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Summary

Faecal incontinence

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Colorectal | IBD | Paediatrics | Pancreas | Primary Care

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The speaker presented a practical approach to faecal incontinence, emphasizing that it is a symptom rather than a diagnosis and reviewing a multisociety guideline for evaluation and management.

KEY POINTS

- Faecal incontinence can be a symptom of IBD (particularly active proctitis), colorectal cancer, and most often irritable bowel syndrome, and is defined as involuntary loss of stool or liquid faeces
- Two main types are urge incontinence (desire to defecate but inability to retain stool) and passive incontinence (lack of awareness of need to defecate, particularly in faecal impaction and elderly institutionalized patients)
- History taking focusing on mechanism of incontinence, perineal inspection, and digital rectal examination are essential first diagnostic steps available to all practitioners
- First-line treatment includes patient education, dietary adjustments, lifestyle modifications, bulking agents, and loperamide, though the speaker noted bulking agents containing sucralose can worsen symptoms and loperamide can cause constipation
- The speaker stated that about 50% of patients have long-term benefit from sacral neuromodulation, and other options include transanal irrigation, anal inserts, stoma, and sphincteroplasty (with better outcomes when done early)
- The speaker recommended engaging patients in shared decision-making, using non-stigmatizing terms like 'accident' to facilitate disclosure, and allowing adequate time (such as 6 to 8 weeks for transanal irrigation) for patients to accommodate to treatments

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