4.9 Specialist Health Expertise Guidelines

4.5.9 Faecal incontinence (Encopresis)

Background

Encopresis may be defined as the voluntary or involuntary passage of formed, semi-formed, or liquid stool into a place other than the toilet for more than one time per month in a child over four years of age for at least three months. If the child has never been continent it may be termed as primary encopresis, whereas secondary encopresis is faecal incontinence in a child who was previously continent. It is reported in approximately 1-4% of school aged children.

Most faecal incontinence in children is functional, meaning there is no known organic defect. It has been suggested that approximately 80-90% of faecal incontinence results from chronic constipation, which leads to impaction and overflow soiling. Non-functional encopresis accounts for about 5-10% of cases (due to medical or physical problems); this is known as organic encopresis. Common organic causes include anorectal malformations, spinal cord abnormalities, Hirschsprung disease, and certain medications.

Nonretentive encopresis is where the child refuses to defecate in an appropriate place, e.g. toilet, but has no history of constipation. These children typically soil daily or regularly but their bowel movements are a normal size and consistency.

Constipation can be caused by the child repetitively attempting to avoid defecation or holding in the stool because of pain, fear, or a dislike of defecation or using the toilet, this can lead to further constipation. One study suggests that 63% of children have a history of passing a painful bowel movement before 36 months of age. It may also be associated with behavioral, emotional or psychiatric issues and impacts on the child’s physical and psychological development as well as their family.

For many children with encopresis there may be a history of an event that made having a bowel movement uncomfortable or frightening. This could range from fear of pain or the toilet flushing to repeated sexual abuse. Whilst most children with encopresis have not experienced sexual abuse, if there is a history of early sexual abuse, encopresis may be more likely. Children with psychiatric and/or behavioural and emotional disorders also have a higher incidence of encopposes. It is also commonly associated with the child being bullied or taunted by peers which can lead to low self-esteem and impact on school progress.

A result of chronic constipation may be loss of bowel elasticity, enlarged (mega) colon, interference with bladder function, recurrent abdominal pain and problems with constipation in later life. Children with encopresis are also more at risk of urinary tract infections and enuresis. They can also have olfactory desensitisation therefore not recognising the smell when soiling occurs.
Evidence suggests that only 50% of parents are aware that their child is constipated and few correlate soiling with constipation. It has also been suggested that some health care professionals can underestimate the impact of constipation on the child and family.

Most constipation in children is idiopathic, that is no organic cause can be found. However early identification can improve outcomes for children and may also help identify an underlying medical condition. Boys are more than twice as likely to be affected as girls and it is most common between the ages of five to ten years.

### Symptoms of bowel dysfunction

- Defaecating <3 times per week
- Straining to defaecate and/or faecal incontinence
- Reflexive withholding behaviours
- Pain on defeacation
- Loss of awareness of smell of faecal incontinence

### Habits to enhance bowel functioning

- Regular, consistent fluid intake (at least 1 litre per day). Water is the drink of choice
- Regular exercise
- Regular meals including fruit, vegetables and cereals
- Foot stool in the toilet or use a potty
- Don’t hurry toilet time, give the bladder and bowel time to empty

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<tr>
<th>Practice principles</th>
<th>Additional information</th>
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<tbody>
<tr>
<td>Refer family to a GP (if not already done so) and consider using an exchange of information form so that the nurse can get feedback from the GP</td>
<td>Encopresis is a medical condition with a large number of underlying causes and treatment pathways. Children with faecal incontinence concerns who are over four years of age should always be assessed through a GP or paediatrician</td>
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<tr>
<td>Encourage the parent to consult with a GP who has the capacity and expertise to manage their problem or ask for a referral to a GP or paediatrician who does</td>
<td>Children can be referred by their GP to PMH, an outlying hospital or a private paediatrician. There are rebates available from the State Disability Services Commission (DSC) and Commonwealth governments for incontinence products. Children need to be over five years of age and meet eligibility criteria. From July 2013, children registered with the DSC will be eligible for continence services via non-government agency/s.</td>
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<td>Encourage family to liaise with the school, if they have not already done so, regarding the need for a case</td>
<td>This will ensure that there is a current care plan for the staff and child to follow.</td>
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Community health nurse role

School nurses are encouraged where possible to support school staff in managing the child’s faecal incontinence, such as advocating that appropriate facilities are available including hot and cold running water, soap, paper towels and gloves. Correct handwashing should be discussed and promoted.

Taking into account that there is an increased risk of bullying and low self esteem in the school environment, children with ongoing encopresis concerns may require additional support from the CHN.

School role

The new National Quality Standard for Early Childhood Education and Care includes the need for all schools, long day care and family day care centres to make appropriate provisions for children who are not yet toilet trained. Parents are encouraged to provide a change of clothes as well as nappies or wipes for their child if required. These facilities need to be considerate of the child’s privacy and the health and safety of the staff and child.

Peer group interaction can accelerate toilet training in the early childhood environment and teachers can also positively contribute to a toileting routine. School aged children (from kindergarten onwards) who are not fully toilet trained will not be excluded from attending school. Consideration should be made for ongoing support for the child including involving family, school staff and other outside agencies as required. This may require the development of a case conference, ongoing monitoring and a documented plan of the child’s progress.

School staff can help promote independence and protective behaviours by ensuring the dignity and rights of the child are maintained at all times and, wherever possible, to support the child to clean him/her self after an incontinence episode.
Associated tools, resources and procedures

Continence Foundation of Australia 1800 33 00 66 www.continence.org.au
- Soiling (faecal incontinence) in Children. (Brochure)
- Good Bowel (Poo) Habits for Kids- you can do it too!
- Toilet tactics kit.
- Bristol Stool Form Scale

Professional development

Kids and Kontinence Study Day PMH. CAHS intranet

Parent information and support

Ngala.
Helpline- 08 9368 9368 or 1800 111 546
Successful Toileting workshops 3 ½ - 5 years
www.ngala.com.au

Continence Advisory Service of WA. Assistance with products, services and advice.
Parent support- 08 9386 9777 or 1800 814 925
www.continencewa.org.au

Continence Foundation of Australia.
National Continence Helpline- 1800 33 00 66
www.continence.org.au

Parenting WA
Parenting Line- 08 6279 1200 or 1800 654 432
www.communities.wa.gov.au

Triple P Parenting Programs
Parenting WA- Triple P @ Home www.communities.wa.gov.au

Raising Children website www.raisingchildren.net.au

References


Community Health
Policies, Procedures and Guidelines
School Aged Children


