

Artificial bowel sphincters for severe fecal incontinence

Are they a solution?

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ABSTRACT

يعد مرض سلس البراز من المشاكل الشائعة والمهكرة التي تؤثر على المريض من الناحية الطبية والاجتماعية والاقتصادية. يشمل العلاج غير الجراحي كلاً من: تعديل النمط الغذائي، وتعاطي الأدوية المضادة للإسهال، واستخدام طريقة الأثر الرجعي البيولوجي (Biofeedback) مثل عمل التمارين الدورية لمنطقة الحوض و العضلات السفلية. ويمكن تقسيم المرضى الذين يعانون من سلس البراز الشديد إلى فئتين: الفئة الأولى وتضم المرضى الذين يعانون من خلل تشريحي معروف و محدود في العضلة الشرجية العاصرة وفي مثل هذه الحالات يمكن لعملية إصلاح العضلة الشرجية العاصرة أن تنجح على المدى القصيرة وذلك بنسبة تصل إلى 80%، أما الفئة الثانية فهم المرضى الذين لن يستفيدوا من عملية تعديل العضلة الشرجية العاصرة، كما لا يُحتم عليهم عمل فغارات معوية جانبية (stomas). وتعد عملية زراعة الصمام الاصطناعي الذي يحل محل العضلة الشرجية العاصرة من العمليات الجراحية المعروفة التي تساعد على إيقاف السلس، واستعادة الحياة الطبيعية والوظيفية وذلك بنسبة نجاح عالية. يحتاج الجراح المتخصص إلى فهم كيفية عمل مثل هذه الصمامات، كما يجب عليه إتقان زراعة مختلف أنواعها وذلك بما يتناسب مع حاجة المريض، وعلى الطبيب أيضاً المتابعة المستمرة لحالة المريض من أجل تقديم خدمة أفضل لمثل هذا النوع من الحالات.

Fecal incontinence is a debilitating and common problem with a profound effect on a patient's well being medically, socially, and economically. Non-operative management of this condition includes dietary modification, antidiarrheal medications, and biofeedback. Patients with severe incontinence can be divided into 2 categories. The first group includes patients with an identifiable and isolated anatomic sphincter defect who can expect 80% short-term surgical success using overlapping sphincteroplasty. The second group is patients who will not benefit from sphincteroplasty; fortunately, they are not obligated to permanent stomas. Artificial bowel sphincter (ABS) implantation is a well-established surgical technique, offers a chance for continence, restoration, and improved quality of life with significant functional success rate. The surgeon needs to understand how they function.

They should be proficient in different procedure types and match these with the patient's need. Post-operative long-term follow-up continues to help surgeons better serve this type of patient population.

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Fecal incontinence (FI) is defined as recurrent uncontrolled passage of flatus and/or stool for at least one month in an individual who is at least 4 years of age or above.¹ It can be a distressing and incapacitating disorder that can devastate the life of the affected individual. It is a common problem that affects both genders at any age with variable age related prevalence reaching 1.5% in children to approximately 50% in nursing home residents. Both genders seem to have an equally increasing incidence with aging.² A survey carried out in the 1990's of American households found that 7.1% of the general population reported having varying degrees of anal incontinence,³ 11% was found in a French study on 3914 patients,⁴ and approximately 1.5-4.8% was found in the Federal Republic of Germany.^{5,6} However, the incidence of FI in Saudi Arabia is unknown. It is not typically a popular topic for discussion because of its highly private nature and negative associations. Likewise, worldwide, it is unknown, and difficult to establish because of the unavailability of a standard scoring scale, differences in data collection, under-reporting of symptoms by patients, and variations in the population sample.⁷ When both non-operative medical treatment and conventional surgery are ineffective, the artificial bowel sphincter

(ABS) emerges as a choice for these patients who would not otherwise opt for, or accept end colostomy. This technological advancement has opened up the prospect of effective therapy for severe fecal incontinence both in regards to performance and long-term reliability. Searching various biomedical bibliographic databases including MEDLINE, EMBASE, HEALTHSTAR, THE COCHRANE LIBRARY, SCOPUS, CENTRAL, and other non-indexed citations and without any limitations, articles and recently published abstracts of meetings were selected based on greatest clinical relevance. All were reviewed aiming to provide an overview of the different ABS types, their descriptions, how they function, indications, contraindications, clinical results, and their complications.

Historical background. Fetal incontinence can be successfully managed by medical treatment. It includes a wide range of measures such as antidiarrheals, bulk laxatives, and biofeedback, which may, substantially benefit some patients. However, the long-term results depend mainly on patient compliance. Surgical treatment for incontinence can only benefit selected patients. Patients with an identifiable and isolated anatomic sphincter defect can expect 70-90% short-term surgical success with a simple overlapping sphincteroplasty.^{8,9} Unfortunately, this repair does not sustain good function in the long run. A 5-year follow-up in 47 patients who had undergone sphincteroplasty for obstetric-related trauma, revealed a success rate of 57% with no need for further therapy, while 14% required further intervention.¹⁰ In another study, at the 10-year follow-up of 191 patients, 40% had gained some improvement in continence and only 6% gained complete continence.¹¹ Sphincteroplasty is not an option for patients who suffer from extensive sphincter damage, muscle loss, or pudendal neuropathy. In the 1980s, external stimulators were applied to muscle transpositions (dynamic graciloplasty [DGP]) to create dynamic neosphincters with resting muscle tone, which was pioneered by Baeten et al.¹² Wexner et al¹³ reported a 62% success rate and improvements in functional and quality of life variables, which persisted for 2 years. However, DGP was associated with high complication (74%) and re-operative rates (40%).¹⁴ Some of these complications led to stoma creation, or death.¹⁵ This leads to the removal of the stimulator device from the US market,¹⁶ and the procedure has not been performed in the United States since 1999,¹⁷ though it does remain a viable option in other countries.^{16,18,19} In the 1990s, both sacral nerve stimulation (SNS) and the artificial anal sphincter emerged as other viable options for patients who had undergone and failed simple surgical repairs, complicated muscle rotation procedures, and others who were not candidates for simple overlapping

