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The Canadian Continence Foundation

the INFORMER

YOUR CANADIAN CONTINENCE RESOURCE

Improving Continence Care in Canada

Jacqueline Cahill

I have now been working for The Canadian Continence Foundation (TCCF) for just over five years. During this time, I am proud to say that I have witnessed a steady increase in the public's awareness of incontinence, particularly urinary incontinence (UI). We still have a long way to go to completely break the stigma, but it is encouraging to see that there are an increasing number of people who are at ease with talking about the condition, and aware that it can be managed and treated.

Possibly because UI is becoming more accepted, I have received a growing number of requests for help with bowel or fecal incontinence over the last year. Therefore, we decided to dedicate this issue of *The Informer* to this devastating and extremely taboo condition. It is my hope that this issue will inform those coping with this condition that they are not alone, as well as provide understanding and help with managing it.

Having said that urinary incontinence is more "in the open," when women I meet (either professionally or socially) find out that I am the Executive Director of TCCF, nine out of 10 over the age of 30 confide that they have some form of UI. Many are amazed that there are millions of women in Canada living with UI, and they are equally surprised it can often be cured through conservative, surgical or medical measures. I have also observed that many women do not understand what UI actually is, and many believe that "leaking" a few times a week is normal. I am often told that family physicians (FPs) do not address the UI issue as diligently as is needed, because patients can be too embarrassed to mention it, or because FPs are not comfortable with counselling and managing incontinent patients due to a lack of formal training.

I suspect that the same issues apply to fecal incontinence.

To address some of these issues, we have enlarged our team by hiring a part-time Health Advisor and Program Consultant who will contribute to the following 2011 initiatives for improving continence care in Canada:

- An e-health initiative for improving access to incontinence care for those living in rural areas
- A survey of women's understanding of incontinence and a subsequent knowledge transfer kit
- A community outreach incontinence awareness program for First Nation rural communities
- A Continued Medical Education (CME) program for FPs on incontinence management
- A rural pilot continence care clinic
- Patient-centred incontinence care guidelines

With best wishes,
Jacqueline Cahill
Executive Director,
The Canadian Continence Foundation

The Truth About Fecal Incontinence

Fecal incontinence is one of the last taboo health topics. People who suffer from fecal incontinence are usually too embarrassed to talk about it, even with a health care professional. And physicians very rarely ask about it during routine examinations. As a result, there are a lot of misconceptions about fecal incontinence.

The Myths

- **It can't be treated**
- **Any treatment a doctor suggests will be painful/ invasive/ineffective**
- **It is a normal part of aging**
- **It will clear up with time**
- **It's too embarrassing to talk about**
- **It is only treated by surgery**

The Facts

Fecal incontinence is the inability to control one's bowels, resulting in the involuntary emission of gas (flatulence), liquid (diarrhea) or solid stool. It is also known as bowel or anal incontinence.

Because people are so hesitant to talk about fecal incontinence, it is difficult to accurately gauge how many people suffer from the problem. Most studies estimate that about 1–10% of the general population experience fecal incontinence. The prevalence rises to 10–15% in people 65 years and older. Among residents of long-term care facilities, rates are estimated to be as high as 20–40%. Double incontinence – both fecal and urinary – is not uncommon, especially among women.

Women are more likely to experience fecal incontinence than men, and it becomes more common with age (although it is not a normal part of aging).

Causes

The primary cause of fecal incontinence is damage to the muscles that control defecation, or damage to the nerves that control these muscles or that sense stool in the rectum. This type of damage can be related to several possible factors:

Chronic constipation. When a person is constipated, large, hard stools can become stuck in the rectum; watery stools may then leak around the lodged stool. Over time, chronic constipation and straining can damage the nerve that supplies the rectal muscles and weaken these muscles to the point that they can no longer retain stool.

Difficult vaginal childbirth. The muscles in the rectum can be injured by prolonged pushing during the second stage of labour, delivering a very large baby, an episiotomy or the use of forceps.

