St Helens and Knowsley Teaching Hospitals NHS Trust

Chronic Constipation

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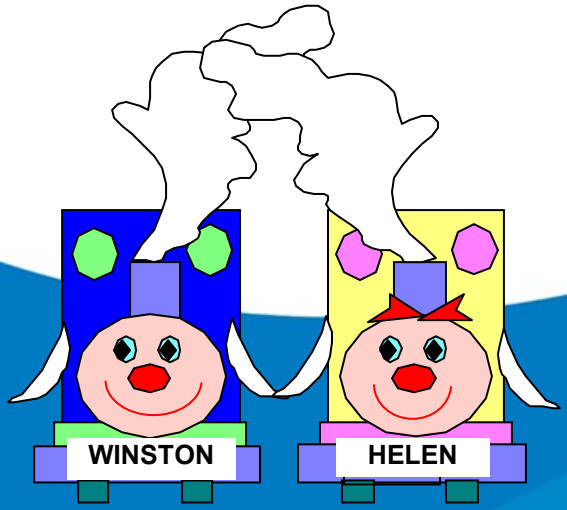

Author: Paediatric Department
Document Number: STHK1533
Version: 5
Review date: 01 / 10 / 2023

Children with Constipation and Soiling

Normal bowel habit can vary considerably in frequency amongst people. A child with bowel movements less than 3 times per week is probably constipated. However, pain and or excessive straining with discomfort during bowel movements are abnormal and are suggestive of constipation. Faecal soiling of underwear in school children is usually due to constipation with 'overflow'. It is more difficult to recognise constipation in a child who appears to have daily bowel movements but passes only small amount of faeces (poo) every time, therefore, incompletely evacuating his/her bowels.

How common is constipation in children?

Chronic constipation can be as common as in 10% of children. Constipation is an increasing problem. Faecal soiling is a common complication of longstanding constipation and may affect 4-5% of school children. Soiling is involuntary and a very distressing problem to the child which affects the whole family. It often leads to social isolation and may be a source of bullying in school. About 20-30% of children with chronic constipation may develop urinary complications such as bedwetting, daytime urinary dribbling and repeated urine infections.

Why do children get constipated?

Beyond the first month of life, over 95% of children with constipation have no underlying disease causing the constipation. This is often referred to as idiopathic or functional constipation.

It is important to note that constipation can affect any child in any family. It is not the child's or the parents' fault. It is often difficult to identify the exact cause of constipation in the individual child. Causes are often complex and may involve one or, more likely, a combination of the following factors:

- Painful bowel movement is probably the commonest cause, particularly in toddlers. This pain may be due to anal fissure (skin crack around the anus), an infection around the anus or simply due to passage of hard stools (poo). Untreated this may lead to withholding behaviour, typically in toddlers and pre-school children. This will lead to harder and more painful faeces. Untreated, this will continue into chronic constipation.
- Poor fluid and fibre intake may complicate an acute (brief) constipation. The child with established constipation may gradually select out foods with high fibre and roughage, and become a faddy eater.
- Other possible causes include; lack of exercise especially walking, delaying normal urge to open bowels (a child in a classroom or deeply engaged in games, particularly computer games!), coercive toilet training, excessive milk intake and possible genetic predisposition in some patients.

Features of constipation

Constipated children may present with painful bowel movements, repeated abdominal pains, blood in stools or when wiping the bottom or faecal soiling (usually with watery or pasty faeces).

Faecal soiling is involuntary overflow incontinence due to retained large stools. The child has no control of it nor is aware of it. Some children with chronic constipation may present with urinary problems such as bedwetting or urinary dribbling.

Treatment

There are generally accepted principles of management, though the dosages and choice of laxatives used may vary a lot. In the majority of patients, the main lines of management involve:

- Adequate assessment and explanations
- Bowel clear out
- Maintenance of regular bowel habit to prevent re-accumulation of faeces
- Gradual withdrawal of laxatives with improving dietary measures

In the vast majority, it is possible and preferable to achieve bowel clear out using orally administered laxatives.

Hard impacted faecal masses may need to be softened first for 1-2 weeks before evacuation.

Movicol Paediatric or Docusate and Picosulfate are frequently used to achieve evacuation.

Enemas often distress the child and parents and are rarely required. In children with faecal soiling, laxatives may initially worsen the soiling problem, usually during the first two weeks.

This means that they are working.

The hardest part of management is maintenance of regular bowel movements and prevention of re-accumulation of faeces.

This often requires regular use of one or more laxatives.

In addition, weekend courses of Picosulfate liquid may be required.

Success requires high motivation by the patient, hard work by the parents and regular follow up.

Uninterrupted regular laxative courses, improving fluid, fibre, fruit and vegetable intake, and daily toileting are essential parts of management.

