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Summary

Panel discussion: ABC of the EAS and the IAS - Why physiology matters when managing faecal incontinence

UEG Postgraduate Teaching Programme Vienna 2024 | Presentation

Colorectal | Education & Training | Neurogastroenterology & Motility

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Panel discussion on faecal incontinence emphasises the complementary roles of clinical examination and anorectal manometry, with conservative management forming the cornerstone of care in most settings.

KEY POINTS

- Digital rectal examination and anorectal manometry provide different information: examination reveals anatomical defects and scarring, while high-resolution manometry offers unbiased, repeatable measurements of sphincter function and guides biofeedback therapy approaches.
- Conservative management includes psyllium fibre (taken without immediate water intake for loose stool), toilet training to avoid prolonged sitting and use of a stool to optimise the anorectal angle, and habit training delivered by physical therapists.
- For post-colitis urgency without active inflammation, the speaker uses tricyclic antidepressants when tolerated, or gabapentin and pregabalin, which have worked fairly well in the speaker's practice.
- Transanal irrigation is effective for reducing leakage episodes, with patients preferring high-volume over small-volume protocols; in the UK, commercial services now provide nurse-led training, reducing the burden on specialist services.
- Intrarectal Botox for faecal urgency showed reduction in urgency in a recent Lancet Gastroenterology publication, though the technique requires multiple injections and expertise is still being developed.
- In peripheral hospitals without access to anorectal physiology testing, the panel recommends thorough history-taking, digital rectal examination, plain abdominal radiography to assess stool burden, and early collaboration with multidisciplinary teams at larger centres.

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