

IN FOCUS

What is Fecal Incontinence?

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Background

Fecal incontinence (FI) is the inability to defer the passage of stool or gas at an appropriate time and place. It can be an embarrassing and debilitating condition that may compromise individuals' social, professional and personal lives. Fecal incontinence results from a variety of factors and may be simple or complex in nature. It is important to understand bowel control to grasp FI.

Bowel control depends on:

- the amount, frequency and consistency of stool,
- a rectum that expands to hold stool and contracts appropriately to empty,
- working anal sphincter muscles to control the outlet,
- proper sensation in the rectum and anal areas, and
- an awake and responsive individual.

Changes in any of these components may lead to fecal incontinence. Furthermore, people living with spinal cord injury, diabetic neuropathy, and multiple sclerosis may develop FI. Evaluation of fecal incontinence requires a medical history and careful physical examination. Additional tests may be needed to identify the cause and choose the best therapy.

Approach to FI

Since fecal incontinence is both a symptom and a diagnosis, it is important to objectively assess each case. During an assessment, a healthcare provider may ask several questions. Individuals should be

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from our guest editors

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in this issue

On a quarterly basis, NAFC loyally brings you the most current facts about bladder and bowel control. And within the last year we have officially expanded our mission to not only provide a host of information about incontinence, but also incorporate the latest news regarding bedwetting, voiding dysfunction and related pelvic floor disorders. During the second quarter of 2007, we will cover overactive bladder and mixed incontinence in post-menopausal women. In the fall issue our focus will be prostate-related problems, such as benign prostatic hyperplasia (BPH) and post-prostatectomy incontinence.

We are eager to announce this as our first newsletter completely devoted to **Bowel Health**. In this issue of *Quality Care*[®] you will take a comprehensive look at the prevention, causes, diagnosis, treatment and management options for fecal incontinence and constipation. ❖

prepared to answer the following questions:

- How frequently do accidents occur? (daily, weekly, monthly, occasionally, never)
- Do you wear pads? If so, how often?
- Has fecal incontinence forced you to modify your lifestyle? If so, how often? What types of modifications have you had to implement?

This information contributes to a scoring system that may be used to understand the severity of the problem.

A description of symptoms, the scoring system, physical findings and additional test results are all used to help a healthcare provider determine which type of therapy is best. Matching the type of intervention with the severity and impact of symptoms is crucial. This assessment can be achieved more quickly and accurately when individuals openly communicate with their healthcare provider.

FI is treatable and controllable. However, successful therapy requires active participation for diagnosis and therapy. Only individuals experiencing FI can determine the severity of the symptoms and its impact on the quality of life. Furthermore, only individuals undergoing treatment can truly assess progress and whether to undergo additional treatment.

Some Causes of Fecal Incontinence

- Vaginal childbirth with injury to the anus or rectum
- Constipation
- Anorectal surgery
- Spinal or pelvic trauma or surgery
- Radiation and chemotherapy
- Diabetes mellitus
- Neurologic diseases
- Tumors of the colon, rectum, pelvis, spine
- Inflammatory bowel disease – ulcerative colitis or Crohn's disease
- Other diarrheal illnesses

Courtesy of Dr. Joshua Katz

Treatment

For some people with mild incontinence, behavioral changes, or a bowel management program, may be all that is necessary. These individuals retain some sphincter function and sensation and can therefore plan their day around predictable, regular bowel function. For others with more complex conditions, fecal continence can be restored through other means offered by a healthcare provider.

Stimulated Defecation

In many cases, bowel management will restore predictability, but not control of bowel movements. Such individuals may benefit from *stimulated defecation*. This regimen involves the regular use of enemas or suppositories along with an anti-diarrhea medication, such as Imodium® or Lomotil®. Enemas or suppositories may be used to stimulate a bowel movement when appropriate and convenient. An anti-diarrheal may then be taken to keep stool from coming down into the rectum until the next scheduled bowel movement. This regimen must be done with a bowel management program further discussed in *A Healthy Balance*), and not merely alone, to avoid excessive constipation. The goal is to stimulate bowel movements at a specific regular time, and constipate oneself for the remainder of the day. Some trial and error is often necessary to predict balance between these agents. The use of a journal to monitor both frequency of bowel movements, meal times, use of fiber and use of the agents is helpful.

