Fecal incontinence in older adults

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Clinical question

How do I assess and manage fecal incontinence (FI) in older patients?

Bottom line

Active case finding is crucial, as patients will often not report FI owing to embarrassment or the false belief that it is a normal part of aging. Causes and contributing factors will differ depending on clinical context and degree of frailty. Initial steps include history taking, including a medication review and functional assessment, and a physical examination, including abdominal, perineal, and digital rectal examinations. Investigations and treatment depend on cause (**Box 1**).

Evidence

A comprehensive approach is necessary for FI.[1] Rates of FI increase with age and are much higher in long-term care.[2] Fecal incontinence is often a marker of increasing frailty and is associated with higher 1-year mortality.[3] Psyllium can reduce FI frequency by up to 50% in those with loose stools and might be as effective as antimotility agents.[4]

Patients and caregivers need to be educated about proper positioning for defecation (well supported, leaning forward, with feet raised about 30 cm using a stool).[5] While a bowel routine can be helpful, current evidence does not support it.

Approach

Questions such as "Do you leak stool or have difficulty controlling your bowel movements?" should be asked routinely of older patients. Understanding FI's effect on quality of life will inform the treatments offered. An anatomic approach can help, although FI often involves systems outside of the gastrointestinal tract (**Box 1**). Fecal incontinence might be categorized as urge (limited time from sense of need to defecate to defecation), passive (no awareness of need to defecate; involuntary loss of stool), or seepage (involuntary leakage after normal defecation). Diarrhea might contribute to FI but is not necessarily present. Physical examination should include an abdominal examination for masses, inspection of the perineum for breakdown and infection, testing of S2 to S4 nerve routes, anal wink testing, and digital rectal examination. Functional and cognitive limitations should be considered. Testing should be individualized but can include a complete blood count and calcium, thyroid-stimulating hormone, and hemoglobin A_{1c} levels. If FI is associated with a change in frequency or consistency of stool, consider a colonoscopy to rule out malignancy.

First-line treatments are nonpharmacologic strategies such as reducing functional barriers, dietary changes, and education about positioning and environmental factors. Medical therapies include psyllium for mobile patients with loose stools. Antimotility agents might help chronic diarrhea and those with past anorectal surgery and passive FI. Care must be taken in the context of arrhythmia or cognitive impairment. Refractory cases with sphincter dysfunction or injury might benefit from interventions such as sacral neuromodulation, sphincter repair, or sphincteroplasty.

Box 1. Causes of fecal incontinence

Anus
- Traumatic: surgical or obstetric injury
- Nontraumatic: radiation, fibrosis, neuropathy (eg, diabetes)

Pelvic floor
- Traumatic: surgical or obstetric injury, chronic straining
- Nontraumatic: obesity, sarcopenia, poor muscle coordination

Rectum
- Traumatic: surgical injury
- Inflammation: inflammatory bowel disease, radiation, infection
- Reduced sensation: neuropathy, constipation

Bowel
- Diarrhea: infection, inflammation, medications (magnesium, antibiotics, metformin, proton pump inhibitors, cholinesterase inhibitors, antifungals, calcium channel blockers)
- Constipation with overflow diarrhea

Central nervous system
- Brain: neurogenerative disorders, stroke, brain tumour, multiple sclerosis
- Spinal cord: injury, spinal stenosis, myelopathy

Implementation

A multidisciplinary approach is ideal and should include practitioners such as nurse continence advisors; social workers, given the stress invoked by FI and its effect on independence; and gastroenterologists, geriatric medicine specialists, and care of the elderly physicians. Pelvic floor physiotherapy is very effective and is recommended as first-line therapy. Establishing buy-in from patients and caregivers for evidence-based therapies is essential.

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Competing interests
None declared

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Geriatric Gems are produced in association with the *Canadian Geriatrics Society Journal of CME*, a free peer-reviewed journal published by the Canadian Geriatrics Society (**www.geriatricsjournal.ca**). The articles summarize evidence from review articles published in the *Canadian Geriatrics Society Journal of CME* and offer practical approaches for family physicians caring for elderly patients.