

FAECAL INCONTINENCE IN THE ELDERLY

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ABSTRACT

Faecal incontinence is distressing both to the patient and the carers. However with accurate diagnosis of its cause, the condition can often be treated.

Causes can be classified by pathophysiology. The most common cause in the elderly is faecal impaction with overflow incontinence. Other causes include inflammatory conditions of the bowel, neurological disorder, functional incontinence and iatrogenic incontinence.

Management depends on an accurate diagnosis. A proper bowel and drug history is important. A rectal examination is mandatory, in order not to miss a diagnosis of faecal impaction with overflow incontinence.

Specific treatment is directed at the cause.

Keywords : Faecal incontinence, constipation, pathophysiology

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Faecal incontinence, although a less common problem than urinary incontinence, is more distressing both to the patient and the carers.

However, with accurate diagnosis of its cause, the condition can often be treated.

Like urinary incontinence, causes of faecal incontinence can also be classified by its pathophysiology.

The five equivalent groups are:

(1) Inflammatory conditions of the bowel causing diarrhoea

These include common illnesses such as acute gastroenteritis and other less common causes such as inflammatory bowel disease, ischaemic colitis and acute diverticulitis.

(2) Faecal impaction with overflow incontinence

This is by far the commonest cause of faecal incontinence in geriatric practice.

Constipation is common in the elderly. This is because transit time is prolonged. It may be 72 hours or longer compared to 24-48 hours in younger individuals⁽¹⁾.

Impaction can occur in the elderly from several causes:

a. Neglect of call to stool

This is especially likely in the sick elderly whose mobility

is impaired and in the elderly admitted to the hospital, who being unfamiliar with the surroundings may try to postpone defaecation.

b. Inadequate dietary fibre and fluid intake

Faulty life-long dietary habits may not cause constipation in the active adult but result in symptoms only in later years.

The elderly may also be more likely to cut down on fluid intake because of an associated problem of urinary incontinence.

c. Drugs

Feeble peristaltic movements in the elderly may be further aggravated by drugs eg. anticholinergics.

(3) Neurological Disorders

a. Central lesions causing faecal incontinence are similar to the loss of central inhibitory control in the uninhibited neurogenic bladder.

Patients with brain lesions or dementia may pass formed stools in response to rectal distension without the overriding effect of central inhibition⁽¹⁾.

b. Transection above the cauda equina seldom causes severe impairment of function once the spinal shock has passed.

The rectum empties reflexly and the patient will learn how to induce reflex contraction by stimulation of the anal canal.

c. In complete lesions of the cauda equina, there is neither muscle activity in the pelvic floor nor sensation and such patients are totally incontinent.

d. Neuropathic changes seen in biopsy of muscles of the pelvic floor are found in a variety of incontinence which was previously labelled "idiopathic".

These changes are believed to be due to stretching of the nerve supplying the pelvic floor either by excessive defaecation efforts practised over many years or by the result of difficult childbirth⁽²⁾.

e. Degeneration of the myenteric plexus is well documented as a result of laxative abuse and may also result from excessive use of anticholinergic drugs or phenothiazines. This may lead to sphincter laxity, diminished sensitivity of the anal canal and decreased tone in the puborectalis muscle,

