Paediatric continence

A mother’s journey to gain a diagnosis of her child’s incontinence

Abstract

Children’s continence has become a passion and my own experience as both mother and nurse was a key factor in my taking on the role of nurse coordinator for the Kiwi Enuresis Encopresis Association (KEEA). My main role is to respond to calls to the KEEA information phone number (freephone) 0800 533 269 and information email info@keea.org.nz, supporting and advising both health professionals and parents. In 2009, I was co-opted to the Executive of the New Zealand Continence Association where I hope to continue to further the cause of children’s continence. It is extremely satisfying to be making a difference.

Acquiring continence is part of normal development for most children; however, for some children and their families acquiring, or reacquiring continence can be a challenge. Health professionals are uniquely positioned to positively influence the experience of children and their families struggling with incontinence.

For me the journey started innocently enough, on one of Nelson’s balmy summer days in 2005, poolside at Mr Pattison’s swimming lessons. Hannah, then nearly 6, waved me frantically to the pool’s edge. Her face portrayed her distress clearer than any words, but when they did come she whispered urgently, “Mummy, I’ve done poos in my togs.” With an army of parents looking on I had her out of the pool and into the changing room so fast her feet literally didn’t touch the ground. Thankfully the poo was contained in her togs – complete disaster narrowly averted.

Despite 10 years of clinical experience as a Registered Nurse, some of it even in paediatrics, I wrote the event off as a one-off. However, the instances of soiling increased, along with daytime and night-time wetting and before long we were at the general practitioner (GP) who correctly diagnosed overflow secondary to constipation. Poloxamer oral drops were prescribed but predictably with little effect.

We were soon back at the GP, this time with a urine infection as well. Lactulose was prescribed at 40ml daily, increasing by 10ml/day until Hannah had a bowel motion. A toilet-sitting regimen was introduced (10 minutes on the toilet with feet supported on a low stool after breakfast and tea, complete with star/poo chart). Hannah was soon having entire bowel motions in her underpants, often while on the mat at school. When she arrived home on the bus her pants were wet and she was smelly. She was teased and stigmatised by other children.

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By the end of the first month Hannah was taking up to 70ml of lactulose syrup twice daily. Compliance was an issue and, I am ashamed to say that, Hannah was sometimes ‘helped’ to have her medicine. Even if she didn’t seem to want to get better (a common feature of encopresis is denial) I was determined that she would!

After several particularly large motions the lactulose dose was reduced to 10ml twice daily. In the months that followed urinary tract infections became the norm with bucketfuls of smelly, wet and soiled underpants jostling for space with the bed sheets in the bath (our ‘laundry’ consists of a concrete tub at the front door although we do have a washing machine). Hannah refused to take any more lactulose, a move I supported. We were both exhausted.

A request to the GP for a referral to a paediatrician was declined, as I was told I hadn’t followed the lactulose protocol adequately (ever tried getting large quantities of sickly sweet lactulose into an uncooperative child twice a day?). I felt powerless. While seeing another GP in the same practice I insisted on an abdominal x-ray, immature ovaries or not.

At the school’s request, Hannah saw a counsellor for play therapy to see if there were any unresolved issues from having her parents separate, moving house, starting school and having her mother remarry and produce a sibling. The counsellor made the referral to the paediatrician. Hannah was tested for learning disabilities, but much to everyone’s surprise the tests show she is “borderline gifted”. A visit to the chiropractor ruled out any spinal misalignment that could have affected nervous innervation to the bladder and bowel.

We saw the paediatrician in January 2006, almost one year to the day since the pool episode. He took one look at the then...
6-month-old x-ray and suggested immediate admission to hospital for a bowel wash out. Even my inexperienced eye could see that Hannah's x-ray showed her entire pelvis was faeces-filled rectum.

