Rethinking faecal continence physiology

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The speaker proposes that faecal incontinence should be understood as a learned behaviour requiring capability, opportunity, and motivation, not solely as a problem of colorectal and anal physiology.

KEY POINTS

- The speaker reported that faecal incontinence affects 8% of community-dwelling adults and 42% of older people in nursing homes, with the strongest associations being dementia and urinary incontinence rather than traditional factors like diarrhoea or constipation.
- Continence is presented as a culturally learned behaviour similar to eating, requiring physical capacity, neurological control, environmental opportunity, and conscious motivation to maintain.
- The speaker stated that in her anorectal manometry studies, even young men with strong anal sphincters cannot squeeze significantly for more than 30 seconds, suggesting sustained sphincter contraction is not how people maintain continence.
- A retrospective analysis of over 300 patients by Allison Malcolm's group found that two thirds responded to biofeedback, with faecal urgency predicting positive response by threefold, and patients improved in symptom severity and quality of life even when episode counts barely changed.
- Evidence from the urinary incontinence literature shows that behavioural therapy reduced leakage by 81% versus 69% with medication in older women, and hypnotherapy was noninferior to medication, suggesting similar approaches may benefit faecal incontinence.
- The speaker recommends expanding treatment beyond anorectal interventions to include psychological therapies, improved toilet access, timed toileting for cognitively impaired patients, and community-based interventions.

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