Keeping a diary, particularly during the first few months of management, often helps in long term monitoring and in assessing progress.

It may be linked to a reward scheme for achievable targets.

Laxatives

There are various types of laxatives. Many of the laxatives are minimally or not absorbed and therefore are less toxic than many other medications. They work on the faeces and/or the large bowel, therefore the amount required may vary from one child to another.

They are generally well tolerated and have only minimal side effects; including abdominal cramps and bloating and wind.

There is no convincing evidence that patients become dependent on laxatives or that their effect in the individual patient wears off with time.

All laxatives, especially bulk-forming laxatives such as bran and ispaghula, require good fluid intake for optimum effect and to reduce their side effects.

Below are some of the commonly used laxatives and their common side effects, however if you have any concerns the doctor, continence nurse advisor and your local chemist will be happy to answer any queries:

- Lactulose is a form of a sugar, but is not normally absorbed. It draws water into faeces to soften them. It is non-toxic and sometimes high doses may be required. Side effects include wind, abdominal cramps and may affect teeth like other sugary foods, therefore, brush teeth after use. It may worsen soiling initially. It is available as liquid or powder
- Senna is a plant extract and one of the oldest laxatives. It stimulates the large bowel to contract and evacuate the stools. It may cause abdominal cramps and pains. These often improve after sometime or with reducing the dose. It may stain the urine dark red. It is available as liquid, granules or tablets. It acts in 6-10 hours and best given at night
- Bisacodyl is a stimulant laxative with similar indications and side effects to senna
- Docusate sodium is a stool softener and a stimulant. It helps breakdown hard faeces. It may cause abdominal cramps. It is available as liquid, capsules and enemas. There is a paediatric solution (12.5 mg/5 ml), and an adult solution (50mg/5ml). If the child dislikes its taste, the adult liquid may be used in older children to be able to give smaller volume
- Movicol paediatric is a solution to be made from the sachet powder. It is well tolerated. This comes in various flavours. It is very useful in initial evacuation, and as continued treatment.
- Sodium Picosulfate is a strong laxative. It draws water and salts into the large bowel. It is not suitable for regular daily intake for very long periods but can be very useful in achieving a bowel clear out, and also in preventing the reoccurrence of soiling when given as weekend courses for several weeks. It is generally very well tolerated
- Microenemas are less effective, but much smaller and gentler than phosphate enemas

Bulk laxatives include Ispaghula husk (such as Fybogel and Regulan), and Sterculia (such as Normacol). They are a source of fibre if the child can not maintain dietary fibre intake. They require especially high fluid intake, or they could worsen constipation.

Bowel re-training

This may be referred to as toilet training and it does not imply failure of toilet training. It often refers to the package of care given to a child with constipation during admission to hospital. With longstanding constipation the bowel loses its normal reflexes and will need re-training. It involves sitting on the toilet for 10-15 minutes regularly once or twice daily, preferably in the morning and after the main meal.

The child should be relaxed and try to open his/her bowels. The child should be encouraged for trying irrespective of the result. A favourite music may be played, or special story books are used.

How long treatment will take?

Children with acute constipation and those under one year may only need to improve their fluid and fibre intake.

Some children may need laxatives for a few weeks.

In older children with chronic constipation, the length of treatment depends on the previous course of illness. The presence of soiling suggests a long course of illness and therefore will take longer duration of treatment, often for several months. Overall a quarter of children with chronic constipation may be able to discontinue laxatives by 6 months, 50% by one year and 75% of patients by 2 years. Therefore, a quarter of patients may still require treatment for longer than 2 years.

It is often very difficult to know exactly when to stop laxatives. A simple and reasonable approach is 6 monthly trials. Provided that the child has adequate fluid and fibre intake, no more soiling for 4-6 months and has a fairly regular bowel habit without pain, then laxatives may be discontinued gradually.

Key points

- Faecal soiling is involuntary and often a complication of chronic constipation
- Improve fluid, fibre, fruit and vegetable intake. Gradual change to healthy eating for the whole family is more likely to succeed. Wholegrain breakfast cereals and whole-meal bread provide a good source of fibre. Laxatives require good fluid intake for optimum effect. It is recommended to have at least 7 – 8 fluid drinks per day
- Daily bowel training (sit on toilet for 10-15 minutes) once or twice daily is important
- Take laxatives regularly and avoid interrupting the courses without medical advice
- A diary with a reward scheme during the first few months of management helps
- It is important to keep regular appointments with the doctor and nurse who are supervising the management of your child’s constipation

If you have any further questions, please contact your child's consultant via their secretary via the hospital switchboard. The secretaries are available Monday to Friday 9.00 am to 5.00 pm

If you need to contact the Department outside of these hours, please phone either:

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