PATIENT POWER

Northwestern Memorial Hospital

Rectal Incontinence After Childbirth and Surgery

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Introduction

Andrew Schorr:
Childbirth can take its toll on a woman's body, and there also can be complications of chronic conditions and obesity, and that can often you cause issues that are difficult to discuss such as urinary and fecal incontinence and constipation. Coming up you'll hear an expert discuss emerging treatments and ways to improve pelvic floor health next on Patient Power.

Hello and welcome to Patient Power sponsored by Northwestern Memorial Hospital. I'm Andrew Schorr. So as a man I have not certainly felt the pain of childbirth, but my wife has delivered vaginally three times, and it took her a while to recover. And sometimes there are complications that can happen related to pelvic floor problems. Now, on other programs we've discussed pelvic organ prolapse, and part of that, one of the problems that can happen is even rectal problems. And we're going to discuss that with a colorectal surgeon, Dr. Anne-Marie Boller, and also understand how even this problem can happen with men as well, not of course from childbirth, but we're going to understand the problem and what can be done about it.

Dr. Boller, thank you so much for being with us.

Dr. Boller:
Thank you. It's a pleasure to be here.

Andrew Schorr:
Dr. Boller, so let's talk about the trauma of childbirth. It's a big medical event, and when you deliver vaginally I know it can move things around, and it can stretch muscles and organs and things. How common it is that some people have ongoing issues and what percentage maybe needs to be addressed surgically.

Dr. Boller:
Well, it's hard to put an actual percentage on it or number because this is actually fairly underreported in terms of long-term follow up, and many of these women get seen later in life and it's not directly linked to a birthing injury. But the obstetric trauma that can happen has to do with many different things, not only factors like the baby, how large is the baby, how is the baby oriented, but difficulty, how difficult the actual birth is. Was a vacuum used? Were forceps used? And then of course also do you have to voluntarily make a cut, like an episiotomy, sometimes all the way back through the rectal and anal sphincter complex. Or is there a tear,

and they have degrees of these tears of which third- and fourth- degree are tears that go all the way and sometimes through the anal sphincter complex disrupting the anterior portion of your anal sphincter.

So these factors all play a role. And then also how were you repaired? Was there infection afterward? Were you seen by someone after these repairs in terms of how well these things do after the fact. So all these things play into your long-term outcomes after what I would term obstetric trauma.

Symptoms of Problems

Andrew Schorr:
Okay. And it's something that women may be embarrassed to talk about. What would be the symptoms? There are urinary symptoms, and there are fecal incontinence symptoms too, right?

Dr. Boller:
There's a number of different symptoms and some of them can occur immediately after, you know, in your acute recovery period, and some of them can gradually occur in the years that follow the childbirth, and some of them can occur later in your life as the rest of your body is relaxing and muscles are giving way. So there's different stages of when you would see symptoms.

But acutely you could have a tear and have some incontinence problems, meaning you can't make it to the bathroom the way you used to, or you don't have the sense of when you have to go to the bathroom like you used to, or you just can't actually hold it. There are some injuries that disrupt and then connect the vagina and the rectum, and these are called rectovaginal fistulas. In this case you would then have maybe stool coming through your vagina or having mucus from your vagina coming back through your rectum. You can also have similar problems with your bladder although that's a little bit more common in men after some of their disease problems. So those would be the acute problems.

The middle- and long-term problems are the ones that kind of gradually come about. Say maybe you did have a fairly good recovery after an obstetric trauma but gradually you've noticed that you really can't afford to go to Target for two hours with your three children because you don't know where the bathrooms are or that you don't have the urge and so you're afraid to go on that nine-hole golf course because you can't be out on the ninth hole because you know you won't make it to a bathroom. And these people tend to adapt around and often don't come to the doctor because of their adaptation kind of behaviors. But those medium- to long-term outcomes are the ones that are a little bit more insidious.

