USE OF ANAL PLUGS IN FAECAL INCONTINENCE MANAGEMENT

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ABSTRACT Herbert, J. (2008) Use of anal plugs in faecal incontinence management. *Nursing Times;* 104: 13, 66–68.

Julia Herbert discusses how anal plugs can be used to improve the quality of life for people with faecal incontinence.

Living with anal incontinence can have a significant impact on the lives of sufferers and their families. A female patient in her 50s shared her experiences of having faecal incontinence as a result of a obstetric injury sustained at the delivery of her first son 24 years ago.

'I even remember pretending to have a sprained ankle at my sister-in-law's wedding; I was the matron of honour. I knew that as soon as we had eaten and the dancing started that I would be expected to get up and dance with the best man.

'My incontinence was so bad then that I just knew I would embarrass myself – and him! – and have a bowel accident on the dance floor, so I pretended to have a sprained ankle so that I wouldn't be able to dance. I spent the whole day pretending to limp with my leg bandaged to fake the injury.'

Imagine inventing stories to avoid social situations because of a fear of losing control of bowel function. This is a regular occurrence for many people who experience anal incontinence.

Sometimes patients do not actually have regular episodes of incontinence but the fear of incontinence without warning can have a serious impact on their quality of life. They describe difficulty coping in the workplace and having to leave work because of their bowel symptoms; others describe difficulties with personal relationships.

Definitions and prevalence

Studies examining the prevalence of anal/faecal incontinence are difficult to compare as researchers have used different definitions to describe the problem.

The commonly used definition of anal/faecal incontinence is the 'inappropriate passing of liquid or stool' (Royal College of Physicians, 1995).

However, this definition does not take into account the more common, yet no less embarrassing symptom of incontinence of flatus or gas (wind). A recent study by Pretlove et al (2006) used the broader term 'anal incontinence' to include the symptom of incontinence of flatus or difficulty controlling 'wind'. This meta-analysis of 29 prevalence studies concluded that prevalence rates for anal incontinence were 0.8% in men and 1.6% in women aged 15–60, increasing to 5.1% in men and 6.2% in women aged over 60.

Assessment of anal incontinence

There are numerous causes of anal incontinence and each case should be thoroughly assessed by a healthcare professional (Box 1).

NICE has published guidelines on the management of faecal incontinence in adults,

BOX 1. FAECAL INCONTINENCE RISK GROUPS (NICE, 2007)

- Frail older people;
- People with loose stools or diarrhoea from any cause;
- Women following childbirth (especially following third-degree and fourth-degree obstetric injury);
- People with neurological or spinal disease/injury (for example, spina bifida, stroke, multiple sclerosis, spinal cord injury);
- People with severe cognitive impairment;
- People with urinary incontinence;
- People with pelvic organ prolapse and/or rectal prolapse;
- People who have had colonic resection or anal surgery;
- People who have undergone pelvic radiotherapy;
- People with perianal soreness, itching or pain;
- People with learning disabilities.

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NICE (2007) *Faecal Incontinence: The Management of Faecal Incontinence in Adults. NICE Clinical Guideline 49.* London: NICE.

Norton, C., Kamm, M.A. (2001) Anal plug for faecal incontinence. *Colorectal Disease;* 3: 5, 323–327.

FIG 1. PERISTEEN ANAL PLUG

stating that: 'People who report or are reported to have faecal incontinence should be offered care to be managed by healthcare professionals who have the relevant skills, training and experience and who work within an integrated continence service' (NICE, 2007).

Treatment

Following a detailed assessment it may be appropriate to offer conservative therapy, medications or surgical interventions. These are outlined in Box 2.

Management using anal plugs

Unfortunately for some patients, none of the options listed in Box 2 are suitable, or the patient may choose not to follow these options.

Other patients may need assistance in managing their incontinence while undergoing treatment for their continence problem. In these cases, the use of an anal plug device may be beneficial to some patients.

In the UK the only brand of anal plug that is commercially available is the Peristeen anal plug. It is available on prescription.

The device is available in two sizes, small and large (prescription codes 1450, 1451). The choice of size is mostly down to individual experience and it is usual to recommend that patients try the smaller plug first, progressing to the larger if leakage still occurs.

The anal plug is made of porous, slightly absorbent foam which is able to let air pass through it.

It is packaged in a dissolvable film which dissolves on contact with the body fluids in the rectum to release a mushroom-shaped plug (Fig 1).

Insertion and removal of the plug

The plug in its unexpanded form looks like a suppository. This is inserted into the anal canal using a lubricant to ease insertion.

It is important that the patient understands the anatomy of the anal canal and lower rectum, so that they know the correct position for the plug.

