Encopresis
Also known as Fecal Soiling

Often Associated with Acquired Megacolon

Ann Stillwater, RN, CSN, M. Ed.
Harrisburg, Pennsylvania
Why Learn About Encopresis?

- Understand the condition
- Refer more quickly to the nurse for speedy care
- Better able to comply with provider orders
- Only 40% of sufferers seek medical care (Coehlo, 2011)
Early signs

- If student has frequent smell of BM that does not dissipate with airflow, consider this diagnosis.
- Contact school nurse or send to school nurse.
- Encopresis is defecation where not supposed to. Over 90% of cases are from chronic constipation. (Coelho, 2011).
Additional factors

- Previously potty-trained for BM’s for at least 6 months.
- May be a congenital condition such as Hirshsprung’s or tethered cord.
- Experienced health care provider needs to evaluate
Possible “withholding” behavior as a toddler

- Resisted toilet training for BM
- Wanted diaper or pull-up on to have BM
- Stood, with tension in body
- Held on to table or wall
- May have passed stool only in bathtub, when relaxed.
Constipation

- Tends toward constipation
- Large BM may clog toilet (Garman & Fica, 2012)
- Parents may not monitor BM’s, so may not know
Painful Cycle of Defecation

- Constipated, so having BM hurts
- Holds it in
- BM becomes dryer, harder, bigger
- More painful
- More determined to hold it in
Colon is stretched

- No longer has normal sensation due to increased diameter of colon.
- Can’t feel when needs to move bowels
Continues to eat

- Semi-liquid BM squeezes around the impaction
- Smear of BM in underpants
- Stretched colon means altered sensation
Shame and Embarrassment

- Shame that cannot hold in BM
- Private topic and area of body
- May be accused of deliberately defecating
Family Dynamics Strained

- Parental fear of “poor parenting” label
- Family stress may be causative too
  - New sibling
  - Parental discord
  - These may exacerbate physical problem
- Often power struggles develop, related to encopresis
See experienced provider

- Mistreatment with only counseling or anti-diarrhea meds from some health care providers
- May need referral to a pediatric gastroenterologist
Medical Supervision!

• Families may feel they can treat it themselves, but don’t have expertise

• In 5-15% there are other factors causing the problem-need professional to check

• Strained dynamics-parents & child working together to carry out medical plan starts the healing process and facilitates family harmony
Treatment: clean out colon

- Medications-as provider instructs
  - Not to be used regularly
  - Just for initial clean out

- Possibly enemas
  - Enemas may be traumatic
  - Not used as much as in past
Treatment: on-going medication

- Keep bowels loose

- Medications, one or more of:
  - Polyethylene Glycol (Miralax™)
  - Stool softeners
  - Bulk-forming laxatives such as Metamucil™
Treatment: diet

- **Diet**
  - **Increase fiber:**
    - Whole grains
    - Fruits
    - Vegetables
  - **Decrease:**
    - Refined grains
    - Sugars
    - Fats
Treatment: Lifestyle

- Fluids--increase water
  - Softens stool
- Exercise helps with stool passage
Treatment: Toileting

- Regular schedule
- Praise/reward BM
- Can’t feel, but needs to be regular!
- May need to sit on toilet after breakfast
  - Ten-fifteen minutes after meal is ideal
  - Best in clinic restroom (for monitoring)
Colon return to close to normal size after 2-12 months

- Colon shrinks, sensation returns to normal.
Encopresis can recur

- Monitor closely
- Should continue high fiber diet, fluids, exercise, perhaps medications
- May be prone to constipation even into adulthood
Normalcy

- This is a medical condition that needs treatment
- Focus on student strengths and accomplishments
- Support student and family in treatment
- Monitor peer interactions and intervene as needed if teasing or bullying
References


- Qureshi, Dr. Muhammad Azim (2013). Personal communication.
Dissemination

- This PowerPoint may be used for non-profit educational use if proper credit is given to author Ann Stillwater.
Additional Resource

- North American Society for Pediatric Gastroenterology, Hepatology and Nutrition
### Table 1. Constipation Contributing Factors

