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Diagnosis & Management of Fecal Incontinence: Obstetric Injury & Defecation Issues

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Disclosures

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Susan T Wolgamott, DNP, FNP-C, CTN-B

Speakers Bureau: AbbVie, Clinical Area- IBD, EPI, IBS-D, IBS-C, CIC
Speakers Bureau: Salix, Clinical Area- IBS-D IBS-C, CIC, HE
Speakers Bureau: Nestle, Clinical Area- EPI
Speakers Bureau: BMS, Clinical Area- IBD
Speakers Bureau: QOL, Clinical Area- CSID
Consulting: BMS, Clinical Area – IBD
Consulting: Salix, Clinical Area – HE, IBS-D, CIC, IBS-C
Consulting: Nestle, Clinical Area- EPI
Consulting: QOL, Clinical Area- CSID
Disclosures

Susan T Wolgamott, DNP, FNP-C, CTN-B

Sub-Investigator: Clinical Research Institute of Michigan, Clinical Area – IBD, IBS-D, IBS-C, CIC, chronic pancreatitis, gastroparesis, GERD, EoE, colonoscopy prep, NASH, cirrhosis, HE, Celiac disease, genetic studies, primary care studies, alopecia areata
Red, 32 Year Old AA Male

- CC: Abdominal pain
- HPI: Three month hx of R and LUQ abdominal pain, sharp/stabbing, bloating and new constipation. He has tried multiple OTC remedies, but they all cause diarrhea and incontinence. He is unable to pass hard stool without significant straining and/or manual disimpaction.
Red, 32 Year Old AA Male

• ROS:
  – No history of bowel obstruction or bowel surgeries.
  – No FHx of CRC or IBD
  – Mild essential HTN
  – Type I DM x 10 years. Last A1c 10.4. Complications of his DM include:
    • Recent CVA (no residual)
    • Neuropathy
    • Mild CKD
Results of Tests/Labs

- Prior testing: ER visit x3 with normal CBC, Lipase, Trop, EKG, UA, US, CMP with Cr 1.6 GFR 65, VS normal. CT abd/pelvis w/ contrast normal except for large stool burden.

- Tests ordered on the first visit: Rectal exam and 2 view Xray.

- Results
  - Results of clean out sent home from ER: **Dismal**
  - Xray showed:
Large Stool Burden: No Impaction
Results of Tests/Labs

- He was given a trial of linaclotide with PEG daily at the first visit

- Results:
  - First stool is hard with straining, followed by several loose explosive stools
  - He had leakage of liquid stool several times a day after the initial stooling
Differential Diagnoses

- Diabetic Enteropathy
- Colonic inertia vs IBS-C
- Anorectal dysfunction
  - Rectocele
  - Impaired sensation and/or muscle strength
  - Prolapse
  - Polyp/Hemorrhoid
Results of Tests/Labs

- Tests ordered 2nd visit:
  - ARM
  - MR defecography
- Optimize bowel regimen
- Results
  - Abnormal sensation but normal sphincter control
  - Small ant rectocele with retained fecal material in rectal vault after several attempts.
  - Bowel regimen results were similar to first attempt and patient now missing work
Diagnosis

- What further workup options should be considered?
  - Full colonoscopy
  - Colon transit test
  - SBFT
  - Anoscopy

Final Diagnosis?

Diabetic Enteropathy causing slow transit constipation and anorectal dysfunction
Treatment Options

• What options are available for this patient?
  – Further manipulate the stool consistency and motility to help facilitate evacuation
  – Encourage excellent glucose management
  – Pelvic floor therapy
  – Surgical referral
  – Sacral nerve stimulator
Patient Follow-Up

- What follow-up is necessary?
  - Education
    - Nature of condition and evolution
    - Alarm symptoms
    - Colorectal cancer screening at 40? or 45? or 50?
      - American Cancer Society
      - USPF
      - ACG
      - Insurance companies
Christina, 27 Year Old Asian Female

- CC: Fecal Incontinence
- HPI: G2P2, 6 months PP with her 2nd child. Two traumatic vaginal births w/ large babies (>4000gm), episiotomy w/ 1st & forceps w/ 2nd. She weaned the 2nd recent & started weight loss plan to shed her baby weight using shakes & supps. Change in bowel pattern with 2-4 loose stools/day, accompanied by urgency & 2-3 episodes of fecal incontinence/day
Christina, 27 Year Old Asian Female

- ### ROS:
  - G2P2A0
  - No major perinatal or postpartum complications
  - Vaginal trauma repaired by OB at bedside. No infections
  - Mild pre-eclampsia with 1st pregnancy
  - No other medical or surgical history
  - VS normal
  - Denies voiding/urinary issues
  - Menses resumed this month, heavier than usual, no hormonal contraception
Results of Tests/Labs

- No prior testing
- Standard post partum labs were unremarkable
- No laxation or anti-diarrheals
- Rectal exam was normal
- Denies other rectal trauma or surgeries
- Admits to doing 100s of Kegel’s daily to restore tone
Differential Diagnoses

- Hormonal changes affecting bowel pattern
- Diet changes causing the stool consistency
- Sphincter damage causing insufficient tone and sensation
Testing/Results

- Trial of diet moderation
- Avoiding lactose and whey based supplements
- Anorectal manometry
Testing/Results

- Stool consistency & frequency improved with diet changes
- Continued to leak stool between bowel movements with continued urgency
- Manometry showed impaired sensation and poor sphincter pressures
Diagnosis

• Final diagnosis?
• Anorectal dysfunction
  – Caused by obstetric trauma
  – Further provoked by diet and hormonal changes
Treatment Options

- Increased fiber/modulation of stool consistency
- Pelvic floor therapy
- CRC consult for over lapping sphincteroplasty
Patient Follow-Up

• What follow up is necessary?
  – Further intervention?
  – Counseling therapy?
    • Psychologic strain
    • Functional strain
    • Depression
    • Social isolation
      – New baby
      – Incontinence