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# The Mother of All Diseases

Dear Readers,

I would like to apologize for the long hiatus from writing. I would also like to thank all my dedicated readers for their constant encouragement over the past few years. I returned to my writing desk after meeting many readers, young and old, who asked me over the past couple of years “Are you Dr. Simai? I really enjoyed reading your column. Why did you stop writing?”

Today, I would like to discuss how addressing and treating one illness can heal and affect so many seemingly unrelated medical symptoms. Here are a few interesting cases that I have encountered so far in my career.

**Scenario A:** I will start with the most fascinating *true case*. Ari, an 11 year old special needs child was never able to use the toilet. He wore diapers since the day he was born. He visited one of the premiere Pediatric Urologist in New York City once or twice a year to address this issue. This year, a report from the urologist stated that Ari’s urinary control had deteriorated. At home, he would stop urinating in his diapers for prolonged periods. A urodynamic flow study showed that Ari’s bladder would not empty even when a tremendous amount of water was injected into it. The urologist called this a Urogenic Bladder, and suggested that there was no effective treatment for this condition. Ari would have to be catheterized daily in order to prevent Urinary Tract Infections (UTI) and relieve him from the mounting pressure in his bladder.

His father discussed the report with me shortly after visiting the urologist. His father asked me what I thought about the urologist’s diagnosis. I told him that as far as I recalled a Urogenic Bladder was a disease that I learned about back in medical school. I remembered that it usually affected the Geriatric population as a result of nerve damage due to long standing diabetes. I had never seen that diagnosis in a pediatric patient. I had heard of the famous pediatric urologist that he saw - the head of a department at one of the most lucrative New York City Hospitals, and I felt humbled to try to find the answer for this condition. I prayed that G-d would help me assist Ari and his family.

I reviewed Ari’s medications: Laxatives, Iron and some psychiatric medicine, basically the same medications he has been on for a few years. I met Ari just a year or two prior to this visit. Is he pooping? I asked. His father replied with a smile - yes - the same way he has been pooping for years - nothing changed. And he is still on a generous dose of the laxative Miralax.

Is it his medications causing this issue? A recent MRI of the spine was performed and showed that the spinal cord was intact with no “tethered cord”. Will his bladder ever work again or would

he have to be catheterized daily? This case was a true mystery and with G-d's help, I was able to make a suggestion that completely relieved his symptoms.

**Scenario B**: Chani, a four year old girl presents in my office with burning on urination. Just a month ago, she was diagnosed with a UTI and given antibiotics. Today again, her urine sample tested positive for a UTI. Her parents are worried. Until recently, she never had any UTI's.

Why is she getting recurrent infections?
I asked if there was a history of any Urinary reflux in the family - negative.
Did she finish the course of antibiotics as prescribed - yes!
I proceeded to ask - is Chani constipated? No, her parents reported confidently that she has been "pooping regularly for the past month".
Does Chani have a kidney issue? Resistant bacteria?
When would her UTI's end? Chani's very concerned parents asked me.

**Scenario C:** Gila is an 11 year old girl. Her extremely frustrated father brought her in today to my office demanding a solution. It seems that Gila's friends and teachers **can no longer tolerate the strong odor that emanates from her for the past few months**. Her principle requested that she should seek medical attention before returning to school.

It seems that Gila suffered from **Enuresis** - she had lost proper control of her bladder. She often wets herself during the daytime which causes a harsh odor. She has a chronic issue with bed-wetting as well. On most nights, she wakes up wet in the middle of the night.

Gila says that she "poops" regularly. She even says that she poops twice or three times a day. Gila's father is frustrated with the school, and concerned that his daughter is not gaining the expected urinary control an 11 year old should have.

**Scenario D**: Chaim a brand new patient in my practice, is a 6 year old boy who visited me for the first time this morning. As I walk into the room, I notice that Chaim is laying on the examination table, doubled over in pain. His parents appear very worried about his condition.

Chaim started developing sharp pains last night that come and go, and they intensify with time. He has no fever, no vomiting and when I offered him his favorite food (pizza) he said that despite the pains he would eat it. The abdominal pains are sharp and very tender in the right lower quadrant area - where the appendix lies. His parents are worried about possible appendicitis and ask whether they should rush him to the emergency room immediately. Chaim does not recall how his bowel movements looked and the frequency. He seems to be too uncomfortable to even think about it.

