ArizonaPreferredSurgeons
GENERAL AND MINIMALLY INVASIVE SURGERY

Brian P. Lipton, M.D., Ph.D., F.A.C.S.
Kara M. Villareal, M.D., F.A.C.S.
Ylli Zhubi, M.D.

Fecal Incontinence

Fecal Incontinence (FI) is a major problem in the United States, affecting as many as 1 in 10 persons over the age of 50. Patients are embarrassed to talk about it and doctors often do not ask about it. Medical management and surgical therapy options are available which can improve control or restore control.

Medical Management

Medical management is the management of fecal incontinence with diet modifications and medications. The management of FI always starts with medical therapy. Most insurance companies will not authorize surgical therapy until we complete a trial of medical management.

Medical Management options include:

Dry Fiber:

- Psyllium (Metamucil) or methylcellulose (Citrucel) comes in a capsule form, and generic forms are more affordable. The powder forms will not work for medical constipation.
- Start with 1 tablet twice a day with a small sip of water
- Can increase up to 4-6 tablets twice a day with a small sip of water

Antidiarrhea Medications:

- Antidiarrhea medications act by calming and slowing the bowels and can be helpful in controlling FI.
- These medications work really well alongside dry fiber.
- Options include kaopectate, Imodium, Lomotil (prescribed) or Tincture of Opium (prescribed).
- Take Imodium 1 tablet twice a day; can increase up to 2 tablets four times per day.

Rectal Evacuation:

- Stool remaining in the rectum after a bowel movement can leak out resulting in fecal after-drainage.
- Washing out stool left behind can provide a period of leakage free time.
- Therapy options include tap-water enema, laxatives inserted rectally (Dulcolax suppository), or non-laxative suppositories (glycerol)
- Treatment is inserted after the bowel movement, held as long as possible, then expelled to clean out low rectum.
- For the tap water enema, empty out a fleets or generic enema bottle, fill 2/3 full of lukewarm tap water and add 2-3 drops of dawn dish detergent. The bottle can be washed and reused.

Biofeedback:

- Prescription therapy for one-on-one treatment with physical therapists who specialize in bowel and urine control problems.
- Studies show between 64%-89% of people will benefit.

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Surgical Management

If medical therapy is unsuccessful, the surgical therapy will be recommended. 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. Our colon and rectal surgeons offer and perform sphincter surgery, sacral nerve stimulator placement, and colostomy placement

Surgical Management options include:

Sphincter Surgery

- The anal sphincter muscle is a doughnut shaped muscle around the anus that you control to hold feces; this muscle can be injured during childbirth, trauma, or anal surgery.
- Surgery involves an incision near the anus. The cut ends of the muscle are sewn back together.
- Patients see improved control between 30% and 80% of the time in the first year after surgery.
- For unknown reasons, control regresses over time and by 5-10 years less than 40% of patients see improved control.
- If you have a major injury to the anal sphincter, we usually recommend correcting the injury before doing other surgical treatments.

Sacral Nerve Stimulation (SNS, Interstim)

- More patient information is available online by searching ***Medtronic Bowel Control Overview*** on any internet browser.
- The sensation of stool and control of the anal sphincter muscle is powered by the external branch of the pudendal nerve in the pelvis; this nerve can fail over time due to pushing with bowel movements, childbirth, obesity, menopause, diabetes, and trauma.
- The sacral nerve stimulator involves placement of an electrode near the nerves that control fecal and urine control, which is attached to a small computer placed into the fatty tissue of the buttock.
- All insurance companies require two surgeries to place an SNS: Step 1 is a nerve test and Step 2 is permanent placement of the system under the skin.
- **Step 1 of Surgery: Nerve Test**
    - Depending on your insurance plan and your symptoms, the test may be performed in the office or in the operating room
    - The nerve test will be scheduled to last between 3-14 days depending on the frequency of your symptoms.
    - During the nerve test, a temporary electrode is placed near the nerves that control feces and urine continence, brought out through the skin of the body, and attached to a computer and battery on the outside of the body.
    - You will communicate with an SNS technician during the test to adjust the system and report results.
- **Step 2 of Surgery: Permanent System Placement**
    - Any temporary components placed in Step 1 are removed.
    - If you had good results in the test phase, the permanent system is installed completely under the skin.
    - If you did not see an improvement in symptoms, the temporary system will be completely removed.

Dynamic Graciloplasty

- A muscle from the patient's leg, the gracilis muscle, is repositioned to encircle the anus, and is connected to electrodes and a generator to recreate the anal sphincter muscle.
- This restores continence in 35-85% of patients
- Done only at a few centers in the USA.

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Artificial Sphincter

- A fluid filled plastic artificial anal sphincter is inserted surgically around the anus.
- As many as 2/3 of patients will achieve complete or improved continence.
- Complications include pain and infection of the device; up to half of devices must be removed due to these problems.
- Done only at a few centers in the USA.

Colostomy Placement

1. The colon is separated from the rectum and the end is brought out through abdominal wall to create a colostomy or “bag”, and all stool comes out into the bag instead of through the anus.
2. Complications include bleeding or infection immediately after surgery and long-term development of a hernia near the colostomy site.
3. In studies, more than 90% of patients achieve resolution of their anal incontinence and 83% report significant improvement in their quality of life.

18699 N. 67th Ave., Suite 280
Glendale, AZ 85308

www.AZPreferredSurgeons.com

(602) 995-0822 OFFICE
(602) 995-0825 FAX