

Faecal incontinence: the management of faecal incontinence in adults

NICE guideline

Draft for consultation, November 2006

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

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Introduction

Faecal incontinence (FI) is a sign or a symptom, not a diagnosis. As such the first task is to diagnose the cause/s for each individual. With a stigmatising condition, active case-finding will often be needed, probably best targeted at high risk groups.

Current epidemiological information shows that between 1 and 10% of adults are affected, depending upon the definition and frequency used. It is likely that 0.5–1.0% of adults experience regular FI which impacts on quality of life. Little is known about the natural history of FI but for some groups (e.g. women immediately after childbirth) there does seem to be some spontaneous resolution of symptoms. For understandable reasons, it has remained a largely hidden problem, with many patients feeling too embarrassed or ashamed to admit to symptoms to healthcare professionals, or even to family and friends.

There is no consensus on methods of classifying the symptoms and causes of faecal incontinence. The most common classifications include: by symptom, character of the leakage, patient group or presumed primary underlying cause.

For many people faecal incontinence is the result of a complex interplay of contributing factors, many of which can co-exist. Some may be relatively simple to reverse.

Patient-centred care

Treatment and care should take account of patients' needs and preferences. People with faecal incontinence should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. It should be recognised that people who have had FI for a long time may become experts in the management of their symptoms, if not the condition as a whole. Where it is believed that patients may lack the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk). From April 2007 healthcare professionals will need to follow a code of practice accompanying the Mental Capacity Act (summary available from www.dca.gov.uk/menincap/bill-summary.htm).

Treatment and care and the information patients are given about it should be culturally appropriate. Information should be accessible to people with additional needs such as physical, sensory, mental or learning disabilities. Specialist techniques and tools should be employed to ensure that people with communication difficulties have the opportunity to receive information. It should be offered in a wide range of languages and formats (including face-to-face, telephone-based, web-based, electronic, printed and audiotapes). Specific strategies need to be put in place to meet the information and advice needs of hard-to-reach groups and those who do not currently access information (The Partnership on Long-term Conditions 2005). Advice on the production of patient information by healthcare professionals is available from www.nhsidentity.nhs.uk. Information by itself is not always enough: people should be offered one-to-one support in understanding and interpreting information and what it means for them as an individual.

Normally carers and relatives should have the opportunity to be involved in decisions about the patient's care and treatment, unless the patient specifically excludes them. Patients must be asked if they want carers and relatives to be involved due to the sensitive nature of the condition and the stigma attached. Carers and relatives should also be given the information

and support they need. In some cultures disclosure of FI could lead to the patient being ostracised.

Key priorities for implementation

- People who report or are reported to have faecal incontinence should have their care managed by healthcare professionals with the relevant skills, training and experience and who work within an integrated continence service (see 'Good practice in continence services' National Service Framework for Older People (www.dh.gov.uk)). [1.1.1.1]
- Faecal incontinence is a socially stigmatising condition. Healthcare professionals should actively yet sensitively enquire about symptoms in the following high-risk groups:
 - frail older people
 - patients with loose stools or diarrhoea from any cause
 - women following childbirth
 - patients with neurological/spinal cord injury or disease
 - patients with severe cognitive impairment
 - patients with urinary incontinence
 - patients with pelvic organ prolapse and/or rectal prolapse
 - patients after colonic resection or anal surgery
 - patients who have undergone pelvic radiotherapy
 - patients with perianal soreness, itching or pain
 - people with learning disabilities. [1.1.1.2]
- When assessing faecal incontinence healthcare professionals should:
 - be aware that faecal incontinence is a symptom, often with multiple contributory factors for an individual patient
 - avoid making simplistic assumptions that causation is related to a single primary diagnosis ('diagnostic overshadowing'). [1.1.1.6]
- Healthcare professionals should carry out and record a focused baseline assessment for patients with faecal incontinence to identify the contributory factors. This should comprise:

- relevant medical history (see Table 1 **Error! Reference source not found.** in Appendix D)
 - general examination
 - anorectal examination (see Table 1 **Error! Reference source not found.** in Appendix D)
 - cognitive assessment, if appropriate. [1.2.1.2]
- Patients with the following conditions should have these addressed with condition-specific interventions before progressing to initial management of faecal incontinence:
 - faecal loading
 - treatable causes of diarrhoea
 - warning signs for lower gastrointestinal cancer (see NICE clinical guideline on referral for suspected cancer (www.nice.org.uk/CG027))
 - rectal prolapse or third degree haemorrhoids
 - acute anal sphincter injury
 - acute disc prolapse. [1.2.1.3]
- Initial management should address bowel habit, aiming for ideal stool consistency and satisfactory bowel emptying at a predictable time. [1.3.2.1]
- Healthcare professionals should provide the following to symptomatic patients who either do not wish to continue with active treatment or who have intractable faecal incontinence:
 - advice relating to the preservation of dignity and where possible independence
 - psychological and emotional support, possibly including referral to counsellors or therapists if it seems likely that patients' attitude towards their condition and their ability to manage and cope with faecal incontinence could improve with professional assistance
 - at least 6-monthly review of symptoms
 - discussion of any other management options (including specialist referral)
 - contact details for relevant support groups

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- advice on continence products and information about product choice, availability and use
 - advice on skin care
 - how to talk to friends and family
 - strategies such as planning routes around public conveniences if patients have to travel. [1.3.8.1]
- Patients who continue to have episodes of faecal incontinence after initial management, should be referred to a specialist continence service for consideration of specialised management options which may include:
 - pelvic floor re-education programmes
 - bowel retraining
 - specialist dietary assessment and management
 - biofeedback
 - electrical stimulation
 - rectal irrigation.

