CONDITION

Encopresis

Encopresis is repeated stool leakage in a toilet-trained child, most often caused by long-lasting constipation.

WHAT IT IS
Repeated stool leakage after the usual toilet-training age

BODY SYSTEM
Digestive system

MAIN SYMPTOMS
Stool leakage, constipation, painful stools, reduced awareness

WHAT CAUSES IT
Usually constipation; sometimes toileting or emotional factors

HOW IT IS DIAGNOSED
Symptom history and physical examination

MAIN TREATMENT
Constipation treatment and planned toilet sitting

CAN IT BE CURED?
Yes - usually resolves with sustained treatment

IS IT AN EMERGENCY?
Sometimes - severe pain, green vomiting, or marked swelling

LONG-TERM OUTLOOK
Most children improve, though relapses can occur

Overview

Encopresis means repeatedly passing stool in underwear or another inappropriate place after the age when a child would usually be toilet trained. It is also called fecal soiling or fecal incontinence and generally refers to children aged 4 or older.

Most cases are caused by long-lasting constipation. Stool collects in the rectum, stretching it and reducing its sensitivity. Softer or liquid stool may then leak around the retained stool without the child noticing or being able to stop it.

Less often, soiling occurs without retained stool or other signs of constipation. This is called nonretentive fecal incontinence.

Encopresis is usually not deliberate misbehavior. Shame, criticism, and punishment can

increase distress without improving bowel control. Although treatment often takes months, most children improve with consistent support.

Symptoms

Stool leakage may appear as small smears, loose stool, or a full bowel movement in the underwear. It may occur occasionally or several times a day.

Signs of constipation can include:

Hard stool may cause an anal fissure, producing a small amount of bright blood on toilet paper.

Because a stretched rectum may not signal clearly, the child may not feel an accident happen or notice its smell. Constipation can also contribute to daytime wetting, bed-wetting, frequent urination, or urinary tract infections.

Children with nonretentive fecal incontinence soil without a large stool buildup. Their usual bowel movements may be soft and painless.

- Hard, dry, very large, or painful stools
- Infrequent bowel movements
- Straining or spending a long time on the toilet
- Stiffening, crossing the legs, hiding, or standing on tiptoe to withhold stool
- Tummy pain or bloating that improves after passing stool
- Blocked toilets from unusually large stools
- Reduced appetite or feeling full quickly

Causes and risk factors

Encopresis commonly begins with stool withholding. A child may avoid passing stool because it hurt previously, a toilet feels uncomfortable, or they do not want to interrupt an activity. Stool then remains in the bowel, loses water, and becomes harder and more painful to pass.

Repeated withholding stretches the rectum, weakens awareness of the need to go, and allows overflow leakage.

Contributing factors include:

Encopresis is not usually caused by laziness. Pain, fear, reduced sensation, or difficulty changing activities may underlie apparent toilet avoidance.

Rarely, constipation and soiling are related to coeliac disease, an underactive thyroid, spinal or nerve problems, or Hirschsprung disease. These causes are considered more strongly when symptoms began in infancy, growth is poor, or examination findings are unusual.

- A previous painful stool or anal fissure
- Pressured or frightening toilet training
- Avoiding school or public toilets
- Changes such as starting school or travelling
- Low fibre or inadequate fluid intake
- Medicines that cause constipation
- ADHD, autism, or developmental differences affecting routines or body awareness
- Emotional stress

Diagnosis

There is no single test for encopresis. Diagnosis usually depends on the child's symptoms, bowel history, and physical examination.

A healthcare professional may ask about:

The examination may assess the abdomen, skin around the anus, growth, and signs of spinal or nerve problems. A rectal examination is not needed for every child. If considered necessary, it should be explained to the child and caregiver first.

Most children with typical constipation do not need X-rays, scans, or routine blood tests. Tests may be considered when the examination cannot be completed, the diagnosis is unclear, or symptoms suggest another condition.

A brief record of bowel movements, leakage, pain, and treatment may reveal patterns. It should be a practical tool, not a way to shame the child.

- Leakage and bowel movement frequency
- Stool size, appearance, and pain
- Withholding behavior and toilet routines
- Diet, medicines, urinary symptoms, and growth
- When symptoms began, including bowel habits during infancy
- Stress at home or school

Treatment and management

When constipation is present, treatment usually involves clearing retained stool and then preventing another buildup.

Clearing a large buildup is called disimpaction. It commonly uses laxative medicine taken by mouth. Temporary cramping or increased leakage can occur as retained stool is cleared.

