KNGF Evidence Statement

Anal incontinence

Royal Dutch Society for Physical Therapy

Methodical approach

Direct Access to Physical Therapy

recommendation: contact family physician/specialist (with patient's permission)

Referral

Red flags*

- (recent) trauma
- pre-existing (unexplained) fever
- recent unexplained weight loss (> 5 kg/month)
- prolonged use of corticosteroids
- constant pain that does not decrease at rest or after changing position
- history of cancer
- general malaise
- nocturnal pain
- extensive neurological signs and symptoms
- inability to urinate/defecate
- blood and mucus in stools
- pain during defecation
- acute loss of stools
- abnormal color of stools not related to food consumed
- brief anemia episode

* Attention to red flags is required throughout the diagnostic and therapeutic process for physical therapy.

(Supplementary) history

- reason for contact and patient's presenting problem
- nature (underlying cause/condition) and severity of anal incontinence (in ICF terms) and modifiability (impeding factors, general and local)
- proctological, gynecological, obstetrical, urological and sexological history in relation to the musculoskeletal system
- comorbidity
- coping strategies
- psychosocial problems
- defecation and micturition patterns
- nutrient and fluid intake
- status of components of continence system (muscle function, reservoir function, consistency of stools, awareness and acknowledgment of health problem; interactions between these)
- patient's pattern of expectations

Physical examination

General inspection

- inspecting breathing, spinal column, pelvis, hips, gait analysis

Local inspection of vagina/anus/perineum

- inspecting pelvic floor at rest (introitus, perineum, vagina, anus)
- inspecting pelvic floor during contraction (contraction strength, performance, co-contractions and breathing)
- inspecting pelvic floor during coughing
- inspecting pelvic floor during straining

Supplementary functional examination

- palpation at rest, anorectal
- palpation during contraction, anorectal
- palpation during straining, Valsalva, coughing (involuntary) rectal
- rectal balloon and electromyography

Measurement instruments

- Wexner score
- Global Perceived Effect
- defecation diary

Physical therapy analysis/diagnosis (consequences of anal incontinence)

identification of impairments (nature, severity), limitations and participation restrictions

© KNGF

Identification of problem category: I, II, III en IV									
Treatment plan for patients with anal incontinence									
	I–II anal incontinence with pelvic floor dysfunction						**III anal incontinence without pelvic floor dysfunction**	**IV anal incontinence (I/II/III) + general factors impeding recovery or adjustment processes**	
	I with awareness of loss of stools (urgency): external anal sphincter + m. puborectalis/levator ani				**II without awareness of loss of stools (passive): internal anal sphincter**				
	neurological problem[a]				neurological problem[b]				
	yes (local/central) no				yes (local/central) no				
	anorectal sensation normal 3rd/4th degree tear traumas		**anorectal sensation abnormal** peripheral dysfunction spinal cord S2–S4						
Disorder	**IA** • without voluntary control of pelvic floor[c]	**IB** • without involuntary control of pelvic floor	**IC** • with voluntary control of pelvic floor[c]	**ID** • plus negative effects on pelvic floor muscle function from respiratory problems, musculoskeletal problems and/or toileting posture, regime and/or behavior	**IIA** **anorectal sensation normal** • 3rd/4th degree tear • traumas • overflow diarrhea • paradoxical straining	**IIB** **anorectal sensation abnormal** • peripheral dysfunction • spinal cord S2–S4 • pelvic organ prolapse (POP)[d]	**III** • reduced rectal capacity • intestinal system function problems[e] • fecal consistency • soiling • loss of discrimination between flatus and feces	**IVA** **without comorbidity** • diet • medication for constipation (incl. antimuscarinic drugs M3/M4), diarrhea, sensitivity, cognition, muscle relaxants	**IVB** **with comorbidities** • increased sensitivity (chronic fatigue, chronic stress, difficulty concentrating) • neurological, urological, gynecological, endocrinological, psychological and cognitive problems • connective tissue diseases • chronic obstructive pulmonary disease (COPD) • morbid obesity • eating disorders • panic/anxiety/ psychosis • functional problems relating to toileting

Goal	improving components of continence : 1. muscle function: basic activity, timing, coordination, relaxation, duration, reflex activity (fast-twitch/slow-twitch) 2. reservoir function (perception of filling sensation): first sensation, first feeling of urgency, maximum tolerable volume, appropriate reaction of pelvic floor to rectal filling (= being continent) 3. fecal consistency: from loose to soft shaped 4. recognition of health problem, acknowledgement of health problem, expression (uttering, setting in motion) and letting go* 5. interaction between the above continence components								
Strategy	optimizing one continence component → optimizing the complex mechanism of continence components → making ADL tasks become automatic								
Therapy	providing education and advice								
	IA • verbal instruction • ES for PFMT (m. puborectalis / external anal sphincter) • ES separate • BF when in doubt about pelvic floor contraction capacity	**IB** • training to reduce anorectal angle • training pelvic floor during trunk stabilization	**IC** • PFMT • BF[f]	**ID** • exercises to address unfavorable factors • PFMT • BF[f]	**IIA** • PFMT • BF[f]	**IIB** • PFMT • BF[f]	**III** • PFMT Note: complete recovery unlikely	**IVA** • addressing impeding factors where possible • informing patient about what exercise therapy can and cannot achieve • PFMT • BF[f]	**IVB** • addressing impeding factors where possible • informing patient about what exercise therapy can and cannot achieve • PFMT • BF[f]
	• voluntary control present PFMT • voluntary control absent refer to family doctor/ medical specialist								
Evaluation	evaluating the outcome: Wexner score, Global Perceived Effect, defecation diary								
Follow-up	checkup at predefined moment(s) → brief reminder therapy (if necessary)								

ES = electrostimulation; PFMT = pelvic floor muscle training; BF = biofeedback (electromyogram, pressure and rectal balloon).

a. without neurological problem (motor); local neurological problem (motor): n. pudendus lesion (S2–S4), iatrogenic; central neurological problem: coordination problem.
b. without neurological problem: 3rd/4th degree tear, traumas, overflow diarrhea, paradoxical straining; local or central neurological problem (sensory): n. pudendus lesion (S2–S4), iatrogenic.
c. voluntary control, i.e. 'awareness'.
d. pelvic organ prolapse (POP).
e. overflow diarrhea, irritable bowel syndrome, Morbus Crohn, colitis ulcerosa.
f. biofeedback (EMG/pressure/rectal balloon training): if insufficient progress and to speed up results.

*Dutch acronym HEEL: **H**erkennen van gezondheidsprobleem, **E**rkennen van gezondheidsprobleem, **E**xpressie (uiten, in beweging brengen) en **L**oslaten (eigen maken)

The full-text Evidence Statement is available from www.fysionet-evidencebased.nl

© KNGF