These treatments may not be appropriate for patients who are unable to understand and/or comply with instruction. For example, pelvic floor re-education programmes may not be appropriate for those with neurological or spinal disease/injury resulting in faecal incontinence due to complete loss of voluntary control. [1.4.1.1]

- All patients considering or being considered for surgery should be referred to a specialist surgeon to discuss:
 - the surgical and non-surgical options appropriate for each patient
 - the potential benefits and limitations of each option, with particular attention to long-term results
 - realistic expectations of the effectiveness of any surgical procedures under consideration. [1.6.1.1]
- Healthcare professionals should consider a proactive approach to bowel management for the following groups of patients:
 - patients with neurological or spinal disease/injury resulting in faecal incontinence due to complete loss of voluntary control

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- patients with limited mobility
- people with faecal loading or constipation
- hospitalised patients who are acutely unwell and develop acute faecal loading and associated incontinence
- patients with acquired brain injury
- patients with cognitive or behavioural issues
- people with learning disabilities. [1.7.1.2]

1 Guidance

The following guidance is based on the best available evidence. The full guideline ('Faecal incontinence: the management of faecal incontinence in adults') gives details of the methods and the evidence used to develop the guidance (see section 5 for details).

1.1 ***Good practice in managing faecal incontinence***

- 1.1.1.1 People who report or are reported to have faecal incontinence should have their care managed by healthcare professionals with the relevant skills, training and experience and who work within an integrated continence service (see 'Good practice in continence services' National Service Framework for Older People (www.dh.gov.uk)).
- 1.1.1.2 Faecal incontinence is a socially stigmatising condition. Healthcare professionals should actively yet sensitively enquire about symptoms in the following high-risk groups:
- frail older people
 - patients with loose stools or diarrhoea from any cause
 - women following childbirth
 - patients with neurological/spinal cord injury or disease
 - patients with severe cognitive impairment
 - patients with urinary incontinence
 - patients with pelvic organ prolapse and/or rectal prolapse
 - patients after colonic resection or anal surgery
 - patients who have undergone pelvic radiotherapy
 - patients with perianal soreness, itching or pain
 - people with learning disabilities.

1.1.1.3 Coordinated public health campaigns to raise public awareness of the causes, prevalence, symptoms and resources to treat faecal incontinence should be carried out in order to:

- aid mutual support between people with faecal incontinence
- decrease the taboo surrounding faecal incontinence.

1.1.1.4 All staff working with people with faecal incontinence should be aware of both the physical and emotional impact this symptom can have upon patients.

1.1.1.5 Healthcare professionals should ensure that people with faecal incontinence:

- are kept fully informed and have access to appropriate sources of information in formats and languages that are suited to an individual's requirements
- are offered access to or made aware of appropriate support groups (which may be alerting patients to likelihood of family and friends having similar experiences, community groups, or more formal organisations). Consideration should be given to cognition, gender, physical needs, culture and stage of life of the individual
- have the opportunity to discuss assessment, management options and relevant physical, emotional, psychological and social issues. Patients' views, experiences, attitudes and opinions about these issues should be actively sought.

1.1.1.6 When assessing faecal incontinence healthcare professionals should:

- be aware that faecal incontinence is a symptom, often with multiple contributory factors for an individual patient
- avoid making simplistic assumptions that causation is related to a single primary diagnosis ('diagnostic overshadowing').

1.2 Baseline assessment

1.2.1.1 Healthcare professionals should ensure that people who report or are reported to have faecal incontinence:

- receive a focused baseline assessment before any treatment is considered
- receive all appropriate initial management before any specialised treatment.

1.2.1.2 Healthcare professionals should carry out and record a focused baseline assessment for patients with faecal incontinence to identify the contributory factors. This should comprise:

- relevant medical history (see Table 1 **Error! Reference source not found.** in Appendix D)
- general examination
- anorectal examination (see Table 1 **Error! Reference source not found.** in Appendix D)
- cognitive assessment, if appropriate.

1.2.1.3 Patients with the following conditions should have these addressed with condition-specific interventions before progressing to initial management of faecal incontinence:

- faecal loading
- treatable causes of diarrhoea
- warning signs for lower gastrointestinal cancer (see NICE clinical guideline on referral for suspected cancer (www.nice.org.uk/CG027))
- rectal prolapse or third degree haemorrhoids
- acute anal sphincter injury
- acute disc prolapse.

1.3 Initial management

1.3.1.1 Healthcare professionals should inform patients that a combination of initial management interventions is likely to be needed to address faecal incontinence. The specific management intervention(s) offered to patients should be based on the findings from baseline assessment, tailored to individual circumstances and adjusted to personal response.

1.3.2 Bowel habit

1.3.2.1 Initial management should address bowel habit, aiming for ideal stool consistency and satisfactory bowel emptying at a predictable time.

1.3.2.2 A bowel habit intervention should contain the following elements:

- encouraging bowel emptying after meals (to utilise the gastro-colic response)
- ensuring toilet facilities are private, comfortable and can be used in safety with sufficient time allowed (see 'Essence of care' (www.dh.gov.uk) and 'Behind closed doors: using the toilet in private' (www.bgs.org.uk))
- teaching patients to adopt a sitting or squatting position where possible while emptying the bowel
- teaching patients techniques to empty the bowel without straining.

1.3.3 Diet and fluid intake

1.3.3.1 Healthcare professionals should recommend a diet that promotes an ideal stool consistency and predictable bowel emptying. When addressing food and fluid intake healthcare professionals should:

- take into account existing therapeutic diets
- ensure that overall nutrient intake is balanced
- consider a food and fluid diary to help form a baseline

- advise patients to modify one food at a time if attempting to identify potentially contributory factors (see Tables 2 and 3 in Appendix D)
- encourage patients with hard stool and/or clinical dehydration to aim for at least 1.5 litres intake of fluid per day. Urinary output should be measured where intake is in doubt
- consider the opportunity to screen patients for malnutrition, or risk of malnutrition (see related NICE guideline on nutrition support (www.nice.org.uk/CG032)).

1.3.4 Toilet access

1.3.4.1 When addressing toilet access in any home or healthcare setting:

- locations of toilets should be made clear
- equipment to help people to gain access to a toilet should be provided
- advice should be given to patients on easily removable clothing to reduce time needed for access
- if patient is dependent on others for accessing the toilet, help should be readily available
- privacy and dignity should be maintained at all times
- if appropriate, patients should be referred to healthcare professionals for assessment of home/mobility.

1.3.5 Medication

1.3.5.1 When reviewing medications, healthcare professionals should consider alternatives to drugs that may be contributing to faecal incontinence (see Table 4 in Appendix D).