Disease. Diseases of the nervous system, such as multiple sclerosis and diabetes, can damage the nerves that control the sphincters or sense stool in the rectum. Inflammatory bowel disease, stroke and Alzheimer's disease can also cause fecal incontinence.

Surgery. Nerves and muscles can be injured during surgeries on the rectum or anal canal (for example, surgeries to remove hemorrhoids).

Diagnosis

First and foremost, talk to your family doctor. In rare instances, fecal incontinence can be a sign of a serious disease. If you experience a sudden change in bowel habits, or if your fecal incontinence is accompanied by blood in your stools, see a doctor immediately.

To diagnose the cause of fecal incontinence, a physician will usually start by taking a thorough medical history (asking questions about your diet, symptoms, bowel habits, etc.) and conduct a physical examination.

If diagnostic tests are required, the two most common are **anal-rectal manometry**, which measures the pressure inside the rectum and determines whether there is any nerve or muscle damage, and **endoanal ultrasound**, which shows the muscles that control defecation and determines whether they are healthy.

While most cases of fecal incontinence can be diagnosed and treated by a general practitioner, more complex cases might be referred to a specialist such as a gastroenterologist, a colorectal surgeon or, for women, a urogynecologist.

Treatment

The good news is that in most cases bowel control can be improved or restored with lifestyle changes. The following simple steps are often effective:

Eliminate problem foods. Keep a food diary to determine which foods cause constipation or diarrhea, then eliminate them from your diet. Problem foods vary from individual to individual but commonly include citrus fruits and fruit juices, caffeinated beverages (such as coffee), spicy foods, dairy products and artificial sweeteners.

Add fibre. Adding soluble fibre to your diet can help make stools soft, formed and easier to control. Vegetables, whole grains (such as bran), beans, legumes and psyllium powder are good sources of fibre. Be sure to drink plenty of water to help your body process the extra fibre. For expert dietary advice, ask your doctor to refer you to a registered dietitian/nutritionist.

Check medications. Some drugs (such as antibiotics) and vitamin supplements (such as vitamin C and calcium) can cause diarrhea that may lead to fecal incontinence, while other drugs can cause constipation. Be sure to give your doctor a list of all prescription and over-the-counter medications and supplements that you are taking. This is particularly important for elderly people or those taking multiple medications.

Regulate bowel habits. Bowel training – practicing the habit of using the toilet at the same time every day – may reduce incontinence by improving awareness of the urge to defecate and strengthening the muscles involved. Excessive straining to move the bowels should be avoided. Developing new bowel habits may take several weeks and requires patience and persistence.

Beyond lifestyle changes

If bowel control does not improve with lifestyle changes alone, other treatment options are available. These will vary

HELP IS AVAILABLE. YOU ONLY NEED TO ASK.

according to the primary cause of the fecal incontinence. For example, if an underlying disease is the cause, the initial focus should be on improving management of that condition (such as improving blood glucose control in diabetes).

Pelvic floor muscle training and biofeedback. Exercising the pelvic floor muscles can improve their strength. Biofeedback helps you exercise more effectively by using a computer to show how well the muscles are working. Biofeedback can be combined with nerve stimulation to improve muscle coordination. These procedures are done with the help of a specialized physiotherapist or nurse continence advisor.

Medication. If diarrhea is the cause of the fecal incontinence, an antidiarrheal medication such as Imodium may help. When there is no obvious cause of the incontinence, a physician may suggest amitriptyline, which is an antidepressant that also has a coordinating effect on the rectal muscles.

Surgery. Surgery to repair the anal sphincter may be required if the incontinence doesn't improve with lifestyle changes, or if it is the result of damage to the anal sphincter or pelvic floor. Results from surgery tend to be very good.

Bulking agents. A fairly new treatment involves injecting bulking agents under the anal canal to improve resistance in the canal.

Colorectal irrigation. For some people with chronic fecal incontinence, colorectal irrigation may improve their quality of life. Similar to an enema, this procedure involves flushing the bowels with water, usually first thing in the morning. With empty bowels you may worry less about "having an accident," and thus increase your comfort and confidence.