Andrew Schorr:
And embarrassing for people. Now, in previous programs we've discussed pelvic organ prolapse, and we've talked about different surgeries there, but if it's okay I

wanted to focus a little more on the rectal issues because I think people just don't discuss them. I imagine there are people who just don't even bring it up with their doctor.

Dr. Boller:
Absolutely. And more often than not people also don't ask, so it's a problem on both sides of the physician-patient relationship.

Non-Surgical Treatment

Andrew Schorr:
All right. You're a colorectal surgeon, so what are the approaches that can be done to help someone? First, are there nonsurgical approaches, and then help us understand if surgery is indicated how can it be done in the most minimally invasive way.

Dr. Boller:
Well, the most important intervention is, as we just discussed, is to intervene, meaning talk to your doctor about your problems at any of those stages that I talked about, the acute, the mid or the long-term outcomes. And make sure that they're aware and that you're talking to them about what is going on. Because of the psychological stigma around fecal incontinence people tend not only not to talk about it but they tend to hide it as much as possible, and that's the wrong thing to do because we know that the earlier we intervene the better our results usually are in the long run.

The initial evaluation is a number of tests that I would do to kind of assess what the damage is and what the exact disorder is. But many people, even if they have gross sphincter disruption, will benefit from a physical therapy that we call biofeedback. This is a therapy that strengthens the pelvic muscles as well as the anal-sphincter complex but more importantly can recoordinate all of these muscles so that they work together to restore a patient's continence. And biofeedback has been proven to work in the literature very, very effectively.

Now, having said that, if it doesn't work in terms of biofeedback there are a number of surgical interventions that we can initiate if the patient is an adequate candidate and is going to benefit from the surgery. If they have a sphincter disruption we can do what is called a sphincteroplasty, meaning we can dissect out to where those sphincter muscles are and rewrap them, recreating the anal sphincter complex. If it's an acute problem that's more along the lines of a rectovaginal fistula there are also a number of repairs for these including things like a Martius flap, which would be putting a flap of muscle or fat, a Martius flap is a labial fat pad, in between the rectum and the vagina to recreate the soft tissue that normally separates the rectum and the vagina.

Again, if it's an attenuated sphincter that means it's just thinner than normal because of the trauma from the childbirth. We not only start with biofeedback but

we would maybe consider some other interventions. On the research side of things there are some people who are injecting bulking agents into the anal sphincter. And soon to be hopefully approved here in America is sacral nerve stimulation which has also been proven in the literature from Europe to help a large percentage of women restore their continence following these types of injuries.

Andrew Schorr:
Let me just understand what that term means. So this is like electrical stimulation, or how does that work?

Dr. Boller:
It is, actually. It's a pacemaker that we would go into your buttock and the electrode would go into the holes in your bony sacrum, your pelvis, and right to where your spinal cord, the nerves come around to enervate your pelvis and the perineum. Sacral nerve stimulation has been used for a number of years by urologists for urinary incontinence. That's actually how we discovered that it works for fecal incontinence because there's a crossover of about 30 percent of people, 30 to 50 percent of people who have urinary incontinence also have some degree of fecal incontinence undiagnosed. And when these patients were having the sacral nerve stimulators placed to help them with their urine incontinence we found out through surveys that they were also having vast benefits from a fecal incontinence standpoint.

So what you would do is you would place a temporary electrode into the foramen, the sacral foramen, that's the hole in the bone, and have them keep a journal to see if they benefit from this, meaning less accidents a week, more warning in terms of being able to make it to a bathroom and in some people even more warning and a more urge capacitance response from the rectum itself. If they then respond to the sacral nerve stimulator that is temporary, European studies have known that they then would be the ones who would benefit from a permanent implantation, and that is when they would go to the operating room and have a pacemaker placed in their buttock, and the node, the electrode, permanently placed.

Andrew Schorr:
Is that done investigationally at Northwestern yet?

Dr. Boller:
It is not yet. We are going to be doing it here as soon as the FDA approves it. It is in the FDA's approval process as we speak.

