PEDIATRIC ANNALS 28:5/MAY 1999

CME

These pages contain excerpts from this article that may help you understand your child's constipation better. Please follow YOUR physicians directions for treatment.

To Do or Not to Do? That Is the Question

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My explanation to the parents is as follows. Everyone occasionally has large, hard stool. The cause of this hard stool is really unimportant by the time the family seeks medical advice. It may have been a low-fiber diet, a decrease in fluid intake, certain medications, not wanting to go to the bathroom at school, or inappropriate toilet training practices. The passage of a hard, painful stool during childhood is entirely different from this passage during adulthood. Pain results because of the size and consistency of the stool, which mechanically stretches and irritates the anal canal. If there has been enough irritation, a "raw area" will be present in the anal canal. If even more trauma occurs, a fissure or tear may develop in the anal canal. This really hurts. The real problem begins when the child has another bowel movement; it may, in fact, be a normal, soft stool, but it has to pass over this raw area—it hurts again.

At this point, children and adults react in opposite ways. Adults will proceed with defecation despite pain, realizing that retaining the stool will only make the problem worse. Adults will then appropriately treat the problem with dietary changes, laxatives, or lubricants. Children do not react in this manner. The urge to defecate elicits memory of the pain they experienced the last time they "went to the bathroom," and they "hold it in." They do not want to hurt again. At this point, it is obvious that the problem becomes self-perpetuating. The longer the child retains stool, the bigger and harder it becomes and the more it will hurt when it eventually passes.

I explain this behavior to the family by telling them that is difficult for children to think in abstract terms. To illustrate this concept, I ask them whether their 4-year-old child, "Billy," can multiply and divide. They, of course, assume I am crazy; I then explain to them that the reason he cannot multiply or divide has nothing to do with intelligence—he simply is unable to grasp those abstract concepts of mathematics at such a young age. Then I point out that there are few concepts more difficult for a child to understand than the idea of voluntarily doing something that he or she thinks might hurt—for his or her own good. "How can something be for my own good if it hurts?" wonders Billy. This does not make sense to the child. Children will virtually always choose to avoid pain rather than voluntarily endure it. Another excellent analogy to further clarify this concept is to point out that if everyone in the room—the physician, the parents, and Billy—had strep throat, the adults would willingly (relatively willingly) get a penicillin shot. Do you think you could ever explain to 4-year-old Billy why he needs to get a shot? Of course not.

Episodes of fecal soiling often occur without the child's being aware of the "accident."

The child holds it in again for fear of pain. As previously described, the urge to defecate eventually dissipates and the child now has a further distended rectum full of stool. This cycle occurs multiple times per day and soon there is a huge fecal mass filling a massively distended rectum. The fecal mass is only a few centimeters from the child's underwear and is held in place almost exclusively by the external anal sphincter. As the fecal mass increases in size and peristalsis continues, there is occasional inadvertent relaxation of the sphincter mechanism and fecal soiling occurs. I must point out that this is a simplistic description of a complex chain of events. However, for purposes of explaining the problem to parents, it is reasonably accurate and easily understood. There are excellent articles readily available for the reader desiring a more detailed review of this complex sequence of events.[35]

It is important to explain to the family that the episodes of fecal soiling often occur without the child's being aware of the "accident." He or she is not deliberately having a bowel movement in his or her clothing. The child often becomes aware of the problem at the same time as others—when he or she smells the odor. The actual soiling is usually only smears and smudges in the underwear as the "tip of the iceberg" of the fecal mass protrudes through the anus. The child is not having one of his or her massive, painful bowel movements. This also explains to the family why they may change the underwear only to have the soiling reoccur in a few hours.

Encopresis may result in tremendous difficulties not only for the child but for the entire family unit. In addition to the obvious problem of teasing and ridicule, I have a number of patients who were essentially social isolates. They were not included in any social or play activities, were never invited over for lunch or to spend the night by their peers, and were eventually ignored completely. This pattern of behavior is obviously devastating to normal social development.

At this point, I tell the child and the family that I have taken care of literally thousands of children with this same problem and they virtually all recover. It is extremely important to emphasize that we are dealing with a common and "fixable" problem. I tell them I treat three or four children a day with the same problem and they all get well. Simply reassuring them that they are not "the only one in the world" with this problem and that it can be solved is unbelievably important. Families may break down and cry when they realize nothing is seriously wrong and a solution is obtainable.

The ability to explain the problem of constipation and resultant encopresis is one of the most important aspects of therapy. If these concepts are understood, the therapy will also make sense. A well-informed family dramatically increases the probability of the treatment plan's being implemented correctly. Spend as long as needed to explain these concepts and allow 30 to 45 minutes, at a minimum, for an initial consultation. This is the best-spent time you will ever have with this patient and family.

The family should be informed that, although therapy for constipation and encopresis is effective, it will require at least 6 to 12 months of treatment to ensure a successful outcome. It is important to explain why the therapy takes so long to avoid unrealistic expectations for a quick cure. The rectum and the colon have been chronically distended and have lost their natural tone and resiliency. A prolonged period of "being empty" is necessary to regain these qualities.

An equally important factor in the need for prolonged treatment is related to the fact that children have good memories. They remember painful events and avoid them. The analogy I make is to ask whether the child has ever been burned (on a hot cookie sheet, a candle, or a light bulb). When the parent responds affirmatively, I say, "I bet it only happened once." Pain memories are firmly implanted in the child's consciousness for a good reason—to avoid being hurt in the same way in the future. The child with functional constipation has a pain memory associated with defecation, and this association has been reinforced multiple times. It is virtually impossible to convince a child to do something he or she fears will hurt. The only way I have found to erase this association is to remove the pain. The child must have a bowel movement without pain day after day, week after week, and month after month to achieve this goal. If the parents understand this principle, they will recognize the need for prolonged therapy.

Behavior Modifications

These consist of explaining appropriate toilet training techniques for the young child and instituting a simple positive and negative reinforcement program for the older child. The use of a simple calendar and stickers (as rewards on days without an accident) is amazingly effective and also provides an objective measure of progress. The immediate reward of a simple treat, such as a piece of candy the child would not normally receive, for defecation in the toilet is useful. An extremely powerful negative reinforcement is to remove television or video games for a day if an accident occurs. An interesting benefit of making the stools loose is that the episodes of fecal soiling will stop in many children. I feel this is due to the child's realizing that he or she can no longer "hold it in" and that the resultant accident will be *horrible*. A note to the school explaining the need for the child to have free access to the bathroom is essential.

Although simple maneuvers such as these are usually effective, the child with prolonged fecal soiling may require specialized therapy with a behaviorally trained pediatrician or psychologist.

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