Following the wash out, Hannah started a lactulose and sennoside or senna granules protocol. The dose was lactulose 10ml twice daily and Senokot® 2-3 tablets daily. This wasn't enough and 2 months later Hannah was again symptomatic, with yet another urinary tract infection. The Senokot® was increased until she was taking more than 6 tablets twice a day. Still she was symptomatic and only having a bowel motion every 3-4 days. The motions were very large and underpants mysteriously ‘disappeared’. Hannah underwent a rectal biopsy to rule out Hirschsprung's Disease and another bowel wash out. She had ultrasounds and a further x-ray to check her lumbar spine. She started a lactulose and paraffin oil protocol and was commenced on prophylactic antibiotics for the recurrent urinary tract infections.

In November 2007, a short time after polyethylene glycol 3350 (Movicol®) was added to the pharmaceutical schedule in New Zealand, Hannah was commenced on a dose of one sachet daily. Within a week she was dry at night. Wetting during the day only occurred once to twice a week and she had a bowel motion 5 out of 7 days. By the time we saw the paediatrician again, in May 2008, Hannah was dry day and night with no soiling and her stool size was reducing. The impact of the new aperient regimen in Hannah's life and that of the family, was that life no longer needed to revolve around Hannah's bowel and bladder function. Before long she was going to sleepovers, being invited to parties and playing netball. Her self-esteem and behaviour improved markedly.

The journey continues with some subtle parental observation, for example checking the compost bin for suspicious white powder, or peering into the toilet bowl with a torch to assess bowel movement characteristics.

Over the last 4 years I have learnt that well-informed health professionals can play a key role in the early detection of childhood continence problems. They are uniquely situated to ask questions about wetting and soiling. Early detection and treatment leads to improved outcomes and less stress on the individual and their family.

By reading stories like Hannah’s they can empathise with the parent who is trying to negotiate the path of medical assessments and interventions at the same time as ‘juggling’ the needs of other siblings, a relationship, the needs of the household, driving to and from appointments, washing load after load of pants and sheets every day and waiting for the inevitable call from school to come and clean up their child.

Health professionals can promote a ‘no fault’ attitude both for parents who are fearful they have caused the situation through...
This reader-friendly textbook, written by Sue Brown and published in 2007, provides a useful introduction to the assessment and care of older people within an Australian context. It is underpinned by a focus on health promotion and wellness; evidence-based interventions; and the personal and professional development of Registered Nurses (RNs) who work with older adults. It differentiates itself from the multitude of other texts on nursing older people by its relevance to Australian care settings (particularly in relation to commonly used, local assessment tools), as well as its broad service focus. This focus on the older person across a variety of clinical settings means that it is a useful resource for those working with older people in primary health, community or acute care, or in residential aged care settings. The fact that it is focused on screening, assessment and intervention and is particularly relevant to Australian settings makes it an ideal and practical, educational resource for RNs caring for older people.

Topics and chapters are varied and reflect the notion that older people are a heterogeneous group. Chapter topics include demographics (e.g. Australian Population Mix); physical conditions (e.g. Continence and Dementia); clinical issues (e.g. Falls and the Quality Use of Medicines); as well as challenges (e.g. Sexuality, Abuse of Older People, Alcohol and Other Drugs) and age-associated clinical foci (e.g. Chronic Disease, Palliative Care, Mental Health). This variety in the type of topics covered means that chapters are quite diverse in presentation, with many figures, tables, assessment forms and information boxes. This occasionally makes the text of the chapter difficult to follow, with pages broken up by information boxes and tables. It does, however, make for an easy and quick reference guide, with many of the key points of each chapter highlighted in dot point form in an information box.

While each chapter presents quite differently, there are some common elements. Each chapter includes examples of commonly used screening instruments and assessment tools; references; web resources; scenarios; multiple-choice questions; and tips for professional portfolio development. The professional portfolio development tips are particularly thought-provoking and provide direction for lifelong learning, career planning and developing an evidence base of professional development and education in line with moves towards national registration.

Brown’s text is a useful resource for students and novice practitioners; for experienced RNs moving into caring for older people; and for educators involved in the teaching of aged care coursework. For those already working with older people, the text offers a ready source of relevant knowledge for self-development; as well as the education and development of other staff involved in caring for older people. It provides an interesting introduction to relevant clinical issues in caring for older people in Australia and a timely reminder that nursing the older person requires commitment and a passion for lifelong learning and clinical development.