Once inserted, the plug should sit at the upper end of the anal canal. It is essential that it is inserted completely through the length of the anal canal as it is extremely uncomfortable if the plug expands in the lower end of the canal.

The plug may be used for up to 12 hours and is removed in a way similar to removing a vaginal tampon by using the 'string' that is securely attached to the plug.

Because of the materials used in the plug, it is not flushable. It should be disposed of in a women's sanitary bin or be double wrapped and disposed of in the normal waste.

Overcoming potential problems

Norton and Kamm (2001) carried out a trial with this product, comparing the two sizes, and found there was a high failure rate with both. Fourteen out of 20 patients were unable to tolerate either size.

In our specialist bowel dysfunction clinic, we were experiencing similar problems. We therefore

BOX 2. TREATMENT FOR ANAL INCONTINENCE

Conservative therapy
- **Pelvic floor muscle/anal sphincter exercise;**
- **Bowel retraining;**
- **Specialist dietary assessment and management;**
- **Biofeedback;**
- **Neuromuscular electrical stimulation.**

Medications
- **Bulking agents, for example isphaghula husks;**
- **Anti-motility medication, for example loperamide;**
- **Suppositories or enemas.**

Surgery
- **Anal sphincter repair;**
- **Rectal prolapse repair;**
- **Sacral nerve stimulation.**

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Pretlove, S.J. et al (2006)
Prevalence of anal incontinence according to age and gender: a systematic review and meta-regression analysis. *International Urogynaecology Journal;* 17: 4, 407–417.

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Royal College of Physicians of London (1995) Incontinence: Causes, Management and Provision of Services. London: RCP.

BOX 3. DEVELOPING CONFIDENCE TO RETURN TO WORK

Mr Green is aged 48 and has a five-year history of undiagnosed rectal mucosal prolapse. His GP did not examine him but treated him for haemorrhoids. Mr Green's symptoms then deteriorated significantly and he could not manage to correct the prolapse.

He was examined by his GP and had a surgical repair of the prolapse but was immediately unable to control faeces and experienced faecal incontinence of soft, formed stool 2–3 times per day.

He attended the specialist bowel dysfunction clinic where he was taught external anal sphincter exercises, given dietary advice and prescribed a combination of bulking agent and titratable doses of liquid loperamide.

He continued to experience episodes of incontinence, although fewer than when he was first referred to the clinic. His main issue was a fear of returning to work.

He tried anal plugs and decided that using these would give him enough confidence to return to work.

decided to try a different approach when patients first try the product.

Our standard practice was to give patients a sample box of plugs containing three of each size and send them home to try them. We found that patients did not use the plugs. When this occurred, we were not sure if it was because of intolerance of the product, misplacement in the anal canal or anxiety about using the plug.

We decided to offer a 'trial' of the plug within the clinic situation. Patients are invited to attend clinic for a short 10-minute appointment approximately one hour before their actual appointment. One of the specialist clinicians inserts the plug device and the patient is able to go and have a drink and walk around the health centre, testing the plug with the knowledge that it has been correctly inserted.

We tell the patients that using a plug for the first time is like getting used to wearing contact lenses, as the tissues around the anus are sensitive to the foreign object.

Patients have been reassured by this approach as they know that a specialist is available if there are any difficulties As a result there have been increased uptake by patients and success with using the plug (Boxes 3 and 4).

Conclusion

Although anal plug devices are not suitable for all patients with anal incontinence, they can make a significant difference to their quality of life.

We have found that it is worth offering new patients a 'trial' in clinic to see if they can become confident in using them.

In some European countries, a wider variety of anal plug devices is available. There is a possibility that, with further research and development, this device could be suitable for more people. ■

BOX 4. ENSURING CORRECT INSERTION

Mrs Ackers is aged 42 and has a history of faecal urgency and faecal incontinence for six years. Her BMI is greater than 35 and she has had multiple operations for anal abscesses.

She tried anal sphincter exercises, dietary modification and medications but there was no improvement.

A trial of a plug was offered to Mrs Ackers but she initially declined this due to embarrassment. She then took a sample pack home with her but reported extreme discomfort with using the plug and did not feel it was suitable for her. On further questioning, the patient reported that due to her size she had had some difficulty inserting the plug.

She had been told by a previous consultant that she had a long anal canal and she did not feel that she would be able to insert plugs herself.

After some discussion she was persuaded to have a trial of the device in the clinic. Her anal canal was actually of average length (3cm) and the device was inserted easily. She was very aware of the device but did not experience extreme discomfort and was prepared to try it again at home.

With a better understanding of her anatomy and the reassurance that the device was correctly inserted, she is now using the plugs regularly and reports a significant improvement in her quality of life.

This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net

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REFERENCES