LRI Children's Hospital

CONSTIPATION IN CHILDREN AND YOUNG PEOPLE

Staff relevant to:	Medical & Nursing staff working within UHL Children's Hospital
Team approval date:	January 2023
Version:	7
Revision due:	January 2026
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Trust Ref:	C29/2005

1. Introduction

Definition: Pain, difficulty or delay in defecation.

Importance in Childhood

- In early infancy may be a feature of lower intestinal partial obstruction
- In the pre-school period is often associated with pain, anal fissure, stressful toilet training, fear and avoidance of defecation with associated intra-family stress.
- In the school age child, any associated overflow faecal incontinence is socially disastrous.

Remember that soiling in a neurologically competent child usually indicates constipation.

2. Guideline Standards and Procedures

2.1 Prevention

Increase intake of fluids
Increase fibre intake – 5 portions of fruit/ vegetables per day
Avoid excessive milk-drinking in later infancy
Discourage too early or too coercive potty training in the 2-3 year old.

2.2 Accurate Diagnosis and Examination

In Infancy:

Diagnosis –

Functional constipation is most likely after first few months, but important to rule out Hirschsprung's disease (NB Hirschsprugs unlikely in constipation starting after 1 month of age, or if meconium passed in first 24-48 hours) and other surgical issues e.g. anterior ectopic anus.

Consider –

Cow's milk protein intolerance, Coeliac disease, hypercalcaemia, hypothyroidism, pelvic or spinal tumours.

Examination –

- Inspection of the perianal area is necessary.

In childhood:

Diagnosis –

Functional constipation with multifactorial causes as above is most likely, but consider cow's milk protein intolerance, Crohn's disease, Coeliac disease, hypercalcaemia, hypothyroidism, pelvic or spinal tumours.

Examination –

- Inspect anus - anal fissures or tags, infection (streptococcal), skin disease (lichen sclerosis), anal ectopia and anal abuse.
- Reflex anal dilatation is an unreliable sign in the presence of rectal faecal retention.
- Palpate abdomen, check lower limb neurology, consider psychological factors. PR not usually necessary
- Rectal prolapse may be caused by chronic constipation with straining.

2.3 Management:

There are 3 essential steps: start at step (1), (2) or (3) as indicated.

(1) Soften retained faeces / early steps:

a) Increase Fluid intake.
b) Increase fibre in over 5s
c) Give softener - lactulose if mild, Macrogols PAEDIATRIC - (e.g. Movicol Paediatric Plain, Laxido paediatric - it must have the "paediatric" name to ensure it is the right strength) paediatric if more severe. Lactulose is cause of dental caries so need to rinse mouth or

brush teeth.

d) Stimulant (e.g. Sennosides or sodium picosulfate) may be given in addition to softener to oppose withholding of faeces and encourage rectal emptying, if the faecal mass is not too big.

NB If there is a large faecal mass or BNO for several days, only give stimulant after 1 or 2 weeks of softener.

(2) Evacuate retained faeces:

If stool is not spontaneously evacuated after above measures, more active methods may be needed as follows:

a) As above add sennosides or picosulphate Use single daily dose and increase dose until stool is passed.
b) Disimpaction with Macrogols Paediatric - (e.g. Movicol Paediatric Plain, Laxido paediatric - it must have the "paediatric" name to ensure it is the right strength) if faecal impaction. Give increasing doses until stools large and loose. Continue dose for 3-5 days, then reduce to maintenance doses.
c) If above disimpaction fails then may consider admission for Klean-prep® over several days (this can take a week or so) – please discuss with gastroenterology team

Avoid rectal route where possible, but if unavoidable:

d) Suppository – e.g. glycerol 1g in babies from 1m to 12m old
e) Enema – phosphates enema
f) Manual evacuation under general anaesthetic is last resort if stool is so large it cannot be flushed from a megarectum despite above measures (examine carefully for ectopia and stenosis.) Refer to paediatric surgeon.

