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Hope on the Horizon: The Evaluation and Treatment of Fecal Incontinence

Dr. Buch:
This is ReachMD, *GI Insights*. I'm your host, Dr. Peter Buch. Joining us today to discuss evaluation and treatment of fecal incontinence is Dr. Kyle Staller. Dr. Staller is an Assistant Professor of Medicine at Harvard Medical School and Director of the Gastrointestinal Motility Laboratory at Mass General.

Welcome back to the program, Dr. Staller.

Dr. Staller:
Thank you, Dr. Buch. Pleasure to be here again.

Dr. Buch:
Pleasure to have you. To start us off, Dr. Staller, can you tell us about the most common causes of fecal incontinence?

Dr. Staller:
This is really an interesting question because I think most of us think of fecal incontinence really as a structural issue. There's been some damage to the pelvic floor primarily from delivery of babies, what we say obstetric trauma or surgery damage to the sphincter from a hemorrhoidectomy or maybe a sphincteroplasty, that type of thing. But in reality, a bigger or perhaps equally as big cause of fecal incontinence, is actually bowel disturbances, so these are things like irritable bowel syndrome with diarrhea, inflammatory bowel disease, post-cholecystectomy diarrhea. In fact, some epidemiological studies would suggest that these are equally as common and may suggest that when we actually look at the data, it seems to be a relatively even split between men and women. And of course, men don't have obstetric trauma to worry about.

Dr. Buch:
How about microscopic colitis? Would that fit in the category as well?

Dr. Staller:
Most certainly. I think any bowel disturbance would count, microscopic colitis being one of them, although in terms of pure prevalence, I think probably the biggest group would be IBS.

Dr. Buch:
Thank you. And how do you evaluate patients with fecal incontinence?

Dr. Staller:
When we think about and when we talk later about some of the treatments that we may offer these patients, we really want to think that there aren't many structural things that we can do, so one of the easiest things to treat are to treat these bowel disturbances. So if a patient is having incontinence of liquid stool, which is not the normal stool consistency, of course, then we really need to think about what are ways that we can actually normalize the stool consistency? And this may be treating the underlying disorder, which may be microscopic colitis, or treating the IBS, but one of the simplest things we can do is fiber. And I urge everyone to think about fiber not as a monolithic type thing that you say, "Oh yes," and on the way out the door, "You should have more fiber in your diet." Fiber is really a remarkable compound that has so many different variations, and the data would suggest that the fiber that's most important or most beneficial to those with fecal incontinence is psyllium. And what psyllium fiber does is it sort of forms a gel. It's considered a soluble fiber, and that tends to pull extremes of bowel habits, particularly those looser stools, more toward a normal bowel consistency. We're actually doing some research that would suggest that psyllium may also have some impact on the microbiome and the way that the

rectum and colon sense what's going on, but at the minimum, looking at psyllium relative to other fibers, it really seems that psyllium is the most beneficial. And that's one of the first things that you can do for those folks, especially those with looser stools as their incontinence type.

Now unfortunately, there are not a lot of specific pharmacologic agents for fecal incontinent, so there have been some studies looking at various alpha receptor blockers, things like that, and unfortunately, they have not yielded any real improvement. However, using your typical antidiarrheal therapies, your loperamide, etc., those can certainly be helpful for people who, again, have diarrhea, but when we see people who have solid stool incontinence, we're really stuck. We don't have a lot of medical treatments.

Now one thing that sometimes is missed is the role of defecatory dysfunction or disordered defecation. And of course, we talk about this probably most prominently in constipation, and that is the idea that the muscles and nerves of the pelvic floor do not work in a synchronous way to effectively evacuate stool. When that happens, that means stool can be left behind, and when stool is left behind in the rectum, that puts you at risk for leakage, particularly if there's some underlying weakness of the pelvic floor. So pelvic floor physical therapy certainly has a role in these patients after some of the conservative treatments, like fiber, has failed and before you move on to the more invasive surgical-type treatments.

Dr. Buch:
Just coming back to the psyllium for a moment, can you tell us about the psyllium to water ratio when we're dealing with fecal incontinence as opposed to constipation?

Dr. Staller:
Yeah. In this case, I don't think it has too much of a role here, that you don't have to overthink it just enough to dissolve the psyllium so that it's tolerable. In general, I recommend patients use psyllium supplements that are not in pill form but are actually in powder form. Unfortunately, that is a bit burdensome for patients. They don't like mixing psyllium into a drink every morning. But often it's the higher doses of psyllium that are more effective, particularly with incontinence, and to get those higher doses, you really need this bulk psyllium in a powder mixed into a drink. Often the pills really don't contain enough psyllium to be as effective as we would like.

Dr. Buch:
And now looking at therapies, what are the initial steps in treatment? And when should we consider pelvic floor muscle training and biofeedback?

