Encopresis and Constipation: Information for Primary Care

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Summary: Encopresis is the involuntary (or intentional) passing of feces in inappropriate locations (e.g. underwear or on the floor), occurring at least once/month for three months, in a child over age 4.

Normal development

Bowel control is an important developmental milestone that normally occurs by age 4
Steps to toilet training typically consist of

- Ensuring that a child is ready
  - The child is able to describe the urge to have a bowel movement
  - Sufficient coordination to sit on a potty, and push out a stool
  - Being able to hold urine for two hours
- Parent training the child, which includes:
  - Parents providing clear instructions and demonstration on how to sit on a potty and have a bowel movement
  - Parents providing routines and opportunity, such as placing the child on a on the potty after meals in order to take advantage of the gastrocolic reflex

Pathophysiology

Encopresis means (usually) involuntary leaking of stool into clothes or passing stools in the wrong place (eg. not in the toilet).

Encopresis typically starts after a period of acute constipation, in which the child experiences a painful bowel movement. In an attempt to avoid future pain, the child withholds stool and refuses to defecate. As the child withholds, more stool accumulates in the colon. The stool becomes harder, drier and bulkier, resulting in an impaction.. As this stool accumulates, there is leakage of stool around the impaction leading to soiling of underwear (‘sneaky poo’). Note that due to loss of sensation, the child is likely unaware if small amounts of stool have leaked and does not have control over this leakage caused by pressure within the rectum.

As it becomes too painful to force out the impacted stool, it becomes a vicious circle with the child ignoring the

urge to defecate, in an attempt to avoid what will eventually be another painful bowel movement.

Initially, there is overflow soiling with release of large stools within 5-7 days.

Over time, the bowel movements become less frequent, but with large bowel movements and chronic overflow, abdominal pain and social withdrawal. Eventually, the child loses the ability to sense the need to defecate or feel the leakage around the impaction, nor notice the extremely unpleasant smell of feces that others notice. This is typical and not on purpose.

Parents, caregivers and teachers can become frustrated at the soiling, leading to blame and anger towards the child, which doesn't help.

Epidemiology

Up to 3% of children under 12 (Fishman, Rappaport, Schonwald & Nurko, 2003).
Gender: Males > Females with 2:1 ratio.

Etiology

Risk factors include

- Males
- Chronic, early constipation
- Experiencing a bowel movement as painful or distressing (e.g. pain on defecation)
- Low muscle tone and poor coordination
- Problems with attention span
- Dietary factors: High fat diet, high intake of sugary fluids (e.g. pop, juice), low fiber intake
- Low activity level
- Stresses such as lack of routine at home
- Children from abusive or neglectful homes: Although most children with encopresis have not been abused, children with sexual abuse have a higher rate of encopresis

Assessment / History

Model a normalizing and reassuring approach.

- Parents and children often present as embarrassed, ashamed and disgusted by this problem.

Ask: "Have you noticed any of the following with your child?"

- Avoidance or fear of using the toilet, such as for bowel movements?
- Hiding soiled underwear?
- Having large stools every few days (e.g. 3-7 days) rather than every day or every other day?
- Bowel movements so large that it plugs the toilet?
- Abdominal bloating or pain?
- Smell of feces?
- Smell of feces to the point where others such as peers, teachers and family members have noticed?
- Smearing of feces?
- Is there a history of anal fissures?

Other relevant history includes:

- Past History
    - What has been tried in the past?

- Associated conditions
    - ADHD, learning disabilities, oppositional behaviours

Physical Exam (Px)

Goal: To rule out underlying neurologic or bowel condition.

In particular:

- Developmental screening
- Abdominal exam
- Rectal exam: To look for fecal impaction

Investigations

Abdominal XR may reveal constipation, or abdominal distension.

DSM-5 Criteria

A. Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
B. At least one such event occurs each month for at least 3 months.
C. Chronological age is at least 4 years (or equivalent developmental level).
D. The behavior is not attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation.

Two subtypes

1. With constipation and overflow incontinence: There is evidence of constipation on physical examination or by history.
2. Without constipation and overflow incontinence: There is no evidence of constipation on physical examination or by history.

Management of Constipation/Encopresis: Behavioural Strategies

Elements of successful behavior programs (Cochrane Review)

- Parent education about encopresis and constipation.
- Providing specific toileting instruction about appropriate positioning and straining
- Designing a program of regular, timed, and uninterrupted toileting
- Maintaining a symptom and toileting diary
- Defining specific achievable target behaviors
- Strongly emphasizing consistency

Management: Parent Education

Key teaching points for parents and families:

- Accept and validate the parents
    - Validate how challenging it is for parents to have a child with encopresis.
    - Families must deal with the smell of feces in their child, clothing and parts of the home, along with peer issues, and severe frustration.

