



وَقُلْ اَعْمَلُوا فَسَيَرَى اللّٰهُ
عَمَلَكُمْ وَرَسُولُهُ وَالْمُؤْمِنُونَ



اللّٰهُ
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**RECENT TRENDS IN MANAGEMENT OF
FAECAL INCONTINENCE**

Essay

*Submitted for fulfillment of M.Sc. Degree
In General Surgery*

By

Ahmed Abdel -FattahEid

**M.B.B.CH Elazhar University
2007**

Supervisors

PROF.DR. TarekElBahar

*Professor of General Surgery
Faculty of Medicine, Ain shams University*

DR.Mohammed AbouZeid

*Lecturer of General Surgery
Faculty of Medicine, Ain shams University*

*Faculty of Medicine, Ain shams University
Faculty of Medicine
Ainshams University
2014*

دراسة الجديد في علاج عدم التحكم في التبرز

رسالة مقدمة من

أحمد عبد الفتاح عيد
بكالوريوس الطب والجراحة

توطئة
للحصول على درجة الماجستير في طب الجراحة العامة

تحت إشراف

أ.د/ طارق البحار

أستاذ طب الجراحة العامة - كلية الطب جامعة عين شمس

د/ محمد أبو زيد

أستاذ مساعد الجراحة العامة

كلية الطب

جامعة عين شمس

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DR.Mohamed Mahmoud AbouZeid

Lecturer of General Surgery

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الأستاذ الدكتور

طارق البحار

أستاذ طب الجراحة العامة - كلية الطب جامعة عين شمس

أ. د / محمود أبو زيد

مدرس الجراحة العامة - كلية الطب جامعة عين شمس

كلية الطب – جامعة عين شمس

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Dedication



***My parent,
My Wife,
My brother,
My sisters.***

***"For their support in every step in my life
giving everything and never waiting for
anything***

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List of Abbreviations

| | |
|------------|---|
| ABS | Artificial Bowel Sphincter |
| ACE | Antegrade Continence Enema |
| AI | Anal Incontinence |
| AES | Anal Endosonography |
| ARA | Anorectal Angle |
| ARM | Anorectal Manometry |
| ASA | American Society Of Anesthesiologists |
| DGP | Dynamic Graciloplasty |
| EAS | External Anal Sphincter |
| EAUS | Endoanal ultrasound |
| EMG | Electromyography |
| FI | Fecal Incontinence |
| GAX | Glutaraldehyde Cross- Linked |
| GASS | German Artificial Sphincter System |
| GMT | Gluteus Maximus Transposition |
| HBO | Hyperbaric Oxygen |
| IAS | Internal Anal Sphincter |
| LAM | Levator Ani Muscle |
| LACE | Laparoscopic Antegrade Continence Enema |
| MACE | Malone Antegrade Continence Enema |
| MRI | Magnetic Resonance Imaging |
| NANC | Non-Adrenergic, Non- Cholinergic |
| NO | Nitric Oxide |
| PAS | Prosthetic anal sphincter |
| PCL | Pubococcygeal Line |

| | |
|-------------|---------------------------------------|
| PEC | Percutaneous Endoscopic Cecostomy |
| PNTML | Pudendal Nerve Terminal Motor Latency |
| PRM | Puborectalis Muscle |
| PTQ | Silicone Biomaterial (Bioplastique) |
| QOL | Quality Of Life |
| RAIR | Rectoanal Inhibitory Reflex |
| RF | Radiofrequency |
| SNS | Sacral Nerve Stimulation |
| STD | Sexually transmitted disease |
| TFF | Tetanic Fusion Frequency |

ABSTRACT

Fecal incontinence is a common problem and can have a major impact on the quality of life of those affected. Various disease processes affecting stool consistency, rectal sensitivity, or the anal sphincters can cause fecal incontinence.

Obstetric trauma is now known to be a major cause of sphincter dysfunction. The evaluation of the patient with incontinence helps to determine the choice of therapy— medical or surgical.

The two most important tests are anorectal manometry, which provides information on sphincter pressures, and rectal sensation, and anal endosonography, which is currently the test of choice for defining the anatomy of the anal sphincters.

The choice of therapy depends on the etiology of incontinence, the anatomy of the sphincters, and also on the effect of incontinence on the quality of life of the patient. Control of diarrhea, regardless of the cause, should be attempted first. Biofeedback therapy is effective in the majority of patients and is particularly attractive because it is safe and well tolerated. Surgery is offered when medical therapy is unsuccessful or when the etiology is thought to respond best to surgery, such as in post obstetric trauma. Sphincter repair, for treatment of selective sphincter defects, is the best surgical option. Neoanal sphincters and implanted artificial sphincters are far less attractive because of technical difficulties and low success rate.

keywords

Keywords : Fecal incontinence , anorectal manometry , endosonography, Biofeedback , Sphincter repair, Neoanal sphincters .