SEXUAL HEALTH AND FECAL INCONTINENCE

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1. Definition and Epidemiology
   a. Causes
   b. Risk factors
2. Alterations in sexuality in elected populations
   a. Obstetric trauma
   b. IBD
   c. Surgical issues
3. Diagnosis and Treatment
   a. Diet and bowel training
   b. Medications
   c. Pelvic Floor Exercises, Biofeedback, Estim
   d. Surgery
4. SEXUALITY MANAGEMENT

Sympathetic fibers from the superior rectal and hypogastric plexuses maintain internal anal sphincter (IAS) contraction = 55% of anal canal resting pressure.

* When the rectum fills beyond a certain capacity, the rectal walls are distended, triggering the defecation cycle. This begins with the rectosinal inhibitory reflex, and the IAS relaxes. Upon distention of the rectal ampulla, voluntary contraction of the puborectalis ms. and EAS cause expulsion of feces. Somatic (motor and sensory) fibers of the pudendal nerve provide innervation to EAS and PFM.

Definitions:
- Accidental passage or staining of solid, liquid or mucous stool (feces) from the rectum, including the inability to hold a bowel movement until reaching the toilet. Flatus incontinence is often the first sign.
- Urges Incont. : most often r/t EAS issues
- Passive Incont.: (no warning) most often r/t IAS issues

Epidemiology:
- 18 million US adults
- Men 1 in 12; women 1 in 10
- More common in older adults
- World Data: 22% of affected individuals feels severe impact upon QOL

"FI is one of the most psychologically and socially debilitating conditions in an otherwise healthy individual"
Causes Fecal Incontinence

- Childbirth/trauma
- Loss of storage capacity in the rectum
- Diarrhea or loss of bulking
- Pelvic floor dysfunction

Risk Factors

- Loss of Rectal Compliance
  - Rectal surgery, RAx and IBd cause inflammation, ulceration and scarring of the bowel lumen which becomes nonelastic. Rectum cannot stretch nor hold normal fecal volume.
  - Childbirth
    - FI related to forceps, vacuum delivery and/or episiotomy. Can appear immediately after delivery or several yrs later.
- Rectal Prolapse
  - Rectum drops down through the anus and prevents sphincter from closing enough to prevent leakage. Mucous and liquid stool escape.
- Rectocele
  - Rectocele—causes straining to facilitate defecation and decreasing the downward force of fecal passage through the anus. Results in retention of stool in rectum.

AT RISK POPULATIONS:
FI r/t Obstetric Trauma

- Up to 38% primiparas
- Up to 44% multiparas
- Up to 80% forceps asstd deliveries

EAS tearing and perineal lacerations

Does Spontaneous Genital Tract Trauma Impact Postpartum Sexual Function?

- Planned primary C/S
  - Lowest rates of long-term incontinence and sexual dysfunction
- Normal spontaneous vaginal delivery (NIVD)
  - Exposure to genital and anal sphincter lacerations
  - FI r/s dependent on degree of trauma
- Operative delivery (forceps/vacuum)
  - Highest rate of short-term maternal/neonatal complications
  - Long-term incontinence and sexual dysfunction
  - More relevant during first delivery

(Confounding factors—age, parity, associated co-morbilities, substance abuse, relationship issues, use of validated measures of sexual function)

Perineal Lacerations and FI

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Safarinejad M et al JSM 2009
**Time to Resumption of Sexual Activity Following Childbirth**


N= 459 primipara vaginal delivery

94% of women who delivered vaginally w/o sphincter laceration resumed sexual intercourse by 6 mos postpartum

Compared with ★★★

88% whose delivery resulted in anal sphincter laceration

★Pain during sex = one of three women in latter group

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**Mode of Delivery : Male Partner Postpartum Studies**

Specific Areas Sexual Function

GRISS – Golombok-Rust Inventory of Sexual Satisfaction


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**The Pelvic Floor and Labor: Pudendal Neuropathy**

Urogenital Diaphragm = Blue

Lavator Ant = Dark Red

Pudendal Nerve = Yellow

Recovery from pudendal neuropathy occurs in the first 2 – 6 months after delivery. Long-term evidence of neuropathy has been demonstrated and relates to FI and dyspareunia.

Handa VL Semin Perinatol 2006; 30: 253-256

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**AT RISK POPULATIONS: Women with IBD**

Some form of FI affects an estimated 24% of men and women with Inflammatory Bowel Disease (IBD)

Norton C, Dibley LB and Bassett P

FI: Effect on QOL

J Crohns Colitis 2013 Sep 1;7(8) 302-22

N=3264

66.7% female; 33.3% male

Mean age 50.26

74% reported FI: QOL significantly affected, including intimate relationships

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**FI in women with POP: Decreased sexual QOL**

- Diaz Colán Rectum, 2013, Oct: 96(10) 1088-98
- N=2369 community sample women ages 40-80; mean 55
- 24% FI (60% sexually active, prev 3 mos)
- 43% FL (Total) (66% sexually active, prev 3 mos)
- 23% sexually active controls w/o FI/FL
- COMPLETED FIQL scale

**In comparison with controls, women w FI (t/t POP) more likely to report low sexual desire, low sexual satisfaction, difficulties with lubrication, arousal, orgasm, dyspareunia and “limited sexual activity due to physical health”

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**FI after rectal cancer-**

- Pnajari, M Bell, RJ et al

- Systematic review of literature of Colorectal Cancer Outcomes
- CRC-second most common Ca
- Urinary (UI) and fecal incontinence (FI) ongoing concerns for up to 60% of women after surgical,chemo and/or radiotherapy for rectal cancer.
- Lack of desire, problems with arousal , orgasm, pain in 80% postop women
FI after sphincteroplasty


Evaluated women after surgery who experienced FI weekly vs <1 x month.