sphincteroplasty, or those who did not wish to undergo more complicated surgeries. A hundred years ago, SNS was described for use in urologic disorders.²⁰ However, it was not until 1995 that it was adapted for the treatment of fecal incontinence.²¹ The SNS procedure is safe with minimal morbidity,²¹⁻²⁴ most commonly, pain (9-26%) at the site of the implantable pulse generator, the subcutaneous tunnel in which the wires run, or at the electrode sites,²⁵ and superficial wound infection (3-17%).²⁰ Although long-term data are not yet mature, the medium-term results are promising. In the last review,²⁶ published by the International Consultation on Fecal Incontinence (ICI) Guidelines, a grade C recommendation has been given to SNS as a second line therapy for patients suffering from sphincter defects of greater than 180 or major perineal tissue loss, if initial reconstruction could not be performed, or failed and incontinence persisted. More information from randomized trials is required to clarify the role of SNS in treating fecal incontinence.

Artificial bowel sphincters. Prosthetic sphincters have been used for incontinence for more than 30 years for urinary incontinence with an excellent success rate that exceeds 90%.²⁷ The ABS was adapted from the artificial urinary sphincter (AMS 800) and introduced in 1972 by the American Medical System (Minnesota, USA) for the treatment of patients with severe fecal incontinence. Christiansen et al²⁸ in 1987, were the first group to report the use of the AMS 800® artificial urinary sphincter for fecal incontinence with excellent results with no complications at a follow-up of 3 months. Since then, several studies and trials have emerged, studying and trying different types of ABSs and comparing them to other treatment models. Currently, there are 3 types of ABSs that have been used on patients, and several others that are still at the laboratory phase, and have not yet been launched to clinical practice. These include, the German Artificial Sphincter System (GASS), which is an entirely new experimental and high-tech sphincter made of polyurethane. It consists of a support ring including 2 cuff elements: a fluid reservoir fixed on its outer diameter and a multi chamber occluding the cuff on the inside diameter. This device was evaluated in pig's anal canals and achieved adequate continence at very low working pressures (17.5-41.4 mm Hg), thus, promising a correspondent low risk of intestinal ischemic injury, erosion, and bleeding.²⁹⁻³¹

In this section, the main discussion will be on 3 clinically applied sphincters, device structure, indications and contraindications, results of clinical studies, future applications, and challenges.

Indications and contraindications for anti-incontinent prosthesis. Benign disease. The indications for the artificial sphincter are usually the same for those

of the biological sphincters, namely, DGP.³² Candidate patients are those who are suffering from substantial anal sphincter damage that is not amenable to simple surgical repair. Examples include a sphincter complex that has become non-functional due to severe neurogenic damage, congenital disease such as anal atresia or spina bifida, or even failure of previous sphincter restoration therapies.³³ The pediatric population with such congenital anomalies as imperforated anus would benefit from treatment with the ABS where implantation of the sphincter device can be deployed at the time of the 'pull-through' operation, or many months/years later as a secondary procedure.³⁴⁻³⁷ In addition, ABSs may be useful in managing fecal incontinence of neuromuscular origin, as in myasthenia gravis or diabetic neuropathy.³⁸⁻⁴⁰

Malignant disease. Recently, ABSs have been successfully implanted in patients who have had surgical resection of the anus, abdominoperineal resection for low rectal or anal cancer.⁴¹ However, there should be sufficient soft tissue in the perineum to support the placement of the cuff around the new anal canal.^{7,42} Only a handful of cases have been reported, possibly because of the general concern regarding the risk of cancer recurrence thus limiting the experience on this subject.

Contraindications to implantation of the ABS include active ongoing or chronic pelvic infection, radiation-induced perineal lesions, excessive perineal descent,⁴³ Crohn's disease, poor functional status, and receptive anal intercourse.^{20,44} Patients with restrictive rectal compliance conditions resulting in chronic diarrhea, persistent fecal impaction, or those who have had previous surgeries resulting in a severely scarred perineum, or impaired vascular supply are not suitable candidates. Inability to cope psychologically, as well as overlying skin disease at the area, or pregnancy,³³ and activities, such as bike riding and horse riding have been considered as limitations to ABS implantation²⁰ (Table 1). Some authors have also considered age as a limitation and a relative contraindication, for patients who are less than 16 and older than 75 years.^{42,45}

Types of anal sphincters. 1. Acticon® Artificial Bowel Sphincter. The first implantation of this new device (the Acticon® ABS, American Medical Systems, Minneapolis, MN, USA) was performed in Nantes, France, in May 1996.⁴⁶ Since this time, experience has been acquired in numerous expert centers worldwide. Three years later, the American Food and Drug Administration (FDA) approved the humanitarian use of the device after completion of a multicenter trial,⁴⁷ ever since, this has become the most commonly used device worldwide. Most clinical trials have been carried out on it. The Acticon® ABS consists of 3 main components (cuff, balloon, and pump) (Figure 1). All 3 parts of the

Acticon® ABS are made of solid silicone elastomers that are inert with minimal to no risk of rejection by the body, totally implanted subcutaneously, and linked by subcutaneous kink-resistant and color coded tubes. The occlusive cuff is implanted around the upper part of the anal or neo-anal canal. The control pump is placed in the scrotum or labium. The pump has 2 parts; a hard upper part, which contains the resistor and valves needed to regulate the rate of fluid circulation throughout the system, and a deactivation button allowing fluid cycling to be stopped by external action. The patient squeezes and releases the soft lower part of the pump several times to transfer fluid within the system. A septum at the bottom of the control pump is designed to allow the insertion of a small amount of fluid, if needed, in the postoperative period.⁴⁸ The pressure regulating balloon

Table 1 - Clinical indications and contraindications.

