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Fecal incontinence, constipation, and pelvic floor dysfunction:

TESTS AND TREATMENTS

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"Quite a number of conditions can affect the colorectal area," notes Domingo E. Galliano Jr., MD, FACS, FASCRS. "One of the most distressing – and taboo – is that of fecal incontinence/constipation and pelvic floor dysfunction."

Perhaps even more isolating than the more well-known condition of urinary incontinence, fecal incontinence and constipation can be caused by a variety of factors, explains Dr. Galliano.

"The bowel function is controlled by three things: the sphincter, a muscle which keeps stool from leaking; the rectum's storage capacity, or how much the rectum can stretch and hold stool before it must be released; and rectal sensation, the feeling that one must void a bowel movement. If anything interferes with these three factors, then fecal incontinence, constipation, and pelvic floor dysfunction, can occur."

The problem is more common than one might think. "It affects as many as five and a half million Americans. Damage to the nerves in the area, weak or damaged muscles – such as from difficult childbirth or episiotomy –inflammatory bowel disease, and irritable bowel syndrome (IBS) are all examples of possible causes of fecal incontinence.

"Fortunately," continues Dr. Galliano, "there are now new techniques for dealing with these problems."

If dietary changes, medical management, or bowel retraining programs do not eradicate the problem, fecal incontinence and constipation may be addressed through surgical and non-surgical procedures to correct the underlying physical problem. In the event that sphincter damage was caused by childbirth or rectal prolapse, surgery may prove to be an effective method of correction.

Testing and treatment

Anal-rectal physiology testing studies the function of the anus and rectum. Physicians order anal-rectal physiology evaluations, which combine several diagnostic tests, to help pinpoint the exact bowel problem a patient is experiencing. Test results determine the proper treatment to help correct or eliminate problems such as constipation, rectal pain, a bulging rectum, or fecal incontinence.

Several painless diagnostic tests can help diagnose fecal incontinence or constipation:

- **Anal rectal manometry:** evaluates the strength of the pelvic floor, the muscles controlling bowel movements, and only takes about 15 minutes.
- **Anal electromyography:** helps determine two things — whether the nerves supplying the sphincter muscles are intact and whether the muscles contract and relax normally.
- **Pudendal nerve latency test:** allows the physician to determine if nerves controlling the anal sphincter muscles have been damaged.
- **Defecography:** tests the motion of the pelvic floor and is performed in the radiology department using x-rays; takes about 15 minutes.
- **Anorectal ultrasound:** used to take images of the anatomy of the internal and external sphincter muscles.
- **Urodynamics:** tests for urinary problems.
- **Colonic transit study:** tracks how food moves through the colon, allowing the physician to detect constipation or problem areas.
- **Smart Pill:** a wireless motility capsule for colonic and whole gut transit time.

Surgical and nonsurgical treatment options for fecal incontinence/constipation include:

- **Pelvic rehab:** a behavioral treatment used for incontinence and constipation through which physicians and nurses work with patients to help them understand the condition and learn specific methods to bring the rectum back to a healthy level of function.
- **The Secca procedure:** delivers heat energy into the anal canal to improve the barrier function of the muscles. The procedure has a much quicker recovery time than standard corrective surgeries; for fecal incontinence only.
- **Sphincteroplasty:** surgical repair of a damaged sphincter muscle; for fecal incontinence only.
- **Sacral nerve stimulation:** a form of nerve stimulation via electrical impulses; for fecal incontinence only.

"Fecal incontinence, constipation and pelvic floor dysfunction typically respond well to non-invasive treatment," assures Dr. Galliano. "The key is finding a specialist who is board certified in colon and rectal surgery able to diagnose the problem and find a treatment that will restore bowel control or, at the very least, substantially reduce the severity of symptoms.

"The best approach is to develop an individualized treatment plan, which is the basis of our practice." **FHCN**–*Michael J. Sahno*

HERNIA HELP

Lose the girdle! Even complex hernias can be eliminated with this leading-edge procedure.

