Interim Updates: 5 New Guidelines to the Modified O'Regan Protocol

Dear Families,

As I often tell my patients, I take the term *medical practice* literally. There is plenty of practice involved in being a doctor: To get better at treating patients, you have to keep an open mind, reflect on what is and isn't working, and try new approaches. When I learn something useful, I'm eager to share it.

I've been using the Modified O'Regan Protocol, in one form or another, for a decade now, and during this time, my approach has slowly evolved. The crux of the protocol, combining enemas and laxatives, has not changed. But over the years, based on my research results and feedback from families — especially the real-time feedback from folks in my private Facebook support groups — I have tweaked and refined and added and subtracted.

My coauthor, Suzanne Schlosberg, and I are hard at work on the next edition of the Anthology. The book will include new recommendations that I believe will make M.O.P. even more effective. I'm excited for folks to put the new guidelines into action. But updating the book is a big job!

I want to share the most important new recommendations now, even before the new edition is published. The guidance I provide here supersedes certain parts of the second edition, which was published in 2018.

The updates won't make sense until you've read the Anthology, so I'm including the relevant page numbers here as a reference. I suggest you flag those pages now, as you read this update, so when you get to the obsolete parts of the book, you'll know to refer back to the new recommendations.

The updates are not strict rules; everything related to M.O.P. is fluid. As I've learned over the years, every child responds differently, and finding the best variation for your child will take trial and error. Even when one iteration works for a while, you may need to take a new turn as your child inches closer to dryness. Many of my new recommendations are based on that very notion.

I owe these M.O.P. improvements in large part to the members of our support groups, who are always willing to try new things and post timely feedback. Over time, patterns have emerged, and my advice has shifted accordingly.

I welcome your feedback as well!

Warmly,

Steve Hodges, M.D.

Associate Professor of Pediatric Urology,
Wake Forest University School of Medicine
July, 2020

Update #1:

When treating encopresis, avoid osmotic laxatives for the first two weeks of M.O.P.

This advice applies to page 9, in the section titled "Phase 1: Daily enema + daily osmotic laxative" and page 15, the M.O.P. Progression chart.

In the past, I've treated encopresis and enuresis in exactly the same fashion. After all, the cause of both conditions is the same, and the same treatment has generally worked well. However, I've come to realize that for many encopresis patients, taking osmotic laxatives early on can make poop accidents worse and/or more frequent. Children with encopresis are so monumentally clogged that softening stool can make even more fall out.

So, for children with encopresis, I now advise holding off on osmotic laxatives (see page 81 for the four main options) until you have completed two weeks of the program. During that time, your child will simply have one enema or liquid glycerin suppository (LGS) per day. **This advice applies to children with both encopresis and enuresis as well as children with encopresis only.**

After two weeks of daily enemas, your child should be cleaned out enough to add an osmotic laxative without a problem. This doesn't mean the poop accidents will have stopped, although that's possible. It just means that adding the laxative isn't likely to make the situation worse.

I continue to believe osmotic laxatives are an important part of treatment for encopresis, just not right away — and definitely not as a replacement for enemas.

Update #2:

If you have your child X-rayed while on M.O.P., arrange your schedule so the X-ray is taken no more than 2 hours after the enema.

This advice pertains to page 41, under "Tips for Getting a Useful X-ray" and pertains only to kids who get X-rayed while on M.O.P. — for example, because the child has not shown progress. If your child is new to M.O.P., you need not do an enema prior to the X-ray.

As I explain on page 41, X-rays are not necessary for starting M.O.P. and are not recommended for children with encopresis. But for children with enuresis, they can be quite informative, even more so if taken very shortly after the day's enema.

Let's say your child normally has an enema at 7 p.m. If the X-ray is taken the next day, you won't really know whether the enema was effective at evacuating the rectum, because the digestive system — a poop factory! — will already have generated more stool.

You can glean useful information even with a delayed X-ray; one purpose of these films is to measure the child's rectal diameter, and that will not change in a matter of one day. If your child's rectum is stretched — as it likely is — you'll know regardless of when the X-ray was taken.

But X-rays serve a second purpose, too: to determine whether that particular enema solution and volume actually stimulate a complete evacuation. As I've come to realize, they often don't.

Most parents new to **M.O.P.** assume that any enema — whether a store-bought phosphate enema, a liquid glycerin suppository, or a large-volume enema — will blast out old stool fully and immediately. Many find it hard to fathom that more than a couple of enemas will be necessary. In reality, a child can have a daily enema for months on end and remain terribly clogged up. I see it all the time on X-rays.

