

Guidelines for the management of *constipation* in children.

Introduction.

The aim of these guidelines is to outline the different management options available for the treatment of constipation from first presentation. The guidelines are research based, but where research does not exist, they are based upon an agreement of current best practice.

Although common, constipation is a poorly understood condition. Children with constipation can become psychologically as well as physically distressed and careful management is always essential. The longer the duration of the symptoms the more difficult treatment becomes. In most cases the problem of constipation is of short duration and of little consequence: however, chronic constipation can follow from an inadequately managed acute problem and overly cautious under treatments can actually compound the problem¹. Chronic constipation can lead to progressive faecal retention, distension of the rectum and loss of sensory and motor functions. Constipation is considered chronic if it continues for more than two months². Soiling occurs when the child has been constipated for several months. Normal stool frequency in infants and children is difficult to define, but ranges from an average of four bowel movements a day in the first week of life to two a day at the age of one. The normal adult range of 3 stools per day to 3 stools per week is usually attained by the age of four³.

Definition.

Constipation is characterised by infrequent bowel evacuations; hard, small faeces; or difficult or painful defecation. The most common cause of constipation is functional and can be defined as either having hard pellet-like stools or firm stools two or less times per week in the absence of structural, endocrine or metabolic disease².

Soiling is caused by the softened stool leaking around the hard stool. It is often referred to as overflow. The faeces are often loose, foul smelling and gritty. It is an involuntary action over which the child has no control.

Encopresis is the passage of a normal stool in socially inappropriate places. The child has normal bowel sensation and if examined the rectum is usually empty. It is often associated with other behavioural problems.

Faecal impaction occurs when there has been no adequate bowel movement for several days or weeks, and a large, compacted mass of faeces builds up in the rectum and/or colon which cannot be easily passed by the child. Symptoms include failing to pass a stool for several days followed by a large often painful or distressing bowel motion. Between bowel movements children with faecal impaction often soil their underclothes.

The management of chronic constipation and faecal impaction has three main components⁴.

1. Education.

This is the most important component for success in the management of constipation and may need to be repeated several times. It is important to give a clear explanation of the pathophysiology of constipation and associated soiling to the parents and children in order to maintain motivation and compliance with treatment.

2. Disimpaction.

It is vital to complete disimpaction prior to starting maintenance therapy.

- **Oral:** *This route is not invasive and may give a sense of control to the child but adherence to the regime may be a problem.*
- **Rectal:** *Expert consensus opinion is that the use of suppositories and enemas are rarely indicated as they are invasive and distressing for the child.*
- **Manual:** *With modern oral therapies, manual disimpaction is rarely performed.*

3. Maintenance Therapy.

Once the faecal impaction has been removed, the treatment then focuses on the prevention of a recurrence of impaction. The aim of the maintenance therapy is to help the muscles and nerves of the rectum to recover sensitivity and strength by promoting regular toileting and preventing further stool impaction. The goal is to achieve one soft stool per day. The minimum acceptable is 3 or more stools per week with no pain or soiling. Maintenance therapy has four components: fluid and dietary interventions, toileting programmes, medication and follow up.

- Diet and fluids:** Healthy eating is encouraged, high fibre intake with regular meals preferably with parents present. An adequate fluid intake is imperative, at least 6-8 cups of per day for children. Encourage water based drinks. i.e. fruit juice, cordial, not milk. Excessive milk drinking reduces the appetite for solid food and because milk has a low residue and high calcium content it may be constipating⁵.
- Toileting programmes and medication:** Encouragement and praise for regular toileting and compliance with medication, try to move the focus away from having clean pants as this can encourage retention of stools and hiding underclothes, use age appropriate reward systems and star charts. Close supervision, privacy and pleasant accessible facilities both at home and school are essential. In the younger child if their feet don't touch the floor it is important that they are supported on a footstool; this ensures that they are in a comfortable position to allow them to push. For older children it helps to establish a regular routine of going to the toilet after breakfast and evening meal. Leave plenty of time so that there is no rush.
- Follow up:** Regular planned review with the family, by telephone or appointment to monitor progress and adjust medication as needed and to offer praise and encouragement for them to carry on with the programme.
- Weaning off medication:** Aim to wean medication when the child has been regularly passing soft formed stools for at least 6 months, and then attempt a slow withdrawal.

References:

1. Rasquin-Weber et.al. (1999) Childhood functional gastrointestinal disorders. Gut. Vol.45 (supplement 2).
2. PACCT group (2004) accessed online 06.01.06. .
3. Rogers J (2005) Reducing the misery of constipation in children. Practice Nursing. Vol.1, No.1. P.12-16.
4. Catto-Smith A (2005) Constipation and toileting issues in children. The Medical Journal of Australia. Vol.182, No.5, p.242-246.
5. Rogers J (1997) Childhood constipation and the incidence of hospitalisation. Nursing Standard.Vol.12, No.8, p.40-42.
6. Vincent R, Candy D (2001) Movicol for the treatment of faecal impaction in children. Gastroenterology Today.Vol.11, No2 summer 2001.

Useful websites:

www.childhoodconstipation.com

www.eric.org.uk

www.constipationadvice.co.uk