Pelvic Floor Rehabilitation and Biofeedback Therapy

Pelvic floor rehabilitation is a method of anal sphincter exercise and sensation training designed to improve the function of weakened muscles and nerves. Using pressure and electrical sensors in the anal canal and rectum, muscles contracted and at rest are shown on a computer screen. This method shows the effect of individuals' efforts. Under the direction of a therapist, this feedback may be used to learn to exercise the muscles or to improve

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Improving Bowel Function and Control

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Who is Affected?

Problems with bowel function are very common; constipation, diarrhea, and irritable bowel syndrome (IBS) are common reasons for visits to the doctor's office and for time lost from work. Problems with bowel control are less common but are thought to occur in about 15% of the population; these conditions occur in men as well as women.

What Are the Causes?

There are a number of factors that can cause or contribute to bowel problems. The most common causes are briefly outlined below:

- **Dietary factors**, such as low fiber diets and inadequate fluid intake, are common contributing factors to constipation and irregular bowel movements. High fat diets can contribute to diarrhea, especially in people with IBS.
- **Medications** and **sugar substitutes** can also contribute to diarrhea and constipation. The two types of medications most likely to contribute to constipation are pain medications, such as codeine, oxycodone, and hydrocodone, and calcium-based antacids, such as Tums®. Medications that contribute to diarrhea are magnesium-based medications such as Maalox® and Mylanta®. Another product that causes diarrhea is sorbitol, an artificial sweetener that is found in many "sugar-free" candies. Although many people do not realize this, sorbitol has a strong laxative effect!
- **Lactose intolerance** is a condition whereby individuals are unable to digest sugars in dairy products. The undigest-

ed sugars cause severe bloating, gas and diarrhea.

- **Irritable bowel syndrome** is a chronic condition that can cause diarrhea, constipation or alternating patterns of diarrhea and constipation. People with IBS typically report bloating and cramping as well as diarrhea or constipation, and many of these individuals find that their symptoms are much worse when they are under a lot of stress. While the cause of IBS is not clear, treatment can provide marked improvement.
- **Surgical procedures** involving the anal canal, rectum or lower back may contribute to problems with bowel control, or the leakage of stool or gas; specific procedures associated with FI include hemorrhoidectomy, or the surgical removal of hemorrhoids, procedures to correct anal fissures, and procedures to reduce lower back pain. While most people undergoing these procedures do NOT develop bowel problems, lower back procedures can cause inadvertent damage to the nerves that control the sphincter muscles and anorectal procedures can cause damage to the nerves or damage to the sphincter muscles themselves.
- **Neurologic conditions** such as multiple sclerosis, Parkinson's disease or spinal cord trauma can all cause problems with bowel control because of damage to the nerve pathways controlling bowel motility and/or the sphincter muscles.

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Constipated? Ask About 'Power Pudding'

- 1 cup unprocessed bran
- 1 cup applesauce, 1/4 cup prune juice

If constipation is persistent, individuals may try this. Start by eating 1 to 2 tablespoons per day and increase the daily amount each week until stool is formed yet soft. Adequate fluid intake must still take place when eating this bran formula. An increase in bloating, gas and stool frequency may occur. As always consult your healthcare provider first.

Courtesy of Dorothy Doughty, MN, RN, CWCN, FAAN

What Can Be Done?

Regardless of the cause of the problem with bowel function or bowel control, there is much that can be done to improve individuals' bowel health and quality of life. The strategies listed below can make a big difference!

