Mersey and West Lancashire Teaching Hospitals NHS Trust

Paediatric Clinical Guideline for Constipation and Soiling in Childhood

Version No: 1

Document Summary
Timely diagnosis of constipation and soiling along with early and consistent management results in better outcomes. Poor outcomes are often a result of a multitude of complex factors including, social stigmatisation, lack of interest or understanding of the problem by health professionals, conflicting advice, inconsistent practice, and lack of evidence based guidance.

This guideline is intended for use at Whiston and St Helens Hospitals.

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Accountable Director	Medical Director	
Policy Author	Consultant Paediatrician	
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Document Control

Section 1 – Document Information	
Title	Paediatric Clinical Guideline for Constipation and Soiling in Childhood
Directorate	Paediatrics
Brief Description of amendments	
No change to national guidance. Minor changes made for local clarification including addition of Acute/ED Investigation at Section 8. Flowcharts from Sections 6.8 and 7.2 copied to Quick Reference Guide. ***Version 3 (STHK) has been superceded***	
Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes
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Section 2 – Consultation Information* *Please remember to consult with all services provided by the Trust, including Community & Primary Care where applicable			
Consultation Completed	☐ Trust wide ☑ Local ☐ Specific staff group		
Consultation start date	26/01/2024	**Consultation end date**	24/06/2024

Section 3 – Version Control		
Version	**Date Approved**	**Brief Summary of Changes**
1 (STHK)	April 2005	New guideline
2 (STHK)	March 2012	Revised to reflect NICE guidance
3 (STHK)	26/04/2021	Updated to reflect current NICE guidance
1 (PD)	24/06/2024	No change to national guidance. Minor changes made for local clarification including addition of Acute/ED Investigation at Section 8. Flowcharts from Sections 6.8 and 7.2 copied to Quick Reference Guide.

Section 4 – Approval *– To be completed by Document Control*			
Document Approved	☐ Approved ☑ Approved with minor amendments		
Assurance provided by Author & Chair	☑ Minutes of Meeting ☐ Email with Chairs approval		
Date approved	24/06/2024	**Review date**	30/06/2027

Section 5 – Withdrawal *– To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by Author & Chair	☐ Minutes of Meeting ☐ Email with Chairs approval

Date Withdrawn:	Click here to enter a date.

Quick Reference Guide 1

Management of Constipation in Children

Is it constipation?

Does the child have 2 or more of the following symptoms?

- Hard or infrequent stools
- Pain on passing stool
- Withholding behaviours

Is it idiopathic?

Rule out RED FLAGS

- **Time of onset** – from birth/within first few weeks of life?
- **Passage meconium** – delayed?
- **Stool pattern** – ribbon stools?
- **Locomotive and developmental symptoms** – leg weakness or motor delay?
- **Abdomen** – distension, mass or vomiting?

Always examine

- Abdomen
- Spine and limbs
- Growth & general wellbeing
- ***Consider*** *examining perianal area*

Check for AMBER FLAGS

- Faltering growth or other indicators of underlying systemic disease
- Suspected CMPA
- Concern of possible child maltreatment

Diagnose IDIOPATHIC CONSTIPATION
OR refer as appropriate

Management Any impaction?

- **Education & Prevention**
  - *Behavioural interventions*
  - *Dietary & fluid advice*
- **Is disimpaction required?**
  - *Disimpaction regime (cBNF)*
- **Maintenance therapy**
  - *Laxative regime*
  - *Improve fluid intake*
  - *Daily bowel re-training*
- **Rehabilitation & support**
  - *Ongoing review*
  - *Community support*

