CONSTIPATION

Introduction

Constipation is common, affecting up to 30% of school-aged children. [1, 2, 3]

Symptoms are variable, with children passing infrequent, hard stools that are often painful. If the problem persists, some children develop a cycle of withholding that results in a cycle of constipation and faecal soiling. [1, 2]

Pre-referral investigations

There are no specific investigations (blood tests or imaging) required. [2] Routine digital rectal examination is not advised. [1] Features that suggest a more sinister cause include a history of failure to have passed meconium within the first 48 hours of life (Hirschsprungs disease), gross abdominal distension with abdominal tenderness, skin changes over the lumbosacral region and abnormal neurology in the lower limbs. [1]

Pre-referral management

Large prospective studies have shown that education about constipation, the use of a diary, assessment of adherence with the regular review of drugs, and clear and realistic information on the expected duration of treatment are essential ingredients for success. [2] Parents need reassurance that laxatives do not cause dependency and that adherence is essential. [2]

The aim is to empty the bowel and keep it empty, by ensuring the child passes soft, painless stools for a long period. [2] If treatment is stopped too soon, the problem frequently recurs. [2] A general rule of thumb is that a child requires treatment to maintain soft stools for as long as they have been constipated (e.g. if constipated for 18 months, it is likely they will require treatment for 18 months).

Effective disimpaction is required for successful management. The National Institute for Health & Care Excellence (NICE) guideline recommends Polyethylene glycol 3350 + electrolytes in an escalating regimen as first line treatment, with addition of a stimulant laxative after 2 weeks if disimpaction has not been achieved. [1,2] Parents need to be supported to understand that it may take 3-5 days before defaecation occurs and that the first bowel action the child passes may be a large hard mass, or a brown fluid that appears like diarrhoea. They also need to understand that this initial motion is just emptying of the rectum and it will take a number of days until all the faeces is passed and the child's bowel can start to recover.

After disimpaction, maintenance treatment with laxatives should be started immediately, with a regimen that produces a daily soft stool. [4,5] Ongoing behavioural modification should include regular toileting for 3-5 minutes three times per day, ideally after meals and age appropriate rewards (e.g. star charts). [2, 4]

Laxative protocol [6]

First line treatment Children < 2 years; stool softener and/or osmotic laxative Children > 2 years; osmotic laxative and/or stimulant laxative	
Stool softeners	
Poloxamer (Coloxyl® drops)	< 6 months, oral 0.3mL three times a day[7] 6-18 months, oral 0.5mL three times a day 18-36 months, oral, 0.8mL three times a day
Paraffin 50% emulsion (Parachoc®)	1-6 years, oral 10-15mL daily[7] 7-12 years, oral 20mL daily >12 years, oral 40mL daily
Osmotic laxatives	
Lactulose (Lactulose ®)	Initial dose: adjust according to response. [7] 1–12 months, oral 2.5 mL twice daily. 1–5 years, oral 2.5–10 mL twice daily. 5–18 years, oral 5–20 mL twice daily. Up to 1.5 mL/kg twice daily. Daily maximum is 60 mL.
Polyethylene glycol with electrolytes (Movicol® presentations)	(Movicol -Half®, Movicol Junior®)[7] 1–12 months, oral, initially half to 1 sachet daily. 1–6 years, oral, initially 1 sachet daily (usual maximum 4 sachets daily). 6–12 years, oral, initially 2 sachets daily (usual maximum 4 sachets daily).

	Movicol® 12–18 years, oral, initially 1 sachet daily (usual maximum 3 sachets daily).
Polyethylene glycol (no electrolytes) (Osmolax ®, ClearLax®)	Using measure provided: one level scoop is 17g. To be given in 250mL water (one cup). [7] 2- 6 years, oral 8.5g (half scoop) once daily in 120mL water. 6-12 years, oral 17g once daily; over 12 years (this can be increased to up to 3 doses if required)
Stimulant laxatives	
Senna Senokot® tablets	6 –12 years, 7.5 – 15 mg at bedtime.[7] 2 – 6 years, 3.75 – 7.5 mg at bedtime. 6 months - 2 years, 2.5 – 5mg at bedtime[8]
Sodium picosulfate7.5mg/mL drops Dulcolax®	Children 4 -10 years : 5 -10 drops once daily at night; >10 years: 10 - 20 drops once daily at night.[8]
Enemas and Disimpaction	
Enemas (e.g. Microlax®) or suppositories (e.g. glycerin) are rarely required and should only be considered in children with acute severe pain/distress related to faecal impaction. **Faecal impaction[7]** Stop once disimpaction occurs, then consider a maintenance dose for constipation. Movicol-Half®, Movicol Junior® 1–12 months, oral half to 1 sachet daily. 1–6 years, oral 2 sachets daily on day 1, then 4 sachets daily on days 2 and 3, then 6 sachets daily on days 4 and 5, then 8 sachets daily on days 6 and 7. 6–12 years, oral 4 sachets on day 1, then 6 sachets on day 2, then 8 sachets on day 3, then 10 sachets on day 4, then 12 sachets daily on days 5–7.	

Movicol® [1,2,5,6,7,8,9]

12–18 years, oral 8 sachets daily (take within 6 hours); for up to 3 days.

Cardiovascular disease, do not exceed >2 sachets/hour of Movicol®.

When to refer

Severe constipation resistant to above management approach or children requiring further investigation for concerning associated symptoms, such as failure to thrive. [1,2] Children with soiling that is prolonged, resistant to treatment and impacting on day to day functioning will likely require multidisciplinary approach to management, with the support of psychological services. [1, 2, 4]

Related policies, procedures, protocols and guidelines

List and hyperlink the titles of related policies, procedures and guidelines.
Treatment Pathway for Children Referred to PMH with Constipation +/- Soiling

References

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File Name and Path:	Constipation		
Document Owner:	Kerry Murphy, Continence CNC		
Reviewer / Team:	Dr Andrew Martin, Mr Ian Gollow, Kerry Murphy, Continence CNC, Charlotte Allen DPAM, CNS, Suret Nel, Shalini Kassam (Pharmacy Department)		
Document Sponsor:	Executive Director Medical Services		
Date First Issued:	October 2013	Version:	
Last Revised:	May 2014	Review Date:	May 2016
Endorsed by:	Medical Advisory Committee (MAC)	Date: May 2014	
Standards Applicable:	NSQHS Standards:		
The accuracy of this document is not guaranteed when printed			