Constipation, Bedwetting and Autism

What the Medical Community Overlooks and How to Help Your Child

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I believe that the most commonly misunderstood medical conditions are bedwetting or daytime pee accidents, and chronic poop accidents. Known as enuresis and encopresis respectively, these issues are even more mishandled in children with autism.

The other morning, I saw two autistic patients, one right after the other, with cases that illustrate what typically goes wrong.

The first patient was a 12-year-old girl who came in for a follow-up visit. Six months earlier, she'd presented with bedwetting and daytime pee accidents, something which caused her considerable embarrassment at school. For years, her doctor had assured the family that she would grow out of it, attributing her enuresis to autism-related developmental delays and sensory issues. "Her brain isn't sensing when she needs to pee," her mom told me at the first visit. This wasn't accurate. In fact, abdominal x-rays showed the actual cause of the girl's wetting: chronic constipation. Her rectum harbored a stool mass the size of a navel orange. The enlarged rectum was encroaching upon the bladder and aggravating the bladder nerves. As a result, the girl's bladder would "hiccup" and empty without warning, day and night.

My second autistic patient that day was a six-year-old nonverbal boy still in pull-ups due to daily pee and poop accidents. The family and referring pediatrician assumed that he couldn't potty train because of his autism. In reality, he was constipated, too. In addition to bothering his bladder nerves, his stretched rectum had lost tone and sensation, so stool would drop out of his bottom. He could not feel it and could not stop it from happening. Bladder and bowel control were simply impossible for this boy.

In both cases, pediatricians assumed that autism explained the accidents. They believed that autism-specific treatment was needed, and referred the patients to me, a specialist. While these assumptions are common, they are incorrect and prevent autistic children from receiving timely and effective treatment.

Patients With and Without Autism

It is true that many kids without autism also miss out on timely and effective treatment. I have seen many teenage patients whose constipation was overlooked for years, and I currently run a support group for parents of bedwetting teens. The accidents experienced by these teens were either ignored (i.e., a doctor might say, "Don't worry, no one goes off to college wearing pull-ups") or attributed to an "underdeveloped bladder," deep sleep, anxiety, or hormonal issues. All of these erroneous explanations led to ineffective treatments.

The difference was that patients without autism tended to land in my office sooner. Their parents got fed up. The families become desperate for a fix given the social fallout of missed sleepovers and sports camps, and the prospect of bedwetting in college.

In contrast, many parents with autistic children are accustomed to dealing with autism-related challenges, and are reassured by pediatricians that accidents are common occurrences. Autistic kids may also offer fewer clues that they are constipated. Many of my autistic patients can't verbalize the stomach pain they may feel, or explain that they can't sense the accidents happening.

By the time autistic kids are referred to me, they're often worse off than kids their age without autism. More years have passed, more poop has piled up, the rectum has been stretched further, and the accidents are more frequent and severe.

Constipation 101

Constipation is usually obvious based on a number of telltale signs. These include not just accidents, but also extra-large poops, stools formed like logs or rabbit pellets, and underwear skid marks.

In general, I x-ray all my enuresis patients to assess possible constipation and to rule out the need to explore the rare causes unrelated to constipation. For example, on occasion wetting is caused by undiagnosed spinal-cord abnormalities that require a surgical fix.

In my patients — whether autistic or not — who have an intact spinal cord, the cause of enuresis is evident on the x-ray. The child's rectal diameter usually measures six to eight cm, at least double the normal maximum of three cm.

I don't x-ray my patients with encopresis because there is no culprit other than constipation. Their problems are not in any way related to "attention seeking" or "behavioral issues," both of which are erroneously suggested to explain the issues.

Why Are So Many Autistic Kids Constipated?

There's no question that autistic kids, like children with ADHD, have elevated rates of chronic constipation. While this may well be related to aspects of autism, it is not my area of expertise. What we do know is that *it doesn't really matter that autistic kids are more prone to constipation.* The point is to begin a treatment plan early.

Of course, parents of autistic kids should be alerted to the "12 Signs a Child is Constipated," and should treat the condition early and aggressively. However, this is true of all parents.

Childhood constipation is extremely common worldwide and runs in families. Note that this does *not* mean there's a "bedwetting gene." Many children, autistic or not, become chronically constipated as babies. This is well before they've been introduced to processed foods. I would also point out that many of my patients are athletes with stellar eating habits.

Other kids develop the withholding habit around preschool age for reasons I discuss in "Why Is Your Child Constipated? Because We Live in the 21st Century." Modern humans are adept at overriding the urge to poop. Children are master withholders, and the withholding habit can become deeply ingrained.

Pinpointing the reason your child becomes constipated may be impossible and is usually irrelevant. What matters more is the treatment plan.