Maintenance treatment then keeps stool soft and regular while the rectum recovers its usual size and sensation. This may take months. Stopping treatment too soon can cause relapse, so laxatives should be reduced only according to the healthcare professional's plan.

Regular toilet sitting helps retrain the bowel. The child may sit for a few minutes after meals, when the bowel is naturally more active. Their feet should rest on the floor or a footstool, with the knees slightly above the hips.

Praise or small rewards should focus on controllable actions, such as sitting on the toilet or taking medicine, rather than only on producing stool or remaining clean.

Helpful measures include:

Diet and fluids support bowel health but may not clear established stool retention alone. Do not force excessive fibre or fluid.

For nonretentive fecal incontinence, treatment focuses on planned toilet sitting, identifying triggers, and supportive behavioral strategies. Laxatives are not used unless constipation is also present. Specialist support may help with persistent difficulties, anxiety, developmental needs, or family stress.

- Access to a clean, private school toilet
- Spare underwear and discreet cleaning supplies
- Age-appropriate fibre and enough fluid
- Regular physical activity
- Calm, neutral cleanup after accidents
- A school plan that protects privacy

Complications

Ongoing constipation can cause anal fissures, abdominal discomfort, appetite changes, and persistent rectal stretching. A stool-filled rectum may also contribute to urinary accidents or urinary tract infections.

Children may avoid school, sports, sleepovers, or friendships because they fear accidents or teasing. Punishment can worsen embarrassment and secrecy.

Repeated stool contact and cleaning may irritate the skin. Gentle washing, careful drying, and a simple barrier product can help. Severe blockage is uncommon but may require hospital treatment.

Prevention

Encopresis cannot always be prevented, but treating constipation early may reduce stool retention and leakage. Seek advice when a child regularly has hard or painful stool, avoids the toilet, or goes several days without a bowel movement.

Keep toilet training calm and appropriate to the child's readiness. Avoid punishment, disgust, or forced prolonged sitting. Comfortable toilets, foot support, regular meals, suitable fibre, enough fluid, activity, and unhurried toilet access may help.

Living with it and what to expect

Improvement is usually gradual. Leakage may temporarily increase during disimpaction before becoming less frequent. A stretched rectum can take months to recover normal sensation and function.

Relapses are common after illness, travel, school changes, missed medicine, or another painful stool. They do not mean the child has failed. Promptly returning to the agreed plan can prevent a larger buildup.

Explain simply that the bowel has become stretched and is not yet sending reliable signals. Keep cleanup private and matter-of-fact.

At school, the child may need unrestricted toilet access, enough time, and a private place to change. Only staff who need to know should be involved.

Most children eventually stop soiling. Persistent symptoms need reassessment to confirm that constipation is fully treated and that medical, developmental, or emotional factors have not been missed.

When to get medical help

Arrange a routine appointment if a child aged 4 or older repeatedly leaks stool. Assessment is

also appropriate for ongoing painful stools, withholding, urinary problems, poor appetite, or constipation that is not improving.

Contact a healthcare professional promptly for persistent blood in the stool, weight loss, poor growth, fever, repeated vomiting, severe pain, leg weakness, or changes in walking or bladder control. Symptoms beginning in early infancy also need careful assessment.

Seek emergency care for severe or worsening abdominal pain with marked swelling, green vomit, inability to pass stool or gas, unusual sleepiness, or signs that the child is seriously unwell. A small bright-red streak after a hard stool often comes from a fissure, but heavy or continuing bleeding needs urgent assessment.

Common questions

Is encopresis done on purpose?

Usually not. Constipation can stretch the rectum and reduce awareness, allowing stool to leak without warning. Withholding often begins because passing stool hurts or a toilet feels uncomfortable.

Why does loose stool leak if my child is constipated?

Softer stool can flow around a hard mass retained in the rectum. This may look like diarrhea, but anti-diarrhea medicine given without medical advice could worsen the blockage.

Will encopresis go away on its own?

It may not improve until retained stool and withholding are treated. Waiting can allow further rectal stretching and prolong recovery.

How long does treatment take?

Disimpaction may take days, but restoring regular bowel habits and rectal sensation often takes months. Treatment commonly continues after accidents stop to prevent relapse.

Should I punish my child for accidents?

No. Punishment does not treat constipation or restore bowel sensation. Calm cleanup and praise for steps such as toilet sitting are more effective.

Can my child still go to school?

Usually, yes. A discreet plan for toilet access, spare clothes, and cleanup can help. Involve the school and healthcare team if symptoms affect attendance or lead to teasing.

Sources

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