- Eat a **healthy diet**; limit the intake of fat and assure adequate intake of fiber and fluid. Fiber is beneficial for people with diarrhea as well as people with constipation because fiber attracts fluid. For people with diarrhea, fiber acts to thicken the stool, and for people with constipation, fiber acts to soften the stool. However, the type of fiber needed by people with diarrhea and people with constipation may differ. Individuals with diarrhea are most likely to benefit from soluble fiber such as fiber supplements, whereas people with constipation benefit both from soluble fiber (fiber supplements) and insoluble fiber (raw fruits and vegetables). It is equally critical to assure adequate intake of fluids. Fiber without fluid can cause an intestinal blockage. Recommended intake for adults is usually eight to ten glasses of fluid a day, and water-based fluids are particularly helpful.
- Try adding **probiotics** to a daily diet. Probiotics are products found in the dairy section of your grocery store that contain “good bacteria” such as lactobacilli. These “good bacteria” interact with fiber in your diet to produce substances that help keep the bowel healthy. Examples of probiotics are DanActive™, kefir, and Activia®.
- **Check medications.** Some medications can contribute to bowel problems. Ask a healthcare provider to explain possible alternatives or adjustments.
- **Stay as active** as possible; regular activity such as walking helps promote normal bowel function and can also help to reduce stress (which makes bowel problems worse for many people).
- **Keep a** “food intake and bowel function” **diary** to log bathroom habits if problems with diarrhea or diarrhea alternating with constipation are frequent. Individuals who keep a record of everything they eat and drink as well as their bowel movements and any bowel-related symptoms can identify any dietary “triggers” for symptoms much easier.

- **Practice** and master “**bowel control strategies**” if there are problems with bowel control related to sudden strong urgency to defecate (which can happen with IBS). Stand still or sit down, contract the sphincter muscles as strongly as possible and for as long as possible, and then focus on deep breathing. Repeat the sphincter muscle contraction and deep breathing till the urgency subsides; then walk slowly to the bathroom.
- **Strengthen weak sphincter muscles** If bowel control related to poor sphincter control is a problem, focus first on maintaining formed stool. A weak sphincter functions best with formed stool. Do sphincter exercises several times a day. This is done by tightening muscles as if trying not to pass gas and hold for as long as possible; then relax the muscles for at least 10 seconds and repeat. Aim for 30 to 45 repetitions per day.
- **Talk to a healthcare provider** about health concerns or changes that have taken place which affect bathroom habits. He or she can help you find the treatment you need.

And Remember

Bowel problems are common among men and women. Common causative factors include dietary patterns, medications, past surgical procedures, and chronic conditions such as Irritable Bowel Syndrome (IBS). In most cases, simple strategies such as a healthy diet, fiber and fluid intake, identification of dietary triggers, and mastery of bowel control strategies and sphincter exercises can produce marked improvement in symptoms and quality of life. And always talk with a health care provider to determine if additional treatment is needed. ❖

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garbanzo beans	1 cup = 9.1 gm
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Constipation: The Move Forward

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An Introduction

Constipation is a word people use to describe difficulty passing stool or infrequent bowel movements. It is a common complaint that has been estimated to affect 10-20% of the population. Constipation means different things to different people. It can mean

- not having a bowel movement often enough,
- not sensing the need to have a bowel movement,
- sensing the need to have bowel movement but not being able to expel some or all of the feces, or
- having to strain excessively or for prolonged period of time on the toilet to achieve a bowel movement.

What Happens?

Constipation occurs when one or more components of digestion become disordered. Some people who cannot properly digest their food may experience diarrhea and constipation. Individuals with cystic fibrosis, Parkinson's disease or diabetes may experience such difficulties. Others may take drugs that interfere with digestion. These health problems may affect gastrointestinal, or digestive, systems.

However, in many cases, constipation may result from a disorder of the colon, pelvic floor or anal sphincters. In these cases, there is a problem with:

- the amount and consistency of stool,
- the passage of stool from the colon to the rectum, or
- ability to evacuate stool from the rectum.

Identifying why a person experiences chronic constipation requires a history of the problem and physical exam. A colonoscopy may be performed to identify polyps, tumors or diseases of the colon and rectum that can cause

constipation. For this procedure, a healthcare provider uses a colonoscope to examine the interior of the colon and rectum. If the colonoscopy is normal, physiology testing, which identifies problems in the digestive process, may begin if needed.