STAR CHART

Images from Pixabay.com

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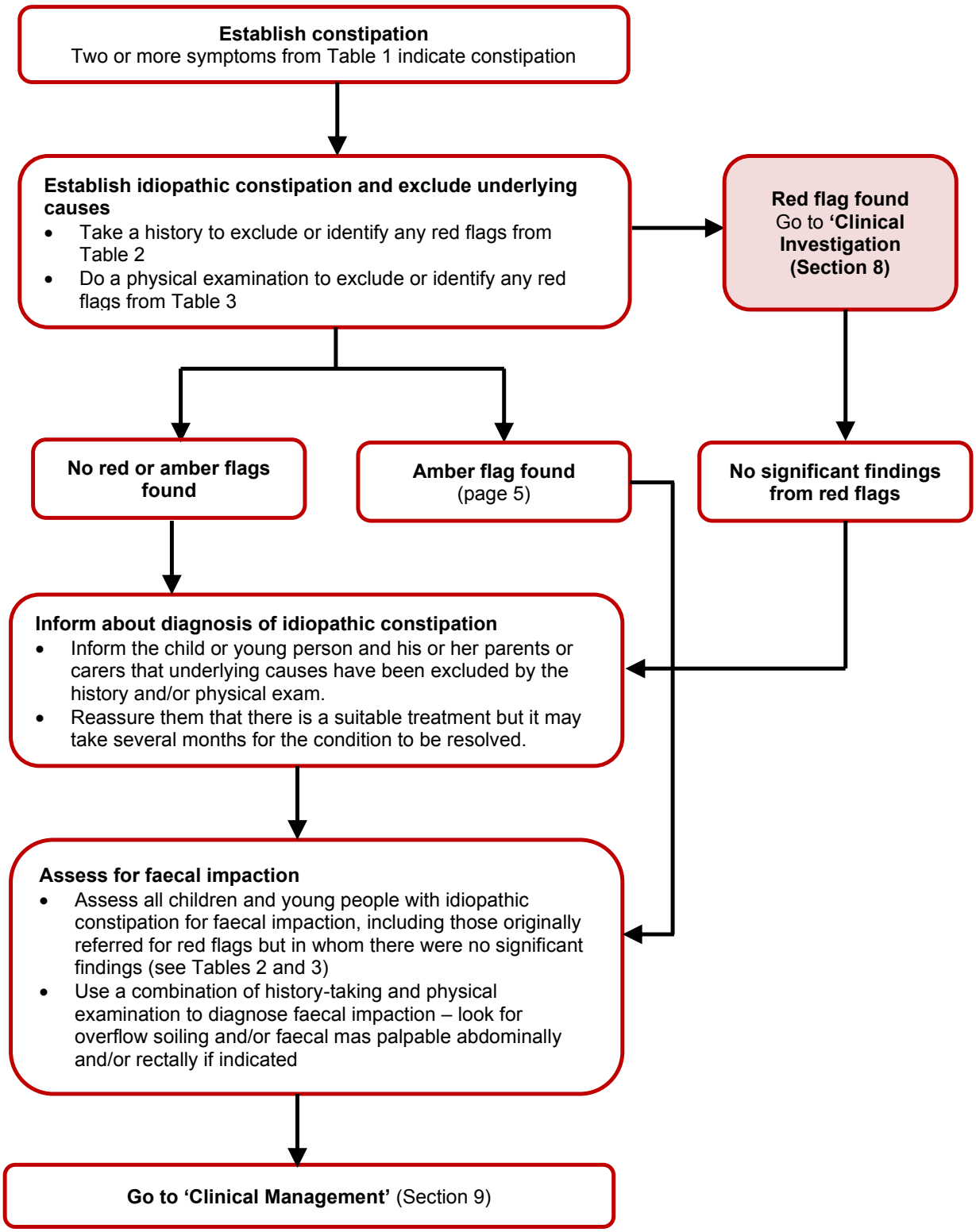
Quick Reference Guide 2

History Taking and Physical Examination Flow Chart



Contents

1. Scope

This guideline has been written to provide guidance to staff on the management of constipation and soiling in children and young people in accordance with NICE guidelines (CG99 May 2010, Updated 2017)

2. Introduction

The reader is advised to refer to the full NICE Guidance [CG99] for more details.

- Constipation is common, and often under-reported in childhood. It is prevalent in around 5–30% of the child population. It's usually under reported by patients/parents for various reasons. The condition becomes chronic in > 1/3 of patients, often due to under-treatment and the child is already in a vicious cycle of pain-holding behaviour. Constipation is more frequent in children with neurodevelopmental disabilities such as cerebral palsy, autism and Down's syndrome.

- Pathophysiology and causes are multifactorial and often not fully understood. Important contributing factors may include: pain, fever, dehydration, dietary and fluid intake, psychological issues, toilet training, medicines and familial history of constipation. However, the vast majority is idiopathic (non-identifiable pathological cause).

- *Usual vicious cycle starts with acute constipation → painful defecation (usually toddlers) → stool retention → larger and harder stools → more pain → more retention → established chronic constipation. If not treated adequately at an early stage often becomes complicated with faecal overflow soiling.*

- Symptoms may be subtle and often not recognised by the patient, carers or health professionals. Features of constipation may include: infrequent bowel activity, foul smelling wind and stools, excessive flatulence, irregular stool texture, passing occasional enormous stools or frequent small pellets, withholding or straining to stop passage of stools, soiling or overflow, abdominal pain, distension or discomfort, poor appetite, lack of energy, an unhappy, angry or irritable mood and general malaise.

- **Painful defecation** is an important factor in constipation but it is not always recognised.

- **Withholding behaviours** to prevent passage of painful stools are often confused with straining to pass stools.

- **Soiling** is debilitating but rarely life threatening so it might be expected to have little impact on healthcare provision. But many children and young people experience social, psychological and educational consequences that require prolonged support.

- Timely diagnosis and early and consistent management results in better outcome. The current poor outcomes are often a result of multitude of complex factors

including, social stigmatisation, lack of interest or understanding of the problem by health professionals, conflicting advice, inconsistent practice, poor compliance (adherence) with medication and lack of Evidence-Based guidance.

- Management of constipation like any other chronic medical condition should be based on a patient-centred care with appropriate communication, involvement of patient and carers in decision making with the appropriate consent and be patient-tailored approach.

3. Statement of Intent

To ensure that children and young people with constipation and/or soiling are diagnosed and managed appropriately to achieve optimal outcomes.

