INCONTINENCE Aetiology

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Continence is dependent upon the structural and functional integrity of both the neurological pathways and the gastro - - intestinal tract. The risk factors for incontinence are many (Table 80.1). Patients complaining of the involuntary loss of rectal contents require a comprehensive assessment of the nature and severity of symptoms; past history , especially of gastrointestinal disease, neurological conditions, obstetric events and anorectal surgery; and clinical examination including sigmoidoscopy and/or colonoscopy as indicated. Soren Laurberg , contemporary , Professor of Surgery , Aarhus , Denmark. diagnostic, but special investigations are then usually required to clarify the exact cause, including exclusion of an underlying malignancy , and to direct management. Faecal incontinence is a symptom not a diagnosis and an underlying cause should be sought. Faecal loading or impaction is a major contributor to incon - tinence in the elderly . A rectum impacted with faeces can result in ‘overflow incontinence’. This is easily diagnosed on digital examination and rectally administered treatment to clear the bowel, followed by regular c hecking to avoid recurrence. When ‘empty’ on digital examination or when there is no relief from incontinence after evacuation of faeces, the three main mech - anisms (sometimes acting in combination) that contribute to incontinence are: loose stool, reduced rectal volume/compli - ance and anatomical and/or functional injuries to the anal sphincter complex. Sphincteric causes of incontinence may be classified as structural, in which ther e is disruption (or atrophy) of part of the sphincter muscles; neuropathic (previously ter med idio - pathic), in w hich the nerve supply to the sphincters is damaged, usually by chronic straining or complicated vaginal delivery (prolonged second stage); or a combination of the two. The most common causes of sphincteric disruption are obstetric damage, anal surgery (following haemorrhoidectomy , dilata - tion or sphincterotomy for anal fissure, and fistulotomy for anal fistula) and trauma (including anal intercourse, forced or oth - erwise). Incontinence may also arise following major colorectal resection with a colorectal or coloanal anastomosis owing to the reduction or loss of the rectal reservoir and disruption of intramural nerve pathways. Function can be further adversely a ff ected by radiation. This is now known as low anterior resec - tion syndrome (LARS) (Laurberg).

(c) (d) A' A Figure 80.9 Off-midline closure techniques for pilonidal sinus. Kary dakis’s operation (a) :

an off-midline incision is made around the sinus complex, which is excised, and a contralateral /f_l ap is mobilised to allow tension-free off-midline closure (b) . The Limberg /f_l ap (c) sinus complex is excised using a rhomboid incision and a measured /f_l ap is r otated (A) to (A') to achieve tension-free closure (d) . (a) Figure 80.10 (a, b) Bascom’s technique for pilonidal sinus (a) ; lateral incision and curetting cavity permission from O’Connell PR, Madoff RD, Solomon MJ (eds). Press, 2015.)

: the (b) (b) ; excision midline pits. (Reproduced with Operative surgery of the colon, rectum and anus , 6th edn. Boca Raton, FL: CRC

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Congenital/ Anorectal anomalies childhood Spina bi /f_i da Hirschsprung's disease Behavioural Acquired/ Diabetes mellitus adulthood Cerebrovascular accident Parkinson's disease Multiple sclerosis Spinal cord injury Other neurological conditions: Myotonic dystrophy Shy–Drager syndrome Amyloid neuropathy Gastrointestinal infection Irritable bowel syndrome Metabolic bowel disease In /f_l ammatory bowel disease Megacolon/megarectum Anal trauma Abdominal surgery: Small bowel resection Colonic resection Pelvic surgery: Hysterectomy Rectal excision Pelvic malignancy Pelvic radiotherapy Rectal prolapse Rectal evacuatory disorder: Mechanical, e.g. rectocele, intussusception Functional, i.e. pelvic /f_l oor dyssynergia Anal surgery: Haemorrhoidectomy Surgery for /f_i stula Surgery for /f_i ssure Rectal disimpaction Obstetric events General Ageing Psychobehavioural factors Intellectual incapacity Drugs: Primary constipating and laxative agents

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