PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #424
FECAL INCONTINENCE IN PALLIATIVE CARE SETTINGS
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Background: Fecal Incontinence (FI) is the loss of control on bowel function resulting in involuntary loss of solid or liquid feces (1). It is common among patients with serious illness (2-4), afflicting 40-50% of home hospice patients and nursing home residents (2,5). FI has been linked to social distress, isolation, embarrassment, care-giver distress, health care costs, and reductions in quality of life (QOL) (6). It may even correlate with a worse prognosis in older populations (7). This *Fast Fact* assimilates the published evidence on FI to describe risk factors and management options for patients with serious illness.

Risk Factors for FI in patients with serious illness: (2,8,9): Age, immobility, dementia, and an anticipated prognosis of days to weeks are all associated with FI. Additional risk factors include:
- Severe constipation or fecal impaction leading to overflow diarrhea
- Polypharmacy
- Medications like laxatives, antibiotics, and chemotherapeutic agents
- Recent abdominopelvic radiotherapy
- Spinal cord injuries including tumor compression of the spinal cord or sacral plexus.
- Diet high in fruits and milk
- Enteral tube feeding.

History and physical examination: Clinicians often do not broach the subject of incontinence because of a mistaken belief nothing can be done for it (8). Also, they may not appreciate the impact FI has on QOL. Similarly, patients may not volunteer the symptom (8). Clinicians should routinely screen patients with serious illness if they are experiencing FI, especially if they are elderly or have risk factors. For example, "*Do you ever leak stool?"* If present, clinicians should ascertain for potentially reversible factors (e.g., infections, malabsorption, medication side-effects) (10). Asking about recent hospitalizations and recent use of broad-spectrum antibiotics is important to assess risk for *c diff* infection. Physical exam should focus on mentation, mobility, hydration status, abdominal palpation, and auscultation. A rectal exam is recommended when there is clinical suspicion for fecal impaction or impaired anorectal tone (9).

Treatment strategies: The fundamental FI management strategies are a) help the patient get to the proper toilet more easily (e.g., use of a commode, call light); b) treating loose stools or diarrhea when present so that the patient has more time and better warning signs to prevent FI. Additional considerations include:
- Dietary changes to avoid causative foods like excessive milk or fruits (9).
- Supplemental fiber via psyllium may reduce FI by providing stool bulk. Caution is recommended in patients on opioids where stool bulking via fiber can worsen constipation (11).
- Discontinue antibiotics, laxatives, PPIs, and other medications with diarrhea as a known side effect if appropriate. Collaborate with a pharmacist to better identify those medications.
- Antimotility medications, like loperamide, may palliate FI. However, they are also associated with equally distressing constipation in elderly patients with poor mobility and oral intake. They also can worsen symptoms from infectious diarrhea (e.g., *c diff*) (11).

Living with FI: For many, FI cannot be eradicated, and clinical efforts are modified to help preserve dignity and well-being for those living with FI. To achieve this, clinicians should consider the following:
- Communication and fostering a trusting relationship with the patient are crucial. Adopt care strategies to promote privacy and dignity via timely incontinence care (e.g., nurse call buttons), keep doors/curtains closed, and conceal incontinence products from easy view (12).
- Create 'cleansing kits' for immediate use. This can prevent staff from needing to look for individual items while the patient waits after an accident.
- Utilize supportive care agents like incontinence pads, deodorants, and local skin ointments to promote hygiene and sacral skin care as appropriate (2). Hyper-oxygenated fatty acid barrier creams are available over the counter and have shown benefit in preventing sacral ulcers (13). Silicone and antiseptic additives have not shown superiority to barrier cream preparations without them (13).

- Ask about toileting needs routinely (every nursing shift) and scheduling toileting if possible (12,14).
- Acknowledging and supporting the efforts of the caregiver (15).

Procedural and Surgical Strategies:

- Insertable collection devices like rectal tubes and trumpets to channel feces from the rectum can be used for persistent FI at the end of life (9). Their use comes with a difficult harm to benefit ratio which must be individualized. While they can reduce the risk of sacral wound infections (16), they can be uncomfortable and prone to leakage, bleeding, and rectal perforation (17). They have also been attributable to longer-term side effects such as rectal mucosal necrosis, strictures, and fistulas (9). Avoid them in patients with low platelets, low white blood cell counts, and those recovering from prostate surgery (9).
- Externally adhesive collection systems, although less invasive, can cause local rash and skin damage from the adhesive tapes attaching the system to the sacral skin, and are best avoided (9).
- Surgical options like sphincteroplasty, ventral rectopexy, and implantable sacral nerve stimulators may be appropriate for patients with extended prognoses (e.g., patients with spinal cord injuries) (10).

Conclusion: FI is common and associated with QOL concerns and caregiver burnout. Effective communication, maintaining patient dignity, and providing caregiver support are paramount. Invasive options like rectal tubes should be used as a last option, when lack of mobility, distress from moving in bed, and persistent fecal leakage preclude other options of management.

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