

## **Categorization of functional fecal soiling: “primary” and “secondary”-abstract terms that hinder understanding**

Functional fecal soiling has been categorized as “primary” (i.e., continuous from infancy) and “secondary” (i.e., onset after gaining control of fecal continence). I’m communicating with you now, during the discussions preliminary to ROMR III, because I find that the “primary” vs. “secondary” classification interferes with the problem of how to help a child overcome soiling.

A more useful classification is based on two much more important considerations: 1) the physiologic/mechanical factors (namely, the presence or absence of fecal retention); and 2) the psychological/environmental factors associated with the development and persistence of soiling (be it retentive or non-retentive).

For example, consider two 6 year-old soilers: The *first* is a boy who has always soiled because he’s had inadequately treated functional fecal retention since toddlerhood. Nevertheless, he is emotionally well and has a well-functioning family. The immediate cause of his soiling is an intra-rectal fecal mass. Management includes help with evacuation of the mass followed by an ongoing stool softener in doses sufficient to keep re-accumulations soft enough to be passed without discomfort until his fear of defecation is overcome. The child’s emotional distress is mostly caused by his worries about defecation, rather than serious psychologic co-morbidity. Solve his mechanical problem, keep it from recurring, and he will recover without the help of a mental health professional. (Fail to solve his mechanical problem, and no amount of psychotherapy or behavior modification is likely to cure him.)

The *second* 6 year-old also has soiled since toddlerhood, but his soiling is non-retentive. His parents have severe marital discord. He has no “mechanical problem,” no fecal mass to evacuate. His soiling is perpetuated by anger and regression. The emotional disorder, not a fear of defecation, drives his fecal soiling. His parents’ punitive responses to his soiling fuel his anger which, in turn, reinforces his impulse to soil. Management involves avoidance of laxatives and cessation of measures that exacerbate conflict, e.g., coercive toileting rituals. Treatment might best be directed at the psychosocial aspects of the problem by helping the parents recognize their own unhappiness and the suffering it causes their child and themselves. At the same time, give them concepts and techniques that help them be more tolerant of their child’s soiling and build an alliance with the child that helps shift his soiling-as-an-act-of-retaliation to prevention of soiling as a way of restoring his self-esteem.

Both of the above 6 year-olds have “primary encopresis”, but its origins, perpetuating factors and approaches to management are very different! Management of the first child’s “primary encopresis” should be easy. The mechanical part of the problem responds well to Miralax and the psychosocial co-morbidity is almost non-existent. Management of the second child’s “primary encopresis” is more difficult because there is no easily dealt-with mechanical problem, and the psychosocial co-morbidity is severe and not easily ameliorated.

Consider the following examples of “secondary encopresis:” Two 10 year-olds, both having a fair degree of trait anxiety, recently began soiling. The first boy developed fecal retention with overflow soiling after an episode of dyschezia that occurred while he was separated from his mother. She was away from home for a few weeks attending to his much beloved maternal grandfather during the grandfather’s terminal illness in a distant city.

The second boy with “secondary encopresis” developed fecal retention with soiling after being sodomized. He is more difficult to treat (e.g., he refuses all laxatives and doesn’t trust adults) because the emotional trauma he experienced is so much greater than that of the boy who missed his mother.

By definition, both boys have “secondary encopresis,” but the severity of their psychologic co-morbidities is vastly different. Diagnostic procedures such as digital exams or contrast enemas might possibly be done without coercion in the first boy, but are nearly impossible with the second boy without adding to his emotional co-morbidity.

Am I saying that whether a child’s soiling has been present since infancy vs a more recent onset is of no interest to me? Not at all! I need to know when the soiling began because it might provide a clue as to what caused it and why it persists. Knowing when it started is a means to an end, not an end in itself. I have no interest in the distinction between “primary” vs. “secondary” as categorical entities because, unless they are used to discover the pathogenesis of a child’s soiling, they are useless clutter. Let’s not invent heuristic labels so that we can feel that we know something important, but that fail to deepen our understanding of a clinical problem.

It’s often been said that we don’t know our patient unless we know what’s on our patient’s mind, i.e., unless we learn of his or her experience and how it relates to the illness. In my opinion, the specialty of Psychiatry has become degraded to the extent that it uses its “DSM” nosology to treat patients’ diagnoses without going to the trouble of developing an understanding of the individual who is the patient. Let’s not use our developing nosology of functional GI disorders in taking the same kind of short-cut.

A “statistical” approach to defining diagnostic entities is useful, but it needs to be supplemented by naturalistic enquiry. The words of Rene Dubos are worth remembering: “Sometimes the more measurable drives out the more important.”

## References

- 1) Forsyth BWC. Early health crises and vulnerable children. In: Levine MD, Carey WB, Crocker AC, editors. *Developmental-Behavioral Pediatrics*, Philadelphia, Saunders, 1999, pp 330 – 334
- 2) Cameron HC. Some forms of habitual vomiting in infancy. *Br Med J* 1925; 1: 872-876
- 3) Fleisher DR. Functional vomiting disorders in infancy: innocent vomiting, nervous vomiting and infant rumination syndrome. *J Pediatr* 1994; 125: S84-94
- 4) Fleisher DR. Comprehensive management of infants with gastroesophageal reflux and failure to thrive. *Current Problems in Pediatrics* 1995; 25 (8) 247 – 253
- 5) Fleisher DR. Infant rumination syndrome: a case report and review of the literature. *Am J Dis Child* 1979; 133:266 – 269
- 6) Levine DF, Wingate DL, Pfeffer JM, Butcher P. Habitual rumination: a benign disorder. *Br Med J* 1983; 287: 255 - 256
- 7) Chial HJ, Camilleri M, Williams DE, Litzinger K, Perrault, J. Rumination syndrome in children and adolescents: diagnosis, treatment and prognosis. *Pediatrics* 2003; 111 (1) 158 – 162
- 8) Khan S, Hyman PE, Cocjin J, Di Lorenzo C. Rumination syndrome in adolescents. *J Pediatr* 2000; 136: 528 – 531
- 9) Kanner L. Historical notes on rumination in man. *Med Life* 1936; 43: 27 – 60
- 10) Parry-Jones B. Merycism or rumination disorder: a historical investigation and current assessment. *Br. J Psychiatry* 1994; 165: 303 – 314
- 11) Reis S. Rumination in two developmentally normal children: case report and review of the literature. *The Journal of Family Practice* 1994. 38 (5) 521 – 523
- 12) Brazelton TB, Koslowski B, Main M. The origins of reciprocity: the early mother-infant interaction. In: Lewis M, Rosenblum, editors, *The Effect of the Infant on its Caregiver*. New York, John Wiley & Sons; 1974: 49 – 76
- 13) Kanner L. *Child Psychiatry*. Springfield, CH Thomas 1972, 4<sup>th</sup> Edition. p. 465

- 14) O'Brien MD, Bruce BK, Camilleri M. The rumination syndrome: clinical features rather than manometric diagnosis. *Gastroenterology* 1995. 108: 1024 - 1029
- 15) Eckern M, Stevens W, Mitchell J. The relationship between rumination and eating disorders. *Int J Eat Disord* 1999; 26: 414 – 419
- 16) Soykan I, Chen J, Kendall BJ, McCallum RW. The rumination Syndrome: clinical and manometric profile, therapy, and long-term outcome. *Dig Dis Sci* 1977; 42 (9) 1866 - 1872

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