# SEXUAL HEALTH AND FECAL INCONTINENCE

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## Disclosures

Dr. Kellogg Spadt serves on the advisory board and/or is a speaker for the following companies:

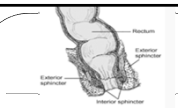
- Shionogi
- Novonordisk
- Sprout
- Neogyn
- Innovus
- Lelo

## Learning Objectives

- Explore the epidemiology, causes and treatment approaches for fecal incontinence
- Identify alterations in sexuality associated with fecal incontinence
- List strategies for counseling patients RE: sexuality and fecal incontinence

## Content

- 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




## Normal defecation

- 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 rectoanal 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.

http://en.wikipedia.org/wiki/Special:BookSources/0-387-24846-3

## Fecal Incontinence (FI)

- Definition: 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.
- Urge Incont. : most often r/t EAS issues
- Passive Incont.: (no warning) most often r/t IAS issues

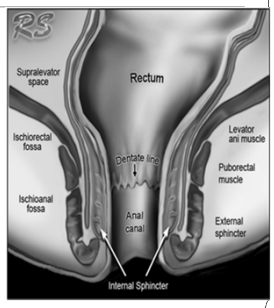
- Epidemiology:
- 18 million US adults
- Men 1 in 12 ; women 1 in 10
- More common in older adults
- World Data: 22% of affected individuals feels severe impact upon QOL

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

www.NIDDK.nih

## Causes Fecal Incontinence

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




## Risk factors

- Diarrhea
  - Loose stools fill rectum quickly-more difficult to hold than solid waste
  - Constipation
  - Large, hard stool stretch rectum causing internal sphincter to relax by reflex. Watery stool builds up and leaks out around hard stool. Most common in PFD were pt unable to relax PFM or external sphincter and mistakenly contracts at the time of defecation rather than relaxes:" dyssynergic defecation".
- Muscle weakness/Damage
  - Internal or external sphincter not strong enough to keep anus closed during ADLs. Most common after childbirth trauma, hemorrhoid surgery, cancer Rx .
- Nerve Damage
  - Nerves which control sphincters and sensation that stool is in rectum damaged. Most common after childbirth trauma, long term straining, SCI, diabetes, MS, CVA, head injury.

http//:NDDIC.org

## Risk Factors

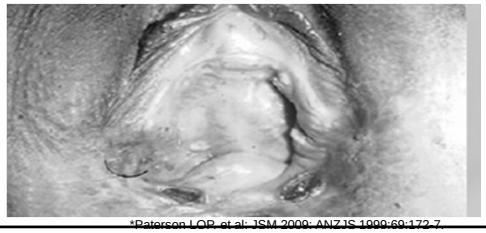
- Loss of Rectal Compliance
  - Rectal surgery, RaRx and IBD cause inflammation, ulceration and scarring of the bowel lumen which becomes nonelastic. Rectum cannot stretch nor hold normal fecal volume.
  - Childbirth
  - FI related to forceps, vacuum delivery and/or episiotomy. Can appear immediately 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 is retention of stool in rectum.

http//:NDDIC.org

## AT RISK POPULATIONS: FI r/t Obstetric Trauma

Up to 35% primiparas
Up to 44% multiparas
Up to 80% forceps asstd deliveries

EAS tearing and perineal lacerations



*Paterson LOR, et al: JSM 2009; ANZJS 1999;69:172-7.

## Does Spontaneous Genital Tract Trauma Impact Postpartum Sexual Function?

*Rebecca G. Rogers, MD, Noelle Borders, CNM, MSN, Lawrence M. Leeman, MD, MPH, and Leah L. Albers, CNM, DrPH*

- Prospective cohort 576 women exposed to minor (1 degree) vs
- major (2,3,4 degree)perineal trauma
  - Validated measure postpartum sexual function - Intimate Relationship Scale (IRS)

RESULTS

- Women with major trauma (2,3,4 degree lac)
  - Less desire to be held, touched, stroked by partner
- Women requiring perineal suturing
  - Lower IRS scores

J Midwifery Women's Health 2009; 54:98-103

## Perineal Lacerations and FI

- Planned primary C/S
  - Lowest rates of long-term incontinence and sexual dysfunction
- Normal spontaneous vaginal delivery (NSVD)
  - Exposure to genital and anal sphincter lacerations
  - FI s/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-morbidities, substance abuse, relationship issues, use of validated measures of sexual function)*