1.3.5.2 Anti-diarrhoeal medication should be offered to patients with loose stools and associated faecal incontinence once other causes for loose stools (such as excessive laxative use and dietary factors) have been excluded. Anti-diarrhoeal medication should be

prescribed in accordance with the Summary of Products Characteristics.

1.3.5.3 Loperamide is the anti-diarrhoeal drug of first choice and can be used long-term in doses from 0.5 mg to 16 mg per day or as required. Patients who are unable to tolerate loperamide should be offered codeine phosphate, or co-phenotrope (Lomotil ®)¹.

1.3.5.4 Loperamide should not be offered to patients with:

- hard or infrequent stools
- acute diarrhoea without a diagnosed cause
- an acute flare-up of ulcerative colitis.

1.3.5.5 When loperamide is used it should be:

- introduced at a very low dose and the dose should be escalated, as tolerated by the patient until the desired stool consistency has been achieved
- taken as required by the patient with faecal incontinence
- advised that patients can adjust the dose and/or frequency up or down in response to stool consistency and lifestyle.

1.3.5.6 If a finer modification of dose is required loperamide syrup should be considered.

1.3.6 Coping strategies for symptomatic patients

1.3.6.1 During assessment and initial management patients should be offered advice on coping strategies including:

- continence products and information about product choice, availability and use
- skin care

¹ Check the Summary of Products Characteristics (SPC) for current licensed indications. Informed consent is needed when using outside the licensed indications. This should be discussed and documented in the notes.

- where to get emotional and psychological support. In some cases counselling or psychological therapy to foster acceptance and positive attitudes
- how to talk to friends and family
- strategies such as planning routes around public conveniences if patients have to travel.

1.3.6.2 Patients should be offered:

- disposable body-worn pads and disposable bed pads if needed
- pads in quantities appropriate to the individual's continence needs. Arbitrary ceilings are inappropriate
- anal plugs for patients who can tolerate them
- a choice of pad styles and designs
- skin care advice; both skin cleansing and protection
- advice on odour control and laundry needs.

1.3.6.3 The use of reusable absorbent products in the management of faecal incontinence is not generally recommended.

1.3.7 Review of treatment

1.3.7.1 After each intervention healthcare professionals should ask patients if faecal incontinence has improved. Patients continuing to experience symptoms should be:

- involved in discussions about further treatment options (including effectiveness and adverse effects) or alternative coping strategies
- asked if they wish to try further treatments.

1.3.8 Long-term management

1.3.8.1 Healthcare professionals should provide the following to symptomatic patients who either do not wish to continue with active treatment or who have intractable faecal incontinence:

- advice relating to the preservation of dignity and where possible independence
- psychological and emotional support, possibly including referral to counsellors or therapists if it seems likely that patients' attitude towards their condition and their ability to manage and cope with faecal incontinence could improve with professional assistance
- at least 6-monthly review of symptoms
- discussion of any other management options (including specialist referral)
- contact details for relevant support groups
- advice on continence products and information about product choice, availability and use
- advice on skin care
- how to talk to friends and family
- strategies such as planning routes around public conveniences if patients have to travel.

1.4 Specialised management

1.4.1.1 Patients who continue to have episodes of faecal incontinence after initial management, should be referred to a specialist continence service for consideration of specialised management options which may include:

- pelvic floor re-education programmes
- bowel retraining
- specialist dietary assessment and management
- biofeedback
- electrical stimulation
- rectal irrigation.

These treatments may not be appropriate for patients who are unable to understand and/or comply with instruction. For example, pelvic floor re-education programmes may not be appropriate for

those with neurological or spinal disease/injury resulting in faecal incontinence due to complete loss of voluntary control.

1.4.1.2 Healthcare professionals should consider if patients with neurological or spinal disease/injury (for example spinal cord injury, spina bifida, stroke, multiple sclerosis) resulting in faecal incontinence, who have some residual motor function and are still symptomatic after baseline assessment and initial management, could benefit from specialised management.

1.4.1.3 A programme of pelvic floor re-education should be agreed with the patient. The progress of patients having pelvic floor exercises should be monitored by digital reassessment by an appropriately trained healthcare professional who is supervising the treatment. There should be a review of patients' symptoms on completion of the programme and other treatment options considered if appropriate.

1.5 Specialist assessment

1.5.1.1 Healthcare professionals should refer patients with continuing faecal incontinence after specialised conservative management for consideration for:

- anorectal physiology studies
- endoanal ultrasound. If not available, consider MRI, endovaginal ultrasound and perineal ultrasound
- other tests, possibly including proctography.

1.6 Surgery

1.6.1.1 All patients considering or being considered for surgery should be referred to a specialist surgeon to discuss:

- the surgical and non-surgical options appropriate for each patient

- the potential benefits and limitations of each option, with particular attention to long-term results
- realistic expectations of the effectiveness of any surgical procedures under consideration.

- 1.6.1.2 Patients with a full length external anal sphincter defect (with or without an associated internal anal sphincter defect) and faecal incontinence which restricts quality of life should be considered for sphincter repair for defects that are 90° or greater. Patients should be given a realistic expectation of what this operation can achieve and possible adverse events, both in the short and long term.
- 1.6.1.3 Patients with internal sphincter defects, pudendal nerve neuropathy, multiple defects, external sphincter atrophy, loose stools or irritable bowel syndrome should be informed that these factors are likely to decrease the effectiveness of anal sphincter repair.
- 1.6.1.4 Patients undergoing a sphincter repair to manage their faecal incontinence should not routinely receive a temporary defunctioning stoma.
- 1.6.1.5 Patients undergoing anal sphincter repair should not receive constipating agents in the post-operative period. Feeding should resume as required by the patient.
- 1.6.1.6 A trial of temporary sacral nerve stimulation should be considered for patients with faecal incontinence where sphincter surgery is deemed inappropriate. These may be patients with intact anal sphincters, or those with sphincter disruption. In those with a defect contraindications to direct repair may include atrophy, denervation, a small defect, absence of voluntary contraction, fragmentation of the sphincter or a poor quality muscle (see NICE interventional procedure guidance on sacral nerve stimulation (www.nice.org.uk/IPG099)). All patients should be informed of the potential benefits and limitations of this procedure and should

undergo a trial stimulation period of at least 2 weeks to determine if they are likely to benefit. Patients being considered for sacral nerve stimulation should be assessed and managed at a specialist centre with experience of performing this procedure.