<table>
<thead>
<tr>
<th>Factor</th>
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<td>Withholding behaviors due to previous painful bowel movements</td>
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<td>Toilet training before a child is developmentally ready</td>
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<td>Toilet avoidance due to unsanitary conditions either at home or at school</td>
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<td>Diet lacking in adequate fiber or low fluid intake</td>
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<td>Medications that cause constipation</td>
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<td>Emotional upsets or changes in the child’s normal routine</td>
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### Table 2. Medications for Constipation Treatment

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<th>Type of Medication</th>
<th>Examples</th>
<th>Recommended Dosage</th>
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<tbody>
<tr>
<td>Bulk forming laxatives</td>
<td>Citrucel</td>
<td>Children greater than 6 years: 1–1.5 g/dose</td>
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<tr>
<td></td>
<td>Metamucil</td>
<td>Children greater than 6 years: ( \frac{1}{2}–1 ) tsp. 1–3×/day</td>
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<tr>
<td>Osmotics</td>
<td>Milk of Magnesia</td>
<td>Children 2–5 years: 5–15 ml/day in divided doses</td>
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<td>MiraLax</td>
<td>Children 6–12 years: 15–30 ml/day in divided doses</td>
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<td>Children less than 2–11 years: 8.5 g (1/2 heaping tbsp) in 4 oz of water.</td>
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<td></td>
<td>Sorbitol</td>
<td>0.25–1.5 gm/kg/day divided twice a day (lower-end maintenance/higher-end disimpaction</td>
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<tr>
<td>Stool softeners</td>
<td>Colace</td>
<td>1–3 ml/kg/day in divided doses</td>
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<td></td>
<td></td>
<td>Children 3–6 years: 20–60 mg/day in 1–4 divided doses</td>
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<tr>
<td></td>
<td></td>
<td>Children 6-12 years: 40–150 mg/day in 1–4 divided doses</td>
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Table 3. Example of an Individualized Health Plan (IHP) for the School-Age Child

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**History:** First-grade male student is reported to be experiencing episodes of fecal incontinence during school hours. He is not aware of when soiling has occurred and is not bothered by the noticeable odor. The child’s teacher reports that he has feelings of embarrassment when the soiling occurs and the other students are beginning to avoid interactions with this child.

**Assessment:** The student is assessed by the school nurse and the student does exhibit signs of abdominal distention, pain, and cramping. Upon speaking with the child’s parents, it is reported that fecal soiling has been occurring at school and at home and that he has a medical diagnosis of functional encopresis.

**Nursing Diagnosis:** Based on the assessment findings, the school nurse utilizes clinical judgment and formulates the following nursing diagnosis:

1. Knowledge deficit related to the clinical diagnosis
2. Alteration in elimination patterns
3. Alteration in self-care
4. Potential for alteration in self-esteem

**Outcomes Planning—Goals:**

1. Child and family will gain understanding of the clinical diagnosis and treatment plan
2. Child will comply with the established plan of care
3. Child will demonstrate self-care practices
4. Child’s self-esteem will be supported with positive feedback for successes

**Implementation/Interventions**

- Provide information regarding elimination patterns that are easy to comprehend
- Assist children and families with compliance of the prescribed treatment plan
- Offer written instruction for parents and students regarding dietary practices and ensure that dietary measures are being followed
- Communicate with the child’s health care provider either through written communication or telephone updates
- Communicate with the child’s teacher regarding the plan of care
- Administer medication as ordered by the health care provider
- Develop a toileting schedule for the child while at school and maintain a log of incontinence occurrences as well as bowel movements in the toilet
- Ensure that the student has a clean, accessible, and private bathroom to access during school hours
- Establish a reward system for reinforcing positive behavior
- Maintain communication with parent and health care provider regarding the progress
- Encourage parents to seek referrals to other resources as necessary

**Evaluation:** It is during this phase that the school nurse will compare student’s behaviors and incidences of incontinence before the IHP was established. Goals are assessed with suspected outcomes such as:

1. The child and the family will verbalize understanding of the encopresis diagnosis and the prescribed treatment plan.
2. The child demonstrates compliance with the prescribed treatment plan maintaining fecal continence throughout the day.
3. The child makes healthy food choices that incorporate adequate fluids and food with increased fiber.
4. The child reports positive interactions with peers.
5. Effective communication has been maintained with the child’s parents and physician throughout the school year with updates of successes and failures.

Garman K, and Ficca M The Journal of School Nursing
2011;28:175-180