(3) Establish regular and effective defaecation:

Increase dietary fibre (may need dietary advice), and increase fluids

a) Use regular softening laxative – e.g. Lactulose or Macrogols Paediatric - (e.g. Movicol Paediatric Plain, Laxido paediatric - it must have the "paediatric" name to ensure it is the right strength). Docusate sodium is alternative.
b) Regular stimulant laxative is quite likely to be needed as well- daily single dose of sennosides or sodium picosulphate

2.4 Supporting Child and Family:

Keep regular and frequent out-patient contact initially, with aim of enabling self-management including dose adjustment within safe ranges. Consider referral to psychology, local family support unit and continence teams. Education and explanation is very important.

2.5 Explanation:

This is essential to success. Take time to explain mechanism behind constipation

i.e. withholding, distended lower bowel and inefficient emptying. Persist with medication over several months in most cases, and explain this to parents. The commonest error is to give doses that are too small or not given for long enough. Explain that the medicines do not make the bowel lazy and have few side effects. Make sure the family understands the way medicines work and that they are empowered to adjust doses according to response.
Explain that no medicine will work without correct behavior and toileting. Sit on toilet regularly, after meals and bedtime, in correct position, with hips flexed, and feet on a stool, and to encourage active pushing (e.g. blow up a balloon) in a relaxed, quiet and encouraging environment.
The ERIC website has useful information for families https://eric.org.uk/

2.6 LAXATIVE MEDICATIONS FOR CONSTIPATION

All laxative dosages need to be adjusted according to their effect, the following are a guide to planning their initial administration. **Please refer to current BNFC for guidance of dosages.** Higher doses should be used after senior discussion, ideally with a paediatric consultant.

Softeners:

I. **Lactulose** (solution containing 3.35g in 5ml)
There is little likelihood of causing harm by increasing the dose but remember that an adjustment in dose may not have its effect for 48 hours. Effect can also wear off over a number of months. It contains sugar so can be bad for teeth – recommend water afterwards, or brush teeth
II. **Macrogols Paediatric** - (e.g. Movicol Paediatric Plain, Laxido paediatric - it must have the "paediatric" name to ensure it is the right strength) for either maintenance treatment or faecal impaction
III. **Docusate sodium–** softens and stimulates (Available as oral solution12.5mg in 5ml or 50mg in 5 ml)
Also available as 100mg capsules for older children / teenagers

Stimulants:

I. **Sennosides** (Available as Senna syrup containing sennoside 7.5mg in 5ml; and tablet containing sennoside 7.5mg per tablet).
Dose in mg sennosides - Adjust according to response
II. **Sodium picosulphate** liquid preparation (5mg in 5 ml) – adjust according to response
III. **Bisocodyl** – available as tablets or suppositories

Most up to date guidance on diagnosis and management of constipation in children and young people is published National Institute of Health and Care Excellence (NICE Guidelines CG99) in May 2010; last updated July 2017, and available at https://www.nice.org.uk/guidance/cg99/chapter/1-guidance. Please refer to these guidelines for further information on the topic.

3. Education and Training

None

4. Monitoring Compliance

None identified at present

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements

5. Supporting References

Management of chronic constipation. GS Clayden, Archives of Disease in Childhood 1992; 67: 340 – 344
Diagnosis and treatment of chronic constipation in childhood. Current opinions in Pediatrics 1998 10(5):512 – 517.
Management of chronic constipation in childhood. Clayden GS et al. Arch Dis Child Education and practice edition. 2005. October, 90(3) 58-63.
Constipation in children and young people: diagnosis and management NICE guidelines [CG99] Published date: May 2010 (updated July 2017) Link - https://www.nice.org.uk/guidance/cg99/chapter/1-guidance

6. Key Words

Constipation, Faeces, Laxative

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Dr Anne Willmott,	**Executive Lead** Chief Medical Officer
eric.org.uk **Details of Changes made during review:** Added ref to - eric.org.uk Updated Macrogols information	