



# Chiropractic care of a 7-year-old male child presenting with resolving encopresis: A case report

John Erickson

Narrative: The purpose of this case report is to share chiropractic care of a 7-year-old male brought to the clinic by his grandmother with a chief complaint of encopresis for three years and learning difficulties.

Encopresis is a condition characterised by the involuntary leakage of stool in children who are typically over the age of four, when they have already been toilet trained.

It is often associated with chronic constipation and the subsequent overflow incontinence.

Indexing Terms: Chiropractic; Subluxation; SOT; encopresis.

## Introduction

**E** ncopresis is a condition characterised by the involuntary leakage of stool in children who are typically over the age of four, when they have already been toilet trained. It is relatively common, with incident rates varying based on different populations and studies. On average, it affects about 1% to 4% of children, with boys being more frequently diagnosed than girls. The condition is more prevalent in younger children, particularly those aged between 4 and 6 years, and the incidence tends to decrease with age. Early intervention and proper management are crucial to address the underlying causes and support the child's recovery. (1)

Adverse childhood events relating to abuse and neglect are often related to paediatric encopresis. Psychological issues and emotional stressors also may contribute or exacerbate these issues. (2, 3, 4) Typical treatments for childhood encopresis involve care for a retentive constipation with interventions such as laxatives and/or biofeedback. (1, 5)

The child's grandmother was particularly concerned about her grandson's social, emotional, and psychological well-being as his 'accidents' often happened at school, on the soccer field, and in front of his peers. He regularly packed a backup set of underwear and clothes to change into

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while at school. The condition caused significant distress for both the child and the family, affecting the child's social, emotional, and psychological well-being, causing him to feel embarrassed and humiliated. This patient had not been seen by another health care provider for this condition prior to being seen at this clinic.

# **Clinical history**

The patient's parents and grandmother noted that there was no trauma or accident prior to the first incident of encopresis which had been occurring since early childhood. He received his childhood vaccinations and had been prescribed antibiotics 3-4 times in his lifetime. It was also noted that the patient did have a history of learning difficulties. The child's early feeding involved him being breast-fed for 1 week and then afterwards being fed 'formula' for 11 months. Solid foods and cow milk began at 12 months with his mother reporting him having a history of lactose intolerance.

The patient at the time of evaluation noted that he had good quality 8-10 hours of sleep each night and did not take naps. It was noted that he had an abscess removed from his throat and a prior hospitalisation for idiopathic thrombocytopenic purpura, an autoimmune disease associated with low platelet counts leading to bruising and bleeding.

Family dynamics were considered to be contributory and the patient's mother and father are divorced with 50-50 shared custody. The mother purportedly has a live-in boyfriend that either ignores or belittles the patient when staying with his mother. The father has remarried presumably to a caring and concerned woman. Attempts to provide care and support for the patient initiated by the father have apparently been resisted by the mother. The mother reportedly treated the patient with laxatives since she believed that constipation can contribute to encopresis accidents however it was a consideration that the child had fewer accidents while spending time with his father.

## **Evaluation**

Postural evaluation noted that there was asymmetry with the child presenting when standing with a right hip higher than the left, left pelvic rotation, a hyperkyphotic thoracic spine, and forward head posture. He also had a left high shoulder with a left head lateral flexion and left rotation all when at rest in a standing position.

The patient's hard palate was assessed and it was found that he had a prominent ridged intermaxillary suture and his hard palate was narrow and elevated. His left palatine bone was inferior relative to the right side and no abnormal gag reflex was noted. Palpation of his cranial sutures revealed swelling and report of tenderness at the patient's bregma, sagittal, left pterion, and left asterion.

Neurological assessment noted decreased left eye convergence with finger to nose dysmetria, essentially with his eyes closed he was unable to find his nose with his either his right or left finger. At the initial evaluation the patient had a positive Romberg's sign and when marching with his eyes closed, he tended to wander around the office. Rapid repeated supination and pronation of his hands, foot tapping, and heel shin touching all failed bilaterally

Sacro Occipital Technique (SOT) assessment (6) revealed a right functional short leg with right hip joint restriction (e.g., iliofemoral), right increased *iliopsoas* muscle tension, and with decreased lumbar spine ranges of motion. The patient had a right anterior sacrum with a right inferior occipital presentation. Assessment of the inguinal ligaments revealed bilateral sensitivity to palpation. Based on the postural, cranial, neurological and SOT assessment he was categorised has have a category two (posterior sacroiliac joint instability) with cranial stress and imbalance. He was considered to have significant postural issues along with neurological findings consistent with decreased functioning of his vestibular system, and multiple related areas of the cerebral cortex.