Indications	
Sphincter trauma	
Neurologic	
Idiopathic	
Failure or contraindications to sacral nerve stimulation	
Imperforated anus	
Advanced age	
Diabetes	
Relative contraindications	
Scarred perineum	
Thin recto-vaginal septum	
Handling difficulties	
Absolute contraindications	
Excessive perineal descent	
Severe constipation	
Irradiated perineum	
Perineal sepsis	
Crohn's disease	
Anal intercourse	

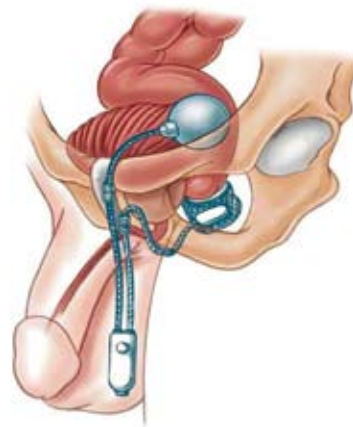


Figure 1 - Acticon® neosphincter implanted in a male. The inflatable cuff around the anal canal is connected to the control pump that is subcutaneously positioned in the scrotum, and connected to the regulating balloon, which is placed either in the prevesical space. Reproduced and published with permission of American Medical Systems, Inc., Minnetonka, Minnesota (www.americanmedicalsyste.ms.com)

is implanted in the lower abdomen, under the muscle layer, just above the pubic symphysis, which is normally filled with a sterile solution usually saline that can be imaged with plain x-ray (Figure 2).⁴³

2. The A.M.I. Soft Anal Band. The A.M.I. Soft Anal Band Implant (Agency for Medical Innovations GmbH, Feldkirch, Austria) is a manually operated system and is implanted subcutaneously. The system consists of 4 parts. The Soft Anal Band Implant is placed inside the surgically created circular pocket around the anal sphincter and is connected to a small and stable, domed shaped valve. When the valve is activated, liquid flows back from the band to the activator, which is a strong and reliable silicone balloon. By applying pressure (with the palm of the hand) on the skin above the activator, liquid flows back into the band resulting in closing the anal band; thus, continence is achieved. The fluid required to obtain maximum continence is adjusted as needed through the calibration port (Figure 3). The anal band ring should be left open for 6 weeks to assure optimal healing before activating it.^{49,50}

3. Prosthetic Anal Sphincter (PAS®). (NPH Design Ltd. Pavilion Road, London, UK) The device was first introduced to the market at the Tripartite Colorectal Conference in Dublin in July 2005 (http://www.ihe-online.com/index.php?id=1186&tx_ttproducts_pi1%5Bproduct%5D=3329), after passing the approval of the European Community regulations and the Medical Devices Agency. This device was designed to overcome the ischemic complications associated with other models.⁵¹⁻⁵³ It is devised to simulate the normal physiology of the ano-rectum, reproducing the action of the puborectalis muscle by flattening and angulating the bowel without causing crenation. Therefore, it reflects the normal action and function of the anal sphincter and pelvic floor muscles,⁵⁴ reproducing the action of the puborectalis muscle. The sphincter consists of 4 parts, 3 parts are implanted intra-peritoneally, an inflatable linear expander, a soft gel-filled pillow, and a balloon reservoir, all are placed around the bowel at the level of the anorectal junction. The control pump is subcutaneously placed in the right iliac fossa where it is manually operated by the patient. Pumping transfers fluid within the system. The device is activated 6 weeks after surgery.⁵⁴

Clinical results. Success rate and functional results. Success rates for the artificial sphincter vary from 49-82%,^{20,55} based on clinical assessment, enhancement in quality of life, and a high degree of safety.^{19,47,56} However, direct comparison of continence outcomes across studies is difficult owing to the use of 3 different continence measurement systems: the Williams, the AMS and the Cleveland Clinic Continence scales (Wexner incontinence scores).^{47,57-59} Unfortunately, not

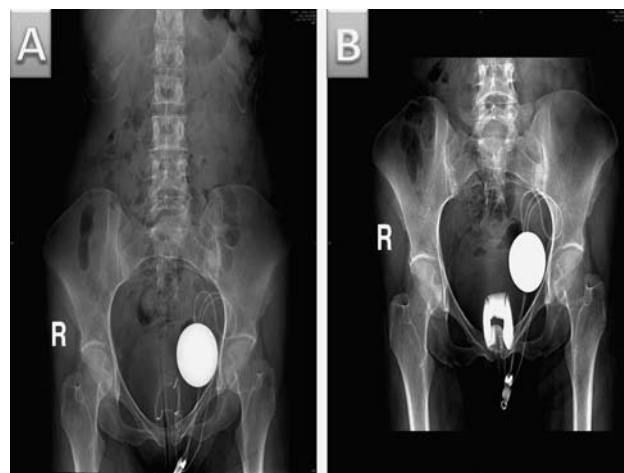


Figure 2 - Abdominal x-ray of Acticon® neosphincters in situ showing: A) at rest, and B) in closed status.



Figure 3 - The A.M.I. Soft Anal Band Implant is a manually operated system that is implanted subcutaneously. Twenty ml of sterile water is needed to achieve proper closing pressure. Reproduced and published with permission of the Agency of Medical Innovations (A.M.I.) (<http://www.ami.at>)

all studies presented fecal incontinence scores before and after implantation, as well as statistical analysis not conducted on an intention-to-treat basis (except one study⁴⁷). Table 2 summarizes the clinical trials results, assessing continence after the device was implanted. Most studies have also shown an increase in resting pressure after artificial anal sphincter implantation. However, changes in squeeze pressures were more equivocal.⁵⁵ Wong et al⁴⁷ implanted 112 Acticon® ABS's in a multicenter cohort study. Eighty-five percent had a functioning device and improved from a mean baseline incontinence score of 106 to 54 postoperatively. Continence rates after Acticon® ABS implantation remarkably improved to between 75-100% for solids, and 50-66% for gas. Parker et al⁶⁰ identified 2 patient