Taking Control Bowel Management

Many people report constipation because they consume insufficient fiber and liquid in their diet. Some dehydrate on the job when they do not drink an adequate amount of water. Others, who travel frequently and have disrupted routines, may not eat proper foods or exercise sufficiently. Eating foods rich in fiber, such as bran, can help. Adding three to six grams per day of either psyllium, methylcellulose or guar gum, along with one to two liters of water per day will relieve constipation in most cases. Gentle aerobic exercise, such as walking, swimming or using an exercise machine, may dramatically improve bowel function.

Medication

When bowel management proves insufficient, there are many laxatives available over the counter and by prescription. These agents are either irritant which trigger the bowels to contract and expel stool, such as: Dulcolax® Bowel Prep Kit, Gentlax® and Senekot®, or osmotic which cause the colon to secrete large amounts of fluid, thereby generating a bowel movement, like Phillips'® Chewable Tablets and Ex-Lax® Milk of Magnesia Stimulant Free Liquid Laxative/Antacid. These are generally useful for periodic, occasional constipation. However, none should be used for more than two days without the evaluation and recommendation of a healthcare provider.

There are medications available that stimulate intestinal activity. Others increase intestinal secretion. Both types of drugs may provide relief in certain cases. These medications are given by prescription only and should be taken under the guidance of a healthcare provider.

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awareness of rectal filling. Pelvic floor rehabilitation therapy generally requires several sessions with a therapist and regular exercise at home.

Surgical Treatment

Most people with fecal incontinence will not require surgical correction. Yet selected individuals may benefit from it. Surgery is not for everyone as it involves varying degrees of risk and complications.

A number of surgical procedures and techniques exist for the treatment of fecal incontinence. These range from low risk outpatient treatments to complex reconstruction with use of prostheses. Among these are:

- **Injection of bulking agents:** A variety of synthetic agents are available to increase the bulk of tissue around the anal area. These can be injected either under local or general anesthesia. This is a low risk, outpatient procedure.
 - **Sphincteroplasty:** This is a surgical repair of a damaged anal sphincter. It involves surgery under general anesthesia and approximately three days of recovery. There are significant risks to this procedure, though it is performed using only the patient's tissues.
 - **Artificial bowel sphincter:** Here, a prosthetic device is used to replace a defective or damaged anal sphincter. An implanted inflatable cuff is placed around the anal muscles and connected to a pump placed in the scrotum in men and the labia in women. This procedure carries a significant risk of infection but when successful can restore continence in appropriately selected patients.
 - **Colostomy or ileostomy:** Fecal incontinence can be cured with artificial openings in the abdominal wall either through the colon or small intestine, respectively called a colostomy or ileostomy. Properly placed and constructed, this opening, or stoma, will restore control over bowel function. However, this requires a surgical procedure, general anesthesia, and introduces a major change in body image and way of life.
- The following treatments are still in the research stage.

- **Radiofrequency Treatment:** This outpatient procedure is performed under anesthesia. Radio wave energy is applied to the anal canal tissue to produce a mild scar. This new barrier helps prevent involuntary stool leakage.

- **Sacral nerve stimulation:** This treatment involves stimulating the nerves that control sphincter function with a pacemaker implanted in back muscles near the tail bone. It is still in the research phase but holds much promise.

Summary

Fecal incontinence can ruin lives. It must be evaluated thoroughly with appropriate medical and physiologic evaluation. Treatment includes dietary and medical management, biofeedback therapy and pelvic floor retraining, and where necessary, appropriately selected surgical procedures. Effective management comes from a partnership in which patients and their doctors match appropriate therapy and risk to maximize quality of life. ❖

IN THE SPOTLIGHT

International Foundation for Functional Gastrointestinal Disorders (IFFGD)