- 1.6.1.7 If a trial of sacral nerve stimulation is unsuccessful patients can be considered for a neosphincter. The two options to be considered are a dynamic graciloplasty or an artificial bowel sphincter (see NICE interventional procedure guidance on stimulated graciloplasty (www.nice.org.uk/IPG159) and artificial anal sphincter (www.nice.org.uk/IPG066)). Patients should be informed of the potential benefits and limitations of both procedures. Patients being considered for either procedure should be assessed and managed at a specialist centre with experience of performing this procedure.
- 1.6.1.8 Patients with an implanted sacral nerve stimulation device, dynamic graciloplasty or an artificial bowel sphincter should receive training and ongoing support at a specialist centre. Patients offered this procedure should be informed that they may experience evacuatory disorders and/or serious infection which may necessitate removal of the device. These patients should be monitored, have regular reviews and be given a point of contact.
- 1.6.1.9 Antegrade irrigation via appendicostomy, neo-appendicostomy or continent colonic conduit may be considered in selected patients with constipation and colonic motility disorders associated with faecal incontinence.
- 1.6.1.10 A stoma should be considered for patients with faecal incontinence that severely restricts lifestyle only once all appropriate non-surgical and surgical options, including those at specialist centres, have been considered. Patients should be informed of the potential benefits, risks and long-term effects of this procedure.

Patients assessed as a possible candidate for a stoma should be referred to a stoma care service.

1.7 Specific groups

1.7.1.1 When assessing faecal incontinence healthcare professionals should:

- be aware that faecal incontinence is a symptom, often with multiple contributory factors for an individual patient
- avoid making simplistic assumptions that causation is related to a single primary diagnosis ('diagnostic overshadowing').

1.7.1.2 Healthcare professionals should consider a proactive approach to bowel management for the following groups of patients:

- patients with neurological or spinal disease/injury resulting in faecal incontinence due to complete loss of voluntary control
- patients with limited mobility
- people with faecal loading or constipation
- hospitalised patients who are acutely unwell and develop acute faecal loading and associated incontinence
- patients with acquired brain injury
- patients with cognitive or behavioural issues
- people with learning disabilities.

1.7.2 Patients with faecal loading

1.7.2.1 Patients in whom acute severe faecal loading is identified as contributing to faecal incontinence should initially be offered a rectally administered treatment to satisfactorily clear the bowel. This will often require treatments to be repeated daily for a few days. The interventions should be offered in the following order, depending on tolerance and if satisfactory bowel clearance is achieved:

- glycerine suppositories

- bisacodyl suppositories
- micro enemas
- phosphate enemas.

1.7.2.2 If these interventions are not appropriate and/or fail to satisfactorily clear the bowel and bowel obstruction has been excluded as possible cause, a potent oral laxative should be offered. Patients should be informed that oral laxatives may cause griping abdominal pain, loose stools and prolonged bowel activity. Toilet access should be ensured.

1.7.2.3 Healthcare professionals involved in the management of faecal incontinence associated with chronic ongoing faecal loading/impaction should aim to reduce the chance of recurrence by recommending a combination of initial management options tailored to the individual patient (see recommendation 1.3.1.1). If this fails, consider use of orally administered laxatives to promote bowel emptying. Rectally administered preparations should be used if use of oral laxatives produces faecal incontinence episodes and there is a need to produce planned bowel evacuations.

1.7.3 Patients with limited mobility

1.7.3.1 Patients with limited mobility who continue to have episodes of faecal incontinence after initial management should be offered a regimen which will produce a planned, predicted bowel action when carers are present. This may be achieved by a combination of oral or rectal laxatives and/or constipating agents. This regimen should also consider:

- toilet access (see recommendation 1.3.4.1).
- appropriate disposable products (see recommendation 1.3.6.2)
- that the stool needs to be in the rectum at the time of the planned bowel action.

1.7.4 Patients using enteral tube feeding and reporting faecal incontinence

1.7.4.1 Healthcare professionals should ensure that patients reporting faecal incontinence who are receiving enteral tube feeding have their type and timing of feed modified on an individual basis to establish the most effective way to manage faecal incontinence.

1.7.5 Patients with severe cognitive impairment

1.7.5.1 Patients with confirmed severe cognitive impairment should be assessed using a behavioural and functional analysis to determine the nature of, and reason for the behavioural presentation of faecal incontinence. Following assessment, patients should be offered cause-specific interventions founded on structured goal planning that aim to resolve as well as manage faecal incontinence.

1.7.6 Patients with neurological or spinal disease/injury

1.7.6.1 Patients with neurological or spinal disease/injury resulting in faecal incontinence due to complete loss of voluntary control who continue to have episodes of faecal incontinence after initial management should be offered a bowel management programme which aims to achieve a predictable routine and avoid faecal incontinence and severe constipation. Management should involve progressing through the following steps until satisfactory bowel habit is established:

- ascertaining patient preferences
- ascertaining pre-morbid bowel habit, if possible
- maximising patient's understanding of normal bowel function and how it has been altered
- modifying diet and/or administration of rectal evacuants and/or oral laxatives, adjusted to individual response, to attempt to establish a predictable pattern of bowel evacuation

- consideration of digital anorectal stimulation for patients with a spinal cord injury and those with other neurogenic bowel disorders
- consideration of manual/digital removal of faeces, particularly for patients with a lower spinal injury if there is a hard plug of faeces in the rectum, presence of faecal impaction, incomplete defaecation, an inability to defaecate and/or all other bowel emptying techniques have failed to achieve bowel emptying and continence in a reasonable time.

1.7.6.2 Healthcare professionals should consider the following management options for a patient unable to achieve reliable bowel continence after a neurological bowel management programme:

- coping and long term management strategies for symptomatic patients (see recommendations in sections 1.3.6 and 1.3.8)
- rectal irrigation if feasible
- a stoma or other surgical options if faecal incontinence or time taken for bowel emptying imposes major limits on lifestyle.