groups: the first who received implants before 1992 (n=10; mean follow-up, 91 months) and the other, those who received implants between 1995 and 2001 (n=37; mean follow-up, 39 months). The overall success rate in the former group was 60% (4/10 explants). The latter group had an overall success rate of 49%. Those patients who had successful implantation procedures enjoyed a 100% functional success rate at 2 years.⁶⁰ Finlay et al⁵⁴ used the PAS in 12 patients with severe fecal incontinence, which was placed in the pelvis around the anorectal junction via a transabdominal approach. At a median follow-up of 59 (range 30-72) months, 9 of the 12 patients had a functioning PAS. The PAS was effective in restoring continence in 10 of 11 patients. Median (range) Cleveland Clinic continence scores improved from 16 (7-20) before to 3 (0-7) after implantation with a corresponding score of 3 (range 0-7) at one year after activation. The PAS has a comparable continence rate of 91% (10 of 11 patients) to Acticon® ABS. The AMI Soft Anal Band was used by a German group led by Baumgartner⁶¹ on 14 patients (10 female) with severe fecal incontinence; all failed optimum conservative treatment with biofeedback, and 9 failed the sacral nerve stimulation trial. The mean patient age was 59 years (39-71), mean duration of follow up was 13 months (3-40). Self-reported quality

of life improvement of 70-100% was reported in 7/14 patients, 30-70% improvement in 4/14 (no data was available in 3/14).⁶² Wexner incontinence scores improved from a median of 16 (12-18) pre treatment to 2 (0-6) post operatively ($p<0.0001$). However, we still await the publication of their work.



Figure 4 - Erosion of the control pump through the scrotum. (Romano G, Bianco F, Ciorra G. Total Anorectal Reconstruction with an Artificial Bowel Sphincter. Rectal Cancer Book. Milan (Italy): Springer; 2005). Published with permission from Springer Science + Business Media

Table 2 - Summary of the functional outcome of studies reporting continence gradient.

References	Year	n	Mean age, years	Follow up, months Mean (range)	Continence grading scale		
					Before implantation Median (range)	After implantation Median (range)	P-value
<i>Cleveland clinical scale</i>							
Baumegranter ⁶¹	2009	14	59	13 (3- 40)*	16 (12-18)*	2 (0-6)*	0.001
Da Silva ³⁵	2004	11	25.3	20.4 (5-68.4)	18.5	7.5 [†]	<0.01
O'Brien ⁶⁵	2004	7	66	6 (0)	19 (1.2)	4.8 (4.0)	<0.001
Finlay ⁵⁴	2004	12	47	59 (30-72)*	16 (7-20)*	3 (0-7)*	NR
Ortiz ⁶⁶	2003	8	34.4	44 (13)	16 (6.75)	8 (14.65)	0.018
Romano ⁴²	2003	8	52	14 (6-28)	11.75	3.8	NR
Devesa ⁵⁵	2002	53	46	27 (7-55) [†]	17 (1.8)	4.5 (3.4)	0.001
Ortiz ⁶⁷	2002	22	47	26 (6-48) [†]	18 (14-20) [†]	4 (0-14) [†]	0.001
Altomare ⁶⁴	2001	28	58	19 (7-41) [†]	15 (11-20)*	3 (0-6)*	<0.001
O'Brien ⁶⁸	2000	13	44	not reported	19 (1.6)	2 (2.6)	<0.001
Lehur ⁵⁶	1998	13	40	30 (5-76) [†]	17 (1.8)	4.5 (3.4)	<0.001
Vaizey ³⁷	1998	6	53	10 (5-13) [†]	19 (0.8)	4.5 (4.9)	0.001
<i>AMS scale (Fecal incontinence scoring system)</i>							
Casal ⁶⁹	2004	10	56	29 (9-56) [†]	99.9 (83-120) [†]	28.4 (0-58) [†]	<0.001
Parker ⁶⁰	2003	47	39.5	91	103 (74-120)	59 (0-108)	<0.001
Lehur ⁶³	2002	16	43	25 (7-49) [†]	105 (14)	23 (22)	<0.05
Michot ³⁶	2003	37	51.1	34 (7-60) [†]	100	63.1	NR
Wong ⁴⁷	2002	112	49	12	106 (71-120) [†]	48 (0-108) [†]	<0.001
Lehur ⁴³	2000	24	44	20 (6-35) [†]	106 (13)	22 (25)	<0.001
Dodi ⁷⁰	2000	8	56	11 (4-23) [†]	96 (12-0)*	19.4 (19.3)*	<0.004
<i>Williams scale</i>							
Christiansen ⁵⁷	1999	17	46	84 (60-120) [†]	5 (0-0)	2.5 (0.9)	<0.001

Values of continence grading scale are means (standard deviation) unless indicated, *median range, [†]means (range). NR - not reported

Complications. A wide range of complications had been reported from a minor wound infection to a major complication that necessitated device explanation and creation of permanent colostomy. Comparison among studies is difficult (Table 3), because of different devices, and different continence scores.

Infection. Infection remains the main harbinger of device failure with rates of 4-60% (Table 3).^{37,43,47,55,56,63-67,69} This high rate is believed to be partly because of the implantation of a foreign object in the anorectal region.⁵⁸ Most of the studies reported postoperative infections in the perineal or abdominal surgical site before the device activation.^{35-37,42,43,47,54,55,57,60,64,67-72} The risk of infection is substantial in those with existing stomas, skin conditions, impaired immunity, and diabetes.^{48,74} Nonetheless, after activation many infections were caused by erosion of the device and resulted in explantation.^{35-37,42,43,47,54,55,57,60,64,67-70,72}

Erosion or ulceration. Erosion and ulceration (Figure 4) occur as a result of ongoing sepsis, improper size, or positioning of the device, prior tissue damage from radiation and skin conditions. Unfortunately, explantation owing to erosion is a common outcome at a rate of 36%.^{47,55,73,75,76}

Chronic pain. Chronic pain had been reported in almost half of the studies in a rate ranging from 4-17%, mostly occurring after device activation.^{19,47,55,56,64,67,68,77}

Constipation/fecal impaction. These 2 common problems are usually resolved by a combination of dietary modification and use of oral laxatives. However, occasionally regular enemas may be required as described by Lehur and colleagues,⁵⁶ 6 of 13 patients experiencing obstructed defecation that required regular enemas. Postoperative fecal impaction rates ranging from 6-83%^{37,57} have been reported in 6 studies that used the Acticon® device.^{37,47,55-57,68}

Mechanical failure. This is nearly always an implantation technical issue, given that less than 3% of all mechanical failures are attributed to the device itself. These can usually be surgically revised with a high success rate.⁷⁸ This mechanical failure is in the majority because of inadvertent blocking or kinking of the tubing system or fluid leakage from accidental damage causing inadequate balloon pressure. Wear and tear of the device parts that may include control pump failure, disconnection of its prime components, or even damage from repeated trauma, all these are reasons for device failure.⁷⁹

Table 3 - Complication rates following device implantation.

