NICE GUIDELINES

Management of faecal incontinence in adults: summary of NICE guidance

Christine Norton,[1] Louise Thomas,[2] Jennifer Hill,[2] on behalf of the Guideline Development Group

[1]Florence Nightingale School of Nursing and Midwifery, King's College London, London

[2]National Collaborating Centre for Acute Care, Royal College of Surgeons of England, London WC2A 3PE

Correspondence to: C Norton
christine.s.norton@kcl.ac.uk

BMJ 2007;334:1370-1
doi: 10.1136/bmj.39231.633275.AD

Members of the Guideline Development Group and further information about the guidance are on bmj.com

This is one of a series of *BMJ* summaries of new NICE guidelines, which are based on the best available evidence; they will highlight important recommendations for clinical practice, especially where uncertainty or controversy exists

Why read this summary?

The prevalence of faecal incontinence in adults living in the community is 1-10%, depending on the definition used.[1 2] Faecal incontinence is a neglected problem that receives limited medical attention, and despite its profound negative impact most patients do not tell their doctor about it.[3 4] Simple, low cost interventions will often improve or even cure symptoms. More sophisticated second line investigations and treatments are available, but referral for these is not common. This article summarises the most recent guidance from the National Institute for Health and Clinical Excellence (NICE) on managing faecal incontinence in adults.[5]

Recommendations

NICE recommendations are based on systematic reviews of best available evidence. When minimal evidence is available, a range of consensus techniques is used to develop recommendations. In this summary, recommendations derived primarily from consensus techniques are indicated with an asterisk (*).

General approach

All staff working with people with faecal incontinence should be aware of the physical and emotional impact this condition can have on patients and their carers. Consider patients' needs and preferences when planning treatment and ensure they have the opportunity to make informed decisions in partnership.

Assessment

Healthcare professionals should actively yet sensitively inquire about symptoms of faecal incontinence in high risk groups (box).

Faecal incontinence often has several contributory factors. Assumptions that it is caused by a single primary condition are therefore not appropriate.* Before starting treatment, perform a focused baseline assessment as follows*:

- Identify contributory factors from a medical history, general and anorectal examination, and, if appropriate, cognitive assessment
- Differentiate between symptoms of urge or passive faecal incontinence and the patient's normal bowel habit (note any changes)
- Assess diet; medical and obstetric history; lifestyle; mobility; and medications
- Assess anorectal abnormalities and function or rectal loading by visual inspection and digital examination.

Management

Treat the following specific conditions (if identified from the assessment), before progressing to more general measures*:

- Faecal loading (treat with rectal or oral medication until the rectum is empty)
- Treatable causes of diarrhoea (for example, infective, inflammatory bowel disease, and irritable bowel syndrome)
- Warning signs for colorectal cancer (for example, rectal bleeding, unexplained change in bowel habit, and anaemia)[6]
- Rectal prolapse or third degree haemorrhoids
- Acute injury to the anal sphincter (will often need surgical repair)
- Cauda equina syndrome or acute disc prolapse.

Once the above conditions have been excluded or treated, offer initial conservative measures, tailored to the patient's presenting symptoms, as follows:

- Try to improve the patient's bowel habit, aiming for an ideal stool consistency and satisfactory bowel emptying at a predictable time.* Patient education may help to establish a bowel routine (such as going to the toilet after a meal to capitalise on the gastrocolic response), optimise evacuation (posture and pushing without straining), and regulate diet and fluid intake. Some patients will benefit from modifying fibre intake (an increase or decrease, depending on existing diet and stool consistency), reducing caffeine, and ensuring easy access to a toilet*
- Thoroughly review both prescribed and over the counter medications.* Side effects of constipation or loose stools can underlie faecal incontinence. Loperamide hydrochloride is the antidiarrhoeal drug of first choice for faecal incontinence associated with loose stools when relevant investigation and treatment have failed to resolve the loose stools. Start at a low dose, and increase until symptom control is achieved without troublesome constipation (the syrup formulation should be considered for doses under 2 mg). Loperamide hydrochloride can be used in doses up to 16 mg a day on a continuous basis, but

Groups at high risk of faecal incontinence

- Frail older people
- Patients with loose stools or diarrhoea from any cause
- Women who have recently given birth (especially after third or fourth degree obstetric injury)
- Patients with neurological or spinal cord disease or injury
- Patients with severe cognitive impairment or learning disabilities
- Patients with urinary incontinence; pelvic organ or rectal prolapse; perianal soreness, itching, or pain
- Patients who have had colonic resection, anal surgery, or pelvic radiotherapy

many patients need a much lower dose or can use only as needed
- Advise on coping strategies, such as the use of continence products (pads or plugs), skin care, and access to emotional and psychological support.*

If symptomatic patients do not wish to continue active treatment or have intractable symptoms*:

- Advise on how to preserve dignity and independence (such as toilet access and use[7])
- Offer psychological support, with referral to counsellors or therapists as appropriate
- Review symptoms at least every six months
- Discuss other management options (including specialist referral)
- Provide contact details for relevant support groups
- Provide information and advice on continence products, and provide information on choice of products and their availability and use
- Advise on skin care
- Discuss how to talk to friends and family
- Discuss coping strategies, such as planning routes around public conveniences when travelling.