In my experience, unclogging the rectum is the first step in resolving accidents in any child, not behavioral or psychological therapy. Once cleared, the rectum must be fully evacuated daily for months. Only then can it shrink back to size, stop aggravating the bladder nerves, and regain tone and sensation.

That's when accidents stop.

The Best Way to Treat Chronic Constipation

Even when flagged by physicians, constipation is usually undertreated. This means accidents linger or recur. Doctors often start with dietary changes by recommending the consumption of more fruits and veggies, or fiber gummies, and the avoidance of dairy. In my experience, this approach is not successful. No amount of broccoli will dislodge the hard, dry mass of stool that is clogging the rectum. While I support nutritious eating, restrictive diets tend to frustrate kids while accomplishing nothing.

It is also common to use osmotic laxatives, powders or liquids that draw water into the colon to keep stool soft so pooping doesn't hurt. PEG 3350, or Miralax, is the most popular, but there are also alternatives, such as lactulose, magnesium hydroxide, and magnesium citrate. Osmotic laxatives can help treat chronic constipation, but often don't suffice once a child has developed encopresis or enuresis. The soft poop just oozes around the hard mass, often making poop accidents even worse.

Typically, kids need more than soft poop. They need help pooping until the rectum heals and accidents stop.

Bowel Movements

There are two effective ways to stimulate a bowel movement: rectal therapy, such as enemas or liquid glycerin suppositories; and oral stimulant laxatives, such as Ex-Lax chocolate squares or senna syrup.

Enemas work best. Often, master withholders need both enemas and Ex-Lax. Enemas are safe, and many of my autistic patients can tolerate them in spite of initial reticence on the part of their parents.

The regimen that I've found most effective is the Modified O'Regan Protocol (M.O.P.). It involves daily enemas until the accidents resolve, which can take at least 30 days or longer. Once the child is reliably accident-free both day and night, we start tapering off enemas.

M.O.P. is named for Dr. Sean O'Regan, the pediatric kidney specialist who developed the protocol in the 1980s to resolve his own son's bedwetting. Dr. O'Regan was the first to publish studies proving that enuresis and encopresis are caused by a stretched rectum and that daily enemas resolve accidents safely and effectively. I discuss his research at length in *The M.O.P. Anthology*.

I understand if you are alarmed by the mention of enemas. It just doesn't *seem* safe to insert a tube of liquid up a child's bottom day after day. Many caregivers worry their child will be injured or traumatized, or will become dependent on enemas to poop. I refute these concerns in the *Anthology*, and will gladly discuss them with any physician who opposes enemas.

When families don't want to try enemas, I recommend stimulant laxatives. Ex-Lax is a reasonable alternative that works for some kids. Keep in mind that it must be taken in a high enough dose to cause some abdominal discomfort, and the timing can be tricky.

While Ex-Lax takes five to 10 hours to kick in, enemas trigger a poop in five to 10 minutes.

Since many parents feel rectal therapy sounds extreme, they assume one or two enemas will do the job, and result in no more accidents. Nothing could be further from the truth. In reality, a rectum stretched for years won't rebound in weeks. Cleaning out a clogged rectum is not an event but a slow process.

If a child starts out with encopresis only and has no bedwetting or daytime pee accidents, poop accidents almost always stop within a month or sooner. To avoid relapse, however, it's important to complete the entire regimen. Daytime pee accidents take longer to resolve, and bedwetting can take many months.

Every child, autistic or not, can overcome accidents with some sort of treatment to evacuate the rectum and keep it clear. While many physicians consider enemas to be too aggressive, half-measures mean that accidents will linger, and kids will suffer.

Conclusion

Let me return to the two patients I mentioned earlier. The 12-year-old autistic patient was amenable to enemas, as was her exhausted mom who was persuaded by the x-ray. The girl's daytime accidents resolved within two months, and it took another four months for the bedwetting to stop. On her third visit, we devised a plan to taper off enemas and maintain soft poop with osmotic laxatives.

In the case of the nonverbal six-year-old boy, the mom did not feel comfortable with enemas, so we started with daily Ex-Lax. I asked her to report back in a month. When a child does not progress within 30 days, I always adjust the regimen. I am optimistic that this boy's issues can be resolved.

Recently, I received an email from the mom of a 16-year-old autistic boy. She wrote: "I just cleaned up my son's wet sheets after another spectacular accident. I know it's not his fault, but it's hard not to be frustrated. I want to try enemas, but with my son's autism, I am concerned. Can you help us build a plan that takes his autism into account?"

I advised her to have her son's abdomen x-rayed. If the x-ray shows a clogged, stretched rectum — which I'm quite sure it will — her son should benefit from the same treatment I would recommend to any other kid.

If your child with autism suffers from enuresis or encopresis, rest assured that effective treatments are available.

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