References	Year	Device type	n	Mean age, years	Constipation/ Fecal Impaction (total)	Infections (total)	Erosion (total)	Mechanical Failure (total)	Revisions (total)	Explants/ Reimplants (total)	Functioning devices (total)	Success(%)
Baumgranter ⁶¹	2009	A.M.I. Soft anal band	14	59	1 (7.1)	0	0	5	5	0/0	14	64
Da Silva ³⁵	2004	Acticon	11	25.3	3 (38)	1	0	1	1	0/0	11	80
Altomare ⁷²	2004	Acticon	28	58	8 (29)	7	7	3	6	0/0	21	66
Casal ⁶⁹	2004	Acticon	10	56	1 (10)	2	3	2	4	3/2	9	90
O'Brien ⁶⁵	2004	Acticon	7	66	2 (14)	0	2	0	3	1/0	6	77
Finlay ⁵⁴	2004	PAS®	12	47	2 (17)	3	0	2	5	3/0	9	not reported
Ortiz ⁶⁶	2003	Acticon	8	34.4	2 (25)	0	4	4	5	4/1	5	20
Parker ⁶⁰	2003	Acticon	45	39.5	5 (11)	12	0	18	25	22/2	25	12
Romano ⁴²	2003	Acticon	8	52	3 (38)	1	0	0	0	0/0	8	63
Michot ³⁶	2003	Acticon	37	51.1	7 (19)	5	5	5	8	11/2	28	78
Devesa ⁵⁵	2002	Acticon	53	46	11 (22)	10	9	2	16	10/6	26	60
Wong ⁴⁷	2002	Acticon	115	49	30 (26)	38	24	7	73	34/9	75	53
Ortiz ⁶⁷	2002	Acticon	22	47	2 (9)	3	5	2	6	9/2	15	40
Lehur ⁶³	2002	Acticon	16	43	5 (31)	0	1	0	2	4/1	12	75
Altomare ⁶⁴	2001	Acticon	28	58	15 (54)	5	2	1	1	7/0	21	75
Lehur ⁴³	2000	Acticon	24	44	9 (38)	1	3	3	9	8/3	19	18
Dodi ⁷⁰	2000	Acticon	8	56	2 (25)	2	1	0	0	2/0	6	60
O'Brien ⁶⁸	2000	Acticon	13	44	not reported	2	2	0	4	3/1	10	77
Christiansen ⁵⁷	1999	AMS 800	17	46	2 (12)	18	2	41	6	7/0	8	47
Lehur ⁵⁶	1998	Modified AMS/ ABS	13	40	6 (46)	1	1	1	1	4/2	11	84
Vaizey ³⁷	1998	Modified AMS	6	53	not reported	2	1	0	1	1/0	5	83
Wong ¹⁹	1996	Acticon	12	33	not reported	2	0	3	7	5/4	9	75
Christiansen ⁷³	1992	Modified AMS	12	50	2 (17)	3	0	4	8	2/0	10	83
Christiansen ³⁸	1989	AMS 800	5	50	1 (20)	2	0	1	3	1/0	4	60

PAS - Prosthetic Anal Sphincter, AMI - Agency for Medical Innovations, AMS - American Medical Systems

Recurrent incontinence. The true rate of recurrent incontinence with the device in situ is not known. There is no universally agreed upon definition of recurrent incontinence with the device in situ. In fact, many patients are highly motivated and determined to avoid a colostomy at any cost. This leads them to ignore reporting variable degrees of incontinence. Nevertheless, the various validation tools in use, to measure fecal incontinence, are subjective and not uniform.⁷⁹

Surgical revision, explantation, and re-explantation. The rate of surgical revision ranged from 2 of 16,⁶³ to 6 of 12.¹⁹ Revision surgery with replacement of a part of or the entire device occurred in between 7-25% of patients (Table 3).⁴⁸ Several leading causes to explantation have been identified that include perioperative infection, failure of wound healing, erosion of part of the device through the skin or the anal canal,^{47,55,75} late infection, and mechanical malfunction of the device due to cuff or balloon rupture. The overall incidence of permanent explantation of the ABS varied between 17-31% in follow-up periods of between 10-58 months.⁴⁸ Even with improved experience, there is a fairly constant explantation rate of 31-33%, although the revision rate has improved.^{75,80} Numbers of device explantation increases with time mostly due to device related problems. However, studies failed to identify any precise predictive patient-related factors leading to device explantation.⁷⁶

In conclusion, in the face of living the rest of your life with a permanent colostomy, the use of artificial sphincters for end-stage fecal incontinence or following rectal excision for cancer is an acceptable management strategy to obtain continence and restore anal defecation. Despite the high morbidity associated with these device implantations, they significantly improve control of defecation and thus, improve QOL for the incontinent patient. Selection of patients is mandatory to achieve best results; operator experience is also very important in the successful outcome of the procedure. Patients' incapability to perceive when to defecate adds restraints on the wide applicability of artificial anal sphincter implantation, so they must be trained to establish the habit to defecate after the device has been implanted. Therefore, a novel artificial anal sphincter system is needed to simulate the normal physiology of the human anorectum based on transcutaneous power delivery. There are some doubts regarding the safety and the effectiveness of these prostheses owing to the low-level of evidence that is available, making one conclude that there is limited or uncertain benefit from implanting these devices. However, to have an accurate and unbiased evaluation on the use of the ABS's, will be possible only when research follows well-defined

standards regarding the study design, together with short- and long-term outcome data on an intention to treat basis. Applying strict rules will result in obtaining standardized data leading to significant evidence-based conclusions.

