

FAECAL INCONTINENCE

Faecal incontinence is a socially debilitating and embarrassing condition that has a huge impact on the quality of life and activities of daily living. It is estimated that it occurs in up to 50% of older people living in residential aged care facilities. It can be difficult to treat; however, a combination of exercise programs and integrated continence care may provide some benefit. Faecal incontinence is an independent risk factor for pressure ulcers in frail older adults.

Definition

Faecal incontinence is defined as the involuntary expulsion of faecal material (liquid or solid stool) through the anus or defecating without reaching a toilet due to functional or cognitive limitations. This uncontrolled leakage of faecal material occurs at least once a month for at least three months.

Urge faecal incontinence occurs when a person senses the need to defaecate but is unable to control or resist the urge. Passive incontinence occurs without warning. Some people have faecal soiling without frank incontinence, evident by stains on underwear. Most people with faecal incontinence will also experience urinary incontinence.

Risk factors

Smoking and obesity are modifiable risk factors for faecal incontinence.

Risk factors specific for women include:

Prior traumatic vaginal delivery

- Menopause

In men, risk factors include:

- Evacuatory dysfunction
- Prior surgery for haemorrhoids
- Radiation for prostate cancer

Causes

Maintaining continence requires the interaction of an intact and functional anal sphincter complex, anorectal sensation and rectal capacity, the consistency of the faeces (ideally formed but not hard), adequate cognitive ability and physical mobility, and bowel motility. Any impairment of these elements can result in incontinence. Faecal incontinence can have multiple causes and can arise from a complex interplay of

physiological, environmental and psychosocial factors. Constipation and impaction of faeces may cause overflow incontinence (“overflow diarrhoea”). Ageing, menopause and diarrhoea play a significant role in the risk of faecal incontinence. Faecal incontinence can be a marker of frailty. Dementia can impair mobility and diminish voiding awareness and inhibitory control. With over 80% of residents in aged care living with dementia, lack of cognitive capacity to recognise the need to go to the toilet is key factor. Some conditions can predispose older people to faecal incontinence, including multiple sclerosis, many neurological conditions and diabetes.

Medicines known to contribute to faecal incontinence:

- Acarbose
- Antibiotics
- Colchicine
- Digoxin
- Laxatives
- Metformin
- NSAIDs
- Orlistat
- Proton pump inhibitors (PPIs)
- Selective serotonin reuptake inhibitors (SSRIs)

Metformin is first-line therapy for type 2 diabetes and is often used in combination with other anti-diabetes medicines. The maximum daily dose is 3g daily. Diarrhoea is a common side effect especially in higher doses. Metformin should be started at a low dose (500mg/day) with food and slowly increased according to effect and tolerance. High starting doses should be avoided. People who have tolerated metformin for many years can develop gastrointestinal adverse effects. Gastrointestinal effects are less likely to occur with extended-release metformin compared with standard metformin tablet.

The current recommended dosing schedule for colchicine in the treatment of acute gout is much less likely to cause diarrhoea than the previous dosing regimen. For treatment of an acute gout attack 1mg (two tablets) should be taken as soon as symptoms occur, followed by 500mg (1 tablet) one hour later (maximum 1.5mg per course).

continued over

Colchicine should not be repeated within 3 days of this initial course. Colchicine is also used in low daily doses (500 micrograms once or twice daily) for gout flare prophylaxis when starting urate-lowering therapy with allopurinol (Zyloprim). Nitrates, calcium channel antagonists (CCBs), beta-blockers, sildenafil, and SSRIs can exacerbate faecal incontinence by altering anal sphincter tone. Constipating medicines contributing to overflow incontinence include loperamide, opioids, tricyclic antidepressants, and antacids containing aluminium. Excessive doses of vitamin C, magnesium, phosphate or calcium can increase faecal incontinence.

Management

Pelvic floor muscle training with or without biofeedback can be useful. Biofeedback therapy relies on good cognitive function and cooperation, so may not be useful in people with dementia. Adjusting water and fibre intake may be necessary and foods that trigger symptoms should be avoided e.g. rhubarb, figs, prunes, beans, cabbage, chilli and caffeine.

Establishing access to a toilet and a routine of regular and complete rectal evacuation at predictable times is a common intervention, particularly in frail older people. Prompted toileting in addition to supervised walking, together with fluids before and after these brief interventions has been shown to reduce the number of faecal incontinence episodes. Transanal irrigation and anal plugs, sacral neuromodulation and various surgical options may be necessary if conservative treatment fails. Perianal dermatitis can be reduced through preventive barrier treatments. Other interventions include exercise to improve mobility or functional ability to use the toilet.

Medications

For residents with loose stools, anti-diarrheal medicines such as loperamide (Imodium, Gastro-Stop, Diareze) and diphenoxylate/atropine (Lomotil) can be used to firm up the consistency, ideally only for short periods of time. If constipation is causing overflow incontinence, psyllium husk products (e.g. Metamucil) may be helpful in reducing the incidence of faecal incontinence. Dietary fibre works primarily by bulking up watery stools, thereby decreasing the fluidity of the stool itself. Dietary fibre supplements can be used in conjunction with loperamide. Suppositories may be necessary to facilitate the evacuation of stools. If faecal impaction is the cause, stimulant or osmotic laxatives may be appropriate.

Tricyclic antidepressants such as amitriptyline (Endep, Entrip) or nortriptyline (Allegron, NortriTABS) may improve faecal incontinence symptoms. Nortriptyline is preferred in older persons as it has less anticholinergic effects than amitriptyline,

and therefore less likely to cause confusion.

Summary

Faecal incontinence is the involuntary loss of liquid or solid stool that is a social or hygienic problem. Comprehensive assessment of faecal incontinence is important to identify causes and tailor interventions to address these problems. Most people can be managed with lifestyle measures, including dietary changes and pelvic physiotherapy. Conservative treatment for faecal incontinence involves staff training, effective bowel emptying to manage constipation and symptom management. As polypharmacy is significant in residents in aged care, a medication review is recommended to identify medications that influence bowel function.

Further information

<https://www.continence.org.au/pages/faecal-incontinence.html>

References

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