# Encopresis

Children 1 to 4 years of age typically have a bowel movement 1 – 2 times a day and over 90% of them go at least every other day. When children are constipated for a long time they may begin to pass stool in their clothing. This is called fecal soiling, and the child is typically unaware that they are going to have an accident. Another term that is frequently used is encopresis. Encopresis refers to fecal incontinence not due to any particular disease. This form of soiling may be voluntary (passage of normal stools in clothing) or involuntary (often loose, liquid stools). Voluntary encopresis may represent significant psychological problems. Involuntary encopresis is much more common and associated with chronic stool withholding and associated leakage of stool.

Children with constipation and fecal soiling have no control over these bowel movements and should not be punished for soiling episodes. They are often embarrassed by the accidents and may hide their soiled underwear in drawers or under the bed. This can be very unpleasant for other family members. Another common upsetting behavior is refusal to change dirty clothing even though the odor is very bothersome to other people. Children may also wet the bed at night or wet their clothing during the daytime, which is called enuresis. Playmates or siblings may tease children who have accidents. Teasing can lead to embarrassment, school refusal, fighting, and other problems. As the child and family battle over the child's bowel control, the conflict may extend to other areas of the child's life. Their schoolwork may suffer, and the child may become angry, withdrawn, anxious, and depressed, often as a result of being teased and feeling humiliated.

**TREATMENT:**

Treatment of constipation and fecal soiling is a three-step process that may take several months to a year to improve, if not longer.

- Step 1 The Initial Cleanout removes the impacted stool from the colon.
- Step 2 Maintenance Therapy prevents stool build-up by keeping stool soft thus cutting down on withholding behavior and allowing the colon to return to its normal shape and muscle tone. During this step, it is important to encourage regular bowel movements in the toilet.
- Step 3 Counseling and Behavior Modifications may help children who are embarrassed or feel they are "bad" because of the soiling. A counselor can help structure the treatment plan and help the child cooperate.

**Step 1: *The Initial Clean out***

The large, rocklike stool in the colon must be softened and broken down before it can be passed. Usually the cleanout is approached from above and below. Oral agents such as mineral oil, Magnesium Citrate, Milk of Magnesia, Miralax TM (polyethylene glycol) or lactulose are used to soften the stool. These oral stool softeners work by pulling water into the stool and are well-tolerated for long periods of time without the child becoming dependant on them. They are not absorbed by the blood stream and stay in the colon, through a small amount of magnesium may be absorbed from Milk of Magnesia. Some children do not like the taste of mineral oil or milk of

magnesia. Some of these medicines come in flavors that your child may like, but they may be expensive. These medicines can be mixed with chocolate or strawberry drink mix, or with jello powder. Mineral oil can be placed in the blender with orange juice concentrate or with ice cream/chocolate milk. MiraLax is the most commonly used medication to treat constipation today. It is now offered over the counter and is a colorless, tasteless powder that can be mixed into a drink of the child's choice. Enemas or suppositories can also be used in the initial clean out phase. Since they only work on the lower part of the colon, near the lower end of the colon (the rectum), they help "jump-start" the process by softening the withheld stool. There are many ways to achieve the initial cleanout. Your doctor will discuss the best plan with you and your child.

**Step 2: *Maintenance Therapy***

The object of maintenance therapy is to prevent stool buildup, allow the colon to return to its proper shape and function, and to encourage the child to have bowel movements in the toilet. Many of the medications used in the cleanout are also used in the maintenance, only at lower doses.

Maintenance therapy involves several steps:

1. Go up or down on the medication to obtain one to two soft formed daily bowel movements.
2. If the child is toilet trained, he/ she should be encouraged to sit on the toilet, and try to have a bowel movement, for five minutes, fifteen to thirty minutes after a meal or snack. Try to do this at least twice a day.

**Potty Practice Guidelines:**

- ❖ After meals, especially after breakfast, is the best time for this "toileting practice" or "sit", because a full stomach makes most people feel the need to have a bowel movement.
- ❖ A large warm drink may help this feeling.
- ❖ After a warm bath may also be a good time to attempt a bowel movement.
- ❖ Place a box or stool under the feet of smaller children to raise their knees higher than their hips to help them bear down.
- ❖ Very small children may feel safer if they face backwards on the toilet, or use a potty chair.

3. Increase fiber intake by encouraging whole grains, fruits, vegetables, peanut butter, dried fruits, and salads. In addition, give at least two Fiber Servings every day.

**Fiber Serving Suggestions:**

- ❖ a bowl of Bran cereal
- ❖ one tablespoon wheat bran mixed in food (yogurt, soup, salad)
- ❖ one tablespoon of psyllium
- ❖ a bran muffin
- ❖ a commercial fiber supplement such as fiber cookies, or one serving of Metamucil or Citrucel in 8 oz water (see the directions)

4. Increase fluids in the diet, especially water and water rich foods (which usually are fiber-rich).
5. Increase physical activity. Exercise helps the colon move.
6. It is important to encourage the older child to take responsibility for their own actions. The child should be responsible for taking the medicine regularly, sitting on the toilet, and for cleaning up stool accidents. Each family must decide what level of responsibility to expect of the child. Having a calendar to mark down doses and "sits" can help keep track.

**Step 3: *Counseling***

A counselor may be helpful to reduce the tension that children and families feel because of constipation and fecal soiling. The child's condition often becomes a family problem. The child may have learned to control other people by having accidents. It is important to try to avoid anger or punishment around accidents, even though this may be difficult. Most often, the child is not misbehaving but simply cannot feel the stool coming out. It is the child's responsibility, however, to take the medicine and to attempt regular toileting. Some children have behavioral and emotional difficulties that interfere with the treatment program. Psychological counseling for these children helps them deal with issues such as peer conflicts, academic difficulties, and low self-esteem, all of which can contribute to constipation and soiling. Children respond well to a carefully planned, consistent system of rewards for appropriate behaviors. Parents can develop behavior modifications or reward systems that encourage the child's proper toilet habits.

Constipation and fecal soiling are curable! Children who follow the treatment plan will be able to control their bowel movements. It may take several months or longer for bowel function to become normal, and many children may benefit from long-term medication. This is especially true if the child is regularly taking other medications that can cause constipation. Relapsing is not uncommon. Repeating the initial cleanout, followed by maintenance therapy, will bring back control. Some children will continue to have constipation into adult life. Some other diseases have symptoms similar to constipation and fecal soiling but are much less common. If a child does not respond to treatment as expected, testing may be recommended. Continuing a high fiber diet and using the stool softeners as necessary can successfully treat this.