Kijabe OPD Guidelines



Constipation in children

Key Facts:

- Constipation is defined as passing <3 complete stools per week (Rome Criteria); also includes withholding stool/incomplete evacuation, painful/hard/large bowel movements, soiling
- Affects 10% of children; usually starting around the introduction of solid food, toilet training or at a change in life e.g. starting school
- The majority is 'functional' constipation painful bowel movements prompt the child to withhold stool
- Alternative causes are Hirschsprung's disease, other congenital bowel anomalies and neurological causes
- We should treat promptly and titrate up laxatives quickly until a good result is achieved; dietary change alone is not an adequate treatment

History - including duration of symptoms, frequency and consistency of stool, blood/mucus, distress, straining, abdo/anal pain, 'retentive posturing' (straightlegged, tiptoed, back-arching), appetite and feeding history, development, hx meconium, painful or frightening precipitant prior to onset, faecal soiling or urinary incontinence, past medication and effectiveness, FH coeliac or hypothyroid Examination - growth; abdomen palpable faeces; lower back/spine; perianal area (fissures, anus); neurology lower limb & gait; DO NOT perform a DRE Investigations - not routinely required, CLINICAL diagnosis; TSH if features of hypothyroidism

Presentation of Constipation

- Confirm constipation and exclude serious cause
- Gain trust of the family and the child

Discuss with consultant if any red flags or diagnostic uncertainty

Make a positive diagnosis of functional constipation

Offer a good explanation and explain behavioural change carefully (printable sheet available); consider referral to nutritionist

Disimpaction if needed

Consider for any child who has not opened bowels for 7 days or more. Palpable faeces in the lower abdomen and soiling from overflow are also suggestive. Use PEG/Movicol as per chart below. Review after 1-2 weeks

Maintenance treatment

Titrate medication aiming for one soft, easy to pass bowel action per day with no soiling. Maintenance laxatives will be needed for at least as long as the constipation lasted to allow a return to a more normal regular bowel habit. See page 2

Stopping treatment

When a regular normal bowel habit is well established, do NOT stop laxatives abruptly but gradually reduce over a period of months

Red flags

- Symptoms from birth/first few weeks of life; age <6w
- >48h delay in passing meconium after birth
- Ribbon-like stools
- Weakness in legs or motor delay
- Weight loss/poor growthPersistent vomiting, abdominal
- distensionAbdominal mass (not consistent
- Abdominal mass (not consistent with large faecal mass)
- Abnormal appearance or position of anus
- Sinus, pit, pigmentation over spine or scoliosis
- Abnormal neuromuscular signs
- Suspicion of maltreatment

Must have ≥2 of the following for at least 1 month (infants) or 2 months (older children):

- ≤2 stools/week
- ≥1 episode/week of faecal soiling/incontinence
- History of retentive posturing or excessive volitional stool retention (withholding or incomplete evacuation)
- History of painful or hard bowel movements
- Presence of a large faecal mass in the rectum
- History of large diameter stools

- Discuss with consultant if:
- Any red flags
- Diagnostic uncertainty
- All new diagnoses
- Not responding to treatment
- High parental concern



Behavioural advice to discuss with parents (printable sheet available – talk through with parents)

Diet and fluids

- Eating a balanced diet with fibre and plenty of fluids will help, but will not cure constipation alone
- Excessive cow milk intake may exacerbate constipation in some children so reduce cow's milk if it is excessive (discuss with nutritionist).

Behaviour around passing stool

- Delay toilet training attempts until child is painlessly passing soft stool
- Review access to a toilet/potty e.g. are their barriers to using school toilets
- Encourage child to sit on the toilet/potty for 5-10 minutes, three times a day, preferably 20-30 minutes after meals. Try to make this fun & relaxing (games, books, toys)! Raising feet up a little on a stool and rocking gently may help.
- Reward behaviours, NOT achievements
 - Reinforce that this is not child's fault. DO NOT punish them but use positive reinforcement
 - Encourage willingness to take the laxatives
 - Reward toilet/potty sits, even if they don't poop
- Keep a diary to monitor progress if you can

Exercise - Encourage child to be physically active

Laxatives for constipation in children			
Disimpaction regimen			
Polyethylene glycol 3350 = PEG 3350 = Macrogol (MovicolPaeds) NOT Peglec 137g! (this is for bowel evacuation in adults prior to surgery/colonoscopy)	6.9g per sachet	1- 1.5gm/kg/day for 3-6 days until there is small or no stool in the rectum and fecoliths are no longer palpated in the left lower quadrant. Then start maintenance therapy, starting at half the dose required for disimpaction.	 Once diluted in water as per instructions, this can be added to ANY food that the child likes. It should NOT be mixed straight into food or drinks other than water as it will not work
Maintenance regimens			
Polyethylene glycol 3350 = PEG 3350 = Macrogol (MovicolPaeds) NOT Peglec 137g! (this is for bowel evacuation in adults prior to surgery/colonoscopy)	6.9g per sachet	Age <1y: ½ to 1 sachet daily; Age 2-5 years: 1 sachet daily, max 4 sachets per day; Age 6-11 years: 2 sachets daily, max 4 sachets per day Adjust dose to produce regular soft stools	 First-line laxative for children but <u>beware of cost</u> and discuss with parents. An alternative may be necessary in the long-term
Bisacodyl (Dulcolax)	5mg tablet	0.3mg/kg OD	 Stimulant laxatives – add to Movicol if insufficient or use on its own or if Movicol not tolerated or affordable. Add lactulose if stool remains hard
Sennakot	7.5mg tablet	Age 2-4y: ½ -2 tablets OD Age 4-6y: ½ -4 tablets OD Age 6-18y 1-4 tablets OD	
Lactulose	liquid	1-2ml/kg once or twice daily, adjust according to response	 Osmotic laxative – add to stimulant laxative if stool still hard

References

BMJ 2021;375:e065046 Indian Paeds Journal 2016 April 53; 319- 327 Modified European Society for Paediatric Gastroenterology Hepatology and Nutrition 2014. Outpatient Pediatric Protocols, Kijabe Hospital, 2020