4. Definitions

Definition	Meaning
Acute Constipation	Constipation less than 8 weeks
Chronic Constipation	Constipation lasting longer than 8 weeks
Idiopathic Constipation	Constipation that cannot be explained by underlying pathological, physiological or radiological abnormality.
Intractable Constipation	Not responding to sustained and optimum management as outlined by NICE guidelines.

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust including and ensuring that this guideline complies with all legal, statutory and good practice guidance requirements and is implemented effectively and efficiently.

5.2 Medical Director

The Medical Director is the accountable Director for this Guideline.

5.3 Clinical Directors, Paediatrics and ED

It is the responsibility of the Clinical Directors for Paediatrics and ED to ensure standards in all aspects of caring for infants, children and young people are maintained.

5.4 Directorate Managers for Paediatrics and ED

The Directorate Managers for Paediatrics and ED are accountable to the Patient Safety Council for assuring compliance with this guideline ensuring that the guideline is reviewed and updated by the specified review dates.

5.5 Paediatric and ED Consultants, Matrons and Ward Managers

Responsible for ensuring that all medical staff working with infants, children and young people are fully aware of their responsibilities within this guideline.

5.6 Paediatric and ED Nurses and Medical Staff (Inclusive of bank staff)

Staff involved in the care of infants, children and young people have a responsibility to ensure that any new and revised guidelines are referred to during the course of their practice and that they have the necessary competencies to carry out their responsibilities effectively. Staff are aware that clinical guidelines are available electronically on the intranet and in shared paediatric folders (Groups T:\PAEDS).

6. Key Priorities for Implementation from NICE Guidance

6.1 Diagnosis (History-taking and Physical Examination)

- **Q1: Is it Constipation?** Constipation and its idiopathic nature are largely clinical diagnoses. Establish during history-taking whether the child or young person has constipation.

  Two or more findings from **Table 1** (Section 6.9) indicate constipation.
- **Q2: Is it Idiopathic?** Establish a positive diagnosis of idiopathic constipation (therefore rule out an associated / causative underlying abnormalities/condition) based on **history** (**Table 2** – Section 6.10) and **examination** (**Table 3** – Section 6.11).
- **RED FLAGS:** If a child or young person has any 'red flag' symptoms (Table 2 – Section 6.10) or signs (Table 3 – Section 6.11), you need to address the underlying cause. If you are in primary care, do not treat them for constipation; instead, refer them urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern.
- Inform the child and his or her parents or carers of a positive diagnosis of idiopathic constipation and also that underlying causes have been excluded by the history and/or physical examination.

6.2 Digital rectal examination

- Do not perform a digital rectal examination in children or young people older than 1 year with a 'red flag' (Tables 2 and 3), in the history-taking and/or physical examination that might indicate an underlying disorder. Instead, refer them urgently to an appropriate healthcare professional such as surgeons if you suspect anatomical abnormalities or Hirschsprung's disease for example
- ***Additional note by author of local guidance:***

  While perianal inspection is a very important part of clinical assessment of constipation, particularly in pre-school children, to rule out streptococcal cellulitis, anal fissures and anteriorly positioned anus, Digital Rectal Examination is very rarely required particularly by trainee or non-specialist health-carers.

6.3 Communication

- Reassure them that there is a suitable treatment for idiopathic constipation but that it may take several months for the condition to be resolved.

6.4 Disimpaction (Table 4 – Section 6.12)

- **Q3: Is there faecal impaction?** Assess all children with idiopathic constipation for faecal impaction using history and examination. (L*ook for overflow soiling and/or faecal mass palpable abdominally and/or rectally if indicated).*

- Disimpaction, if indicated, should be via **oral route** and be based on **Polyethylene Glycol** (Movicol or Laxido) as first-line treatment:

    - Polyethylene glycol 3350 + electrolytes (Movicol / Laxido), using an escalating dose regimen (**Table 4**).
    - Adjust the dose of polyethylene glycol 3350 + electrolytes according to symptoms and response.
    - Add a stimulant laxative if polyethylene glycol 3350 alone is not effective (**Table 4**).
    - Substitute a stimulant laxative with or without an osmotic laxative if polyethylene glycol 3350 is not tolerated (table 4).

- ***Additional note on Disimpaction by author of local guidance:***
  A large number of children will achieve Disimpaction by as much as only ½ of the dose regimen stated by BNF. This may facilitate compliance and reduce risk of vomiting.

6.5 Maintenance Therapy (Table 4)

- Maintenance therapy often needed for several months or years to establish regular habit.
- As a guide for children and young people who have had Disimpaction, the starting maintenance dose might be half the disimpaction dose (**Table 4**).
- Add a stimulant laxative (**Table 4**) if polyethylene glycol 3350 + electrolytes does not work.
- Substitute a stimulant laxative if Movicol is not tolerated by the child or young person.
- Add another laxative such as **lactulose** or **docusate** (**Table 4**) if stools are hard.
- Do not stop medication abruptly: gradually reduce the dose over a period of months.