- Accept and validate the child
    - "On one hand, your child is doing the best that he can. No one willingly wants to have troubles with constipation and encopresis. When you've had constipation for a long time, it becomes so painful to have a bowel movement that your child is simply doing his best to avoid pain."
    - "On the other hand, together we will overcome this problem."
- What is constipation?
    - Constipation is when your poop is hard, painful, large diameter, takes effort, and/or doesn't happen regularly.
- What is encopresis?
    - Encopresis, also known as "sneaky poo" is when poop doesn't go into the toilet, but ends up in other places, like one's underwear, clothes and other places.
- How common is it?
    - Constipation is common and often missed by parents.
- What are the parts of the bowel?
    - Small intestine - absorption of nutrients;
    - Colon - transportation and reabsorption of water into the body).
- What is healthy stool?
    - Show the Bristol Stool chart to demonstrate healthy stool types (3 & 4), and for monitoring treatment
    - Teach both child and parent to look before flushing and child to show parents if stool is not type 3 or 4
    - Consider watching the YouTube video: "The Poo in You", which explains bowel function.
- How to deal with constipation
    - Addressing the constipation will help the child feel more capable and confident and relieve stress for parents.
- Parenting strategies
    - Understand that any parenting strategies work best in context of healthy relationship between parent/child
    - When the child soils, do not respond with anger or punishment; increased stress does not help the child have more success.
    - Use natural consequences such as having the child help parent with cleaning soiled clothing; taking a bath.
    - Thank the child for their hard work in the improvements made.
    - Try to avoid rewards, as they should not be necessary.
- Thank the child for participating in this discussion.

Parent handout on eMentalHealth.ca

- https://www.ementalhealth.ca/i...

Management: Acute Treatment of Bowel Impaction / Constipation

Acute treatment

- Most patients will have constipation with overflow incontinence, and hence it is important to start with evacuating the distal colon (aka "a cleanout")
- Treatment includes
    - Oral cathartics
    - Enemas:
        - Enemas were used more often in the past, but are rarely required nowadays.
        - Explain pros/cons and allow family to choose.
        - Indications
            - Neurological impairment
            - Severe impactions

        - Contraindications
            - Avoid if it has been experienced as shaming, painful, or if constipation is not severe.

Maintenance laxatives

- After the colon is cleared, laxatives are used in order with the goal of having 1-2 soft stools daily

Management: Non-Medication Strategies for Treating and Preventing Constipation

Nutritional / dietary changes

- Add fiber to diet
- Add fiber (e.g. bran flakes) to breakfast foods (such as cereal), once daily
- Continue increasing until dietary recommendations for fiber are reached, or until stools are soft, passing without pain, and occurring once daily
- Reduce high fat and high sugar foods (e.g. fruit juice, soda pop, cookies, candy, fast foods)
- Reduce constipating foods (e.g. bananas, dairy such as milk, Greek yoghurt, white rice)
- Ensure enough hydration, i.e. Drink enough water to ensure that child urinates every 2-hrs
- Foods which help:
    - Pears
    - Pear nectar (with fibre)
    - Prune or mixed prune & other juice

Lifestyle changes

- Increase physical activity such as daily walks with family
- Reduce sedentary activities such as TV or video games

Bowel training

- Bowel training is to help the child re-learn bowel control, and learn awareness of a full rectum
- 20-minutes after breakfast, sit on toilet for 10-minutes
- 20-minutes after dinner, sit on toilet for 10-minute

Management: Medications for Treatment of Constipation

PEG 3350

- Start with 17 g capful daily, adjust to effect, plan to give daily for 3 months
- Usual mode of administration: Drinking it directly
- Are there problems with nausea or tolerating it?
- If so, then, consider putting PEG into a soft food (e.g. apple sauce, yoghurt) and increase fluid separately, or
- Try a different brand

Other options

- Magnesium glycinate powder
    - It can be included in smoothies, and other foods. It is very natural and can be used long term without concern.
    - Dosage is 10-15 mg/kg/day; this dose can be given once in the evening, or twice a day
- Benefibre
    - This was commonly used in Canada prior to PEG coming onto the Canadian market
    - It is a natural fiber supplement that dissolves completely in any fluid (whereas PEG does not dissolve

fully).
    - Completely safe as a non-stimulant and non-absorbable laxative.
- Metamucil
    - Works by irritating the gut
    - Can cause impaction if hydration insufficient
    - Children may find it difficult due to the texture
    - Comes in different versions, including Metamucil cookies (Apple or Chocolate) that can be eaten, accompanied with lots of fluids
- Lactulose
    - Works for many, however some find it is very sweet and causes gas
    - Generally more used as needed
- Lansoyl jelly (mineral oil based)
    - May be used as needed for short periods
    - Not used long term because may lead to fat soluble vitamin deficiencies
- Docusate liquid or caps
    - Advantage is small administered volume and capsule format.

Course and Prognosis

The good news: Most children respond to treatment.
Bad news: Because this is a chronic condition when it is first diagnosed, inform parents that it can take several months up to a year before child has regular and appropriate bowel elimination.

When to Refer

Refer if the child is having significant emotional/behavioral problems.

Who to Refer to

- Paediatricians
- Psychiatrists

About this Document

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Disclaimer

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