In recent years, I have increasingly used X-rays to fine-tune a patient's enema formula. Some kids respond better to phosphate enemas, others to glycerin and/or Castile soap. Some kids need 500 cc of saline solution, others need 300. And so on. If an X-ray is taken within 2 hours of the enema and the child's rectum is still full of poop, you know it's time to tweak the formula.

So, on the day you've scheduled your X-ray, you'll need to shift to a daytime enema. Yes, it is fine if your child had the previous day's enema in the evening, as usual, and then has another enema in the morning or during the day, prior to the X-ray. Typically you want about 24 hours between enemas, but it's fine to do the enemas closer together for X-ray purposes.

Update #3:

Add Ex-Lax during the tapering phases of M.O.P. if your child still has not achieved a daily spontaneous poop.

This advice pertains to pages 8 to 12, "The 4 Phases of **M.O.P.**," and page 89, "About That Spontaneous Poop."

For any family dealing with bedwetting and/or daytime accidents, the goal, of course, is for the accidents to stop. That's what **M.O.P.** is designed to achieve! However, after years of close observation, I've noticed that the kids most likely to experience a relapse are those who achieve dryness without achieving the "spontaneous poop." In other words, kids who don't poop every day on their own, in addition to pooping after an enema.

These kids tend to be super withholders, and adding a daily dose of Ex-Lax can help them achieve that all-important spontaneous poop. **You'll find Ex-Lax guidelines on page 83.**
I have a couple new ones to add:

- **Don't give your child Ex-Lax at night.** The medication usually takes 5 to 8 hours to stimulate the urge to poop. Connecting that sensation, psychologically, with the act of pooping is very helpful for kids with a deeply ingrained habit of withholding. So, you want the child to be awake to feel the urge.

  Many parents give Ex-Lax at night, in hopes the child will poop first thing in the morning, before school. That's understandable, since most constipated kids won't poop in school bathrooms. But night-time Ex-Lax defeats half the purpose of giving this medication.

- **Give your child enough Ex-Lax to stimulate a strong urge**. Ex-Lax can trigger cramping, and that is not fun at all. My goal is not to make kids feel uncomfortable, but a small amount of discomfort may be necessary for the Ex-Lax to do its job. Many parents dial back the dosage so much that the child feels nothing and therefore makes no progress.

Update #4:

When switching to M.O.P.+, add stimulants to the saline solution right away.

This advice pertains to pages 107 and 108.

When kids make little no progress after one month on **M.O.P.**, I recommend switching **M.O.P.+**, our large-volume enema regimen. You buy a reusable enema kit and make the solution yourself. In the current edition of the Anthology, one option is to simply use saline solution, without stimulants such as glycerin and Castile soap.

However, I've found that saline solution alone, even in a larger volume, is not nearly as effective for kids as saline plus stimulants. So, if you're doing **M.O.P.**, start with stimulants right away, using the doses recommended on page 108.

Update #5:

If your child has overcome daytime accidents, whether poop or pee or both, on M.O.P.+ but cannot nip bedwetting in the bud, try shifting to a smaller volume enema and adding Ex-Lax.

This advice will be added to the section on page 106, "When **M.O.P.** Isn't Enough."

I'm calling this new variation **M.O.P.*x***. It essentially calls for a reversal of the normal progression. Often, for kids with enuresis who don't progress on M.O.P., increasing enema volume (M.O.P.+) is what resolves daytime accidents. But many kids get stuck there; despite the volume increase, bedwetting persists. For these kids, I suspect, the large volume is keeping the rectum stretched, compromising the final step toward a resolution of accidents: shrinking to normal size.

As you know, resolving accidents doesn't just require a daily rectal evacuation; the rectum must also bounce back, so it stops aggravating the bladder nerves. The clean-out part can be a struggle; you have to find an enema solution and volume that works for your child and keep it up daily, often for several months. But for many kids, that's the easy part; even once it's empty, the rectum stays stubbornly stretched.

I've seen this phenomenon on many X-rays and now believe that for some kids, the solution is reducing the enema size to help the rectum shrink while adding Ex-Lax to help stimulate spontaneous pooping. This isn't a sure-fire solution; it has set back some kids while helping others.

You can reduce the enema volume two ways:

- Stick with the large-volume enema kit but reduce the saline solution to about 250 cc while maintaining the same stimulant volume or even increasing the stimulant a bit. So, the overall volume is reduced but the stimulant-to-saline ratio is increased. This is the less expensive option.
- Go back to store-bought phosphate enemas, liquid glycerin suppositories, or DocuSol mini-enemas.

At the same time, introduce Ex-Lax following the new recommendations in Update #3.