6.6 Diet and lifestyle

- Do not use dietary interventions alone as first-line treatment for idiopathic constipation
- Laxative therapy should be combined with negotiated and non-punitive behavioural interventions that may include regular toileting and support to establish a regular bowel habit, maintenance and discussion of a bowel diary, information on constipation, and use of encouragement and rewards systems. Dietary modifications to ensure a balanced diet and sufficient fluids are consumed. (**Table 5**, for fluid intake recommendations).
- ***Additional notes by the author of the local guidance:***
  Maintaining adequate fluid intake is paramount to management, this may simply be given as 8 – 10 cups/glasses per day, where the size of glasses matching the child's age. This should be mainly water, but fresh juices such as orange juice is helpful.

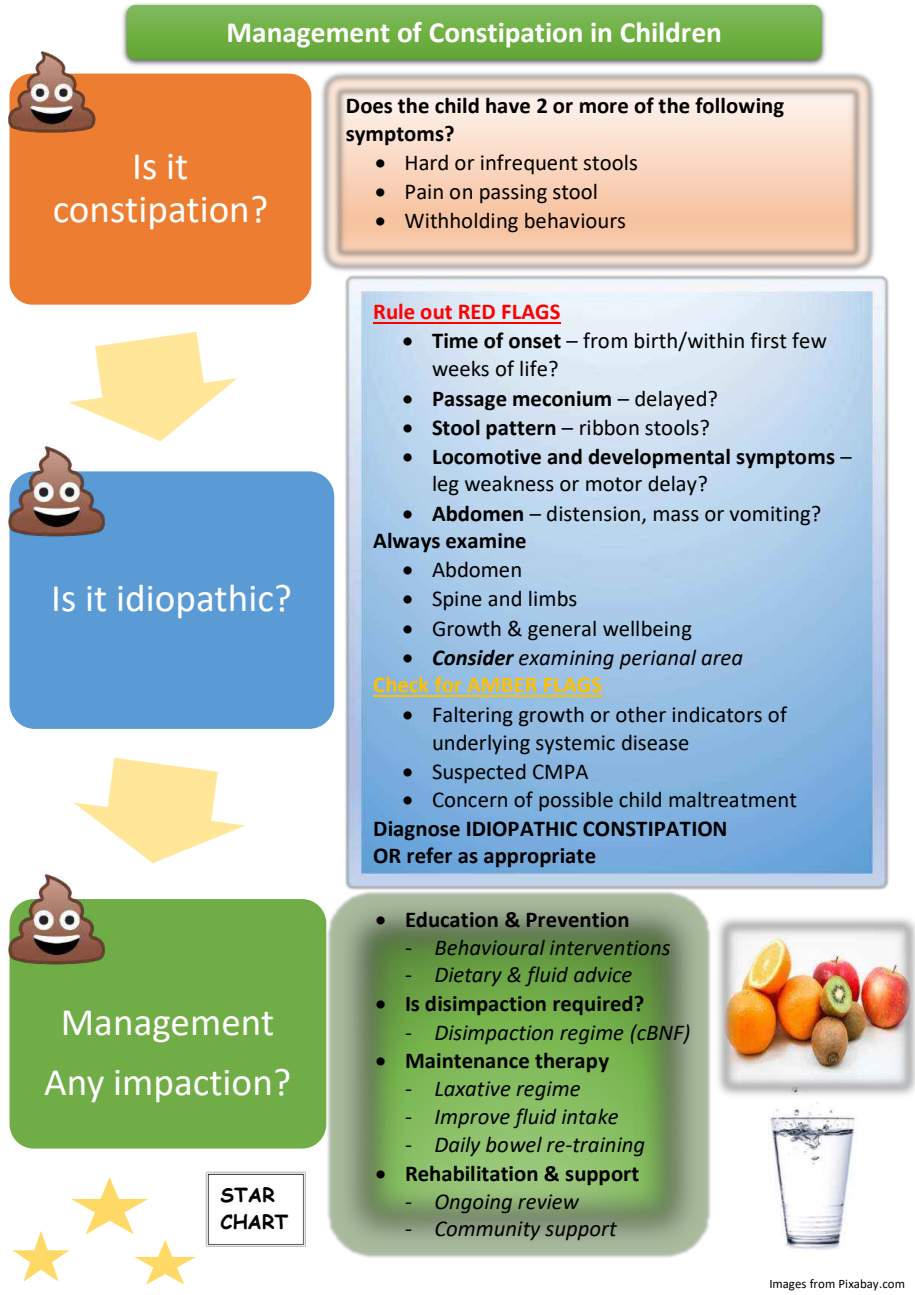
  Maintaining daily bowel training is also very important. This may simply be sitting

on toilet for 10-15 minutes either after breakfast or within an hour of main meal, and try to open bowels.

6.7 Information and support

- Offer children and young people with idiopathic constipation and their families a point of contact with specialist healthcare professionals, including school nurses, who can give ongoing support. Local Paediatric Continence Nurse Advisory Services have very large experience in this field.

