Medical Management and Supportive/ Hygienic Measures

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7.1 Introduction

The causes of fecal incontinence are several and often due to a combination of different factors. This implies diversified therapeutic approaches, which depend on the causes. Medical treatment and especially hygienic support should be the first steps and should support the different surgical and rehabilitation treatments that will be applied later on.

Since fecal incontinence in adults can create a situation of discomfort that negatively affects quality of life and leads to embarrassment and social isolation, conservative treatment should be instituted as soon as the patient seeks medical attention.

Treatment should begin immediately by modifying the patient's lifestyle, reducing foods that trigger/aggravate the symptoms and using antidiarrheal/thickening agents. Treatment should also be tailored to the patient, considering the possibility to choose one or more strategies, according to the causes of incontinence, the patient's age and general health condition, and the impact of incontinence on quality of life. Unfortunately, the symptoms of anal incontinence are seldom reported spontaneously and/or openly by the patients, who often turn to us long after the onset of the problem or because of worsening of the condition.

Therefore, where possible, it is fundamental to identify the root cause as soon as possible and plan treatment accordingly.

A key determinant is the patient's recent and past medical history, such as previous surgery, ongoing drug therapies, possible intolerances, allergies, and comorbidities. Several medical history questionnaires may be found in the medical literature that can help classify the degree of incontinence and its impact on the patient's life [1].

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Once a diagnosis has been formulated, then a therapeutic approach may start. This must include proper hygiene and dietary education, if necessary combined with drug therapy. Dietary recommendations are discussed in another chapter of this book, whereas the suggested drug therapy will be discussed below.

Pelvic floor rehabilitation techniques, patient education about the use of devices and the management of transanal irrigation will be considered at a later stage of the treatment, depending on the patient's response to this first approach. These methods may also be suggested in a nonsequential order, in relation to the current situation.

At the beginning, in order to put the person at ease and establish the patient care agreement, taking charge of the patient's care should include [1]:

- reception of the patient
- empathy
- relation with the patient.

7.2 Nursing Assessment

The initial nursing intervention should consist of an assessment of the patient's situation through a complete collection of all the patient data needed to devise the most appropriate treatment plan in collaboration with the multidisciplinary team.

Therefore, nurses should:

- collect a detailed patient history;
- collect the patient's defecation diary and educate the patient about the importance of establishing a routine to gradually achieve regular bowel movements;
- administer a test to evaluate the impact of incontinence on the patient's quality of life;
- evaluate the patient's ability to evacuate independently;
- assess fluid and fiber intake and inform both the patient and caregiver about the importance of regular hydration and diet for maintaining soft and bulky stool;
- evaluate the use of devices such as incontinence pads, sanitary napkins, incontinence briefs, stool collection systems;
- educate the patient about the use of containment devices, if necessary;
- verify perineal skin integrity and educate the patient about correct intimate hygiene and the use of zinc oxide and dimethicone moisture barriers, to prevent perianal and perineal complications;
- perform a manual check to evaluate possible fecal impaction;
- provide assistance to prepare the patient for the various tests.

At this stage, the nurse's role is to explain, educate, actively involve and interact with the person affected by fecal incontinence. This should result in the patient taking charge of his/her care and consequently an improvement in quality of life. It is also crucial that both the patient and health care provider use the same evaluation sheets in order to avoid ambiguous interpretations (e.g., Bristol Stool Chart) [1].

7.3 Hygiene and Dietary Guidelines

Already at the patient's first visit, the nurse can do the following to help alleviate the patient's complaint [1]:

- suggest stimulating daily bowel elimination after breakfast, possibly at the same time every day, as the gastrocolic reflex is triggered by food and drink intake;
- suggest insoluble fiber intake to obtain soft and bulky feces, especially in patients who have fragmented stool;
- promote the intake of natural stool-bulking agents such as rice, yogurt, and bananas, because of their absorption power;
- if possible, ensure a fluid intake of up to 3000 mL/day, or start fluid replacement therapy to compensate volume loss in the case of diarrhea;
- encourage the patient to do regular physical activity, when possible, in order to stimulate peristalsis;
- if necessary, suggest the use of a suppository, digital stimulation every 10–15 min, or direct stimulation of the rectal sphincter and lower colon to start peristalsis;
- suggest keeping assistive devices at hand to ensure immediate access to toileting facilities and avoid unpleasant "accidents";
- promote a comfortable position for defecation (squatting position) as this will allow a more effective bowel evacuation.

7.4 Medical Treatment

The goals of medical therapy are to treat any disorders which may cause diarrhea or constipation and to:

- relieve annoying and embarrassing symptoms;
- restore bowel control;
- improve quality of life.