Safarinejad M et al JSM 2009

## Time to Resumption of Sexual Activity Following Childbirth

Brubaker L, Handa VL et al. 2008. Obstet Gynecol: 111(5) 1040-1044

N= 459 primipara vaginal delivery

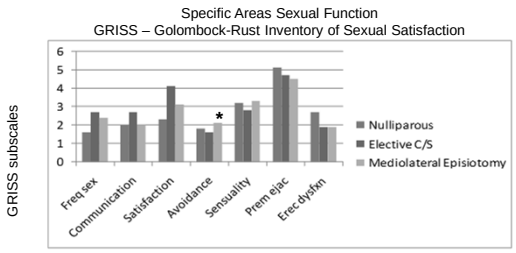
94% of women who delivered vaginally w/o sphincter laceration
resumed sexual intercourse by 6 mos postpartum

Compared with: ☆ ☆

88% whose delivery resulted in anal sphincter laceration

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

## Mode of Delivery : Male Partner Postpartum Studies




Gungor, S et al. J Sex Med 2008; 5:155-163

## The Pelvic Floor and Labor: Pudendal Neuropathy

Urogenital Diaphragm = **Blue**
Levator Ani = **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

## 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

## FI in women with POP: Decreased sexual QOL

- Imhoff LR, Brown JS, et al.
- Dis Colon Rectum, 2012, Oct :55(10) 1059-65

- N=2269 community sample women ages 40-80; mean 55
- 24% FI (60% sexually active, prev 3 mos))
- 43% FL (flatal) (66% sexually active, prev 3 mos)
- 23% sexually active controls w/o FI,FL
- COMPLETED FIQL scale

- **In comparison with controls, women w FI (r/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"

## FI after rectal cancer-

- Pnajari,M Bell, RJ et al
- J Sex Med 2012,Nov 9(11) 2749-58.

- 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 60% postop women

## FI after sphincteroplasty

- Trowerbridge ER, Morgan D et al.. Am J Obstet Gynecol
- 2006. 195(6)1753-47

- 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

## Sexual Function after Sphincteroplasty

- 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

Pauls et al. Sexual function following anal sphincertoplasty for fecal incontinence. Amer J Obstet Gynecol 2007;197:618.e1-618.e6.

## FI Diagnosis

- HISTORY
- ?onset
- ?frequency
- ?w or w/o urge
- ?worse after eating
- ?flatus 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/COLONOSCOPY

## FI management

- **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

- *Pelvic Floor rehab with Physiotherapy
- *Home programs:
- Perineal exercises to strengthen muscles / decrease urgency:
- 50-100 Kegel reps/d

*Biofeedback/ESTIM

Sensory training + Muscle training
- Candidates must have some
- Sensation, ability
- to voluntarily contract EAS,
- highly motivated, and cognitively intact
- Improvement in 70-80% cases
- Results long-lasting

INTONE MV

InToneMV is a non-invasive, home-based treatment for bowel leakage. Combines a customizable probe with stimulation to strengthen PFM Voice-guided volitional exercise and visual biofeedback reinforcs proper completion of exercises. Data from each home-based session is recorded for review by clinician

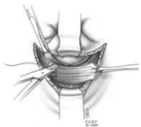
Eynes MM et al. Dis Colon Rectum. June 1999753-758

## Non-surgical management

- **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
  - **Motility agents:**
    - Diphenoxylate: delay colonic transit and facilitate increased reabsorption of water = decreased stool volume and frequency.
    - Loperamide: also increases rectal resting pressure

## Surgical Procedures

Surgical procedures most likely successful when FI due to sphincter defect: obstetric trauma, fistula repair, hemorrhoidectomy, and lateral sphincterotomy.



- Sphincteroplasty
- Prolapse Repair
- Artificial Anal Sphincter
- Bulking agent: anus narrowing
- Sacral Nerve Stimulation
- Colostomy


## 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.

Cichowski et al. The association between fecal incontinence and sexual activity and function in women attending a tertiary referral center. Int Urogynecol K (2013)24:1489-1494

## 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

## 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, I wan to tell you 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 Rsch 1999; 47(1) 27-49

## 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

Sacomori C, et al J Sex Marital Ther 2010; 36: 124-36

## INTERVENTIONS: Prevention of Perineal Trauma

- Perineal massage/stretching
  - Optimal if performed daily 10" x 6 wks 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 TY, Padoa A, JSM 2012
*Labrecque M, et al AJOG 1999

## Evaluation for Sexual Pain Following PF Surgery

- Evaluation
  - Mesh or graft complications,or exacerbation of pre-existing pain issues (pelvic floor dysfunction,vulvodynia,IC)

Pelvic exam

- Vaginal length, caliber, scarring, ridges, palpable grafts/sutures
- 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 2006; 30:253-256