6.8 Simple approach to the management of constipation and soiling



Authors: Katrin Little, Abubaker Elbadri, Rachel Ewart. Paediatric Department, Whiston Hospital, Merseyside, UK

6.9 Key components of history taking to diagnose constipation (Table 1)

Table 1: Key components of history taking to diagnose constipation		
Key components	**Potential findings in a child younger than 1 year**	**Potential findings in a child/young person older than 1 year**
Stool Pattern (Refer to Bristol Stool Chart – Page 22)	Fewer than three complete stools per week (Type 3 or 4, see Bristol Stool Form Scale). This does not apply to exclusively breast fed babies after 6 weeks of age Hard large stool 'Rabbit droppings' (Type 1, see Bristol Stool Form Scale)	Fewer than three complete stools per week (Type 3 or 4, see Bristol Stool Form Scale) Overflow soiling (commonly very loose [no form], very smelly [smells more unpleasant than normal stools], stool passed without sensation. Can also be thick and sticky or dry and flaky.) 'Rabbit droppings' (Type 1, see Bristol Stool Form Scale) Large, infrequent stools that can block the toilet
Symptoms associated with defecation	Distress on stooling Bleeding associated with hard stool Straining	Poor appetite that improves with passage of a large stool Waxing and waning of abdominal pain with passage of stool Evidence of retentive posturing; typical straight legged, tiptoed, back arching posture Straining Anal pain
History	Previous episode(s) of constipation Previous or current anal fissure	Previous episode(s) of constipation Previous or current anal fissure Painful bowel movements and bleeding associated with hard stools

6.10 Table 2: Key components of history taking to diagnose idiopathic constipation

Table 2: Key components of history taking to diagnose idiopathic constipation		
Key components	**Findings and diagnostic clues that indicate idiopathic constipation**	**'RED FLAG' findings and diagnostic clues that indicate an underlying disorder or condition; not idiopathic constipation**
Timing of onset of constipation and potential precipitating factors	**In a child younger than 1 year:** • Starts after a few weeks of life • Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, infections **In a child/young person older than 1 year:** • Starts after a few weeks of life • Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, timing of potty/toilet training or acute event such as infections, moving house, starting nursery/school, fears and phobias, major change in family, taking medicines	Reported from birth or first few weeks of life
Passage of meconium	Normal (within 48 hours after birth, in term baby)	Failure to pass meconium/delay (more than 48 hours after birth in term baby)
Stool patterns		'Ribbon stools' (more likely in a child younger than 1 year)
Growth and general wellbeing	**In a child younger than 1 year:** • Generally well, weight and height within normal limits **In a child/young person older than 1 year:** • Generally well, weight and height within normal limits, fit and active	No 'Red Flag', but see 'Amber Flag' below
Symptoms in legs / locomotor development	No neurological problems in legs (such as falling over in a child/young person older than 1 year), normal locomotor development	Previously unknown or undiagnosed weakness in legs, locomotor delay
Abdomen		Abdominal distension; with vomiting
Diet and fluid intake	**In a child younger than 1 year:** • Changes in infant formula, weaning, insufficient fluid intake **In a child/young person older than 1 year:** • History of poor diet and/or insufficient fluid intake	
'Amber Flag' :Possible idiopathic constipation – You may like to rule out conditions likes coeliac disease by checking AttG, and if supported by clinical findings may also consider hypothyroidism. If Hirschsprung's disease is clinically suspected refer to surgeons to consider rectal biopsy. **Personal / familial / social factors:** • Disclosure or evidence that raises concerns over possibility of child maltreatment		

6.11 Table 3: Key components of physical examination to diagnose idiopathic constipation

Table 3: Key components of physical examination to diagnose idiopathic constipation		
Key components	**Findings and diagnostic clues that indicate idiopathic constipation**	**'RED FLAG' findings and diagnostic clues that indicate an underlying disorder or condition; not idiopathic constipation**
Inspection of perianal area: appearance, position, patency, etc	Normal appearance of anus and surrounding area	Abnormal appearance/position/patency of anus: fistulae, bruising, multiple fissures, tight or patulous anus, anteriorly placed anus, absent anal wink
Abdominal examination	Soft abdomen. Flat or distension; that can be explained because of age or excess weight	Gross abdominal distension
Spine/lumbosacral region/gluteal examination	Normal appearance of the skin and anatomical structures of lumbosacral/ gluteal regions	Abnormal: asymmetry or flattening of the gluteal muscles, evidence of sacral agenesis, discoloured skin, naevi or sinus, hairy patch, lipoma, central pit (dimple) that you can't see the bottom of), scoliosis
Lower limb neuromuscular examination including tone and strength	Normal gait. Normal tone and strength in lower limbs	Deformity in lower limbs such as talipes Abnormal neuromuscular signs unexplained by any existing condition, such as cerebral palsy
Lower limb neuromuscular examination: reflexes (perform only if 'Red Flags' in history or physical examination suggest new onset neurological impairment)	Reflexes present and of normal amplitude	Abnormal reflexes