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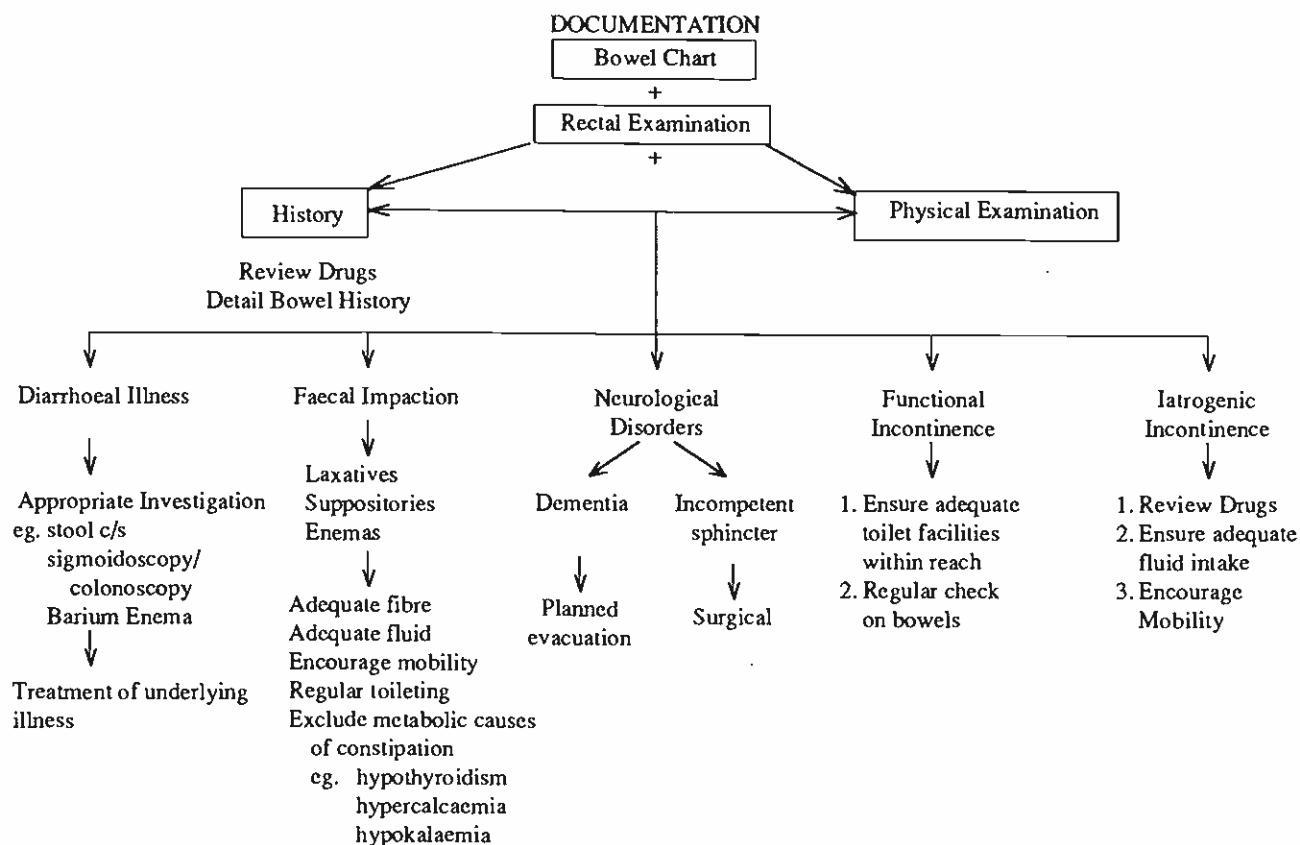
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Fig 1 - Faecal Incontinence - Clinical Approach



which interferes with the important flap-valve mechanism associated with rectal angulation⁽¹⁾.

(4) Functional Incontinence

Functional urinary incontinence implies the inability of a normally continent person to reach the toilet in time to avoid an accident.

In the case of faecal incontinence, the lack of convenient or accessible toilet facilities more often results in faecal impaction with overflow incontinence.

(5) Iatrogenic Incontinence

Laxative abuse can result in acute diarrhoea with incontinence. It can also give rise to myenteric plexus damage as mentioned above.

Drugs such as diuretics could result in dehydration, thus aggravating faecal impaction.

Drugs causing constipation are anticholinergics, anti-parkinson's drugs and opioid drugs (found in analgesics and cough mixtures).

MANAGEMENT AND TREATMENT

The same principles apply in the management of faecal incontinence as in urinary incontinence.

A thorough history and physical examination is needed to identify the main cause and other contributing factors causing incontinence. Faecal impaction is easily excluded by a simple rectal examination.

In the hospital setting, faecal incontinence from faecal impaction can be avoided by attention to details.

A good bowel history on admission together with accurate recording of bowel movements in the ward is necessary to draw attention to the problem.

Adequate lavatory facilities or their substitutes, are necessary. Defaecation is easier in the sitting position and a bed pan should only be used if absolutely necessary. It is known that it involves a greater degree of straining than normal

defaecation. This has significance for patients with cardiovascular disease. Whatever receptacle is used, privacy and warmth must be ensured⁽²⁾.

Treatment of established faecal impaction involves first clearing the bowels with regular enemas and suppositories. If removal of faeces needs to be immediate, digital evacuation is effective. Once the lower bowel has been cleared, a regular laxative regime may be required during the restorative period. Oral laxatives or suppositories may be required to initiate defaecation. To avoid future impaction, the particular circumstances which led to its existence must not be allowed to occur. Attention must be paid to diet to ensure adequate fibre content. The use of bulk formers such as Isogel, metacucil or bran is recommended. Adequate fluid intake is encouraged.

Acute diarrhoeal illness requires a definitive diagnosis from appropriate investigation and treating the underlying disease.

In patients with dementia, incontinence can be controlled by planned evacuation, eg. Senokot at night followed by enema or suppository the next morning, 3 times a week. This has to be tailored to the patient's individual needs, but such a regime results in absence of soiling in between times⁽⁴⁾. Patients with neuropathic pelvic floor may be amenable to reconstruction surgery⁽²⁾.

Last but not least, consideration should be given to the effects of any drugs prescribed.

A summary of the clinical approach is given in Fig 1.

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