References

1. Fonseca AP, Correia P, Sousa JC, Tenreiro R. Association Müller C, Belyaev O, Deska T, Chromik A, Weyhe D, Uhl W. Fecal incontinence: an up-to-date critical overview of surgical treatment options. *Langenbecks Arch Surg* 2005; 390: 544-552.
2. Nelson RL. Epidemiology of fecal incontinence. *Gastroenterology* 2004; 126 (1 Suppl 1): S3-S7.
3. Drossman DA, Li Z, Andruzzi E, Temple RD, Talley NJ, Thompson WG, et al. U.S. householder survey of functional gastrointestinal disorders. Prevalence, sociodemography, and health impact. *Dig Dis Sci* 1993; 38: 1569-1580.
4. Denis P, Bercoff E, Bizien MF, Brocker P, Chassagne P, Lamouliatte H, et al. [Prevalence of anal incontinence in adults]. *Gastroenterol Clin Biol* 1992; 16: 344-350. French.
5. Enck P, Gabor S, Von Ferber L, Rathmann W, Erckenbrecht JE. [Prevalence of fecal incontinence and degree of information possessed by family physicians and health insurance]. *Z Gastroenterol* 1991; 29: 538-540. German
6. Giebel GD, Lefering R, Troidl H, Blöchl H. Prevalence of fecal incontinence: what can be expected? *Int J Colorectal Dis* 1998; 13: 73-77.
7. Madoff RD, Parker SC, Varma MG, Lowry AC. Faecal incontinence in adults. *Lancet* 2004; 364: 621-632.
8. Young CJ, Mathur MN, Evers AA, Solomon MJ. Successful overlapping anal sphincter repair: relationship to patient age, neuropathy, and colostomy formation. *Dis Colon Rectum* 1998; 41: 344-349.
9. Sitzler PJ, Thomson JP. Overlap repair of damaged anal sphincter. A single surgeon's series. *Dis Colon Rectum* 1996; 39: 1356-1360.
10. Malouf AJ, Norton CS, Engel AF, Nicholls RJ, Kamm MA. Long-term results of overlapping anterior anal-sphincter repair for obstetric trauma. *Lancet* 2000; 355: 260-265.
11. Bravo Gutierrez A, Madoff RD, Lowry AC, Parker SC, Buie WD, Baxter NN. Long-term results of anterior sphincteroplasty. *Dis Colon Rectum* 2004; 47: 727-731;
12. Baeten CG, Konsten J, Spaans F, Visser R, Habets AM, Bourgeois IM, et al. Dynamic graciloplasty for treatment of faecal incontinence. *Lancet* 1991; 338: 1163-1165.
13. Wexner SD, Baeten C, Bailey R, Bakka A, Belin B, Belliveau P, et al. Long-term efficacy of dynamic graciloplasty for fecal incontinence. *Dis Colon Rectum* 2002; 45: 809-818.
14. Baeten CG, Bailey HR, Bakka A, Belliveau P, Berg E, Buie WD, et al. Safety and efficacy of dynamic graciloplasty for fecal incontinence: report of a prospective, multicenter trial. Dynamic Graciloplasty Therapy Study Group. *Dis Colon Rectum* 2000; 43: 743-751.
15. Wexner SD, Gonzalez-Padron A, Rius J, Teoh TA, Cheong DM, Noguera JJ, et al. Stimulated gracilis neosphincter operation. Initial experience, pitfalls, and complications. *Dis Colon Rectum* 1996; 39: 957-964.
16. Susan M. Cera and Eric G. Weiss. ACYST, Secca, Sacral Nerve Stimulation, Artificial Bowel Sphincter, and Stimulated Graciloplasty. In: Davila GW, Ghoniem GM, Wexner SD, editor. *Pelvic Floor Dysfunction, A Multidisciplinary Approach*. London (UK): Springer; 2006. p. 155-162.

