Clinical Practice Guidelines – Fecal Incontinence

Measures that **assess nature & severity of FI including QoL tools** should be used as a part of the assessment of FI. 2C

Anorectal physiology testing (manometry, compliance, etc) can be considered to help define the elements of dysfunction & guide management. 2C

**Endoanal ultrasound** may be useful to evaluate sphincter anatomy when planning a sphincter repair. 2C

**Endoscopy** should be performed according to established screening guidelines and in patients presenting with symptoms that warrant further evaluation (ie, changes in bowel habits, bleeding). 1B

Pudendal nerve terminal motor latency testing is not routinely recommended. 1C

Dietary & medical management should be first-line therapy. 1C

Bowel training programs & biofeedback can be considered in selected patients. 2C

Overlapping sphincteroplasty may be considered with a defect in the external anal sphincter, but clinical results often deteriorate over time. 2C

Sacral neuromodulation may be considered as a first-line surgical option with or without sphincter defects. 2C

Injection of bulking agents & application of radiofrequency energy are not routinely recommended. 2C

Antegrade colonic enemas can be considered in highly motivated patients who are seeking an alternative to a colostomy, which is also an option for patients who have failed other therapies. 2C