6.12 Table 4: Laxatives: recommended doses

Table 4: Laxatives – Recommended doses	
Laxatives	**Recommended doses**
Macrogols Polyethylene glycol 3350 + electrolytes	**Paediatric Formula:** Oral powder: macrogol 3350 (polyethylene glycol 3350)[b] 6.563 g; sodium bicarbonate 89.3 mg; sodium chloride 175.4 mg; potassium chloride 25.1 mg/sachet (unflavoured) [a] **Disimpaction** • Child under 1 year: ½ - 1 sachet daily (non-BNFC recommended dose) • Child 1-5 years: 2 sachets on 1st day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily (non-BNFC recommended dose) • Child 5 – 12 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 12 sachets daily (non-BNFC recommended schedule) **Ongoing Maintenance** (chronic constipation, prevention of faecal impaction) • Child under 1 year: ½ - 1 sachet daily (non-BNFC recommended dose) • Child 1-6 years: 1 sachet daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) (for children under 2, non-BNFC recommended dose) • Child 6-12 years: 2 sachets daily; adjust dose to produce regular soft stools (maximum 4 sachets daily)
	Adult Formula: Oral powder: macrogol 3350 (polyethylene glycol 3350) 13.125 g; sodium bicarbonate 178.5 mg; sodium chloride 350.7 mg; potassium chloride 46.6 mg/sachet (unflavoured) **Disimpaction** • Child/young person 12 – 18 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 8 sachets daily (non-BNFC recommended dose) **Ongoing Maintenance** (chronic constipation, prevention of faecal impaction) • Child/young person 12-18 years: 1-3 sachets daily in divided doses adjusted according to response; maintenance, 1-2 sachets daily
Osmotic Laxatives Lactulose	• Child 1 month to 1 year: 2.5 ml twice daily, adjusted according to response • Child 1-5 years: 2.5 to 10 ml twice daily, adjusted according to response (non-BNFC recommended dose) • Child/young person 5-18 years: 5-20 ml twice daily, adjusted according to response (non-BNFC recommended dose)
Stimulant Laxatives	
Sodium Picosulphate[b]	Non-BNFC recommended doses Elixir (5mg/5ml) • Child 1 month to 4 years: 2.5 – 10 mg once a day • Child/young person 4-18 years: 2.5 – 20 mg once daily
Bicacodyl	Non-BNFC recommended doses By mouth: • Child/young person 4-18 years: 5 – 20 mg once daily By rectum (suppository): • Child/young person 2-18 years: 5-10 mg once daily
Senna[d]	Senna syrup (7.5 mg/5ml) • Child 1 month to 4 years: 2.5 – 10 ml once daily

Table 4: Laxatives – Recommended doses	
Laxatives	**Recommended doses**
	• Child/young person 6-8 years: 1-4 tablets once daily
Docusate sodium[e]	• Child 6 months – 2 years: 12.5 mg three times daily (use paediatric oral solution) • Child 2-12 years: 12.5 – 25 mg three times daily (use paediatric oral solution) • Child/young person 12-18 years: up to 500 mg daily in divided doses

All drugs listed above are given by mouth unless stated otherwise.

Unless stated otherwise doses are those recommended by the British National Formulary for Children (BNFC) 2009 (NICE). Always check the current BNF before prescribing. Informed consent should be obtained and documented whenever medications/doses are prescribed that are different from those recommended by the BNFC.

[a] A range of paediatric plains are available, but not all are licensed for children under 12
[b] Elixir, licensed for use in children (age range not specified by manufacturer). Perles not licensed for use in children under 4 years. Informed consent should be obtained and documented.
[c] Perles produced by Sanofi should not be confused with Ducolax tablets which contain bisacodyl as the active ingredient
[e] Adult oral solution and capsules not licensed for use in children under 12 years. Informed consent should be obtained and documented.

6.13 Table 5: American dietary recommendations

Table 5: American daily recommendations[a]		
Age	**Total water intake/day (including water in food)**	**Water from drinks/day**
Infants 0-6 months	700 ml assumed to be from breast milk	
7-12 months	800 ml from milk and complementary foods and beverages	600 ml
1-3 years	1300 ml	900 ml
4-8 years	1700 ml	1200 ml
Boys 9-13 years	2400 ml	1800 ml
Girls 9-13 years	2100 ml	1600 ml
Boys 14-18 years	3300 ml	2600 ml
Girls 14-18 years	2300 ml	1800 ml

[a] Institute of Medicine (2005) Dietary reference intakes for water, potassium, sodium chloride and sulphate. Washington DC: The National Academies Press

The above recommendations are for adequate intakes and should not be interpreted as a specific requirement. Higher intakes of total water will be needed for those who are physically active or who are exposed to hot environments. It should be noted that obese children and young people may also need higher total intakes of water.

7. History Taking and Physical Examination

- First use history to **establish the presence of constipation** (Two or more findings from Table 1).