Surgical Treatment

Andrew Schorr:
Doctor, let's talk about the degree of surgery. So we talked about the possibility of sort of a pacemaker to help with nerve stimulation related to rectal incontinence. I know there can be minimally invasive approaches and sometimes there needs to be abdominal surgery. How do you decide which?

Dr. Boller:
If the incontinence is because of a sphincter issue, meaning muscle, sphincter is just a fancy word for the muscle around your anus. It helps you hold your feces in so that you can make it to a bathroom. And those repairs that I talked about previously, sphincteroplasties, are a major repair. They do require general anesthesia, but certainly they are not abdominal. We do that from underneath, a direct repair of the anal sphincter complex. The same can be said for a rectovaginal fistula.

But then we get into the area where if you have a rectal prolapse or a sagging of your entire rectal complex or a fistula that is too high to repair from below, meaning between the legs, then we have to do an abdominal surgery, whether laparoscopic or open surgery. We can make that decision based on other patient factors. But a rectal prolapse or an internal sagging that's causing some thinning of the sphincter muscle leading to fecal incontinence or a fistula from traumatic events, there are a few of those that can only be addressed through the abdomen.

Andrew Schorr:
Dr. Boller, so if someone has one of these surgeries does it last, or might they need surgery sometime in the future?

Dr. Boller:
There's a good study that was out from the University of Minnesota that showed that even sphincteroplasties in the best of hands tend to start to not perform as well after ten years. We don't have long-term results for sacral nerve stimulation yet. And in terms of fistula repairs and prolapse, those are a bit sturdier in terms of long-term results.

Having said that, because of this fact that sphincteroplasties can break down and that recurrent surgery is difficult, it's important to make sure you institute physical therapy before and after the surgery and make sure that you're doing everything possible to give the patient a fighting chance, meaning modulate the consistency of their stool so that they get the most sense of urgency that they can. Make sure that you work with them on their diet and make sure that they have colonoscopies to make sure there aren't other problems affecting them. So it's very, very important that these medical and conservative management tools are used prior to any surgery and also after the surgery.

The Risk for Problems

Andrew Schorr:
Dr. Boller, I was looking at a study from Kaiser Permanente from California, and this study from 2008 said 80 percent of the 4,000 women studied had given birth, and of those 4,000 women 25 percent suffered from anal incontinence and then 15 percent from stress urinary incontinence, 13 percent from overactive bladder and then 6 percent pelvic organ prolapse where they felt that organs were dropping out

at the bottom. But what I was surprised about was how common it was, these anal issues. So then a woman says, okay, I don't want to go there. Is there anything I can do in preparing for childbirth to make that less likely?

Dr. Boller:
You know, we have studies that broadcast or publish the risk factors for tearing or needing episiotomies, but not everyone who tears or needs an episiotomy then has fecal incontinence, so there's clearly some other issues that contribute to this. We're just getting a study up here at Northwestern to look at what is the relationship between obstetric trauma and fecal incontinence, and what are these risk factors that we need to look at.

Having said that, the important intervention that we know now can help is that once you have had obstetric trauma, meaning even episiotomy or a third- or a fourth-degree tear or even just an infection in that area, we call it the perineum, after childbirth it's important to have the doctors, a multidisciplinary team of doctors see you at that time. Because we know that if we can get healing to occur that that is better to do in the acute setting. So I think the most appropriate intervention is to have this multidisciplinary team of obstetrics and gynecologist doctors, your primary doctor and a colorectal doctor and perhaps a urogynecologist on board if you have any problems after giving birth to your baby.

Andrew Schorr:
Now, my wife did have bladder problems that persisted for a long time after the birth of our third child, fortunately not the other issues. So how do we get women to start talking about it? First of all, things like IBS are real common in women, and we have TV commercials. A woman might say, well, I've got IBS or some other issue, you know, just food doesn't agree with me. How do we identify that this is the problem and they need to speak about it?