Hernias can be simple or complex. There are many different types of hernias – including femoral and umbilical hernias – but by far the most common type is the inguinal, or groin, hernia. Hernias are mostly repaired by minimally invasive surgical procedures.

A hernia is essentially a rupture or tear. Hernias typically occur in the abdominal wall cavity, but the areas near the natural openings in the groin (*inguinal*), below the groin (*femoral*) or through the navel (*umbilical*) are among the most common.

Another common type of hernia is *incisional*, which is to say the hernia is in an area where there has previously been a surgical incision. These types of hernias are fairly common among patients who have had a bowel resection or open gall bladder surgery, and women who have undergone total abdominal hysterectomy.

One thing is certain about hernias: they do not always resolve, even after a surgical procedure. Unfortunately, there are many hernia sufferers who have had surgery three or four times and are still not better. These people have *recurrent* hernias, since they occur over and over again.

Not surprisingly, incisional hernias often become recurrent. Whereas incisional hernias can occur in areas where the abdominal wall has been weakened by a previous surgery, recurrent incisional hernias are those that return even after having been repaired.

Patients in this group are truly facing a dilemma: each time they have their hernia repaired, it seems to heal. Then, within a period of months or even years, the hernia returns, usually worse than ever. Many of these patients go from doctor to doctor, sometimes being told to lose a hundred pounds or more before additional surgery can be attempted.

As few general surgeons want to take on these challenging cases, the patients often end up going through life wearing an abdominal binder under their clothes – the same type of binder used to keep a surgical site stable after abdominal surgery.

Like a girdle, the abdominal binder is a way to hold everything in place, but it is hardly a long-term solution: beneath it, the patient still has a large abdominal bulge, and underneath that their external and internal oblique muscles, and rectus abdominus muscle – all the muscles that hold in the intestines and bowel – have lost their shape.

Fortunately, there is now a solution for these complex hernia cases.

Domingo E. Galliano, Jr., MD, FACS, FASCRS, has received advanced training in Cleveland, OH for a minimally invasive procedure known as *reconstruction of the abdominal wall*, or *complex abdominal wall reconstruction.* Dr. Galliano is a surgeon in the Charlotte County area who is currently performing this leading-edge surgery.

During the procedure, the surgeon actually performs a closure of the complex abdominal wall defect. Even in situations where all of the abdominal muscles have separated, and the patient's internal organs are not being held back by the muscles anymore, Dr. Galliano can use the advanced surgical technique to provide a solution. Recently, he held a screening session for hernias where half a dozen patients who attended were suffering with these specific types of hernias. Some were candidates for complex abdominal wall reconstruction.

If you are suffering from recurrent hernias and are unsure where to go; if you have been turned away by hospitals and surgeons; if no one else has been able to help you, then you may be a candidate for complex abdominal wall reconstruction. For an evaluation, call **(941) 625-3411.**

Domingo E. Galliano, Jr., MD, FACS, FASCRS, is board certified in colon and rectal surgery by the American Board of Colon and Rectal Surgery and by the American Board of Surgery in general surgery. He is also board certified in Surgical Critical Care. After completing undergraduate work and receiving his medical degree, magna cum laude, Dr. Galliano completed a five-year general surgery residency at Jersey City Medical Center, NJ. He completed a fellowship in colon and rectal surgery at Greater Baltimore Medical Center, Baltimore. He also completed a fellowship in advanced colon and rectal surgery at the Cleveland Clinic, Florida. Dr. Galliano is a clinical assistant professor at the University of South Florida College of Medicine, Tampa. He has been in private practice in Port Charlotte since 1989, and he is affiliated with Fawcett Memorial Hospital, Peace River Regional Medical Center, and Charlotte Regional Medical Center.

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Dr. Galliano welcomes your inquiries regarding this article. He can be seen at **18308 Murdock Circle, Suite 108 &109** in Port Charlotte. For more information or to schedule a consultation appointment, please call **(941) 625-3411.**
Coming soon: future office opening in Englewood! Call for more details.