Gastrointestinal disorders can be painful, frustrating and difficult to understand. The International Foundation for Functional Gastrointestinal Disorders (IFFGD) is a non-profit education and research organization dedicated to informing, assisting and supporting individuals living with GI disorders. Founded in 1991 by the IFFGD President Nancy Norton and her husband William, the group has gone to great lengths to support research, professional education and awareness activities. Please visit their Web site at www.iffgd.org or call **1 (888) 964.2001** to learn more about what IFFGD can do for you. For those with internet access, look for other related Web sites such as:

aboutConstipation.org
aboutGERD.org
aboutIBS.org
aboutIncontinence.org

aboutKidsGI.org
aboutgiMotility.org
giResearch.org

Fecal Incontinence in Women: Exploring the Link to Childbirth

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The Concern

Reduced control over the bowels is one of the most distressing and embarrassing problems faced by women after childbirth. Unfortunately, it's far more common than once believed. By age 45, the problem is eight times more prevalent in women than in men, occurring in nearly 25% of women with a previous vaginal delivery.

In recent years, we've learned that all of the following types of anal incontinence can occur in otherwise healthy individuals.

- **Fecal Incontinence:** Accidents involving solid or liquid stool, impacting anywhere from 0.5 – 15% of the general population, and 10% of women after childbirth in their forties to some degree. Higher rates seem to be found with increasing age, increasing numbers of children, and obesity.
- **Flatal Incontinence:** Loss of control over gas, reported by up to 26% of women after childbirth and also increasing with age for both women and men.
- **Fecal Soiling (or 'seepage'):** Soiling of underwear and inability to keep oneself clean, self-reported by around 10% of post-reproductive women.

The Link

Childbirth is an important cause of fecal incontinence in women, along with the other major risk factors that include age, obesity and gastrointestinal disease. The Evanston-Northwestern Twin Sisters Study (Obstetrics and Gynecology, 2005)

recently examined this condition in 542 identical twin sisters. Identical twin studies offer unique insight into health problems because the twin pairs share identical age and genetics – as a result, the impact of 'environmental' risk factors (such as childbirth) on disease conditions (such as anal incontinence) can be more accurately assessed. In this study, when childbearing and non-childbearing women were compared, rates of fecal incontinence increased more than three-fold after two deliveries. Women with two or more deliveries also reported higher levels of psychological distress over colorectal symptoms. The study suggests that anal incontinence should be considered a key post-reproductive problem, becoming much more common in younger women who have delivered several children.

But what exactly is the damage that occurs for some women during pregnancy, labor and delivery, leading to anal incontinence in the post-childbearing years? And can these injuries be prevented? The reasons appear to relate to injuries involving muscles, nerves, connective tissues, or all of these structures.

The Causes

Anal Sphincter Muscle Injury

To keep you continent of stool, the anal sphincter muscles normally encircle the anal opening like a donut. When functioning properly, these muscles provide constant involuntary pressure even at rest. They should also have the ability to tighten the anal opening even more strongly in order to control fecal urges. During childbirth, the anal sphincter muscles can be torn par-

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Biofeedback

In previous issues, we have explained the value of using biofeedback for urinary incontinence and to assist in identifying and strengthening the pelvic floor. Now healthcare providers are using the same therapy for people who experience fecal incontinence to identify and gain control of sphincter muscles. If you have fecal incontinence or think you might benefit from using biofeedback, talk to your healthcare provider today!

Physiologic Testing

Further evaluation is needed when constipation does not respond to dietary and medical management. This includes:

- a colonic transit study to evaluate the colon,
- defecography, or imaging of the passage of stool,
- anal manometry, and
- electromyography.

The last two evaluations study the nerves and muscle tone and function of the structures involved in passing stool.

These studies can identify the following disorders.

Colonic Inertia

Certain patients have difficulty passing stool through the colon. The colon, a large hollow muscular tube, contracts as it pushes stool toward the rectum. In some individuals the colon cannot do this sufficiently and stool accumulates in the colon. People with this condition usually experience difficulty in their teenage years and continue to do so throughout life. They do not sense the urge to pass a movement, but instead feel full, bloated, and may have chronic abdominal pain. They can go 1-2 weeks without a bowel movement. When they do pass stool, they can pass a giant movement that can cause severe pain and require exhaustive maneuvers such as prolonged straining or pressure on the belly. Often times, these individuals depend on large doses of laxatives to achieve a bowel movement.