# **Methods/Intervention**

The patient was treated initially by reducing his right hip restriction and right *iliopsoas* tension. Supine pelvic blocks were used to reduce the posterior sacroiliac joint hypermobility was based on the patient's presenting functional short leg and upon block placement it was noted that the sensitivity in the inguinal ligaments began to resolve. While the child was on the pelvic blocks the cranial 'Basic Two' technique which enhances cranial flexion (inhalation) and extension (exhalation) was employed to coordinate cranial and sacral function improving cranial motion which reducing sacroiliac joint hypermobility. (6) He was also assessed and treated for sphenobasilar symphysis cranial strain (7, 8) imbalance as well as treated with trans cranial therapy (TCT) low level laser.

#### **Results**

While the grandmother did not set up a follow-up appointment the child's step-mother brought him in for a follow-up appointment two weeks later. She reported that the patient has not had a single accident since his first adjustment and the two weeks was the longest period of time for him without having an accident. During this time he had participated fully at school and on the soccer field. It was recommended that he return for care if there were any flare-ups or possibly for maintenance care. However since his second office visit the child has not returned for care at this office and it is presumed at this time that his condition has remained stable.

## Discussion

Chiropractic care has emerging evidence discussing the successful care of paediatric patients with encopresis. The earliest mention in the literature about Chiropractic care of encopresis in a seven-year-old child was by Patterson in 1986. (9) Barber and Ring also discussed a case of paediatric fecal incontinence and encopresis that responded positively to Chiropractic care. (10)

Meeks et al discussed successful treatment of a eight year old female child with unremitting encopresis with six weeks of Chiropractic care that included Thompson Terminal Point protocols. (11) Johnson and Clark shared a case of an ten year old female suffering from incontinence and encopresis successfully treated with SOT care and at 8 weeks referred for addition collaborative care. She was referred for nutrition consultation and fecal laboratory testing that revealed dysbiosis in her gut flora. (12)

Another study of an 8 year old boy with a history of chronic constipation since birth with associated fecal incontinence and abdominal pain was treated with Chiropractic care incorporating diversified technique, with high-velocity, low-amplitude adjustments. After twelve visits, the mother reported the patient having daily bowel movements with decreased abdominal pain. The patient was also able to voluntary control bowel movements. (13)

Last, a 9-year-old male with a lifelong history of constipation and recent episodes of encopresis was treated with Chiropractic care that included Chiropractic adjustments techniques and cranial therapeutic techniques along as well as referred to a naturopathic physician managing nutritional supplementation and psychotherapist. Nine months after beginning treatment, the patient reported having improved bowel movements and reduced incidents of encopresis and laxative usage. (14)

With case reports it is always difficult to rule out regression to the mean, placebo/ideomotor effect, and psychosomatic interactions contributory to a patient's positive response to an intervention. Often times it becomes important to determine if the patient had been responsive to prior care or if the condition was only transitory.

In the child in this case report he had had issues with encopresis his whole life and was being treated with laxative unsuccessfully. It does appear that he was dealing with familiar stressors associated with parental separation and some disagreements in his upraising. While emotional factors can be causative or contributory it is also possible that the Chiropractic care either improved his viscerosomatic/somatovisceral innervative function or reduced his stressors so the threshold for his psychological issues were more manageable for him.

### Conclusion

It was compelling that prior to care his condition had been stable and unresponsive to watching and waiting, patient attempts to control his behaviour, and the use of laxatives.

It is unclear what the specific mechanism might have been that helped this child. They could have been from reducing pelvic imbalance, improving cranial function, and stress reduction which could have any psychogenic contributions to his condition.

Further studies are indicated to see if this is an isolated case or if other children suffering from encopresis might be helped with Chiropractic care in isolation or in conjunction with collaborative nutritional, psychological, and allopathic care.

John Erickson DC Private practice of Chiropractic Santa Monica CA

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# About the Chiropractor

**John Erickson, DC** is a 1997 graduate of *Palmer Chiropractic College, Davenport.* He and his lovely wife Michelle have six children. His practice in in Loveland, Colorado and incorporates a multidisciplinary approach, currently incorporating sacro occipital technique (SOT) and SOT cranial techniques. This is his second research presentation and was delivered at this year's 2025 SOT Research Conference.