1.7.7 Other specific groups

1.7.7.1 Healthcare professionals should consider a faecal collection bag for patients in intensive care settings and patients receiving palliative care who report or are reported with faecal incontinence and associated loose stools who are not undergoing active treatment.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from www.nice.org.uk/page.aspx?o=260865

How this guideline was developed

NICE commissioned the National Collaborating Centre for Acute Care to develop this guideline. The Centre established a Guideline Development

Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process: an overview for stakeholders, the public and the NHS' (second edition, published April 2006), which is available from www.nice.org.uk/guidelinesprocess or by telephoning 0870 1555 455 (quote reference N****).

3 Implementation in the NHS

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health', issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CGXXX).

[NICE to amend list as needed at time of publication]

- Slides highlighting key messages for local discussion.
- Costing tools
 - Costing report to estimate the national savings and costs associated with implementation.
 - Costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives which support this locally.
- Audit criteria to monitor local practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 *Pelvic floor exercises*

The value of pelvic floor exercises in preventing and treating obstetric-related faecal incontinence.

Why this is important

Obstetric related faecal incontinence is a distressing symptom which may occur early after childbirth. Obstetric injury is also the major cause of incontinence in older women, so reducing risk would have important benefits for both young and old patients. Obstetric risk factors relate not just to sphincter disruption, but also to pelvic floor damage, and there is reason to suggest that improving pelvic and sphincter strength prior to potential injury may be beneficial. Equally, early intervention post-partum may help reduce the well recognised risks of delayed faecal incontinence in women.

Pregnant women and those who have given birth within the last 6 months (possibly excluding third and fourth degree tears) would usefully be randomised to one of 3 groups:

- standardised pelvic floor exercises
- generic advice and no specific pelvic floor intervention in second and third term pregnancy
- generic advice and no specific pelvic floor intervention in women post-partum.

All groups could be stratified according to presence of symptoms. Within the post-partum group, patients could be stratified to those with and without known risk factors for faecal incontinence. This would allow comparisons to be drawn between treatment groups and also across strata of symptoms and risk factors. Outcome measurement would include symptoms, quality of life, carer outcomes, physiology, imaging data and health costs with intention of detailed

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economic modelling. Measurements should be taken at short term (6 months) and longer term (3 years) to allow comparison with baseline and between standard vs complete assessment limbs.

There is no standardisation of what pelvic floor exercises should comprise. There is also no evidence base of whether treatment prior to potential injury (i.e. labour) serves a protective role. This study will require the interaction of obstetric, colorectal and physiotherapy services across primary and secondary care.

4.2 *Patient-related outcomes*

Development of a valid and reliable tool to measure patient-rated outcomes including symptom severity and quality of life for people with faecal incontinence.

Why this is important

Research into and treatment of faecal incontinence is hampered by the lack of a valid and reliable tool which has been refined through iterative piloting and consultation stages. Such a tool would allow standardisation of outcome measures with which to compare results of interventions, allowing effectiveness of interventions to be genuinely compared, and accurately assessed.

Qualitative review for this guideline has highlighted paucity of information on patients' views and the crudeness of current evaluation of symptoms and outcomes. By involving users, healthcare providers and qualitative researchers in the design of a tool, the most relevant outcomes (to all groups) would be measured, including symptom severity and quality of life. Each group would bring different perspectives to the tool which would ensure that all relevant topics are covered and that the tool is useful to all groups.

4.3 *Self-care educational programmes*

Would a self-care educational programme for patients and carers improve patient outcomes (symptom severity and quality of life)?

Why this is important

Qualitative evidence suggests that mutual support groups improve patient quality of life. Moreover, there is evidence to suggest that information about management and treatment options are scarce, and that the taboo surrounding faecal incontinence hinders help-seeking behaviour. A self-care group programme to provide an integrated education and support programme covering topics such as support networks, coping strategies, identifying and provision of suitable products and treatments (including assessment and surgery options) may aid practical care and offer increased support, improving both physical and psychological outcomes.

In the study design patients with faecal incontinence and their carers in the community receiving standard care would be compared (at regular intervals) with a similar group exposed to the self-care programme. Assessed outcomes could include patient-rated outcomes (including symptom severity and quality of life).

The programme should be designed using qualitative research, patient input and advice from healthcare professionals. This programme should be piloted and refined after a process evaluation, incorporating views of health-care professionals, qualitative research and patients as well as effectiveness data. Regular refinement of the components would allow tailoring of the programme to the individual needs of the group. Evidence suggests that patients should benefit from mutual support and improved access to health care options, as well as better awareness of available management and treatment options, allowing (patients to be involved in) tailoring of individual care plans. It would provide community-based healthcare, involving healthcare professionals including continence specialist clinicians, clinical psychologists and integrate with social care. This type of patient/carer self-care programme may reduce the demand on secondary care. The views of those attending may shape future health/social care by reducing the number of admissions to residential care due to faecal incontinence.

4.4 *Bowel management programme*

Does a bowel management programme for older people in care homes improve faecal incontinence, constipation and patients' and carer's perceptions of quality of care?

Why this is important

Over 50% of older people in care homes suffer from bowel related problems. This is the cause of much anxiety and discomfort for patients, as well as adding to the carer burden. Moreover, with the UK's ageing population, this problem will only increase with time. Little research has been done on effective bowel care in this population, and care is expensive (laxatives, pads and carer time) all contributing to the overall cost.

A management programme for this population may provide a way to improve quality of patient and carer lives, and improve overall healthcare.

4.5 *Specialist assessment*

What is the prognostic value of physiological assessment for defining outcome of surgery for treatment of faecal incontinence?

Why this is important

It is currently hard to predict which patients will benefit from surgical treatment for faecal incontinence. Developing an improved selection procedure would cut down on unnecessary procedures, cutting costs and improving patient care pathways.

By comparing standard physiology and structural assessment (anorectal physiology, pudendal nerve latencies, endoanal ultrasound) with full physiological and structural assessment (including anorectal physiology, pudendal nerve latencies, anorectal reflexes, rectal compliance dynamometry, endoanal ultrasound and MRI) in patients referred for specialist assessment in whom surgery is contemplated, a better correlative description of the relationship between symptoms and physiology or structure may be drawn. This in turn would allow a better selection procedure to be developed. By following patients through surgery and over a long-term follow-up period, the

prognostic value of certain physiological/structural abnormalities in defining outcome from surgery would be evaluated. An additional point of investigation would be the long-term outcome of certain surgical procedures, particularly sacral nerve stimulation and evacuation dysfunction surgery. The decision to operate will be based on the individual indications for the procedure.