Pelvic Floor Disorders

Some people with constipation may sense the urge to have a bowel movement but cannot actively pass stool unless they strain excessively. These people generally have a disorder of the pelvic floor, or the muscles that support the pelvis and its organs including the urethra. These muscles may be weakened through surgery, childbirth, trauma or radiation. As these individuals attempt to pass stool, the force of defecation is displaced from the anal canal and defecation is blocked as a result.

There are various types of pelvic floor disorders and

diagnosis usually requires defecography, which is the radiological imaging of the passage of stool during a bowel movement. These conditions can be managed somewhat with medication, but when this proves insufficient, surgical repair may be indicated by a healthcare provider.

Paradoxical Puborectalis Dysfunction (Anismus, Levator Syndrome)

This term refers to loss of coordination of the structures and muscles necessary for effective bowel function. To pass stool, contracting some muscles is required to generate downward force. Then relaxing the sphincter muscle, and another muscle called the puborectalis, allow the anus to open. Some people cannot do this well and try to defecate while the sphincters are contracted and the anus is closed. Individuals with this problem may have had prior anorectal surgery for another condition, may have abdominal and pelvic pain, or may have a history of physical or psychological abuse. This may be diagnosed on physical examination and confirmed with the physiology tests mentioned previously. It should be noted that this condition should not be treated with surgery. Rather, biofeedback therapy and pelvic floor retraining, together with bowel management has been shown to be most helpful.

Conclusion

Constipation can result from conditions affecting the entire body, from dietary habits and lifestyle, medications, medical disorders, an issue with the colon, a condition with the pelvic floor muscles, and poor muscle coordination. Evaluation should start with individuals sharing their history and undergoing physical examination. After this, most will improve with a regimen of fiber and fluid intake. Laxatives and new medications recently approved by the FDA, tegaserod and lubiprostone, may be helpful when advised and supervised by a healthcare provider. Beyond this, physiology testing is necessary to distinguish those who need physical therapy and those who may benefit from other methods, such as surgery. ❖

tially or completely, leading to a loss of bowel control. Among three million vaginal deliveries each year in the U.S., it has been estimated that nearly 5 percent (150,000) are complicated by a torn anal sphincter, and 25% of these injuries (40,000) will lead to anal incontinence later in life. Interestingly, even in cases where the anal sphincter appears intact after childbirth, hidden injuries detectable with anal ultrasound have occurred up to 34% of the time with a woman's first vaginal birth, and in up to 44% after two or more vaginal births. Rates are even higher after episiotomy (an incision to the perineum and vagina) and/or forceps delivery. Fortunately only a fraction of these hidden injuries will cause a problem later in life.

Even if the external anal sphincter sustains childbirth intact and maintains continence of stools, damage to the less visible internal anal sphincter may occur, leading to gas, or flatal, incontinence. Unlike the 'donut shaped' external sphincter, the internal sphincter muscle is a thin, sheet-like layer surrounding the rectal tube. It is thought that an intact internal sphincter is essential in maintaining the rectum as a high-pressure area, giving you the ability to sense the presence of gas and appropriately deal with it.

Nerve Injury

It is known that nerve injuries occur in the majority of vaginal deliveries, and this may have a long-term impact on pelvic muscle strength. The fact that anal incontinence can develop in women who delivered only by cesarean (with no delivery through the vagina), is cited as a strong argument that neurological changes during pregnancy may play a role in causing anal incontinence later. However vaginal births – especially traumatic vaginal births involving long labor, forceps or especially large newborn weight – do tend to introduce the highest risk of neurological injury.

Connective Tissue Injury

For some women, tissues supporting the vagina can be significantly weakened by labor and delivery resulting in the descent of pelvic organs, or pelvic organ prolapse. Various organs may potentially be affected, but when this weakening occurs in the

portion of the vagina lying adjacent to the rectum, a rectocele, or support problem in the wall of the vagina that separates the bladder and vagina, may form. Rectoceles form a pocket that can create difficulty passing stools, feelings of incomplete defecation, and in some cases fecal incontinence. Some women notice fecal urgency, accidental passage of stool when sitting to urinate, or the need for splinting, which means using a finger, or several fingers, to push down around the vaginal wall or rectal area in order to assist with defecation.

