SUMMARY

Faecal incontinence affects women and men in all ages. The disorder causes great personal disability and has a high financial cost. An awareness of the high prevalence and predisposing factors for the development of faecal incontinence , together with a multidisciplinary approach to treatment , can lead to relief from this distressing symptom in most patients .

Historically , anal incontinence has been poorly understood and treated . Increasing knowledge of the anatomy and physiology of continence has advanced the testing procedures that help to predict the appropriate therapeutic alternative for a given problem .

Before referral for specialist tests , all patients should have careful documentation of their history and undergo general clinical examination and in particular , through local examination of the anorectum by careful inspection , digital rectal examination , proctoscopy and sigmoidoscopy .

The introduction of anal endosonography as away of imaging enables accurate identification of the lesions causing faecal incontinence and has allowed rational planning of the treatment . Also , magnetic resonance imaging with an anal coil can be helpful in investigation paraanal structures or when the ultrasound findings are equivocal .

Endosonography has largly replaced electromyography , although the latter may be useful when scarring makes interpretation of ultrasonograpgy difficult pudendal nerve latency testing is less variable

than was previously believed , as most patients have identifiable structural damage or muscle degeneration rather than neuropathy .

A scoring system for the assessment of the severity of faecal incontinence is required to gain an objective comparison of outcomes of both conservative and surgical treatment . Frequency and quantity of stool lost and effect of incontinence on life style should be include in the scoring system .

Accurate identification of the etiology and severity of the condition is essential for the choice of the suitable surgical intervention .

Reconstruction of the sphincter by overlapping sphincter technique or postanal repair of the sphincter may be suitable in simple structural defect. But in case of severely disrupted sphincter , more complex surgical techniques are required .

These patients were traditionally treated by permanent stoma , However , in recent years such patients were offered another alternative , which is creation of neosphincter using either a transposed skeletal muscle or artificial anal sphincter .

More recently, and because of the incontinence results of skeletal muscles transposition, electro-stimulation was used to convert the muscle from a fast twitch muscle (not ideal substitute for a sphincter function) , into a slow, twitch ,fatigue resistant one , suitable for sustained contraction as a sphincter . Variable techniques for graciloplasty are present including three stages procedure . bilateral graciloplasty and more recently single stage dynamic graciloplasty with a modified (split sling) technique .

Malone antegrade enema could be considered as an attractive option for treatment of faecal incontinence as an antegrade colonic lavage in patients with overwhelming damage to the continence mechanism with evacuatory problems. Also, it is suitable for elderly patients who are unfit for complicated surgical peocdure, or in-patients with neurological disease or congenital disease such as spina bifida and cerebral palsy . It is easy procedure , safe and its results are satisfactory with very little risk of surgical complication .