Greater FI assoc w lower sexual satisfaction, greater limitation of sexual activity due to physical health and accidental bowel leakage, lower sexual frequency.

52 women (26 cases, 26 controls) sent FSFI, FIQOL, FISI, and a general questionnaire.

Preop correlations between FSFI domains and the FIQOL depression/self-perception scale.

Sexual activity and function was similar following anal sphincteroplasty compared to controls.

HISTORY

?onset
?frequency
?w or w/o urge
?worse after eating
?status affected
?hemorrhoids
?Affect on ADLs, sex

STOOL DIARY

www.bowelcontrol.nih.gov

ANAL MANOMETRY

Pressure balloon – assess fx of sphincter and rectum

ANAL UZ

MRI

ANAL EMG- eval PFM

DEFECOGRAPHY- eval evacuation fx, rectocele, prolapse

SIGMOIDOSCOPY/COLONSCOPY

ANAL EMG - eval evacuation fx, rectocele, prolapse

ANAL UZ

MRI

ANAL MANOMETRY

Pressure balloon – assess fx of sphincter and rectum

DIETARY CHANGES

Fiber supplementation: 20-35 g/d
Water: 64 oz/d
Avoid foods which exacerbate s/s
Caffeine, milk, alcohol, spicy or fatty foods, cured meats, artificial sweeteners, carbonation.

Bowel management

Planned defecation (timing toileting after every meal, use of gastrocolic reflex)

Non-surgical management

INTONE MV

*Pelvic Floor rehab with Physiotherapy
*Home programs:
Perineal exercises to strengthen muscles / decrease urgency.
So-100 Kegel reps/d

Biofeedback/ESTIM

Involves home-based treatment for bowel leakage. Combines a voice-guided volitional exercise and visual biofeedback to reinforce proper completion of exercises. Data from each home-based session is recorded for review by clinician.

Pharmacologic interventions

Steroids, sulfasalazine for IBD
Steroid enemas for post radiation FI
Bulk laxatives: Citrucel, Metamucil
Cholestyramine for diarrhea d/t malabsorption of bile salts

Moxibustion:

Diphenoxylate: delay colonic transit and facilitate increased reabsorption of water = decreased stool volume and frequency.
Loperamide: also increases rectal resting pressure
Surgical Procedures

- Sphincteroplasty
- Prolapse Repair
- Artificial Anal Sphincter
- Bulking agent: anal narrowing
- Sacral Nerve Stimulation
- Colectomy

Consequences

- Fecal incontinence: sexual consequences
  1. Shame, humiliation and depression. Organize life around access to bathroom and avoidance of activities to meet partners.
  2. Stigmatized issue that creates barriers to entering into sexual relationships with partners.
  3. If sexual behavior often shrouded in secrecy, lack of support/resources. Results in sexual dysfunction

Preparing for sex

- Place disposable pads on bed
- Use antidiarrheal meds 1-2 hrs before activity
- Tapwater enema +/- ESTIM 60 min before activity
- Limit food intake 4-6 hrs before sexplay
- Minimize anal stim during foreplay
- Place anal plug before lovemaking

Strategies:

- Coital positioning: side-by-side, woman lying, partner standing
- Alternatives to vaginal intercourse while maintaining sexual intimacy: Kissing, hugging, breast fondling, sex toys, massage, mutual masturbation

*** Couples with greater intimacy/communication/flexibility accept and negotiate a wider variety of sexual strategies

Fecal Incontinence and Sexual Function

- Retrospective chart review of 1115 patients
  - 588 with FI
  - 527 without FI
- FI associated with worsened PISQ-12 scores.
- Women with FI report: more dyspareunia, fear and avoidance of sexual activity, greater partner problems.

Practical Recommendations: Counseling Sexuality

- Engage in dialogue on emotional and sexual expectations – role play disclosure with new partners:
  - “I’m hoping we will have sex at some point, and there are a few things about my body that I want you to know”
  - “Since we’re both really attracted to each other, let’s talk about a few things having sex with me includes”
- Acknowledge possible fears, embarrassment feelings
- Provide anticipatory guidance on partner reactions, managing communication
- Discuss PLANNING for FI and how to deal with it “in the moment”

Von Sydow K. J Psychosom Res 1999; 47(1) 27 - 49
**Interventions: Prevention of Perineal Trauma**

- Perineal massage/stretching
  - Optimal if performed daily 10" x 6" weeks prior to delivery
  - 9% reduction in trauma requiring suturing

- Birth Positioning
  - Non-supine positions (i.e. upright, side-lying, squatting, semi-sitting, hands/knees)
  - Fewer episiotomies
  - Greater comfort

- Avoiding Directed and Valsalva Pushing
  - Instead push once feel urge, with exhalation rather than breath-holding

- Mindfulness in Childbirth
  - Encourages women to stay in the present moment and avoid controlling every step of labor and delivery process

Rosenbaum T, Pada A, JSM 2012

**Evaluation for Sexual Pain Following PF Surgery**

- Evaluation
  - Mesh or graft complications, or exacerbation of pre-existing pain issues (pelvic floor dysfunction, vulvodynia, IC)
  - Vaginal exam
  - Atrophy / Levator tenderness

- **INTERVENTIONS:**
  - Local Estrogen
  - PFM Physiotherapy
  - Dilators
  - Muscle relaxants/MTRP injx

**Future Directions: Research**

- Incorporate FSFI at baseline before and after childbirth, PF surgery, Ra Rx, treatment for IBD
- Eval quality-of-life and FI impact on sexual function
- Prospective, longitudinal trials which clarify the long-term impact FI on women, couples

**THANK YOU FOR YOUR ATTENTION**

Handa VL Semin Perinatol 2008; 30:253-256