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Letter to the Editor

Fecal Incontinence in Older Patients: A Narrative Review[☆]



Incontinencia fecal en el paciente anciano. Revisión de conjunto

We have read with interest the narrative review on fecal incontinence (FI) in elderly patients by the authors García Cabrera et al.,¹ published in the March issue of CIRUGÍA ESPAÑOLA.

The authors comment that the treatment of FI in these patients should be a combination of habit modification, hygiene-dietary measures, medication and, to a lesser extent, surgery. We cannot agree more with this statement, but it should be emphasized that, among the predisposing factors mentioned, polypharmacy in the geriatric population is associated with a high morbidity secondary to adverse reactions and interactions, including fecal incontinence.

In the USA, 21.6% of the population over 65 years of age have diabetes mellitus² with associated gastrointestinal disorders, including FI.³ The latest studies frequently give more importance to the side effects of oral antidiabetics (OAD) than to the disease itself. Metformin has been associated with intestinal transit alterations (25%) and diarrhea.^{4,5}

Coloproctology units are referred diabetic patients with fecal incontinence secondary to pharmacological treatment in whom the simple withdrawal of the drug can rule out a significant cause of FI or its aggravation. Metformin causes intestinal hypermotility, malabsorption and sphincter hypocontractility.⁶ According to Dandona et al. in an older review,⁷ there is a strong association between episodes of diarrhea incontinence and reduced sphincter tone, and symptoms remit after the drug is withdrawn. Another drug implicated in FI is olmesartan, which is used in hypertension, with less impact than metformin, but with associated severe diarrhea and weight loss, and has been described as a “sprue-like” enteropathy.^{8,9}

“De-prescribing” should be considered when there is polypharmacy and adverse drug reactions.¹⁰ In acute adult care, the number one cause of FI has been associated with medications (49%), followed by neurological disorders (40%).¹¹

Therefore, we should bear in mind that certain medications such as metformin and olmesartan may cause or aggravate previous FI. At the same time, it is necessary to emphasize and remember the importance of the patient’s clinical history and explore any possible adverse pharmacological effects by systematically reviewing current medication before performing complementary tests such as manometry, endorectal ultrasound or other functional tests.¹²

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