17. Hetzer FH, Hahnloser D, Clavien PA, Demartines N. Quality of life and morbidity after permanent sacral nerve stimulation for fecal incontinence. *Arch Surg* 2007; 142: 8-13.
18. Galandiuk S, Roth LA, Greene QJ. Anal incontinence-sphincter ani repair: indications, techniques, outcome. *Langenbecks Arch Surg* 2009; 394: 425-433.
19. Wong WD, Jensen LL, Bartolo DC, Rothenberger DA. Artificial anal sphincter. *Dis Colon Rectum* 1996; 39: 1345-1351.
20. Tan JJ, Chan M, Tjandra JJ. Evolving therapy for fecal incontinence. *Dis Colon Rectum* 2007; 50: 1950-1967.
21. Matzel KE, Stadelmaier U, Hohenfellner M, Gall FP. Electrical stimulation of sacral spinal nerves for treatment of faecal incontinence. *Lancet* 1995; 346: 1124-1127.
22. Kenefick NJ, Christiansen J. A review of sacral nerve stimulation for the treatment of faecal incontinence. *Colorectal Dis* 2004; 6: 75-80.
23. Matzel KE, Kamm MA, Stösser M, Baeten CG, Christiansen J, Madoff R, et al. Sacral spinal nerve stimulation for faecal incontinence: multicentre study. *Lancet* 2004; 363: 1270-1276.
24. Mellgren A. Fecal incontinence. *Surg Clin North Am* 2010; 90: 185-194.
25. Tjandra JJ, Lim JF, Matzel K. Sacral nerve stimulation: an emerging treatment for faecal incontinence. *ANZ J Surg* 2004; 74: 1098-1106.
26. Abrams P, Andersson KE, Birdir L, Brubaker L, Cardozo L, Chapple C, et al. Fourth International Consultation on Incontinence Recommendations of the International Scientific Committee: Evaluation and treatment of urinary incontinence, pelvic organ prolapse, and fecal incontinence. *NeuroUrol Urodyn* 2010; 29: 213-240.
27. Leo ME, Barrett DM. Success of the narrow-backed cuff design of the AMS800 artificial urinary sphincter: analysis of 144 patients. *J Urol* 1993; 150: 1412-1414.
28. Christiansen J, Lorentzen M. Implantation of artificial sphincter for anal incontinence. *Lancet* 1987; 2: 244-245.
29. Schrag HJ, Padilla FF, Doll A, Goldschmidtböing F, Woias P, Hopt UT. [German Artificial Sphincter System--GASS. Development and in vitro evaluation of a novel, fully-implantable, highly integrated sphincter prosthesis for therapy of high-grade fecal incontinence]. *Biomed Tech (Berl)* 2004; 49: 274-278. German.
30. Schrag HJ, Ruthmann O, Doll A, Woias P, Hopt UT. [German Artificial Sphincter System--GASSII: first in vivo evaluation of a novel and highly integrated sphincter prosthesis for therapy of major faecal incontinence]. *Biomed Tech (Berl)* 2005; 50: 371-374. German.
31. Schrag HJ, Ruthmann O, Doll A, Goldschmidtböing F, Woias P, Hopt UT. Development of a novel, remote-controlled artificial bowel sphincter through microsystems technology. *Artif Organs* 2006; 30: 855-862.
32. Niriella DA, Deen KI. Neosphincters in the management of faecal incontinence. *Br J Surg* 2000; 87: 1617-1628.
33. Zhao X, Pasricha PJ. Novel surgical approaches to fecal incontinence: neurostimulation and artificial anal sphincter. *Curr Gastroenterol Rep* 2003; 5: 419-424.
34. Bracale U, Nastro P, Beral DL, Romano G, Renda A. Anorectal atresia treated with non-continent pull through and artificial bowel sphincter: a case report. *Tech Coloproctol* 2005; 9: 45-48.
35. da Silva GM, Jorge JM, Belin B, Nogueiras JJ, Weiss EG, Vernava AM 3rd, et al. New surgical options for fecal incontinence in patients with imperforate anus. *Dis Colon Rectum* 2004; 47: 204-209.
36. Michot F, Costaglioli B, Leroi AM, Denis P. Artificial anal sphincter in severe fecal incontinence: outcome of prospective experience with 37 patients in one institution. *Ann Surg* 2003; 237: 52-56.
37. Vaizey CJ, Kamm MA, Gold DM, Bartram CI, Halligan S, Nicholls RJ. Clinical, physiological, and radiological study of a new purpose-designed artificial bowel sphincter. *Lancet* 1998; 352: 105-109.
38. Christiansen J, Lorentzen M. Implantation of artificial sphincter for anal incontinence. *Lancet* 1987; 2: 244-245.
39. Christiansen J, Sparsø B. Treatment of anal incontinence by an implantable prosthetic anal sphincter. *Ugeskr Laeger* 1993; 155: 885-886.
40. Zmora O, Tulchinsky H, Ron Y. [New horizons in the treatment of fecal incontinence]. *Harefuah* 2007; 146: 776-780. Hebrew.
41. Person B, Wexner SD. Advances in the surgical treatment of fecal incontinence. *Surg Innov* 2005; 12: 7-21.
42. Romano G, La Torre F, Cutini G, Bianco F, Esposito P, Montori A. Total anorectal reconstruction with the artificial bowel sphincter: report of eight cases. A quality-of-life assessment. *Dis Colon Rectum* 2003; 46: 730-734.
43. Lehur PA, Roig JV, Duinslaeger M. Artificial anal sphincter: prospective clinical and manometric evaluation. *Dis Colon Rectum* 2000; 43: 1100-1106.
44. Tan EK, Vaizey C, Cornish J, Darzi A, Tekkis PP. Surgical strategies for fecal incontinence--a decision analysis between dynamic graciloplasty, artificial bowel sphincter and end stoma. *Colorectal Dis* 2008; 10: 577-586.
45. Romano G, La Torre F, Cutini G, Bianco F, Esposito P. Total anorectal reconstruction with an artificial bowel sphincter: Report of five cases with a minimum follow-up of 6 months. *Colorectal Dis* 2002; 4: 339-344.
46. Lehur PA, Michot F, Denis P, Grise P, Leborgne J, Teniere P, et al. Results of artificial sphincter in severe anal incontinence. Report of 14 consecutive implantations. *Dis Colon Rectum* 1996; 39: 1352-1355.
47. Wong WD, Congliosi SM, Spencer MP, Corman ML, Tan P, Opelka FG, et al. The safety and efficacy of the artificial bowel sphincter for fecal incontinence: results from a multicenter cohort study. *Dis Colon Rectum* 2002; 45: 1139-1153.
48. Lehur PA. The anal artificial sphincter in severe anal incontinence. *Int J Surg Invest* 1999; 1: 268-269.
49. Agency for Medical Innovation (AMI). Soft anal band. (Accessed 2010 January 01). Available from URL: <http://www.ami.at/en/>
50. International Pelviperineology Congress. The implantation of the A.M.I. Soft Anal Band significantly improves fecal incontinence and quality of life. (Updated 2009 February 8. Accessed: 2010 January 3). Available from URL: <http://videosurgery.mediasite.com/mediasite/SilverlightPlayer/Default.aspx?peid=e08bac7e9d474757ae95346c38a6c2a51d>
51. Hajivassiliou CA, Carter KB, Finlay IG. Assessment of a novel implantable artificial anal sphincter. *Dis Colon Rectum* 1997; 40: 711-717.
52. Hajivassiliou CA, Finlay IG. Effect of a novel prosthetic anal neosphincter on human colonic blood flow. *Br J Surg* 1998; 85: 1703-1707.
53. Hajivassiliou CA, Finlay IG. Uneven pressure application by the artificial urinary sphincter: an explanation for tissue ischaemia? *BJU Int* 1999; 83: 416-419.
54. Finlay IG, Richardson W, Hajivassiliou CA. Outcome after implantation of a novel prosthetic anal sphincter in humans. *Br J Surg* 2004; 91: 1485-1492.
55. Devesa JM, Rey A, Hervas PL, Halawa KS, Larrañaga I, Svidler L, et al. Artificial anal sphincter: complications and functional results of a large personal series. *Dis Colon Rectum* 2002; 45: 1154-1163.