Embarrassment, worry, shame, loneliness, sadness. These feelings are common to people who suffer from fecal incontinence. Left untreated, the condition can significantly impair quality of life and result in time off work, loss of social activities and sexual dysfunction. But help is available. If you experience fecal incontinence, tell your doctor about your symptoms. Do not wait for him or her to ask you about it.

For support and information about fecal incontinence, contact The Canadian Continence Foundation at www.canadiancontinence.ca

President's Message

Perhaps the most debilitating thing about incontinence is the psychological effect that it has on people. Many people who begin to experience involuntary leakage of urine or feces experience profound embarrassment, which can be so severe that they can't bring themselves to reveal their symptoms to their physician or to seek information about how to manage their problem effectively. Beneath these difficulties is the idea that people look down on anyone who cannot control their bladder or bowels. This fear of other people's reactions is the essence of the stigma of incontinence.

A good place to start dealing with the stigma is to think about its "location." You may feel that the stigma emanates from other people who will reject you if they find out about your problem. However, a more useful way to look at the situation is to consider that much of the stigma lies within yourself. A big part of the problem is your own fear and embarrassment. There is nothing that you can do about what other people think. Other people's behaviour and feelings are their own problems. But you can deal with and change your own behaviour. Embarrassment and shame are unpleasant emotional feelings, and psychologists have found that one of the most effective ways to change our emotional feelings is by changing our behaviours. If you can begin to deal more effectively with your incontinence, you will start feeling less embarrassed.

So despite your embarrassment, go to your doctor and seek medical help. If you don't feel comfortable discussing your problem with your family doctor, consult a doctor you don't know. Another excellent way to start dealing constructively with your incontinence is to join an Internet discussion group for people who are living with incontinence, such as **www.depend.com** and **www.incontinentsupport.org**. Participants in these two groups have experienced the same problems that you are experiencing, and can thus provide you with a helpful kind of peer support that it is difficult to find anywhere else. They know what you're going through and can offer useful practical advice about coping with your situation.

Thomas Alloway

Dr. Thomas Alloway, Ph.D.
President, TCCF

"This fear of other people's reactions is the essence of the stigma of incontinence."

Stool Incontinence In Children May Be Caused By Constipation

by Claudia Brown, Physiotherapist,
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An estimated 1–3% of children under the age of 10 suffer from encopresis. This condition is a form of fecal incontinence caused by chronic constipation. About 80% of these children are boys, and up to one quarter of them also have difficulty controlling their urine.

"My child is soiling his undergarments, and you're telling me it's because he is constipated?"

How can this make sense?" Stool that accumulates in the rectum can result in impaction, causing the anal sphincters to become underactive and fatigued. Also, the rectum can lose some of its sensitivity and become unable to respond properly. New stool arriving in the rectum can seep around the impacted stool and leak out into the undergarments. This is called "overflow incontinence." Overflow incontinence is usually associated with a history of constipation and/or painful bowel movements. Unfortunately, many parents and caregivers mistake this seepage for diarrhea and treat it inappropriately.

"So what does this have to do with urinary control?"

In the child's pelvis, the bladder and the rectum are quite close to each other. When a child has impacted stool, the bladder has less room to expand as it fills with urine; this can lead to urine leakage. Also, the muscles that control the bladder can have more difficulty contracting properly due to pressure from the rectum.

"What can be done about this?"

The way to treat this problem is to treat the constipation. If the constipation is not due to a disease or some other medical condition, it may be considered "functional constipation," and can be treated with a multi-faceted treatment approach including deep breathing exercises and eating proper foods.

