



Fecal Incontinence

Fecal Incontinence is a major problem in the United States. It is underdiagnosed both because patients are embarrassed to discuss the problem and doctors don't ask about it.

Medical management is the management of fecal incontinence with diet modifications and medications. In order to offer further treatment options, we must show you have tried medical therapy and not experienced an improvement in your symptoms. We request patients sent home on medical therapy keep a bowel journal in the two weeks prior to return to office.

Medical Therapy:

1. Dry Fiber: take dry Metamucil or Citrucel, 2 tablets twice a day, and increasing up to 2 tablets four times per day.
2. Antidiarrheal Agents: even if you do not have diarrhea, you need to add these agents to the dry fiber. Options include kaopectate, Immodium, Lomotil (prescribed) or Tincture of Opium (prescribed). Take immodium 1 tablet twice a day, and increase up to 2 tablets four times per day.
3. Rectal Evacuation: after a bowel movement, use of the agents can wash out residual stool left behind, giving a period of leakage free time. Agents include enemas, laxatives, or suppositories. Try taking an enema or glycerol suppository after your usual bowel movement, hold it as long as possible, then evacuate your bowels.
4. Biofeedback: this is one-on-one treatment by physical therapists who specialize in bowel and urine control problems. Studies suggest that between 64%-89% of people will benefit.
5. Anal Plug: this is a plug the patient places into the anus to block the anus. Most patients are unable to tolerate the presence of an anal plug.

Surgical Therapy:

If you fail medical therapy and request surgery, we will start the process of authorizing a procedure with your insurance company. Many times this process is lengthy and requires appeal letters, so patience is necessary. Some insurance companies refuse to cover any of the surgery options. Our group offers and performs Sphincter Surgery, Sphincter Bulking Agent Injection, Radiofrequency Augmentation, Sacral Nerve Stimulation, and Colostomy Placement.

Sphincter Surgery

1. In patients with an injury to the anal sphincter muscle, this surgery is to repair the injury and put the cut or torn ends of the anal sphincter muscle back together.
2. Between 31-83% see early excellent results; studies show that over time results deteriorate and by 5-10 years most regress and less than 40% of patients are satisfied with results after 5-10 years.
3. If a major injury to the anal sphincter, we usually recommend correcting the injury before doing other surgical treatments.

Sphincter Bulking Agents (Sphincter Injection Therapy, Solesta)

1. This in-office procedure involves four injections of a bulking agent into or just above the anal sphincter.
2. With Solesta, a second set of four injections can be offered a month after the first injection
3. In studies, patients experience as much as a 50% decrease in the number of episodes of incontinence 6 months, with sustained improvement at a year and 3 years.
4. Risks include mild pain for 2-3 days, low grade fevers in first days, and failure to improve control.



Radiofrequency Sphincter Augmentation (Secca)

1. This procedure is done as a day surgery in the operating room. When a patient is asleep, we place needles into the anal sphincter muscle and create multiple small burns inside the muscle. In the weeks following surgery, the tone of the anal sphincter muscle becomes stronger.
2. Risks include 7-10 days of pain after surgery, and small risks of bleeding or infection.

Sacral Nerve Stimulation (SNS, Interstim)

1. This is a two phase procedure in which a pacemaker and electrodes are placed near the nerves that run the rectum, anus and bladder to stimulate better sensation and control. In Phase I, temporary or permanent electrodes are placed and attached to an external portable system – responsiveness to the system is assessed over a 1-2 week period. In Phase 2, a permanent long term system is placed completely under the skin. The battery will require replacement every 5-7 years, which is a subsequent minor surgery.
2. Between 83% to 100% of patients undergoing Phase 2 surgery will maintain improvement with greater than 50% reduction in accidents at 24 months.
3. Between 5-26% of patient will have problems early after surgery, including pain at the generator site, wound infection.
4. Not currently FDA approved for treatment of fecal incontinence in the USA, although it is FDA approved for treatment of urinary incontinence.

Dynamic Graciloplasty

1. This surgery involves several surgeries where a muscle from the patients leg, the gracilis muscle, is repositioned to encircle the anus, and is connected to electrodes and a generator to recreate the anal sphincter muscle.
2. This restores continence in 35-85% of patients
3. Done only at a few centers in the USA. It is not performed in Phoenix/Glendale/Scottsdale.
4. Not currently FDA approved.

Artificial Sphincter

1. This surgery involves inserting a fluid filled plastic artificial anal sphincter around the anus.
2. Studies show as many as 63% of patients will achieve complete or improved continence.
3. Complications include pain and infection of the device – as many as 20 – 37% must be removed due to these problems.

Colostomy

1. This procedure involves bringing the colon out through abdominal wall to create a colostomy or “bag”. Most of the rectum is generally removed or the patient will experience mucous discharge and wetness at the anus.
2. Early complications include bleeding and infection in less than 5%. More than 80% of patients will develop a small or large hernia near the colostomy, with risks being much higher in overweight people.
3. Though no one “wants a bag”, studies show that greater than 90% of patients achieve resolution of their anal incontinence and 83% support a significant improvement in their quality of life.