Using physiological and structural assessment outcomes at short and long-term, a comparison between the standard vs complete assessment limbs may be carried out. Additional outcomes could include a quality of life scale to gain the patient perspective, and health costs to allow detailed economic modelling. This research question would be best answered by a multi-centre study based on a network of NHS secondary care sites.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'The management of faecal incontinence in adults' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Acute Care, and is available from http://www.rcseng.ac.uk/surgical_research_units/nccac/, our website (www.nice.org.uk/CGXXXfullguideline) and the National Library for Health (www.nlh.nhs.uk). **[Note: these details will apply to the published full guideline.]**

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org/CGXXXquickrefguide

For printed copies, phone the NHS Response Line on 0870 1555 455 (quote reference number NXXXX). **[Note: these details will apply when the guideline is published.]**

5.3 'Understanding NICE guidance'

Information for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CGXXXpublicinfo

For printed copies, phone the NHS Response Line on 0870 1555 455 (quote reference number NXXXXX). [Note: these details will apply when the guideline is published.]

6 Related NICE guidance

Urinary incontinence: the management of urinary incontinence in women.

NICE clinical guideline no. 40 (2006). Available from www.nice.org.uk/CG40

Artificial anal sphincter. *NICE interventional procedure guidance* no. 66 (2004). Available from www.nice.org.uk/IPG066

Sacral nerve stimulation for faecal incontinence. *NICE interventional procedure guidance* no. 99 (2004). Available from www.nice.org.uk/IPG099

Stimulated graciloplasty for faecal incontinence. *NICE interventional procedure guidance* no. 159 (2006). Available from www.nice.org.uk/IPG159

Circular stapled haemorrhoidectomy. *NICE interventional procedure guidance* no. 34 (2003). Available from www.nice.org.uk/IPG034

Percutaneous endoscopic colostomy. *NICE interventional procedure guidance* no. 161 (2006). Available from www.nice.org.uk/IPG161

NICE is developing the following guidance (details available from www.nice.org.uk):

Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care. *NICE clinical guideline*. (Publication expected February 2008.)

Injectable bulking agents for faecal incontinence. *NICE interventional procedure guidance*. (Publication expected 2007).

7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline

should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The Panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