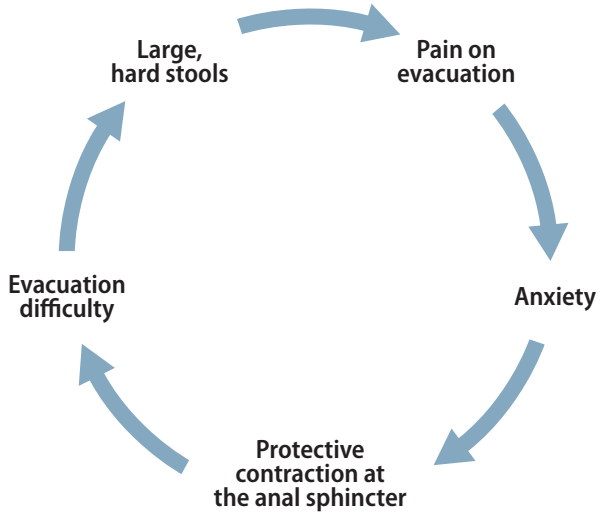
"What is functional constipation?"

A child more than four years of age without a specific medical condition that is causing the constipation can be considered to have functional constipation if he has two or more of the following:

- Two or fewer defecations into the toilet per week
- One or more episodes of incontinence per week
- Attempts to prevent the stool from coming out by changing his position or squeezing closed
- Painful or hard bowel movements
- A large mass of stool in the rectum
- Stools so large that they obstruct the toilet

A child who has a large and painful bowel movement may become afraid to go to the toilet. Since he fears that going to the toilet might hurt again, he may contract his anal sphincter instead of relaxing it when he tries to push out the stool. This often happens unconsciously and is not the child's fault. If the sphincter is contracted, the stool is not able to come out, stays in the rectum and becomes hard. Eventually, when the child is able to evacuate the hard stool, it can be very painful, and can make the child even more fearful of going to the washroom. This dysfunctional evacuation cycle is illustrated by the following:

Dysfunctional Evacuation Cycle



"So what exactly is a multi-faceted treatment approach?"

A multi-faceted treatment approach targets each element of the dysfunctional evacuation cycle:

1 Decrease anxiety

The child's family must establish and model a positive attitude towards toileting. Caregivers can reward successful attempts at evacuation, for example with stickers on the calendar.

"A recipe for success includes a non-threatening and non-judgemental approach…"

Once the child has successfully evacuated a certain number of times, the parent may give him a special outing, more computer time or a homemade dessert. Failures to evacuate should not be punished, but de-dramatized so that the child has no guilt feelings and maintains a positive approach. The parent can also help the child track his progress and help improve motivation by keeping a bowel and bladder diary.

The parent, caregiver and child should understand exactly what is happening. They should have guidance in dealing with the psychological causes and consequences of the condition. Deep breathing exercises and imagery techniques can help to remove the stress before attempts at evacuation.

2 Decrease the protective contraction at the anal sphincter

The child must learn to relax the anal sphincter and its surrounding muscles while he tries to go to the washroom. Instead of contracting to protect himself from the pain he is afraid of, he should learn to relax his muscles so that there will be less pain. This will help the opening enlarge and allow for stool to pass more easily. Many children are able to relax this muscle instinctively, but some may require the assistance of a health care professional, who can show them specific exercises for opening the anus.

Sometimes, the anal sphincter can be stretched to allow it to open more easily; health care professionals can teach this dilatation technique to parents. Older children can use a biofeedback machine to help them to learn how to contract and relax their muscles. This involves placing electrodes on the skin beside the anus; when the child contracts and relaxes, the movements can be seen on a graph on a computer screen.

3 Decrease the evacuation difficulty

Evacuating stool can be made easier with the proper routine, proper technique and good stool consistency. The washroom should be a comfortable and private place, with no distractions. Give the child enough time to evacuate. Use a toilet insert when necessary, so the child can be well supported and does not fear falling into the toilet. Place the feet on a small bench so the knees can sit higher than the hips, allowing for better relaxation at the anal opening.

The best time for the child to try to go to the washroom is 10–20 minutes after a meal (especially after breakfast). This is when the gastro-colic reflex takes place, which helps to propel the stool for evacuation. Give the child a firm tummy massage (making large circles in a clockwise direction, upwards on the child's right abdomen, across under the ribcage and downwards on his left) for five minutes, just before he sits on the toilet. This will relax the child and can help increase the intestinal activity to assist in evacuation.

