound being unable to undertake simple tasks such as shopping without fear of an accident. People suffering from fecal incontinence are reluctant to speak about their disease with their families and also with their doctors. Only half of them will open themselves to their family doctors and it may take them years to do so. Fecal incontinence is a silent affection because of the shame of the patient and the difficulty of the society to allow to freely communicating on these problems. The human impact is high. The cost of this disease is unknown but it is probably very expensive. In 1995, in the USA, the cost of fecal and urinary incontinence was estimated as high as 26 billion of dollars (!) in patients older then 65.

There are many reasons explaining fecal incontinence in adults. Some of these causes may be difficult to treat but all of them are possible to prevent if addressed early. So that educating the public becomes essential.

Women are concerned by fecal incontinence since vaginal delivery and menopause have been implicated as significant causal factors.

Vaginal delivery is a major cause of fecal incontinence. In many cases childbirth results in damage to the anal sphincters, which is the ring of two muscles that closes the anus and keeps stools within the rectum until one can find an appropriate opportunity to defecate. Injuries to the anal sphincter are regrettably one of the most common injuries sustained during vaginal childbirth. Using sophisticated methods of diagnosis of anal tears such as ultrasound performed inside the anus show between 30% to 40% of women having occult and defect. About 10% to 25% of the women will complain about anal incontinence, urgency for stool or incontinence for gas. The first delivery is the more traumatic one. Further deliveries will be much less aggressive to the anus.

In case of a complete tear of the anus during childbirth the primiparae concurs the risk of suffering from fecal incontinence later. The use of forceps increases the risk; other obstetric risk factors include midline episiotomy (which is done mainly in the USA and not in Israel) birth weight >4000 g , probably a prolonged second stage labor and multiparity (several babies) . Not all the cases of fecal incontinence in the early post partum will remain.

Importantly, anal spincter damage from a prior delivery and symptoms of altered anal continence are risk factors for worsened continence status after a second delivery.

Therefore, these patients should have a pre labor counseling with sometimes, several examinations, such as anal ultrasound and manometry (a technique that allows to measure the anal strength) to assess their pelvic floor functions. Experts now agree that a pre labor scheduled C-section should be an option for a woman with prior anal sphincter trauma or evidence of anal dysfunction.

Vaginal delivery may be responsible for pelvic nerve injuries. Since these nerves activate the pelvic floor muscles it may explain that even in some cases of intact anal sphincters, their function is weakened. At the difference of the direct trauma on anal sphincters, which is higher during the first delivery, the lesion of the nerve occurs more frequently in further childbirths. This can also explain why the incontinence can appear sometimes years after the delivery. Recently, we have become aware that pregnancy may worsen the frequency of incontinence possibly due to the relaxing affects of pregnancy hormones or by the pressure on the pelvic floor and the rectum. It is not clear whether different ethnic groups of women have different risk of incontinence or if there is a genetic predisposition.

Fecal incontinence can be treated efficiently in many cases. But prevention is by far the best option. The treatment depends on the underlying causes of the problem, as different causes may be associated to alter a normal continence. If needed, the diet is adapted to the patient's needs with the intention of giving him more fibers, reducing diarrhea, showing the bowel transit. Good bowel training is indicated in incontinent patients with daily timing of evacuation about thirty minutes after meal, with sometimes enema or suppository to induce the defecation and to empty the bowels. Biofeedback is an essential adjunct to the treatment.

Patients will learn to feel their stool in their rectum and contract their sphincter muscle. This process can be learned again with the help of a monitor that would demonstrate the sphincter contractions and coordinate the sensation of stool in the rectum with the contraction of the anus. Learning the technique requires patience and practice. Patients will do also some "homework" and exercise at least three times a day. These techniques will greatly ameliorate or cure up to 70% of the cases.

In severe cases or in case of failure of all these treatments, surgery is an option. Surgery may offer a reconstruction of anal tears in some cases with good early results in 70% of the cases even though the quality of the results will decrease with time. Other operations could repair the pelvic floor muscle. Their results are variable. Interestingly new methods give promising results such as implantation of artificial anal sphincter or sacral neuromodulation. The former method deserves surgery. The latter is much easier and consists of implantation of small electrodes close to some nerve of the back tail (sacrum), which is activated by a pacemaker. When incontinence remains a problem despite medical treatment, disposable underwear and other commercial incontinence products are available to make life easier.

Fecal incontinence does not have to be one of the inevitable consequences of motherhood. It is not a question of fatality. A good professional treatment can solve or clearly relieve 70%-80% of the patients. The treatments are best given in pelvic floor cliniques where specialists such as gastroenterologists, gynecologists, urologists, colorectal surgeons are working together with physiotherapists and psychologists.

Counseling, information and an open communication are essential adjunct to the medical treatments.

Dr. Marc Beer-Gabel
Gastroenterologist
Director of the Pelvic Floor Service
Sheba Medical Center
Tel Hashomer