

Establishing the Cause of Fecal Incontinence

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Fecal incontinence occurs eight times as often in women as it does in men and is especially common after childbirth. In addition, some degree of fecal incontinence is present in 7% of women with pelvic organ prolapse and in 35% to 50% of women with urinary incontinence. However, most women, unless specifically asked—or unless experiencing symptoms so severe that medical help is sought—will remain silent about their symptoms. Here we describe the components of a thorough assessment for fecal incontinence.

HISTORY

If the patient is experiencing or has experienced fecal incontinence, a thorough bowel history should be obtained. Ask the patient:

General queries

- ◆ What are your usual bowel habits? Could you describe the consistency of the stool and the frequency of stool production?
- ◆ Please describe the timing of incontinence. Do symptoms improve or worsen when certain foods are consumed or certain activities are performed?
- ◆ Are you experiencing other symptoms, such as fecal urgency or abdominal pain?
- ◆ How are your symptoms affecting your lifestyle?
- ◆ What, if anything, leads to improvement? What therapies, dietary or medical, have you initiated, and which are you still adhering to?

Specific queries

- ◆ How often are you experiencing fecal leakage?
- ◆ Have you had to wear a perineal pad?
- ◆ Could you describe the physical characteristics of the substance passed? Is it mostly gas, liquid, or solid?

PHYSICAL EXAMINATION

Three major assessments mark a thorough physical examination for fecal incontinence. They are, in the order in which they should be performed:

- ◆ A brief neurologic examination of the lower extremities and perineal reflexes. The absence of a cuta-

neous anal reflex suggests a diagnosis of pudendal neuropathy.

- ◆ Perineal and anorectal examination. Inspect the vagina, perineal body, and anus and note any deformities, lesions, or soilage on the skin. Perform Valsalva's test: Note the presence or absence of perineal descent. Next, perform a digital anorectal examination: Record sphincter tone both at rest and with maximal squeeze effort; inspect for mass lesions and fecal impaction; and note stool consistency.
- ◆ A test for fecal occult blood.

DIAGNOSTIC TESTS

Several tests are helpful. The first four below are highly recommended for all patients. The remaining tests should be ordered on a per case basis.

- ◆ Endoscopic evaluation of the anorectum and/or colon. Useful in identifying several common causes of fecal incontinence, such as mass lesions, hemorrhoids, and fistulas.
- ◆ Endoanal sonography. Useful in assessing the sphincter mechanism. Enables direct visualization of the integrity of the internal and external sphincter muscles.
- ◆ Anal manometry and compliance testing. Useful in determining resting and squeeze pressures of the anorectum and in assessing anorectal sensation and the ability of the anorectum to act as a reservoir.
- ◆ Pudendal nerve terminal motor latency. Useful in identifying a disorder of nerve conduction.
- ◆ Cinedefecography. Useful in identifying occult intussusception and rectal prolapse. May also reveal involvement of the puborectalis muscle. Especially useful in evaluating patients with constipation and obstructive defecatory symptoms.
- ◆ Electromyography. Useful in identifying abnormalities of the sphincter mechanism. However, because the test causes discomfort for the patient, it has been replaced by endoanal sonography, which offers better visualization of the anal sphincters and is better tolerated.