It has been found that 63% of constipated children don't use the proper technique when trying to go to the washroom. To evacuate properly, first relax the anal sphincter and surrounding muscles. Then, push gently, simply by holding their breath and contracting their tummy muscles. Sometimes, it can help to breathe out gently as they contract their tummy muscles. It is important not to push too hard, as this can lead to pain.

4 Soften up the large, hard stools

Parents, caregivers and children should know which foods will help them obtain the proper stool consistency, and understand the importance of drinking lots of water each day. Over-the-counter stool softeners can be necessary in extreme cases. Short-term use of laxatives or disempactment of the rectum can be used only if absolutely necessary.

Because up to 70% of constipated children have decreased sensitivity of the rectum, they may not be able to feel the presence of stool. Stool that stays too long in the rectum hardens and is painful to evacuate. Rectal sensitivity can improve significantly once the constipation is resolved.

5 Decrease the pain on evacuation

As the above aspects of constipation are resolved, pain on evacuation will decrease. Deep breathing exercises, relaxation and de-dramatization will help to decrease the pain. Light massage of the perineal area (the skin around the anus) can also be performed. At times, a topical anaesthetic applied around the anus can numb the area prior to attempts at evacuating.

Toilet training is an important phase in the psychological and physical development of the child. To treat constipation, the child must be involved in the entire management process, as it is he who will feel the urge to go and it is he who needs to understand the proper evacuation technique. Parents and caregivers must be closely involved to make dietary modifications, to establish evacuation routine, and to encourage and motivate. A recipe for success includes a non-threatening and non-judgemental approach, with the encouragement of regular bowel habits and a healthful, well-hydrated high-fibre diet. With encopresis, once the constipation is resolved, the problem of incontinence is usually eliminated.

*See **FreePrintableBehaviorCharts.com** for motivational charts*

Continence Q&A

Q: "I don't know when I will have an episode of not controlling my bowels, I can no longer leave the house. The specialists I have seen say there is no cure or treatment, do you have any advice?"

A: It is hard to say without knowing your exact diagnosis, but there are some tips you might try:

Your bowel movements will be less likely to take you by surprise if you have a good regular routine for them. Try going to the washroom every morning, about 20 minutes after your breakfast. If you usually tend to go more than once per day, make a point of visiting the washroom about 20 minutes after every meal. This is when the gastro-colic reflex helps to move the bowels. Once you have emptied completely, you should have time to go out before the next bowel movement comes along.

If your stool is too soft or liquid, it will be more difficult to control. Try to determine which foods you should eat to make your stool more solid, such as rice, cheese and cooked carrots. It may be a good idea to visit a dietitian to help you make the proper food choices.

When you go out or when you are about to leave the house, avoid drinking coffee, tea or colas, as they stimulate the intestines.

Learn to contract the muscles of the pelvic floor and anus. Squeeze for five to 10 seconds when you are trying to control the urge to go. Relax the muscles, and then squeeze again. Repeat this until you make it to the washroom. Visit **www.tena.ca** for a good explanation of how to do pelvic floor exercises.

A physiotherapist might be able to help you if you are having trouble learning how to contract the proper muscles.

Calmly tell yourself that you know that you can make it to the washroom on time. This will help you use specific brain centres that can help you to control the urge.

Q: "Are there any specific absorbent products or 'devices' for bowel incontinence?"

A: Visit your local pharmacy to find a wide range of products available for managing different types of incontinence.

Q: "I have trouble going to the washroom. I have to push very hard for the stool to come out. Any suggestions?"

A: First of all, try to be sure your stool is relatively soft so that it will be easier for it to come out. Drink lots of water every day and eat plenty of fruit and fibre.

When you are sitting on the toilet, place your feet on a small bench so that your knees are higher than your hips. Try to relax your anal sphincter by first squeezing gently in that area and then releasing. Keep the sphincter relaxed and then take a deep breath. Hold your breath for five seconds. Repeat this three or four times. If this has not yet made you go, try to contract your tummy muscles gently as if you are about to cough, which may help.

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