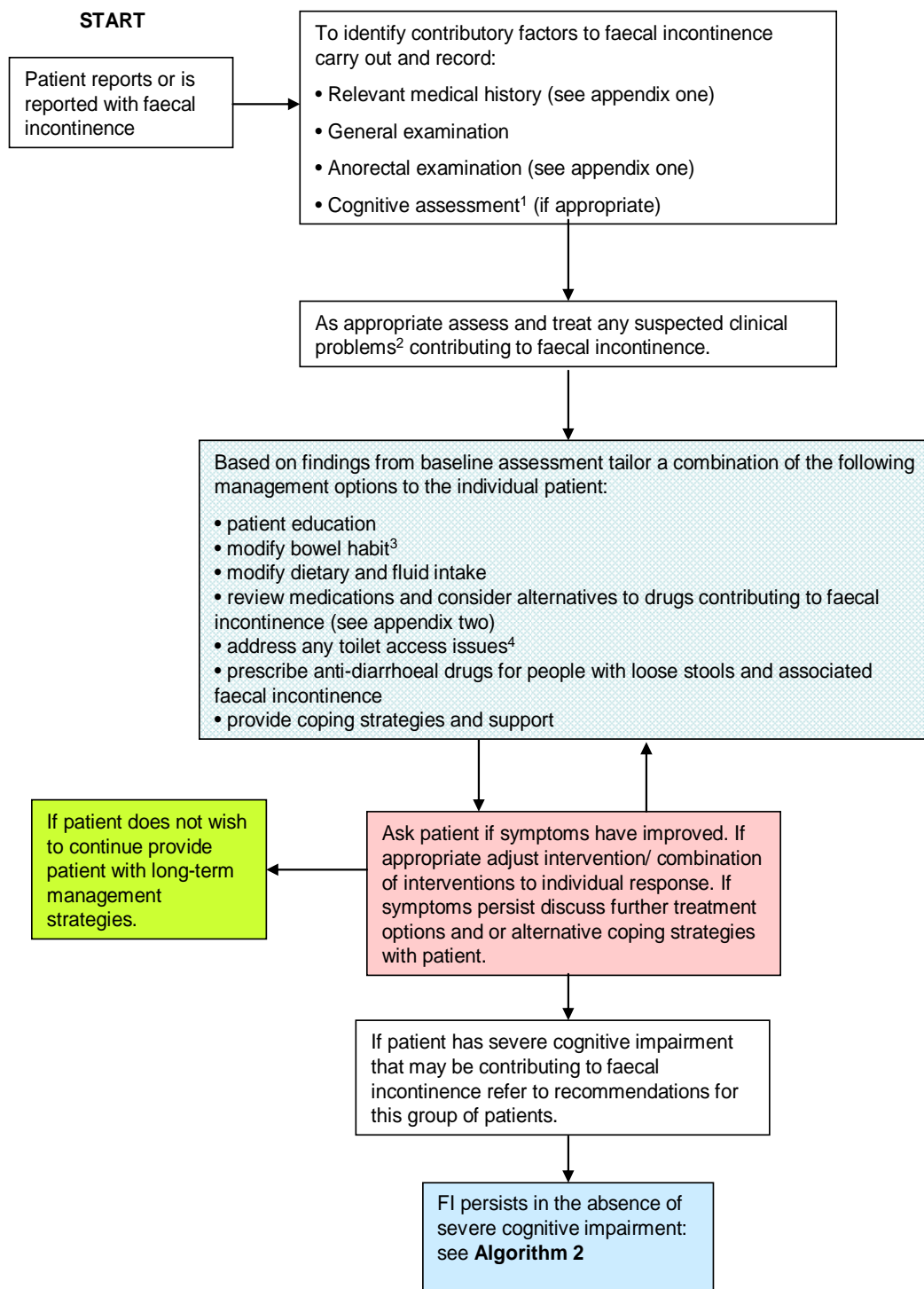
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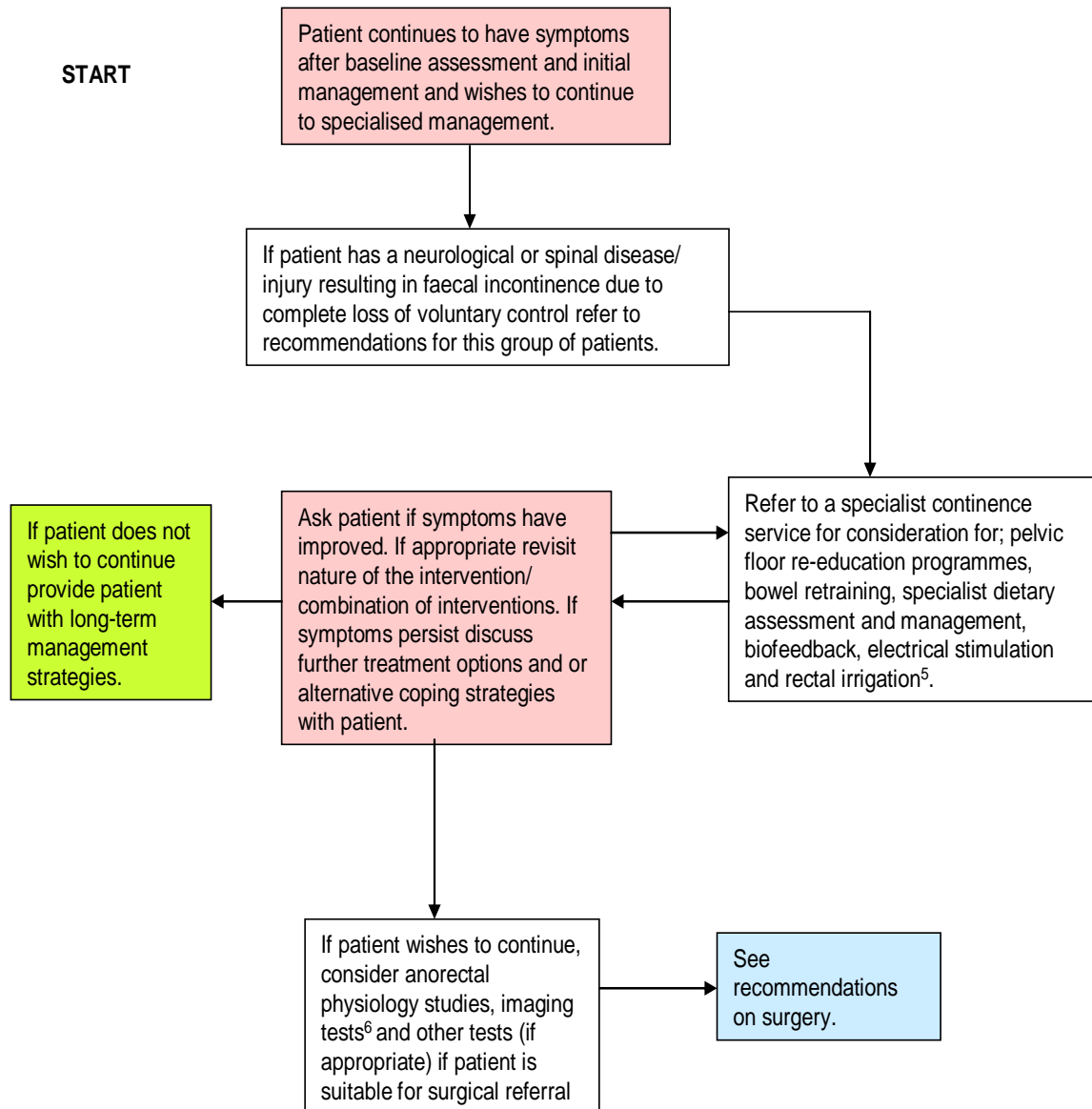
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Appendix C: The algorithms

Algorithm 1



Algorithm 2



Footnotes:

- Cognitive assessment: in patients with suspected cognitive impairment contributing to FI it may be appropriate to conduct or refer for more formal cognitive testing.
- For example, faecal loading, treatable causes of diarrhoea, warning signs for lower gastrointestinal cancer (see NICE clinical guideline on referral for suspected cancer (www.nice.org.uk/CG027), rectal prolapse, third degree haemorrhoids, acute anal sphincter injury, acute disc prolapse.
- Aim for ideal stool consistency, and satisfactory bowel emptying at a predictable time.
- If appropriate refer to healthcare professional for assessment of home/mobility.
- This referral may not be appropriate for patients who are unable to understand and/ or comply with instruction, for example, pelvic floor re-education programmes for those with neurological or spinal disease/injury resulting in faecal incontinence due to complete loss of voluntary control.
- Endoanal ultrasound. If this is not available endocoil MRI, endovaginal ultrasound and perineal ultrasound should be considered.

Appendix D: Tables

Table 1: Medical history

Medical history can be amassed in a personal history, discussed with carers (as appropriate) and information referred from previous clinicians.

Additional information may be obtained from a bowel diary.

Questions to consider:

1. History of bowel habit: Questions to ask patients

What is your normal bowel habit?

Has it changed recently? If so how? Has there been any bleeding from the back passage? Or loss of mucus?

What is the usual consistency of your stools (bowel motions)? (Refer to stool chart such as the Bristol Stool Chart to assist the patient/carer to describe)

Do the stools vary in consistency?

Do you have to strain to empty your bowels? If so, for how long?

Are you able to tell the difference between when you are about to pass wind or stool?

Do you pass much wind?

Can you control this wind?

Are you able to delay emptying your bowels?

If so for how long?

Do you experience any abdominal pain or bloating before passing a bowel motion?

Does that relieve the sensation?

Do you have a feeling of incomplete emptying after an attempted bowel evacuation?

Do you ever have to assist the passage of stool with your finger?

Are you able to clean yourself after passing stools?

Do you have to clean yourself several times after passing stools?

Do you ever leak stools without being aware of it?

When faecal incontinence is reported, ask the following:

How often does it happen?

When has it happened? Is there any pattern to this or any factor that provokes it?

