Fecal Incontinence (Encopresis)

Definition

Fecal Incontinence (Encopresis) is loose stool involuntarily leaked into the clothing by a child developmentally 4 years of age or older. This is usually due to impacted stool (caused by chronic constipation) blocking the passage of regular feces, thus new and softer feces seep out, often without the child's being aware.

Treatment, designed by the Health Care Provider (HCP), usually includes 1) getting rid of the impacted stool (typically by using high doses of a stool softener such as Miralax or rarely enemas), then 2) keeping the stool soft (to keep the evacuation process from hurting, and to allow the stretched out rectal muscles to strengthen) and 3) establishing regular stool habits (since children with this issue don't pay attention to their body's signal to stool and they withhold their stool, thus causing the buildup of stool). Encopresis and its treatment are usually long-term (at least 6 months) and can be very frustrating for families.

Incidence

Encopresis affects about 2% of kindergarten and 1st graders, and 1.6% of 10-11 year olds (Schmitt; Garman). Boys outnumber girls by 3:1.

Causes

Functional: 95% of the time, the cause of encopresis is stool withholding. Most children hold back stools in an attempt to avoid any pain associated with defecation. Others may hold back stool as part of a power struggle with their parent/guardian(s). Some children postpone stools because they do not want to leave some enjoyable activity or they don't want to use a public bathroom (such as at school).

Nonfunctional: Rarely, encopresis is caused by an organic cause, such as Hirschsprung disease, pelvic mass, anal or rectal stenosis, hypothyroidism, perianal cellulitis, chronic anal fissure, poor diet, stress, or medication with constipation as a side effect. These diagnoses can be relatively easily determined by a HCP.

Initial Management

1. Subjective data
    a. Abdominal pain
        - when, where, how often?
        - does pain resolve after a bowel movement?
        - onset (when started? chronic versus acute)
    b. Stools
        - size, consistency, pain, blood, clogs the toilet?,
        - how often, soiling interval, leakage frequency & consistency?
        - Is the child aware of stool in their clothing?
        - Previous history of constipation?

        - Use public bathrooms?
    c. A more thorough history can be done by the HCP (such as diet & meds).

2. Objective data
    a. Measure temperature.
    b. Examine abdomen (nurse can listen, percuss, & palpate).

Secondary Management

1. Toileting–Advise to use bathroom; help with wiping & give clean underwear if needed.

2. If blood in stool – Contact parent/guardian and advise follow up with HCP.
    a. If student has large, hard stools that hurt, and the blood seen is bright red and a small amount, then chances are that the blood is from a rectal fissure. It is OK for student to remain in school unless amount of blood is large or has other concerning symptoms. Treatment advice for at home includes: Sitz bath, diaper balm, and management of constipation.

3. Eliminate shame, guilt, or punishment. This is not under a child's voluntary control.

4. Involve the school nurse, teacher & parent/guardian if child has:
    a. Frequent symptoms of abdominal pain
    b. Crying or resistance for using bathroom
    c. Stool leakage in underwear (or frequent smell of stool)

    d. Document in electronic student health record.

Role of school nurse

1. Identify encopresis (soiling at school).

2. Encourage family to have medical evaluation to rule out organic causes of fecal incontinence and to develop a treatment plan. Some stool softeners such as Miralax (polyethylene glycol 3350) are available over the counter, but are covered by Medicaid if the HCP writes a prescription. Help with access to medical care if needed.

3. Nutrition counseling with family if needed: adequate fiber in diet (child's age in years + 5 =recommended gms of fiber per day, up to 25gms of fiber daily); if child's daily total is under the recommended amount then increase fiber gradually so as to avoid extra gas and abdominal distension), push fruits and vegetables, increase water intake.

4. Develop a behavioral plan for toileting at school including:
    a. Toileting time (10 minutes, 20-30 mins after every meal; approach as a "practice time,"especially for those kids who are resistant and say they don't have to go)
    b. Private bathroom if possible (if student dislikes public bathrooms)
    c. Foot stool available (if student's feet don't touch the floor, a footstool helps with the Valsalva maneuver)
    d. Wipes available if needed
    e. Books if needed to help child relax

f. Incentives if needed (such as stickers)

If student can't take their stool softening medicine at home and/or if needs toileting help, write an Individual Health Plan

References

Sood, M. R. (2024). Chronic functional constipation and fecal incontinence in infants, children, and adolescents: Treatment. *Up To Date.* Retrieved July 15, 2024 from https://www.uptodate.com/contents/chronic-functional-constipation-and-fecal-incontinence-in-infants-children-and-adolescents-treatment?search=fecal%20incontinence%20children&topicRef=5859&source=see_link#H1

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