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News of the surgical treatment of anal incontinence: "Not everything is for everyone"

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As a caveat, I want to emphasize that the term anal incontinence is more correct than fecal incontinence, since the latter would not include incontinence to gas but only the loss of fecal matter. Anal incontinence is the inability to delay the evacuation, preventing voluntary control of rectal emptying. This pathology severely affects the quality of life of those who suffer from it and has a variable incidence of 8-21% with a considerable underreporting.

Multiple factors are related to its etiology: obstetric, traumatic, surgical, nerve injury, spinal cord injury, mental disorders and alterations in the consistency of stool.

After an initial evaluation that includes questioning, severity scores, quality of life scores, physical examination and the necessary complementary studies for each case, the treatment of these patients begins with diet, water restriction, fiber supplementation, pharmacological treatment and pelvic floor rehabilitation or biofeedback, if applicable.

In the event that the patient continues with symptoms, a range of treatment possibilities opens up, including: a) surgery (sphincteroplasty), b) alternative treatments (anal bulking substances, radiofrequency), c) devices to prevent involuntary emptying of the rectum (magnetic artificial anal sphincter, vaginal bowel system, anal insert device), d) electrical stimulation of the sacral roots or posterior tibial nerve, e) stem cell treatment and f) bypass or ostomy.

It is not the objective of this editorial to cover the latest news about each treatment, but rather to reflect on the current situation of surgical treatment for anal incontinence.

Each case must be well studied, it is essential to know the mechanism and causes of incontinence; Is it passive or active? Is it associated with hyper or hyposensoriality? Is there urgency to evacuate? All these data are the key to indicate the correct treatment. It is a mistake to interpret that all patients improve with the same and only treatment, or to consider that all cases are due to a muscle functional disturbance. There are complex mechanisms, reflexes and other factors involved. In my daily practice, I have seen many patients treated as incontinent, even in a surgical plan, when they presented a fecal discharge resulting from obstructive defecation syndrome (ODS), that is, treating a constipated patient as incontinent. Therefore, I insist, it is essential to understand the mechanism of continence and what particular situation is altered in each patient.

Sphincteroplasty is indicated when there is lack of continuity of the anal sphincters, in order to restore the circumferential configuration of the muscle and achieve the correct occlusion of the anal canal through its contraction.

Generally, incontinence occurs with muscle injuries ranging from 60o to 180o. The main indication of sphincteroplasty is a tear or injury of obstetric cause, usually involving the anterior portion of the sphincter complex. In many cases, must be associated with perineorrhaphy due to the decrease or absence of the perineal body.

The main disadvantage of this technique is that the symptomatic improvement initially obtained shows a near to 60% decrease after 5 years of follow-up. It has been demonstrated that the main adverse prognostic factor is patient age preoperatively and wound infection postoperatively. The latter complication occurs in 4-12% of patients and even up to 27% in some publications. Infection of the skin and soft tissues almost inevitably leads to the opening of the sphincteroplasty. Faced with this situation, there are authors who do not contraindicate a second surgical repair, but the opinions and results obtained are generally worse than those of the first repair.

Some considerations are necessary when evaluating the results of any therapy for the treatment of incontinence. On one hand, there is frank heterogeneity in the classification of clinical severity and, on the other, in the evaluation of results obtained. It is complex to compare patient studies when each author uses a different classification and definition of success, making their results difficult to interpret. Many authors consider an improvement greater than 50% as a successful treatment, underestimating the remaining symptoms of the patient. For example, a patient with a Wexner score of 18 may have gone to a score of 9 that continues to affect her/his quality of life, however some authors classify it as "success". Each patient is different and the effect on their mood, embarrassment and de-

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pression in an incontinence situation is also different, so I consider it more complete to use severity scores together with quality of life scores (FIQL).

Although there is no "gold standard" in the treatment of anal incontinence, it is inevitable to mention sacral neuromodulation as it is probably on the way, due to the good results obtained throughout the world. This is the treatment that has more advantages than disadvantages and in a certain way occupies a central place in the management of this type of patients, with short, medium and long-term results close to 80% of effectiveness and even more. Its contraindications are very few and they will be even fewer since new devices (cables and generators) compatible with the performance of an MRI are being developed. Undoubtedly, the main factor against it is its price, which increasingly affects underdeveloped countries like ours.

While neuromodulation therapy is interesting and attractive, and the results are so good that it excites any physician who performs it, I do not share the opinion of some colleagues who suggest it in any patient, regardless of cause and severity. You can sometimes hear "I neuromodulate all patients", even those with only gas incontinence.

Several authors demonstrated that sacral neuromodulation is also effective in patients with a muscle defect that has not been previously repaired, with similar results to those of patients who underwent a previous sphincter reconstruction. This is another matter of controversy, partly based on the economic difficulties that we must overcome in our health system. There are different realities between developed countries and ours. In this sense, in Argentina it is very impractical to be able to neuromodulate a patient without having previously corrected the muscle defect, since any third party payer or audit will request the treating physician to have exhausted all previous therapeutic instances to approve the cost of neuromodulation. I consider surgical repair to be helpful but there are also particular situations where the first line treatment should be neurostimulation. The benefit of sphincteroplasty exists and even more so if the damage is extensive, since it not only restores continence (even temporarily) but also normal anatomy, with its consequent benefit in the aesthetic, functional and sexual aspects.

I always remember having witnessed in a congress when the pioneer in the world in neuromodulation was consulted after an extensive and interesting presentation on how he would treat a patient unresponsive to sacral neuromodulation and stated "I would do the patient a sphincteroplasty because half deteriorates, but the other half does not ".

For all the aforementioned, I consider that sacral neuromodulation is probably the best treatment that can be offered to our patients, but the sphincteroplasty, a therapy neglected by many authors and reference centers in the first world, still continues to be a currently alternative, especially in the face of financial difficulties to acquire a high-cost therapy. It offers the benefits of returning normal anatomy and has good results in the short, medium and even long term in a percentage of patients.

Neuromodulation is here to stay, but sphincteroplasty has not gone away, even less so in Argentina. Each case must be carefully evaluated and without generalizing, since not everything is for everyone.