How much leaks? What is the consistency of the leakage? Can it be wiped away easily?

Do you get the sensation of the need to empty your bowels before you leak? Is that sensation an urgent need to empty your bowels? (Passive soiling)

Does soiling occur after a bowel motion has been passed? (post defaecation soiling).

Do you wear pads (or something else) in your underwear? If so, are they effective in preventing soiling of clothes/surroundings/furnishing?

2. Previous Medical History

Assess the patient for possible contributory factors:

Constipation/diarrhoea

Acute severe illness

Terminal illness

Severe cognitive impairment

Assess the patient for limited mobility:

Does the patient have adequate toilet facilities (for example, is there limited availability, access problems, lack of privacy, unclean, unsafe?)

Does the patient need assistance for toileting? If so, is there delayed assistance when there is an urgent call to stool?

Is the patient able to communicate when there is a need to defecate?

Are there any physical or environmental difficulties with toilet access, for example, anonymous doors, steps, non-slip shiny floors, patterned carpets, excessive distance?

Is there a history of a neurological disorder(s)?

If yes - how long has it been present?

Is it expected to improve?

Is it permanent?

Does the patient have an obstetric history and/or history of weak pelvic floor (as appropriate)

Parity

Difficult delivery

Large birth weight

Is there a history of perianal trauma or surgery?

Is there a history of urinary continence?

Is there a history of rectal prolapse?

Is there a history of other co-morbidities e.g. diabetes, Parkinson's disease

3. Perform a Medication Review

Is the patient taking any of the drugs which may exacerbate faecal incontinence (see

)?

What treatment alterations have already been made in the management of the problem?

How effective were these alterations?

4. Diet and fluid history

Enquire about meals and snacks taken.

Review food intake versus the list of foods which may exacerbate faecal incontinence (see Table)

5. Consequences of faecal incontinence

Do you experience itching or soreness around the back passage?

When is this present?

6. Impact of symptoms on lifestyle/quality of life

Do the patient's bowel symptoms affect the following?

General lifestyle

Family life

Leisure and social activity

Work

Sexual activity

Emotions

Self-image

Relationships, particularly any changes in close relationships

Ability to travel

Ability to manage within place of residence, for example does the patient require any structural changes to be made to their residence?

7. Physical examination

General examination (as indicated)

Cognitive and behavioural assessment (if indicated)

Assess patients ability to use toilet, including:

Access

Mobility

Ability to adjust clothing

Ability to wash after using toilet

Anorectal examination:

<p><i>Visual inspection of anus</i></p> <p><i>Assessment of perineal descent</i></p> <p><i>Digital rectal examination for anal tone, ability to squeeze anal sphincter voluntarily</i></p> <p><i>Assessment of faecal loading</i></p>

Table 2: Food/drink which may exacerbate faecal incontinence in patients who present with loose stools or have rectal loading of soft stool.

Food Type	Examples/Rationales
Fibre	Fibre supplements for example bulking agents such as ispaghula husk, methylcellulose, sterculia or unprocessed bran Wholegrain cereals/bread (reduce quantities). Porridge/oats may cause fewer problems than whole wheat based cereals.
Fruit and vegetables	Rhubarb, figs, prunes/plums best avoided as contain natural laxative compounds. Beans, pulses, cabbage and sprouts. Initially limit to the portion sizes given on the DH list www.dh.gov.uk , for example, one apple or 1 tablespoon dried fruit. Space out portions over day.
Spices	For example chilli.
Artificial sweeteners	Sorbitol is best avoided. It is found in special diabetic products such as chocolate, biscuits, conserves and in some sugar-free items including many nicotine replacement gums. Aspartamine
Alcohol	Especially stout, beers and ales.
Lactose	A few patients may have some degree of lactase deficiency. Whilst small amounts of milk for example in tea or yoghurt are often tolerated, an increase in the consumption of milk may cause diarrhoea. For more information on lactose intolerance see www.eatwell.gov.uk
Caffeine	Excessive intake of caffeine may loosen stool and thus increase faecal incontinence in some predisposed patients.

Vitamin and mineral supplements	Excessive doses of vitamin C, magnesium, phosphorus and/or calcium supplements may increase faecal incontinence. For more information on lactose intolerance, vitamin and mineral supplements see www.eatwell.gov.uk
Olestra fat substitute	Can cause loose stools.

Table 3: Food/drink to increase slowly in patients with faecal incontinence and hard stools or constipation.

Food Type	Examples/Rationales
Fibre	Current guidelines (DH 1991) are for an average intake of 18 g/day. Some patients may need an intake of up to 30g/day. Increase intake of wholegrain cereals, wholemeal, wholegrain bread, or white breads with added fibre. Encourage patient to have extra fluid with cereal fibre rich foods. Some patients may require a fibre/bulking agent supplement to be prescribed to achieve a normal stool consistency.
Fruit and vegetables	<ul style="list-style-type: none"> • Fresh, tinned, dried or frozen • Encourage a minimum of five portions a day (see www.dh.gov.uk)

Table 4: Drugs that may exacerbate faecal incontinence/loose stools

Drug (and mechanism)	Examples (not exhaustive list)
Drugs altering sphincter tone	<ul style="list-style-type: none"> • Nitrates • Calcium channel antagonists • Beta-adrenoceptor antagonists (beta-blockers) • Sildenafil • SSRIs
Broad spectrum antibiotics (multiple mechanisms)	<ul style="list-style-type: none"> • Cephalosporins • Penicillins • Erythromycin
Topical drugs applied to anus (reducing pressure)	<ul style="list-style-type: none"> • GTN ointment • Diltiazem gel • Bethanechol cream • Botulinum toxin A injection
Drug causing profuse loose stools	<ul style="list-style-type: none"> • Laxatives • Metformin • Orlistat • SSRIs

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	<ul style="list-style-type: none">• Magnesium-containing antacids• Digoxin
Constipating drugs	<ul style="list-style-type: none">• Loperamide• Opioids• Tricyclic antidepressants• Aluminium-containing antacids• Codeine
Tranquillisers or hypnotics (reducing alertness)	<ul style="list-style-type: none">• Benzodiazepines• Tricyclic antidepressants• SSRIs• Anti-psychotics