**Scenario E**: Dina is an 18 year old college student. She dorms at college in Manhattan but came home this particular Shabbos. She started having excruciating stomach pains after the Shabbos day meal. Dina's father is a physician, concerned with his daughter's pains. He

brings me to her room and asks me to examine her. Her appetite was amazing right until the pains started. Dina has intermittent severe pains that are getting worse. She says that she has soft bowel movements a few times a day. She recounts having two soft bowel movements today, “maybe like diarrhea”. On exam, she has diffuse, widespread tenderness and increased bowel sounds.

Linking the report of the diarrhea to the pains and gas pattern on exam, I feel that her issue is a stomach virus and suggest to hydrate her and avoid dairy.

The following day, Dina is rushed to the emergency room. A surgical resident examines her and orders a CT scan of her abdomen. The scan shows that her intestines are completely filled with feces, and the Appendix can not be visualized. The Attending surgeon insists that Dina should be rushed to the operating room for an *emergency appendectomy*.

Her dad who is a physician is concerned about appendicitis as well. Dina’s mom However, is very nervous about the operation, she calls and asks if I could convince the surgeon not to operate yet.

**Scenario F** - Moshe is a 19 year old yeshiva/college student who comes to my office complaining of frequent urination for a month and low back pain for one week. Prior to coming to see me, he was seen at a local urgent care and had normal urine and blood test results. No medication was given to him. He denies any fever, weight loss or fatigue. Moshe says that he has no constipation. He moves his bowels “twice a day or more”. His bowel movements are soft and normal in appearance. His blood and urine tests rule out a UTI and diabetes. His back pains did not start after trauma or intense exercise. His interesting presentation was a mystery.

**Case Discussions:**
Here is how each of these scenarios unfolded:

**Scenario A: Ari - Special needs child with Urogenic Bladder -** In the most fascinating chain of events, I started Ari on a much higher dose of laxatives. As suggested by the Normal MRI, I believed Ari did not have any neurological damage to his spinal cord. My hypothesis was that Ari’s years of fecal impaction and sub optimal treatment of his constipation, led him to develop a completely neurogenic - dysfunctional bladder.

I met my two friends Dr Elliot Paul and Dr Jeffery Lumerman - two fine adult urologists (who encounter patients with neurogenic bladders) at a Shalom Zachor and asked if there was a chance that treating constipation would be the right remedy for my patient and they both felt optimistic about the idea.

We were all surprised how Ari’s bowel movements dramatically increased in volume with the higher laxative regimen. After several weeks of treatment, Ari started urinating on his own, with even better flow then before all of his troubles started. His Urogenic Bladder, a condition that is incurable - completely resolved.

**Scenario B** - **Chani, 4 year old girl with frequent UTI’s -** with further consultation, it seems

that Chani only poops **once every two or three days**. I showed Chani the Bristol Chart and she pointed out that most of her bowel movements resemble Bristol #1 (most constipated type).
She also reports that “pooping hurts”, and can be a time consuming ordeal.
Giving Chani a treatment that started with laxatives and continued with supplemental fiber and most importantly - proper bowel training, resolved her constipation and prevented her UTI’s from recurring.

**Scenario C - Gila - the unhappy girl with Enuresis -**
Our very depressed Gila also reported to me that her bowel movements were irregular. She pooped twice daily because she only partially defecated each time. Her bowel movements were very small and painful (again, Bristol 1). I suggested that in order to get her back into the classroom as soon as possible, she should start on two medications - a bladder muscle stabilizer and a regimen of laxatives. Within just a few days Gila’s odor was gone and she would return to her classroom smiling.
After the first week of treatment, her night time Enuresis was significantly reduced as well.

**Scenario D - Chaim - 6 year old with Pain in the Right Lower Quadrant.**
Despite his very severe abdominal pains, Chaim did not have fever, vomiting, and was able to walk and jump with minimal pain. Therefore, I decided that we had enough time to try him on a high dose laxative treatment before ordering any tests. I gave him a few capfuls of Miralax and sent him home with a bottle of Gatorade.
At lunchtime, on my way home, I stopped by Chaim’s house and found him to be completely pain free. He moved a very large bowel movement and was walking around the house, looking for that Pizza with a re-invigorated appetite.