Dr. Boller:
Well, I think that that's another thing that we're trying to work on here at Northwestern is in developing and starting our pelvic floor center here getting almost a public service announcement out that these problems are out there and if you have them there are people who can help you. Unfortunately I don't see those kind of public service announcements or even ads out there right now. And I think that that's probably the biggest issue because until you identify a problem and make a patient feel at home with their symptoms, make them understand that this is a legitimate medical surgical problem and that there are many other people out there that have these problems and there are also many of us out here who want to help them, and that's the message that has to start getting across to the general public and certainly to the obstetric population postpartum.

Andrew Schorr:
Well, we're working on that today and hopefully people will hear this message far and wide. So what should a woman say? If it's not brought up by the doctor, what should a woman say? Should she say, you know, I can't seem to hold my stools as

well, I just have to run to the bathroom, I don't even know when I need to go? What would be things that they would bring up to sort of put it on the radar of the medical team?

Dr. Boller:
I think the first thing to do if you've had a baby is to, because the labor suite is not, you don't always know what's going on there, and of course I think most people's priority is to see a healthy baby, but I think it should be of great importance to every woman to ask their doctor after the fact, what happened? Did I tear? Did you have to sew me up? How much did you have to sew me up? And I think that those are important questions, and I'm constantly struck by how many women don't know if they had a third-degree tear or a fourth-degree tear or an episiotomy. And when I see them, even though I can see the sutures down there in the perineum, that area between the vagina and the anus, they are unaware of why they were sewn up.

So I think the first thing that any woman has had a baby should do whether or not there are problems or not is ask, how did the birth go and did you have to sew me up? Did I rip? Certainly if forceps or vacuums were used or there was a breech birth you should know these things so that we can all get together, as I said, in a multidisciplinary fashion and evaluate you and see if you are someone who is going to have problems.

Having said that, even if you do know and were told that nothing happened, nothing went awry and everything was just fine, you can still have a sphincter tear just from the actual birth itself, and if you start to have leakage when you didn't have leakage before, if you start to not have the normal urge that you used to have giving you enough time to get to the bathroom, heaven forbid, if you start to have frank accidents, which does happen, then you need to get to your doctor, your gynecologist, and get referred to someone who deals with these sorts of problems and get the right workup. That could be a gastroenterologist at your institution. That could be a colorectal surgeon. It could be a general surgeon that specializes in this. It could be a urogynecologist. But there are people around the country that specialize in this, and it's important once you have those symptoms, lack of urge, lack of warning, increased leakage, unable to hold solid stools, unable to hold liquid stool, unable to take walks, difficulty exercising without having leakage, these kinds of problems you need to bring to your doctor's attention.

Andrew Schorr:
We've talked about this in the setting of childbirth and trauma from childbirth. Let's talk about a couple of other situations. Does obesity or obesity with childbirth come into play in putting more pressure that then can cause damage?

Dr. Boller:
Obesity is certainly evaluated in terms of obstetric outcomes in the literature, but even just from a pelvic floor dysfunction standpoint people who are obese are at marked increased risk for pelvic floor dysfunction and fecal incontinence. Actually

across the literature we know that these are the people who have the problems earlier, have more difficult problems, and more importantly are more difficult to solve their problems. So certainly obesity, even aside from the obstetric factors, obesity is a risk factor for pelvic floor dysfunction.

On the other side of the coin, you can also talk about men have these problems, and they're even less talked about than the females. And certain risk factors seem to be for them long-standing bowel problems, prostate cancer that was treated with radiation. These all can be in their medical history and their surgical history. Certainly if they have had surgery on their prostate or rectum or they have a history of radiation then these factors can also predispose males to fecal incontinence.

Males at Risk

Andrew Schorr:
Can you help in that setting?

Dr. Boller:
Absolutely. They can also get sphincteroplasties, but having said that all of these patients get a comprehensive workup which includes an ultrasound of the sphincter complex. Remember, that's the muscles. They also get manometry testing, which is a dynamic test which tells us how strong the muscles are and how well they relax and how coordinated they are. It can also tell us how their urge is in terms of how much volume and the rectal capacitance, whether it's working for them or working against them.