- Then use history (Table 2) and examination (Table 3) to establish a positive **diagnosis of idiopathic constipation** by excluding underlying causes. If a child

or young person has any **'red flag'** symptoms (Table 2) or signs (Table 3), do not treat them for constipation. Instead, refer them urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern.

- If any evidence of faltering growth treat constipation and test for coeliac disease and hypothyroidism or any other potential underlying problem.

- If there is any evidence of possible maltreatment treat for constipation and discuss with a senior staff and safeguarding team and refer to NICE guidance on 'Child maltreatment: When to suspect maltreatment in under 18s'.

- If there is any evidence of perianal streptococcal infection, treat for constipation and the treat the infection.

- Inform the child and parents of **diagnosis of idiopathic constipation** and also that underlying causes have been excluded by the history and/or physical examination. Reassure them that it is treatable but may take several months for the condition to be resolved.

7.1 Digital rectal examination

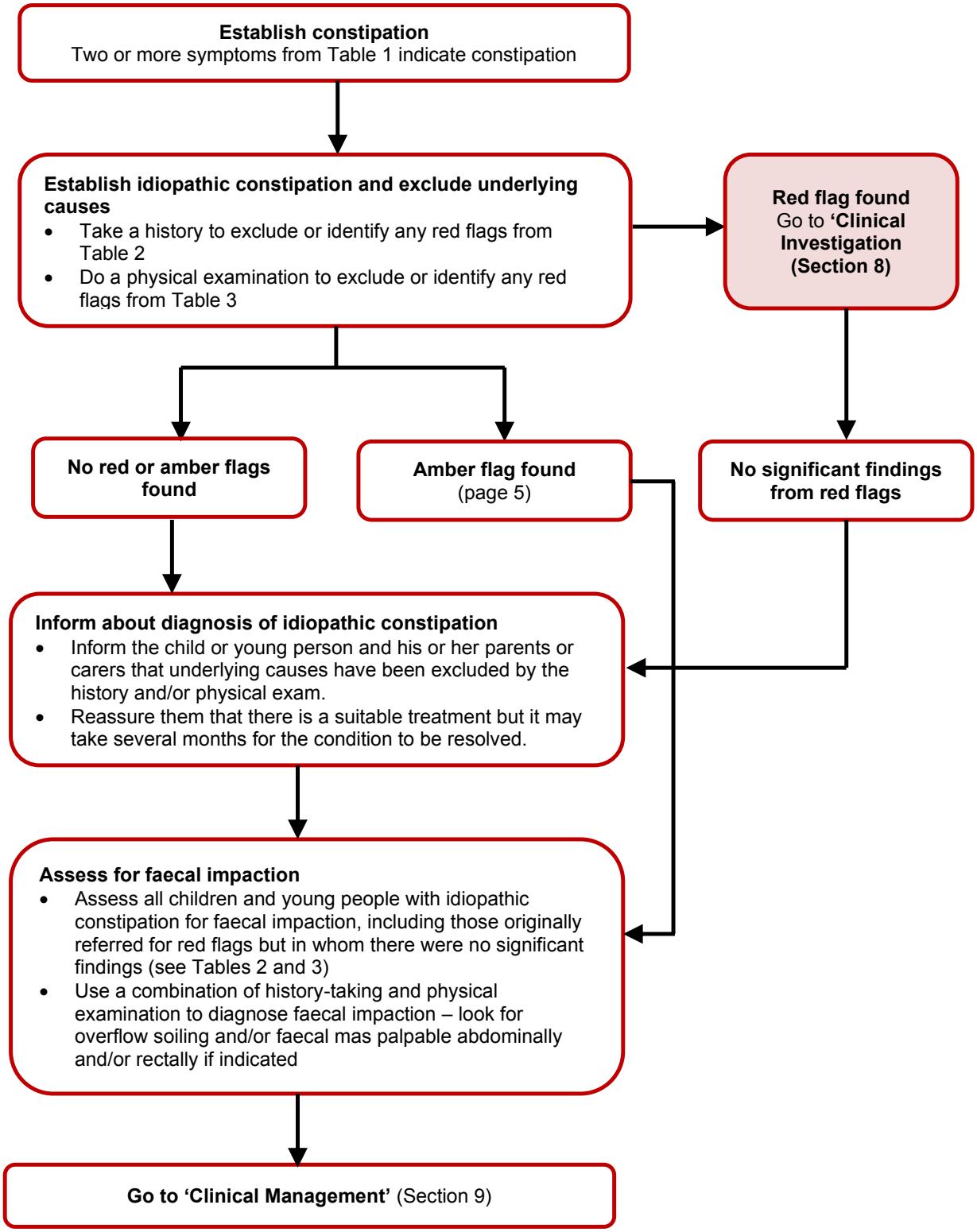
- A digital rectal examination should be undertaken only by healthcare professionals competent to interpret features of anatomical abnormalities.

- If an infant under 1 year old has a diagnosis of idiopathic constipation and does not respond to optimum treatment within 4 weeks, or an infant with "red flag" (tables 2 and 3) refer them urgently to a healthcare professional competent to perform a digital rectal examination and interpret features of anatomical abnormalities or Hirschsprung's disease.