**Scenario E - Dina - Our college student who was about to be operated on for possible Appendicitis**
Dina’s case was a bit more complex. When I called and voiced my concern, the attending surgeon sent a message that if the patient is not operated on, he would not assume any responsibility for her. I agreed to accept Dina onto my service and treat her under my watch.
I ordered the pediatric floor to give Dina a complete bowel clean out (like adults do before colonoscopies).
The following morning, I visited Dina and was shocked that she also, was pain free. She recalled that after few doses of laxatives, she started having huge bowel movements and felt relief.
A week later, her father reported to me that Dina admitted that she was not completely honest with us about her bowel habits. The truth was that she really **did not have a bowel movement for 2 straight weeks before the pain started**.

An important lesson I learned from this case is that **kids are often fearful or reluctant to share information about their health in front of their family members** (especially if the family member is an adult). When I was getting medical history from Dina in her house, her father was in the room with me. Because her father was in the room, she stuck to her initial story she told him. Her management would have been completely different if she would have told me the truth.
So today, when I see patients with stomach aches, I often ask parents to leave the exam room

for a minute so I can get a clear description of bowel habits. The parents are immediately asked to come back to the room for the physical exam and comfort their children.

**Scenario F - Moshe - our yeshivah/college boy with frequent urination and back aches.**
This case was not so easy to treat. I asked Moshe to try a laxative for two weeks and phoned his mother to discuss this. She strongly felt that "Moshe has the opposite problem". I agreed that if the laxatives would not help these issues, I would send him to a urologist. Mom agreed to the plan.

After 2 weeks, I called Moshe's mom and asked if he was doing better. She replied that "he took his medicine *"but he did not feel any improvement at all*". He was still urinating frequently and having back pains.

Moshe even showed up at the office again for another urine test which was normal. At his request, I referred him for abdominal xray and ultrasound. A few days later I phoned his concerned mom to discuss the results. The abdominal ultrasound was completely clear and the X-ray - you guessed it - showed a *pattern of gas consistent with constipation.*

I commented that its interesting that the laxatives I prescribed did not help Moshe - I was perplexed as to why that was the case. But his mom said half laughing - you know Doctor, he did not take the prescription as written. We were so convinced that he was not constipated that he only took it *once every 2 or 3 days*…..

Luckily, after taking his laxative regimen as prescribed for one week, all of Moshe's symptoms completely resolved. He was urinating regularly, and his back pains disappeared.

**In conclusion**
I often joke around with parents that constipation **affects nearly 100% of our patients**, yet **nearly 100% of the parents** in the practice report (*and insist*) that their kids are "pooping fine".

One of the most memorable comments that my father Dr. Eliyahu Simai told me numerous times: "remember what I tell you my son: "*Constipation* is *the mother of all diseases*".

My father's words stay with me all the time and I hear his words each time I encounter a patient with abdominal pains. I am fascinated sometimes, when my mind quickly scans many "exotic" diagnosis, or when excruciating pains set fear of abdominal emergencies, ultimately, the good old fashioned diagnosis of constipation comes back and "saves the day".

The point of this article is that as parents, we should focus on a few fundamental ideas:

1. **Diet** - make sure that children have enough fiber in their diet by eating more fruits and vegetables that are high in fiber (such as berries, oranges, kiwis, dates & prunes). Try to buy fiber enriched bread, brown rice, cereals & crackers and other products. Routinely examine the Nutritional facts of every item that you pick up and choose the type of product that has the highest fiber content.
2. **Monitor** - do not assume that your child is pooping "fine" - look up the Bristol bowel movement chart and familiarize yourself with it. Know that *normally, children should have*

*one, soft BM daily.*

3. **Bowel Training** - just as you remember your young infant defecating each time they nursed, older kids and adults have a similar gastro-colic reflex. *Our bodies react to food entering our gastrointestinal tract by emptying it from the other direction*. It is crucial for us to train ourselves and our kids to listen to our body and set aside time after meals to defecate. This may mean that you will need a few extra moments before breakfast, but those few minutes with literally change your day and your life.
4. **Do not hesitate** to give your child a laxative as prescribed by your healthcare professional. And always keep in touch and follow up with your physician. If your symptoms do not improve, it may mean that you are not being treated correctly, or alternatively, your diagnosis may be wrong.

As trained physicians, it is easier for us to recognize “acute abdominal pain” which necessitates emergency treatment from milder conditions. We are trained to analyze the medical history we hear and combine it with the physical findings in front of us to properly diagnose our patients.

If your child is in severe abdominal pain please contact your doctor for medical advice. Please do not try to self diagnose your children. As you read in this article, making a correct diagnosis may be extra difficult, especially since your children may prefer not to volunteer important details about their health with you.

Wishing you a fun filled, pain free summer,

David E. Simai M.D.