Elimination (Toileting) Disorders

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TOILET TRAINING

Separate steps of toileting:
1) discussion
2) undressing
3) eliminating
4) dressing again
5) flushing
6) hand washing.

- when to start training:
  for bowel control - at age 2-3 yr;
  for urinary control - at age 3-4 yr.
- by age 5 yr, average child can go to toilet alone.
- incontinence at age ≥ 4 yr is abnormal.
- signs of readiness to train (at age ≈ 18-24 mo):
  1) is able to walk and sit well
  2) can remain dry for several hours
  3) shows interest in sitting on potty chair
  4) expresses visible signs of preparing to urinate or defecate
  5) wants to be changed after either
  6) has demonstrated ability to place things where they belong
  7) can understand and carry out simple verbal commands
  8) has desire to please parents.
- approaches to toilet training must be *consistent among all caregivers*.

Timing method (for children with predictable schedule):
1) once child has demonstrated readiness, parent ***discusses*** with child what will be happening, selecting words that child can readily understand and say.
2) child is gradually introduced to ***potty chair*** and briefly sits on it fully clothed.
   – child who resists sitting on potty should try again *after meal*.
   – if resistance continues for days, *postponing* toilet training for at least several weeks is best strategy.
3) child then practices ***taking pants down***, sitting on ***potty chair*** for ≤ 5-10 min, and ***redressing***; purpose for exercise is explained repeatedly (and emphasized by placing wet or dirty diapers in potty).
4) parent should try to ***anticipate child's need*** to eliminate and provide ***positive reinforcement*** for successful elimination (once pattern is established, rewards are gradually withdrawn).
   Anger or punishment for accidents / lack of success is counterproductive!
5) child is ***encouraged*** to practice using potty whenever need to eliminate is sensed.
6) child should also be ***taught about flushing and hand washing*** after each elimination.

For child with unpredictable schedule, training is delayed until child can anticipate elimination himself.

- toilet-trained *children may regress* during illness, emotional upset, or when they feel need for more attention (such as when new sibling arrives).

ENURESIS

- child continues to urinate at inappropriate times and places after age when continence has been reached by most children (5 years in girls, 6 years in boys);

DSM-IV criterion – *DEVELOPMENTAL** age ≥ 5 yrs and episodes occur at least twice weekly for ≥ 3 months. *coincides with *CHRONOLOGICAL* age in developmentally normal children

PRIMARY ENURESIS – bladder control was never achieved.
SECONDARY ENURESIS – bedwetting in patient who have been fully continent for 6-12 months.

Nocturnal enuresis (85%) – parasomnia. see p. S46 >>
Diurnal enuresis (5%) – more serious type (increased risk of organic pathology)
Mixed enuresis (10%)

- physiologic during first 2-3 yr of life.
- boys > girls.
- etiology:
  1. Delayed neuromuscular maturation of lower urinary tract.
  2. Organic disease (e.g. UTI, distal urethral stenosis in girls, posterior urethral valves in boys, neurogenic bladder, frontal lobe tumor).
- **imaging diagnostic procedures** to search for organic etiology **should be avoided** (unless evidence points to such); urinalysis (for UTI and diabetes) is all that is necessary.
- because enuresis is self-limited disorder*, sometimes best treatment is no treatment.
  for helpful measures – see p. S46 >> *especially primary nocturnal pattern.

ENCOPRESIS

- repetitive voluntary or involuntary passage of stool in inappropriate places in child > 4 yr who do not have organic illness.

PREVALENCE: 3% of 4-yr-olds, 1-2% of 5-yr-olds, 1.5% of 7-yr-olds.

ETIOLOGY:
1) **RETENTIVE TYPE** (most common type!) - **overflow due to chronic constipation**: encopresis results from children avoiding evacuating their bowels and retaining feces - stool is passed around fecal impaction; impaction is readily identifiable within rectal vault (other causes of stool retention - Hirschsprung's disease, anal stenosis, anal fissures).
2) **NONRETENTIVE TYPE** - **psychological factors**: unresolved anger at parent, regressive wishes; fecal smearing may be psychotic symptom.

- most physical causes are apparent on history and physical examination; in their absence, testing is usually not indicated.

TREATMENT - **educating** parents and child about physiology of encopresis, removing blame from child, and diffusing emotional reactions of those involved.
- initially *bowel should be emptied* by using laxative (such as Mg hydroxide or polyethylene glycol) → *maintenance of regular bowel movements*:
  1) high-roughage **diet** with liquids
  2) **bowel retraining**: child should sit on toilet at consistent times twice/day for 10 min at most (best after meals).
  3) intermittent, short-term **laxatives** sometimes needed.

BIBLIOGRAPHY for ch. "Psychiatry" → follow this LINK >>