Faecal incontinence: tables

Education
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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 FI 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 urge to empty your bowels? (urge faecal incontinence)* *Does soiling occur after a bowel motion has been passed? (post-defecation 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 and toilet access: *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, unmarked doors, steps, non-slip shiny floors, potentially confusing floor patterns. 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 incontinence? • Is there a history of rectal prolapse? • Is there a history of other comorbidities such as diabetes
3.	**Perform a medication review** • Is the patient taking any of the drugs that may exacerbate faecal incontinence (FI) (see table 4)? • 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 against the list of foods that may exacerbate FI (see table 2)
5.	**Consequences of FI** • 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 patient's ability to use toilet, including: *Access* *Mobility* *Ability to adjust clothing* *Ability to wash after using toilet* • Anorectal examination: *Visual inspection of anus* *Assessment of perineal descent* *Digital rectal examination for anal tone, ability to squeeze anal sphincter voluntarily* *Assessment of faecal loading*

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 and plums best avoided as contain natural laxative compounds. Beans, pulses, cabbage and sprouts. Initially limit to the portion sizes given on the DH list, for example, one apple or 1 tablespoon dried fruit. Space out portions over day.
Spices	For example, chilli.
Artificial sweeteners	May be found in special diabetic products such as chocolate, biscuits, conserves, and in some sugar-free items including many nicotine replacement gums.
Alcohol	Especially stout, beers and ales.
Lactose	A few patients may have some degree of lactase deficiency. While small amounts of milk (for example in tea or yoghurt) are often tolerated, an increase in the consumption of milk may cause diarrhoea.
Caffeine	Excessive intake of caffeine may loosen stool and thus increase faecal incontinence (FI) in some predisposed patients.
Vitamin and mineral supplements	Excessive doses of vitamin C, magnesium, phosphorus and/or calcium supplements may increase FI.
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 30 g/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 achieve a normal stool consistency.
Fruit and vegetables	Fresh, tinned, dried or frozen. Encourage a minimum of five portions a day.

Table 4 Drugs that may exacerbate faecal incontinence/loose stools

Drug (and mechanism)	Examples (not exhaustive list)
Drugs altering sphincter tone	Nitrates Calcium channel antagonists Beta-adrenoceptor antagonists (beta-blockers) Sildenafil Selective serotonin reuptake inhibitors

Broad-spectrum antibiotics (multiple mechanisms)	Cephalosporins Penicillins Erythromycin
Topical drugs applied to anus (reducing pressure)	Glyceryl trinitrate ointment Diltiazem gel Bethanechol cream Botulinum toxin A injection
Drugs causing profuse loose stools	Laxatives Metformin Orlistat Selective serotonin reuptake inhibitors Magnesium-containing antacids Digoxin
Constipating drugs	Loperamide Opioids Tricyclic antidepressants Aluminium-containing antacids Codeine
Tranquillisers or hypnotics (reducing alertness)	Benzodiazepines Tricyclic antidepressants Selective serotonin reuptake inhibitors Anti-psychotics