The Reality

Though injury of the anal sphincter muscle, nerves and connective tissue may be caused during childbirth, there are steps to take which improve bowel control. A great number of women can alleviate anal incontinence symptoms without any procedure or surgery – starting with lifestyle, habit changes and pelvic muscle exercises. Talk to a healthcare provider about changes in your body and the restorative options available.

More to Come

Stay tuned for the second part of this article in our next issue of *Quality Care*®. Dr. Goldberg will explain effects of c-sections on bowel function. He will also lay out steps for improving bowel control and what to expect when visiting a specialist. Look in the 'Bottom Line' article to learn more about bowel health. ❖

PERSONALLY SPEAKING

Years ago, my first daughter was a breech birth. During the birthing process, my doctor performed an episiotomy procedure (an incision through the perineum which enlarges the vaginal opening). Later in life, I began experiencing fecal incontinence. I was frustrated and unable to find help. It seemed the only remedies I could find were medications for urinary incontinence.

I searched for management options and finally found one that works for me. After watching an OB tampon commercial, I decided to use one as a "plug" in my rectum. It worked perfectly and gave my life back to me. I love to snorkel and go on vacations several times per year. At 78 years old, I am planning more trips because of the security I have. And I am so thrilled that NAFC has added bowel health to their mission! ❖

-- Betty in California

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FROM THE HEADQUARTERS

Gastroenterologist Robyn Nagel has teamed up once more with noted physiotherapist Shirley Owen to co-author their third edition of **The Good Bowel Habit**. Published in Queensland, Australia, this condensed monograph is intended for women as a self-help guide aimed at improving their understanding and thus management of chronic constipation, difficult bowel evacuation, and fecal incontinence. It is without question the single most comprehensive yet remarkably accessible treatise on this topic that I have read in recent years. I am grateful that the authors have shared a copy with us here in the U. S. so that I in turn can recommend it to you.

The overarching goal of the publication is to establish healthy habits, anchored by an educated appreciation for how the lower intestinal tract is designed to function. For orientation, Ms. Owen and Dr. Nagel take the reader on a brief journey through the landmarks of the GI tract, from the esophagus to the anus. We learn about such things as the absorption of nutrients, how food is propelled through the bowel (“motility”), how fats differ from simple sugars in transit time, and the role of our individual bacterial profiles.

In this backdrop, the pelvic floor is described and illustrated in detail, including useful and concrete tips for women on identifying these particular muscles. What is perhaps most valuable is the connection drawn between the importance of maintaining correct postural balance and the help of the core stability muscles of the abdominal wall, spine, and pelvic girdle in maintaining and re-establishing continence. In fact, the significance of proper posture is repeated throughout instructions in how to correctly perform pelvic floor muscle exercises as well as how to empty the bowel most effectively and without harmful muscle strain. As readers, we cannot help retaining the key message that a strengthened pelvic floor, in combination with a discipline about posture, is central to ideal bowel habits, as much as diet and routine physical exercise.

In addition, the four common types of constipation are discussed; namely: simple, slow transit, obstructed defecation, and combined slow transit-obstructed defecation. The clinical team explains each of these diagnostic categories and in turn offers techniques for remedies in addressing them.

The closing section of the book addresses management of fecal incontinence, anal fissures, hemorrhoids, varicose veins in the vulval area at the entrance to the vagina, persistent pain in the rectum and around the tailbone, and anismus (i.e., the medical term given to a condition in which a woman is unable to fully relax her pelvic floor with defecation, often resulting in constipation, incomplete evacuation, and straining to pass stool).

In sum, the publication spotlights four essential factors that must be optimized to achieve and maintain good bowel health; namely: stool constancy, comfort, frequency, and ease of evacuation. All of this – and more – is covered in fewer than 50 pages and accompanied by simplistic, easy-to-grasp illustrations.

Inquiries for pricing and ordering should be directed to:

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