56. Lehur PA, Glemain P, Bruley des Varannes S, Buzelin JM, Leborgne J. Outcome of patients with an implanted artificial anal sphincter for severe faecal incontinence. A single institution report. *Int J Colorectal Dis* 1998; 13: 88-92.
57. Christiansen J, Rasmussen OO, Lindorff-Larsen K. Long-term results of artificial anal sphincter implantation for severe anal incontinence. *Ann Surg* 1999; 230: 45-48.
58. Christiansen J. The artificial anal sphincter. *Can J Gastroenterol* 2000; 14 Suppl D: 152D-154D.
59. Jorge JM, Wexner SD. Etiology and management of fecal incontinence. *Dis Colon Rectum* 1993; 36: 77-97.
60. Parker SC, Spencer MP, Madoff RD, Jensen LL, Wong WD, Rothenberger DA. Artificial bowel sphincter: long-term experience at a single institution. *Dis Colon Rectum* 2003; 46: 722-729.
61. Chartoor DR, Abdel-Halim M, Emmanuel SA, Taylor CR, Cohen G. The Anal Band for Severe Fecal Incontinence: A Multi-Centre Experience. (Updated 2009 May 2. Accessed 2010 May 15) Available from URL: http://www.fascrs.org/gedownload/ASCRS10_Abstracts%20v6-3.pdf?item_id=4253004&version_id=4253005
62. Kenefick NJ, Vaizey CJ, Cohen RC, Nicholls RJ, Kamm MA. Medium-term results of permanent sacral nerve stimulation for faecal incontinence. *Br J Surg* 2002; 89: 896-901.
63. Lehur PA, Zerbib F, Neunlist M, Glemain P, Bruley des Varannes S. Comparison of quality of life and anorectal function after artificial sphincter implantation. *Dis Colon Rectum* 2002; 45: 508-513.
64. Altomare DF, Dodi G, La Torre F, Romano G, Melega E, Rinaldi M. Multicentre retrospective analysis of the outcome of artificial anal sphincter implantation for severe faecal incontinence. *Br J Surg* 2001; 88: 1481-1486.
65. O'Brien PE, Dixon JB, Skinner S, Laurie C, Khera A, Fonda D. A prospective, randomized, controlled clinical trial of placement of the artificial bowel sphincter (Acticon Neosphincter) for the control of fecal incontinence. *Dis Colon Rectum* 2004; 47: 1852-1860.
66. Ortiz H, Armendariz P, DeMiguel M, Solana A, Alós R, Roig JV. Prospective study of artificial anal sphincter and dynamic graciloplasty for severe anal incontinence. *Int J Colorectal Dis* 2003; 18: 349-354.
67. Ortiz H, Armendariz P, DeMiguel M, Ruiz MD, Alós R, Roig JV. Complications and functional outcome following artificial anal sphincter implantation. *Br J Surg* 2002; 89: 877-881.
68. O'Brien PE, Skinner S. Restoring control: the Acticon Neosphincter artificial bowel sphincter in the treatment of anal incontinence. *Dis Colon Rectum* 2000; 43: 1213-1216.
69. Casal E, San Ildefonso A, Carracedo R, Facal C, Sánchez JA. Artificial bowel sphincter in severe anal incontinence. *Colorectal Dis* 2004; 6: 180-184.
70. Dodi G, Melega E, Masin A, Infantino A, Cavallari F, Lise M. Artificial bowel sphincter (ABS) for severe faecal incontinence: a clinical and manometric study. *Colorectal Disease* 2000; 2: 207-211.
71. Drossman DA, Li Z, Andruzzi E, Temple RD, Talley NJ, Thompson WG, et al. U.S. householder survey of functional gastrointestinal disorders. Prevalence, sociodemography, and health impact. *Dig Dis Sci* 1993; 38: 1569-1580.
72. Altomare DF, Binda GA, Dodi G, La Torre F, Romano G, Rinaldi M, et al. Disappointing long-term results of the artificial anal sphincter for faecal incontinence. *Br J Surg* 2004; 91: 1352-1353.
73. Christiansen J, Sparsø B. Treatment of anal incontinence by an implantable prosthetic anal sphincter. *Ann Surg* 1992; 215: 383-386.
74. Lehur PA, Letessier E. [Adult fecal incontinence due to anal sphincter lesions: which preoperative preparations? Which surgical solutions?]. *J Chir (Paris)* 1998; 135: 83-89.
75. Mundy L, Merlin TL, Maddern GJ, Hiller JE. Systematic review of safety and effectiveness of an artificial bowel sphincter for faecal incontinence. *Br J Surg* 2004; 91: 665-672.
76. Wexner SD, Jin HY, Weiss EG, Noguera JJ, Li VK. Factors associated with failure of the artificial bowel sphincter: a study of over 50 cases from Cleveland Clinic Florida. *Dis Colon Rectum* 2009; 52: 1550-1557.
77. Vaizey CJ, Kamm MA, Nicholls RJ. Recent advances in the surgical treatment of faecal incontinence. *Br J Surg* 1998; 85: 596-603.
78. Malouf AJ, Vaizey CJ, Kamm MA, Nicholls RJ. Reassessing artificial bowel sphincters. *Lancet* 2000; 355: 2219-2220.
79. Obichere A, Suliman I. Artificial Sphincters. In: Lumley JSP, Hakim N, editors. *Artificial Organ. New Techniques in Surgery*. London (UK): Springer; 2009. p. 107-132.
80. Person B, Wexner SD. Advances in the surgical treatment of fecal incontinence. *Surg Innov* 2005; 12: 7-21.

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Kouranloo J, Sadeghian N, Monfared MK. Treatment and postoperative complication of 420 patients with congenital megacolon. *Saudi Med J* 2003; 24 Suppl: S25-S28.