In the last years several techniques have been developed to help patients with severe fecal incontinence. It is important to determine the severity of incontinence. Severity is determined by the frequency the volume and consistency of the faeces that is lost. Soiling or staining of the underwear is no real incontinence. Real incontinence is uncontrolled loss of real faeces. The loss of solid faeces is seen as more severe in all grading systems, but for the patient the loss of diarrhea forms a bigger handicap. In case of loss of diarrhea it is important first to treat the diarrhea before diagnostic tools are used to look at the sphincters, pelvic floor or rectal capacity. For the determination of the cause of incontinence, several diagnostic tools are used, like anamnesis, physical examination, anal manometry, defaecography, endosonography, electrophysiology and sometimes MRI and endoscopy. These investigations make clear whether the anal sphincter and pelvic floor are anatomically intact, whether they are functional and what the capacity of the rectum is. In case of an intact pelvic floor and sphincter many patients can be helped with biofeedback therapy. When the result is insufficient, sacral nerve stimulation can give a solution. Sacral Nerve Stimulation can be given first as a test with the help of percutaneous electrodes that are inserted through the foramina of S3 or S4. These electrodes are connected with an external stimulator. The correct location can be found by motoric signs like contraction of the pelvic floor and sphincter or a sensation of twinkling around the anus. When the patient becomes continent during the time of the test which is normally three weeks, the percutaneous electrodes can be removed and an operation will follow and a definite electrode is implanted and connected to an implanted neurostimulator. The results of sacral nerve stimulation are 84% so far. In case of a rupture of the sphincter the first option remains an anal repair. In about 70% of the cases this will lead to continence. When the patient remains incontinent, there are two other options. An artificial bowel sphincter or a dynamic graciloplasty. An artificial bowel sphincter consists of a cuff placed around the anus with a pressure regulating balloon that keeps the cuff inflated by its own tension. To allow the patient to defecate, the fluid of the cuff can be pumped back to the balloon and the anal canal enwidens to allow defaecation. A dynamic graciloplasty is a modification of the conventional graciloplasty. Electrodes are implanted in the muscle and connected to an electrical stimulator that keeps the muscle contracted. By switching the stimulator off, the muscle can relax and defaecation is possible. Success rates of ABS and DGP are 70–80%. When nothing seems to be successful, there always remains the possibility of a colostomy.