**Anal incontinence**

**KNGF Evidence Statement**

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.

**Methodical approach**

**Direct Access to Physical Therapy**

_recommendation: contact family physician/specialist (with patient’s permission)_

**Referral**

- 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 vaginal/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_

The full-text Evidence Statement is available from [www.fysionet-evidencebased.nl](http://www.fysionet-evidencebased.nl)
## KNGF Evidence Statement

### Anal incontinence

#### Identification of problem category:

<table>
<thead>
<tr>
<th>I-II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>anal incontinence with pelvic floor dysfunction</td>
<td>anal incontinence without pelvic floor dysfunction</td>
<td>anal incontinence (I-III) + general factors impeding recovery or adjustment processes</td>
</tr>
</tbody>
</table>

#### Treatment plan for patients with anal incontinence

<table>
<thead>
<tr>
<th>Disorder</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>without voluntary control of pelvic floor</td>
<td>without awareness of loss of stools (urgency): external anal sphincter + m. puborectalislevator ani</td>
<td>without awareness of loss of stools (passive): internal anal sphincter</td>
<td>neurological problem^a</td>
<td>neurological problem^a</td>
</tr>
<tr>
<td>yes (local/central)</td>
<td>no</td>
<td>yes (local/central)</td>
<td>no</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>anorectal sensation normal</th>
<th>anorectal sensation abnormal peripheral dysfunction</th>
<th>Spinal cord S2–S4</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-12 degree tear, traumas</td>
<td>overflow diarrhea, paradoxical straining</td>
<td></td>
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</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>IA</th>
<th>IB</th>
<th>IC</th>
<th>ID</th>
<th>IIA</th>
<th>IIB</th>
<th>III</th>
<th>IVA</th>
<th>IVB</th>
</tr>
</thead>
<tbody>
<tr>
<td>verbal instruction</td>
<td>training to reduce anorectal angle</td>
<td>with voluntary control of pelvic floor</td>
<td>plus negative effects on pelvic floor muscle function from respiratory problems, musculoskeletal problems and/or toileting posture, regime and/or behavior</td>
<td>anorectal sensation normal: 3-12 degree tear, traumas, overflow diarrhea, paradoxical straining</td>
<td>reduced rectal capacity</td>
<td>elimination of impeding factors where possible</td>
<td>increased sensitivity/chronic fatigue, chronic stress, difficulty concentrating</td>
<td></td>
</tr>
<tr>
<td>ES for PFMT (m. puborectalislevator ani) ES separate BF</td>
<td>training pelvic floor during trunk stabilization</td>
<td></td>
<td></td>
<td>anorectal sensation abnormal peripheral dysfunction spinal cord S2–S4 pelvic organ prolapse (POP)^a</td>
<td>intestinal system function problems</td>
<td>medication for constipation (e.g. antimuscarinic drugs, My/ MA), diarrhea, sensitivity, cognition, muscle relaxants</td>
<td></td>
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</tr>
<tr>
<td>BF</td>
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#### Evaluation

- Evaluating the outcome: Wexner score, Global Perceived Effect, defecation diary

#### Follow-up

- Checkup at predefined moment(s) → Brief reminder therapy (if necessary)

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^a: Electrostimulation; PFMT = pelvic floor muscle training; BF = biofeedback (electromyogram, pressure and rectal balloon).

- without neurological problem (motor); local neurological problem (motor): n. pudendus lesion (S2–S4), iatrogenic; central neurological problem: coordination problem.
- without neurological problem: 3-12 degree tear, traumas, overflow diarrhea, paradoxical straining; local or central neurological problem (sensory): n. pudendus lesion (S2–S4), iatrogenic.
- voluntary control, i.e. ‘awareness’.
- pelvic organ prolapse (POP).
- overflow diarrhea, irritable bowel syndrome, Morbus Crohn, colitis ulcerosa.
- biofeedback (BMG/pressure/rectal balloon training): if insufficient progress and to speed up results.

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