We can also do nerve testing, which we do for all of these patients to tell whether their nerves are actually functioning, and if they are functioning are they functioning at the right time and place. Because a nerve that's been stretched or broken from a trauma, obstetric or otherwise, often will not convey the signals in a normal timely manner.

Lastly we can also get what's called a defecating proctogram, which is where we take a radiologic picture of someone as they are defecating so that we can see if anything else is causing these problems, meaning causing them not to have the control they used to have. Is there bowel coming down in on itself? We call that intussusception. Is their rectum prolapsing so that their sphincter is stretched and they don't have control anymore? Or is their anatomic and pelvic dysfunction where they're just not able to coordinate all of these muscles and all of these nerves and all of the rectal capacitance and get that coordinated together?

So all of these tests go into the workup for fecal incontinence and give us a complete picture. And you should always have that picture before you operate because you don't want to operate on the muscles if what the problem is is the

nerves. You don't want to operate on the muscles if what the problem is is the rectum. So it's very important to get the entire workup and look at the entire picture before intervening.

Andrew Schorr:
Dr. Boller, as I hear about this, you talk about things that are difficult for people to discuss, and then these exams you talk about, I know it's useful information for you, but you think, we were that way with colonoscopy, and I think more people are having it. Thank god for Katie Couric and other people who have spoken out about it.

Dr. Boller:
Yes.

Andrew Schorr:
So can we get there with these issues of fecal incontinence, because, sure, it can be a complication for men related to prostate surgery or radiation. We talked about childbirth, and the studies show it's not at all uncommon. I'm sure you want to help people, and we do need to talk about it more.

Prevention

Dr. Boller:
Absolutely. I think that the number one thing that has to happen is that these issues have to be acceptable in some way. We have to get our society to stop marginalizing these symptoms so that people can talk about them. Because if you don't tell your doctor, that's the first step, so there's a very real way in which the first step is the patient's. If as a society we don't empower the patient instead of as we do now ostracizing anybody with these symptoms, we're not going to get the patients and all the people out there with these problems to make that first step.

Andrew Schorr:
I want to go back to one thing. We all think, though, is there something we can do. So I know my wife and some of her friends, they worked out really hard at the gym. They would keep in shape anyway, were not obese, for muscle tone going into childbirth. Can that be preventative? Or women are instructed about Kegel exercises before or even after childbirth. Those sorts of things, can that help?

Dr. Boller:
I think that anybody who is in shape going into a surgery or a surgical trauma, which can be a descriptive term for childbirth, unfortunately, but anybody who is more physically fit rather than less is going to have an advantage. I have not seen any data on doing the physical therapy that I called biofeedback earlier in this conversation. I certainly know that it helps my patients to have it done before and after my surgeries because, as I always tell my patients, biofeedback is like doing pushups and getting cardiovascularly fit just down here in your perineum. And so I

think that certainly in a perisurgical atmosphere biofeedback and physical therapy and exercises that those therapies entail are very important to pursue and take seriously.

Andrew Schorr:
It sounds like we'll be learning more. As more people talk about it, then more studies knowing risk factors.

Dr. Boller:
Exactly.

Andrew Schorr:
We talked about obesity, but diet, all sorts of things, even can these conditions run in families and I read that maybe some, but we'll understand that a lot better. I want to thank you for talking about it today, Dr. Anne-Marie Boller, colorectal surgeon, and helping women and men to better understand that we need to talk about it more and that there is help available.

Dr. Boller:
Thank you very much.

Andrew Schorr:
Thank you very much, Dr. Boller.

This is what we do on Patient Power. Special thanks to Northwestern Memorial for connecting with us leading experts who can help you understand both common issues that are discussed a lot and even in this case a fairly common condition that needs to be discussed a lot more. So please, please if you're having these issue that certainly affect your quality of life, bring it up with your doctor and connect with a team that can help.

I'm Andrew Schorr. Remember, knowledge can be the best medicine of all.