Fecal incontinence is a sensitive topic in which patients are uncomfortable to discuss in public. While urinary incontinence products are seen in every day social media, fecal incontinence has little or minimal literature and educational material available both to the patients and health care providers.

Fecal incontinence is the involuntary loss of gas or stool. It affects 10 to 15% of the general population. If not treated, the patients can lead to a chronic condition and involve physical and psychological morbidity. Patients retreat to social isolation; compromising their quality of life.

Office gastroenterology nurses can advocate patients with their knowledge about fecal incontinence management and coach them to follow through. There are options available such as dietary modification, medication, physical therapy, and surgical interventions.

METHODS

A sample patient population was selected from November 2013 to September 2015 with fecal incontinence diagnosis.

- 69 patients were participants in this study.
- Age ranged from 30 to 85.
- 51 females and 18 males.
- 14 patients did not have follow up care after recommendation.
- There were different degrees of severity.
- There were different causes of fecal incontinence.
- Initial consultation by our surgeon included patient’s history and physical examination which included digital rectal exam to evaluate sphincter tone, presence of stool or masses, perineal sensation and anal wink sign.
- Additional laboratory tests were stool culture, ova and parasites, and Clostridium difficile.
- Other diagnostic tests were magnetic resonance defecography, anorectal manometry, endorectal ultrasound and pudendal nerve testing.
- After completion of all the testing, the patient was offered all five options. The pros and cons of each option was reviewed with the patient.
- The patient would decide which option would be best suited for him. Insurance approval played a part as some medications were not approved by insurance. Prior authorization was needed.
- The patient would come back to the office in about 6 to 8 weeks to monitor his progress.
- A bowel diary was used to determine the outcome.

REFERENCES

- Olson, C. “Fecal Incontinence-Management and new options” UT Southwestern Pelvic Floor Symposium. UT Southwestern Medical Center, Dallas, Texas. 15 Sept. 2012.

Purposes

- In our university hospital clinic system, we have a Pelvic Floor Disorders Program with multiple specialty providers.
- Providers include colon rectal surgeons, physical medicine and rehabilitation physicians, certified physical therapists, urologists and urogynecologists.
- Once the patient is referred to our colon and rectal clinic, our provider will provide a thorough assessment and diagnostic testing for the patient.
- They are offered multiple treatment options and have shown significant improvement after treatment.

OBJECTIVES

- To identify the cause of the patient’s fecal incontinence.
- To provide a thorough assessment and diagnostic testing for the patient.
- To teach patients about bowel management protocol to improve their quality of life.
- To prevent and treat skin breakdown.
- To benefit from the expertise of a Certified Wound Ostomy Continence Nurse.

OUTCOME

Fecal Incontinence Treatment Option Outcomes