When the cause of defecation disorders is not easily identifiable or modifiable, medicines can only manage the symptoms. Pharmacological therapy is often combined with other therapeutic options and it is closely dependent on the root cause of incontinence symptoms [2].

The use of antidiarrheal drugs, such as loperamide or codeine phosphate in patients who tend to present liquid stool is extensively described. Loperamide presents minor systemic effects and is therefore generally prescribed at low dosages (2 to 4 mg/day); administration of loperamide should be optimized according to the clinical picture. Dosages may be increased in specific clinical settings, such as patients with ileoanal pouch. There does not seem to be any evidence regarding the use of such drugs in incontinent patients who have normal stool.

In the case of watery stool, thickening agents may be used in combination with loperamide. When incontinence is caused by fecal impaction, the use of laxatives in

combination with manual bowel disimpaction and/or evacuating enemas may help improve continence. Furthermore, some topical agents such as zinc-aluminum ointment, phenylephrine gel or sodium valproate may increase sphincter muscle tone. These products are not always readily available for this purpose and there is little evidence of their efficacy, although their use has been reported in the literature.

Transanal irrigation (TAI) is a good alternative or supplement to medical treatment and kits are commerically available (e.g., Peristeen). If well tolerated, the system offers unique advantages: it is simple to perform, reversible and minimally invasive and it may also be used with young children. It aims to clear the left colon and rectum, thanks to the introduction of a certain amount of water through a closed circuit by using an anal catheter equipped with a small retention balloon and connected to a water bag.

When performed regularly, TAI prevents stool leakage in between washouts. Therefore, it suggests a state of pseudo-continence and restores control over the time and place of evacuation. It is safe and effective, positively influencing the patient's quality of life, dignity, and independence [3]. It is suitable for patients with neurogenic bowel, multiple sclerosis and spinal cord injury, for patients with anterior rectal resection syndrome, and other forms of incontinence. The patient may perform the irrigation at home, if necessary with the help of a caregiver, after at least two treatments carried out under the supervision of a specialist [4].

A bedridden patient with fecal incontinence may develop other complications in addition to the sense of discomfort and hygienic problems related to incontinence. These patients may therefore benefit from a fecal diversion and collection system (e.g., Flexi-Seal FMS), which has the additional advantage of possibly reducing the nurses' workload as well as the duration of hospitalization and hospital costs [5].

7.5 Mechanical Treatments and Containment Devices

Available devices for the management of even the very first symptoms of fecal incontinence are external absorbent health aids, such as panty liners, absorbent stripes, absorbent briefs or panties and diapers up to more sophisticated items such as insert devices. The former cannot control incontinence or prevent odor problems or possible skin problems. The latter may be distinguished into anal and vaginal plugs, which are very simple devices designed to keep the anal canal closed while inserted. However, conformity and long-term benefits still need to be proven, given their side effects such as discomfort, displacement, and non-tolerability [6].

These devices apparently improve symptoms in over 70% of patients, but their efficacy has not been widely studied yet. Anal plugs may reduce incontinence episodes but are not well tolerated and this limits their use. A more recent device, the Renew anal insert, is a disposable, soft and flexible silicone anal insert. In an observational study on 91 patients who used the device for 1–12 weeks, over 75% showed at least 50% reduction in the frequency of fecal incontinence episodes [6].

An endovaginal device for fecal incontinence treatment is also available. Called the Eclipse system, it needs to be inserted by a qualified physician and it requires

continuous self-care to be used properly. The device is inserted into the vagina and is equipped with a small balloon that, once inflated, seals the anal canal. An observational study on 73 women who used the device for 12 months showed a high satisfaction rate: 79.6% of patients reported a significant improvement [7].

7.6 Mind and Incontinence

Psychological factors can originate from or cause incontinence and should be considered as part of the general management plan. Coexisting mental health conditions may influence successful treatment outcome and there is still very little evidence to support any treatment for over 3–6 months [8].

A person with pelvic floor and incontinence symptoms, who is well motivated and has good cognitive abilities and a non-seriously impaired psychological status, has a better chance of responding positively to the proposed therapies, especially if a good relationship has been established between the patient and his/her health care provider [9].

7.7 Conclusions

Hygiene and health measures, devices, bowel lavage and possible drug treatment should be considered the first-line treatment of fecal incontinence patients. Psychological support and a fruitful relationship between the physician, rehabilitation nurse, and patient may facilitate the pathway to rehabilitation or surgery, which may eventually become necessary.

The results that may be obtained—some of them decisive, others often only improving the patient's situation—require perseverance and regular follow-up, both of which are highly recommended.

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