

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 $\approx 18-24$ 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 $\leq 5-10$ 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and provide **positive reinforcement** for successful elimination (once pattern is established, rewards are gradually withdrawn).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](#) >>

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