

Toilet Training for Patients Previously Treated With a Bowel Management Program

Children with fecal incontinence, meaning they are unable to control their bowels, can be treated with a [bowel management program](#) that uses daily enemas to keep their colon quiet and clean 95% of the time. [Anorectal malformations](#) are defects of the anus, the opening at the end of digestive tract where stool exits the body, and the rectum, the final section of the large bowel leading to the anus.

When a patient reaches 3 years of age and is still incontinent and the parents are considering sending the child to school, we talk to the parents about the necessity of implementing a bowel management program to keep the child's bowel clean. This will allow the child to go to school with normal underwear and nobody at school that does not have to know should be aware of the child's problem.

Parents frequently ask, "Is this treatment for life?" The answer is, "Not necessarily." Some of those patients were born with anorectal malformations with a very bad prognosis or chance of gaining control of their bowels and most likely they will continue with the bowel management for many years. Other patients may have partial fecal incontinence, anatomical features such as well constructed sacrum (the lower part of the spine that forms part of the pelvis), and other factors that may indicate these patients could achieve bowel control in the future. For these individuals, bowel control trials should be conducted periodically.

Each year during summer vacations, when the child is not attending school, we can conduct a trial with laxatives. For this, we stop the enemas and see how much bowel control the child has. Within one or two weeks, the parents would be able to determine whether or not the patient is ready to continue without enemas.

Parents should learn about the specific type of malformation that their child was born with, since each defect has a different prognosis. This knowledge will enable parents to have realistic expectations about whether their child may achieve bowel control.

Basic Principles of Bowel Control Trial

A bowel control trial is carried out at home for a period of one or two weeks and must follow certain basic principles and procedures.

- Talk to your child about the trial and make sure your child understands the trial's purpose and the general process.
- Explain that during the trial, the child must avoid social gathering because of the risk of having unexpected embarrassing bowel movements.
- Motivate your child to keep a clean colon. Establish some incentive, such as buying new underwear, and provide rewards for every day "clean day."
- Stop the enemas.
- Give three meals per day with no snacks. The purpose of this is to try to condition the colon to empty periodically at the same time. It is much easier to toilet train a child that has one, or even two or three bowel movements every day at predictable times, than a child that has very irregular bouts of diarrhea and constipation. Regularity is very important, but not always possible to achieve because of the difficulty in regulating colonic motility (the movement of food through the digestive tract).
- Try to include the same type of food in every meal. The type of food largely depends on whether the child has been classified as belonging to the constipated group or the diarrhea group. Most patients with anorectal malformations suffer from constipation and therefore need a laxative type of food. Most parents know what type of food has a laxative effect in their children, but if you need help determining types of foods that are laxative or constipating, call the Colorectal Center at Cincinnati Children's Hospital Medical Center.
- Make sure the child stays close to the bathroom.

Laxatives Are Often Needed

Because most of these children suffer from [constipation](#), they commonly need some form of laxative to have bowel movements without enemas. The type and amount of laxative that a specific patient needs must be determined on an individual basis by trial and error. Most children with anorectal malformations do not respond to the usual recommended dosage of laxative. In determining how much laxative your child needs, try to remember if your child previously took laxatives and if so, how the child responded.

The laxative must be given once a day (not three times per day) in order to try, again, to provoke one or two bowel movements per day. Start by giving 1 teaspoon of a determined laxative at night. Keep in mind the effect can be expected the day after the laxative was administered. If the entire day goes by without the child having a bowel movement, that means that that not enough laxative was given and the amount should be doubled that night. It also means that the child needs an enema to remove the stool that has been there for 24 hours in order to avoid fecal impaction.

If the child does not have bowel movement the following day, the amount of laxative should be increased further and you should continue that way every day, while also giving enemas to avoid impaction. If the child suddenly develops diarrhea, that means that the amount of laxative given the day before was excessive and therefore should be reduced, but not eliminated completely. What we are describing here is a process of trial and error to try to find the right amount of laxative — the dose that provokes bowel movements but not diarrhea.

Most of the time we suggest parents also administer some form of fiber product in addition to the laxative. The fiber will provide bulk in the stool so the child can have formed stool rather than liquid stool. If the child's stools are too liquid, increase the amount of fiber and decrease the amount of laxative. Conversely, if the child has formed stool, but can't have bowel movements easily, increase the amount of laxative.

Sometimes the child is having bowel movements in the toilet, but the parents are not sure whether the bowels are being completely emptied. Under those circumstances, we recommend getting an X-ray film of the abdomen so we can see how well the child is emptying the colon. To promote complete emptying of the colon, the child is asked to sit on the toilet or potty three times per day, particularly after breakfast, lunch and dinner, or at another time the parents think the child is most likely to have a bowel movement. Sometimes suppositories can be used to provoke and help regulate the bowel movements.

Using Results To Determine Future Course of Action

With this trial and error approach, within a week or two, parents should be able to determine the type and amount of laxative their child needs, how much bowel control the child has, and whether or not the child is able to maintain a clean colon. If the test shows the child actually has bowel control, this means the child does not need any more enemas but must continue with the same bowel management program. If the test shows that the child has some bowel control, with



occasional voluntary bowel movements, but still soils significantly, the child may need to go back to being treated with enemas. If the child is still soiling significantly, our recommendation is to go back to the bowel management for another year, and not to take unnecessary risks of embarrassing accidents at school.

Every summer, when the child is not attending school, the parents may try again. Every year, they will be dealing with an older patient, more interested in becoming fecally continent, and therefore, with more possibilities of success.

Contact the Colorectal Center

For more information or to request an appointment for the Colorectal Center at Cincinnati Children's Hospital Medical Center, please [contact us](#).