MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

New bowel incontinence or loss of bowel control

Structured history, interpretation & clinical review

Symptom 84 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

New bowel incontinence requires assessment of stool consistency, urgency, sensation, spinal/cauda-equina signs, diarrhea/constipation, cognition, mobility, and anorectal disease.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person's usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. "Not sure" is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for New bowel incontinence or loss of bowel control

1A. Immediate safety screen

Is there new urinary retention, loss of bladder or bowel control, saddle numbness, or new sexual dysfunction?

☐ No ☐ Yes ☐ Not sure

If Yes: Go to an emergency department now for cauda-equina assessment; do not wait for routine imaging.

Is there rapidly progressing weakness in one or more limbs, a sensory level, or new inability to walk?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now for possible spinal-cord compression or another acute cord process.

Is there fever, immune suppression, recent spinal procedure, injection-drug use, cancer, or severe unremitting night pain?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day assessment; fever or progressive neurological deficits require emergency care.

Did significant trauma precede the pain, or is there new deformity or immediate neurological loss?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now and avoid unnecessary movement of the spine.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which pattern best describes the loss of control?

☐ Cannot reach the toilet despite urgency ☐ Leakage without awareness ☐ Complete loss of bowel control ☐ Soiling around constipation or incomplete emptying

Is there diarrhea, severe constipation, blood, or severe abdominal pain?

☐ Diarrhea ☐ Constipation or impaction ☐ Blood or black stool ☐ Severe abdominal pain ☐ None

Is there back pain, saddle numbness, leg weakness, urinary retention, or new sexual dysfunction?

☐ Yes ☐ No ☐ Not sure

Is there known neurological disease, prior pelvic/anal surgery, cognitive change, or reduced mobility?

☐ Yes ☐ No ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Bowel change with spinal emergency features

Is there back pain, saddle numbness, leg weakness, urinary retention, or new sexual dysfunction? Yes

Emergency warning pattern — Now

Bowel dysfunction with saddle, urinary, back, or leg findings requires emergency spinal assessment.

Differential to review:

- Cauda equina or spinal-cord dysfunction

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Bleeding or severe abdominal pathway

Is there diarrhea, severe constipation, blood, or severe abdominal pain? Blood or black stool / Severe abdominal pain

Emergency warning pattern — Now

Blood/black stool or severe abdominal pain requires urgent medical assessment.

Differential to review:

- Diarrhea, impaction, or anorectal disorder

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 3: Impaction or diarrhea-associated pattern

Is there diarrhea, severe constipation, blood, or severe abdominal pain? Constipation or impaction / Diarrhea
Is there back pain, saddle numbness, leg weakness, urinary retention, or new sexual dysfunction? No

Urgent assessment pattern — Same day

Stool-consistency abnormalities need prompt bowel and anorectal assessment.

Differential to review:

- Diarrhea, impaction, or anorectal disorder

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 4: Passive or chronic neurogenic pattern

Which pattern best describes the loss of control? Leakage without awareness / Complete loss of bowel control
Is there known neurological disease, prior pelvic/anal surgery, cognitive change, or reduced mobility? Yes

Prompt clinical review pattern — Promptly

Passive leakage with neurological context requires sensory, spinal, and anorectal evaluation.

Differential to review:

- Chronic neurogenic bowel or sensory dysfunction
- Cauda equina or spinal-cord dysfunction

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Cauda equina or spinal-cord dysfunction

Discriminating features: New bowel dysfunction with saddle loss, urinary retention, back pain, leg weakness, or sexual dysfunction.

Logical investigations: Emergency spinal assessment and MRI; do not attribute new combined sphincter and limb findings to constipation alone.

3.2 Diarrhea, impaction, or anorectal disorder

Discriminating features: Urgency with diarrhea, overflow around impaction, hemorrhoidal/anal disease, or prior pelvic surgery.

Logical investigations: Abdominal, rectal/anorectal, and medication assessment; targeted stool or structural testing as indicated.

3.3 Chronic neurogenic bowel or sensory dysfunction

Discriminating features: Passive leakage or impaired rectal sensation with neurological disease or spinal findings.

Logical investigations: Neurological and colorectal assessment, bowel diary, and selected anorectal testing.

3.4 Cognitive, mobility, medication, or functional contributor

Discriminating features: Reduced mobility, confusion, sedatives, or inability to access a toilet can present as incontinence.

Logical investigations: Functional, cognitive, medication, and bowel assessment while excluding objective neurological signs.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2010, updated 2023). *Transient loss of consciousness (“blackouts”) in over 16s (CG109)*. https://www.nice.org.uk/guidance/cg109
2. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127