Management of Behavioral Problems in the Primary Care Office: Enuresis and Encopresis

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Disclosures

• I will discuss no off-label products.
• I have not yet received money or other gifts from any industry.
• If someone wanted to bias me, I fear that I would be cheap.
Objectives

1. Track your learning goals & address them
2. Speak my thoughts on 1° Nocturnal Enuresis
3. Speak my thoughts on Encopresis
4. Speak my thoughts on variations on 2 & 3
5. Address your concerns/questions on 2-4
What are my goals?

- Keeping y’all awake until 3:15
- Keeping it “simple” & “real”
- Cooking advice (not just a “cook book”)
- Framing within ABC and Trauma

- Witness a ND national championship this year
What are your learning goals?
Primary Enuresis: Universal

Department of Pediatrics, Faculty of Medicine & Health Sciences, Aden University, Yemen

- Nocturnal enuresis decreased by age from 31.5% at 6-8 years to 8.7% at 15+ years (P < 0.05). Primary nocturnal enuresis affected 76.1%, of which the majority of children were bedwetting every night. Positive family history of nocturnal enuresis, deeper sleep, daytime enuresis, tea drinking, being non-working father or with less education showed significant association with the occurrence of enuresis in the students.

- Stressful events in the previous 6 months of the study were twice more frequently noted. The study concluded that the prevalence of nocturnal enuresis in Aden public school children and its associated factors are almost comparable with that reported in epidemiological studies from various countries.
Primary Enuresis: Not just for kids

Division of Paediatric Surgery, Department of Surgery, Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong

• Overall, 2.3% of Hong Kong adults aged 16-40 years have persistent PNE. Unlike PNE in early childhood the prevalence remained relatively unchanged with age, suggesting that enuretic symptoms persisting into adulthood are probably less likely to resolve with time.
Primary Enuresis: Nature v. Nurture?

Long history of debates between:

• Bladder v. Brain
• GU v. Psychology
• Drugs v. “therapy”
• Medical v. non-medical

ALL are false dichotomies
Speaking my thoughts

• Take a history and rule out (98%):
  – Toxic Trauma
  – Congenital anomalies
  – UTI
  – Developmental variations

• Meds ONLY for “emergencies” (sleep-overs)

• “Alarm” and “practice” as main treatment

• 100% “cure” rate
Main Treatment: 3 steps

1. Get the “alarm” and discuss its use/theory

2. PRACTICE nightly:
   – Bedtime routine
   – Strict script: return to bathroom
   – SLOW & steady improvement expected

3. Track daily (minimum of 30 “D” to “quit”)
   – “D” or “W” every morning on calendar
   – Return to schedule for 30 D if “relapse”
Questions/rebuttals?
Encopresis: Same Debates

Long history of debates between:

- Bladder Bowel v. Brain
- GU GI v. Psychology
- Drugs v. “therapy”
- Medical v. non-medical

ALL are false dichotomies
Speaking my thoughts

• Take a history and rule out (98%):
  – Toxic Trauma
  – Congenital anomalies
  – Developmental variations

• Meds to start and maintain

• Consistency & **calm** as main treatment

• 66% “cure” rate initially, 90% longer-term
Main Therapy: 2 Steps

1. “Clean out”
   - “old days” = stimulant laxatives
   - Now = Polyethylene glycol 3350
2. Routine/schedules/tracking
   - “old days” = stool softeners
   - Now = Polyethylene glycol 3350
Questions/rebuttals?