Specialist referral

If symptoms continue, consider referral to a specialist continence service for options such as a pelvic floor re-education programme, bowel retraining, specialist dietary assessment and management, biofeedback, electrical stimulation, or rectal irrigation.* These interventions will usually need to be individually tailored and monitored closely (for example, by digital reassessment). Some of these treatments may not be appropriate for people who cannot understand and/or comply with instructions. Pelvic floor re-education programmes, for example, may not be appropriate for those with neurological or spinal disease or injury that results in faecal incontinence.*

If specialised investigation is needed, a combination of anorectal physiology tests and endoanal ultrasonography will assist selection of patients for surgery.* Where endoanal ultrasonography is not available, magnetic resonance imaging or endovaginal ultrasonography and perineal ultrasonography may be considered.*

Refer patients considering surgery to a specialist surgeon to discuss the potential benefits and limitations of surgical and non-surgical options, particularly long term expectations of effectiveness. Most surgery should be conducted in specialist centres. Anal sphincter repair has limited long term efficacy and should be reserved for patients with major symptoms and an external anal sphincter defect of 90 degrees or more. Neosphincters, such as an implanted inflatable artificial anal sphincter or a transposition of the gracilis muscle around the anus, are generally associated with high complication rates (such as infection, erosion, or equipment failure); no long term data are available yet for sacral nerve stimulation. Training and long term support are needed when implants are used.*

Specific groups

Adopt a proactive approach to bowel management for the following patient groups, who are prone to faecal incontinence or constipation*:

- People with faecal loading or constipation
- Acutely unwell and hospitalised patients
- Patients with neurological or spinal conditions
- Patients with limited mobility
- Severely or terminally ill people
- Patients with acquired brain injury, learning disabilities, or other cognitive or behavioural problems.

Overcoming barriers

The most crucial barriers to implementing this guideline may be traditional taboos associated with discussing defecation and the stigma of faecal incontinence. Many people (including some health professionals) do not find it easy to talk about this subject. Local and national campaigns may raise awareness and help to break down taboos on discussing bowel function.

As a symptom, faecal incontinence does not fall under the responsibility of any one professional group. A multidisciplinary approach is recommended.* Most nurse continence advisers focus on urinary incontinence, and many of them may need additional training to take a lead on faecal incontinence. Specialised investigation and management facilities are also lacking.

Although most of this guideline is based on consensus methods rather than high quality research evidence, the guideline development group believes that the commonsense recommendations it contains provide a practical approach to managing the common and neglected problem of faecal incontinence. We hope this guideline will stimulate both clinical and research interest in this topic, and that future updates will have an expanded evidence base on which to work.

LT was a project manager at the National Collaborating Centre for Acute Care until December 2006. She now works for the National Patient Safety Agency.

Contributors: All authors contributed to reviewing the evidence and writing and correcting the article. CN is the guarantor.
Funding: The National Collaborating Centre for Primary Care was commissioned and funded by the National Institute for Health and Clinical Excellence to write this summary.
Competing interests: None declared.
Provenance and peer review: Commissioned; not peer reviewed.

1 Macmillan AK, Merrie AEH, Marshall RJ, Parry BR. The prevalence of fecal incontinence in community-dwelling adults: a systematic review of the literature. *Dis Colon Rectum* 2004;47:1341-9.
2 Perry S, Shaw C, McGrother C, Flynn RJ, Assassa RP, Dallosso H, et al. The prevalence of faecal incontinence in adults aged 40 years or more living in the community. *Gut* 2002;50:480-4.
3 Johanson JF, Lafferty J. Epidemiology of fecal incontinence: the silent affliction. *Am J Gastroenterol* 1996;91(1):33-6.
4 Chelvanayagam S, Norton C. Quality of life with faecal continence problems. *Nursing Times* 2000;96(31):suppl 15-7.
5 National Institute for Health and Clinical Excellence. *Faecal incontinence: the management of faecal incontinence in adults*. London: NICE, 2007. www.nice.org.uk/49
6 National Institute for Health and Clinical Excellence. *Referral for suspected cancer*. 2005. (NICE clinical guideline No 27.) www.nice.org.uk/CG027.
7 British Geriatrics Society. *Behind closed doors: delivering dignity in toilet access and use*. 2007. www.bgs.org.uk/campaigns/dignitypress.htm.