Dr. Staller:
I think initially it's really conservative treatment of altered bowel habits. So if you have a patient with liquid stool incontinence where they're having diarrhea, those patients can really benefit from a stepwise pattern that really may benefit from psyllium or antidiarrheal agents, of course treatment of the underlying condition, as I mentioned before. But the next step really would be evaluating for dyssynergic defecation. In general, those patients with constipation who have incontinence would certainly benefit from having an evaluation with an anorectal manometry to really measure the synchrony between the pelvic floor nerves and muscles and the effective evacuation. Patients who may have things like pelvic floor prolapse, they may benefit from a more in-depth evaluation, including something like a defecography either by MRI or by a fluoroscopy. And those types of studies, although they do often find abnormalities that may not be clinically intervenable, they can also identify people who may benefit from a surgical fix. But pelvic floor physical therapy does have a role. In fact, I would argue that most patients with some incontinence who have failed conservative treatments should have a trial of pelvic floor physical therapy. And then after that, we go on to more invasive treatments, like sacral nerve stimulation, injectable anal bulking agents, or even surgery.

Dr. Buch:
Thank you for that. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Staller about evaluation and treatment of fecal incontinence.

So, Dr. Staller, if therapies we discussed don't work, when should we consider sacral nerve stimulation or injectable anal bulking agents?

Dr. Staller:
To speak to the latter first, the injectable anal bulking agents, they certainly have had some benefit in some uncontrolled trials, but there's still more to be done with them, and thus, they're generally not part of the standard of care currently. I would say, for many patients who do fail conservative therapies, sacral nerve stimulation is probably what the average patient will be offered. And the trials for sacral nerve stimulation have not been terribly high-quality, rigorous types of trials, but this is such a bothersome condition that really it's one of the few things that we can offer, and so we generally tell patients we can expect about a 50 percent hit rate or 50 percent improvement rate. Now that may be a 50 percent decrease in incontinence, which means at the end of the day, many patients still will

be incontinent despite having a decreased frequency of incontinence, but sacral nerve stimulation is really the mainstay of the more invasive treatments. And the idea is that these stimulator wires go and stimulate the pelvic floor. Exactly how they work is actually a little bit of a black box because when we measure what happens to patients after they undergo stimulation, we don't actually see why they are better, but certainly, many patients will get better. They have an implanted sacral nerve stimulator into the surface of the skin with the wires that then go through the sacral foramina and actually innervate the anus and the rectum to help improve the function and the continence function of the anal rectum.

Interestingly, you would think, "Well, this is a problem of the valve." The valve is leaky, there's been damage due to obstetric trauma or otherwise to the sphincter itself, and the road of these types of invasive surgical treatments is really littered with many failures, so you would think that just repairing the sphincter itself would be helpful, but it doesn't seem to work. There certainly can be many complications. And at the minimum, many patients who undergo a so-called sphincteroplasty, where the sphincter is reconnected, have only a temporary improvement in their symptoms. The patients that would be a best candidate for a sphincteroplasty would be those patients who are on the younger side and maybe have immediately recognizable obstetric or other trauma that would benefit from undergoing treatment of the sphincter.

But many patients that we see in the clinic, they are often many years after whatever sphincter trauma they've had. These may be women in their 60s, 70s, 80s who had babies when they were in their 20s and 30s and maybe had a sphincter tear during that childbirth. As we get older and there is some degree of neuromuscular decline, and then perhaps combined with a bowel disturbance that may lead to looser stools, this may be the straw that breaks the camel's back. And suddenly, we have someone who has incontinence that never had before, so going back and trying to repair that sphincter when the defect and the damage has been so far out is often really not going to work. For many patients, the sacral nerve stimulation can be helpful, but sometimes we have to go to more invasive things, like diverting ileostomies and other types of surgery.

Dr. Buch:
Thank you. So in the last few minutes of our discussion, are there any additional thoughts you'd like to share with our audience?

Dr. Staller:
I think a couple of thoughts. I think there is some hope on the horizon for these patients. Our group in conjunction with Augusta University and Satish Rao in Georgia have been piloting a type of therapy, called Translumbosacral Neuromodulation Therapy, or what we call TNT, and that is basically the idea where you can stimulate the spine with electromagnetic impulses and actually improve some of these neuromuscular pathways, and essentially, what you may be doing is a noninvasive approach to sacral nerve stimulation, and that so far seems very promising. Stay tuned for more publications from our group we hope showing that this is beneficial.

I would also say, though, at the end of the day that this is a disease that's vastly underrecognized. It affects probably seven percent of the population, and some estimates would say it affects up to one in seven women in the United States. Many patients will be too embarrassed to tell their physician that they have fecal incontinence, so if someone comes to me and says that they have diarrhea, I'm very careful to ask young and old, "Do you have any leakage incontinence?" Because often that's the door to open to really get the patient to explain that actually what really bothers them is the incontinence. And multiple studies have shown that incontinence has a profound impact on quality of life, a really socially isolating condition, and in some cases a more invasive surgery may be needed. So I've had plenty of patients where an ileostomy diverting or a colostomy really seems like something that would be extreme, but after patients have undergone it, realize that they have had such a benefit to their quality of life because they're not living in fear anymore. So I urge listeners to really discuss this with their patients, ask them, especially those people who have diarrhea, do they have any incontinence? Because you'll be surprised how many people don't mention it unless you ask.

Dr. Buch:
What an excellent review of fecal incontinence. I want to thank my guest, Dr. Kyle Staller, for sharing his insights.

Dr. Staller, thanks so much for joining us today.

Dr. Staller:
Thank you so much for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.