- **For a digital rectal examination ensure:**
  - Privacy and a chaperone present.
  - To obtain informed consent and should be documented.
  - Respect of child's preferences about degree of body exposure and gender of examiner. To document findings.

Please note the local author's caveat regarding digital rectal examination in children that is rarely useful in constipation.

7.2 History Taking and Physical Examination Flow Chart



8. Clinical Investigations

Acute/ED Investigation:
Please note, in idiopathic constipation, no investigations are generally required. If you have identified red or amber flags, then referral for appropriate investigations will be necessary based on the concern.

As below, routine abdominal X-ray is not indicated but may be considered by the specialist in certain circumstances.

8.1 Endoscopy
Do not use gastrointestinal endoscopy to investigate idiopathic constipation

8.2 Coeliac disease and hypothyroidism
Consider testing for coeliac disease and hypothyroidism in intractable constipation.

8.3 Manometry
Do not use anorectal manometry to exclude Hirschsprung's.

8.4 Radiography
Do not use a plain abdominal radiograph to make a diagnosis of idiopathic constipation.

Plain abdominal radiograph may be requested by specialist in intractable constipation

8.5 Rectal biopsy
Rectal biopsy may be considered in the presence of those features of Hirschsprung's:

- Delayed passage of meconium (more than 48 hours after birth in term babies)
- Constipation since first few weeks of life
- Chronic abdominal distension plus vomiting
- Family history of Hirschsprung's disease
- Faltering growth in addition to any of the previous features (Rule out coeliac disease as well).

8.6 Transit studies
Do not use transit studies to make a diagnosis of idiopathic constipation.
Specialist may request transit studies in intractable idiopathic constipation.

8.7 Ultrasound
Do not use abdominal ultrasound to make a diagnosis of idiopathic constipation.
Specialist may request ultrasound studies in intractable idiopathic constipation.

9. Clinical Management

9.1 Disimpaction

- Assess all children and young people with idiopathic constipation for faecal impaction, including children and young people who were originally referred to the relevant services because of 'red flags' but in whom there were no significant findings following further investigations (tables 2 and 3).

- Use a combination of history-taking and physical examination to diagnose faecal impaction – look for overflow soiling and/or faecal mass palpable abdominally and/or rectally if indicated.

- **Start maintenance therapy if the child or young person is not faecally impacted**.

- Offer the following **oral** medication regimen for Disimpaction if indicated: (Table 4)

- Escalating dose of Polyethylene glycol 3350 + electrolytes (Movicol/Laxido), as the first-line treatment.

- Polyethylene glycol 3350 + electrolytes (Movicol) may be mixed with a cold drink.

- Add a stimulant laxative (Table 4) if Movicol does not lead to disimpaction after 2 weeks.

- Substitute a stimulant laxative singly or in combination with an osmotic laxative such as lactulose if Movicol is not tolerated.

- Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain.

- Do not use rectal medications for disimpaction unless all oral medications have failed and only if the child or young person and their family consent.

- Administer **sodium citrate enemas** only if all oral medications for disimpaction have failed.

- **Do not** administer phosphate enemas for disimpaction unless under specialist supervision in hospital/health centre, and only if all oral medications and sodium citrate enemas have failed.

- Consider manual evacuation under anaesthesia only when oral and rectal medications have failed.

- Review children and young people undergoing disimpaction within 1 week, to ensure that the "mass" has resolved.

9.2 Maintenance Therapy

- Start maintenance therapy as soon as the child or young person's bowel is disimpacted.

- Reassess children frequently during maintenance treatment to ensure they do not become reimpacted and assess issues in maintaining treatment such as taking medicine and toileting.

- Tailor the frequency of assessment to the individual needs of the child and their families (this could range from frequent contact to contact every few weeks). Where possible, reassessment should be provided by the same person/team.

- **Offer the following regimen for maintenance therapy**
    - **Polyethylene glycol** 3350 + electrolytes (such as Movicol or Laxido) as the first-line treatment.
    - Adjust the dose of polyethylene glycol 3350 + electrolytes according to symptoms and response.
    - As a guide for children and young people who have had disimpaction the starting maintenance dose might be half the disimpaction dose (table 4).
    - Add a **stimulant** laxative (table 4) if polyethylene glycol 3350 + electrolytes does not work.
    - Substitute a stimulant laxative if polyethylene glycol is not tolerated by the child or young person.
    - Add another laxative such as **lactulose** or **docusate** (table 4, appendix 4) if stools are hard.
    - Continue medication at maintenance dose for several weeks after regular bowel habit is established – this may take several months.
    - Children who are toilet training should remain on laxatives until toilet training is well established.
    - Do not stop medication abruptly: gradually reduce the dose over a period of months in response to stool consistency and frequency.
    - Some children may require laxative therapy for several years.

9.3 Diet and lifestyle

- Do not use dietary interventions alone as first-line treatment for idiopathic constipation.

- **Treat constipation with laxatives and a combination of:**
    - Negotiated and non-punitive behavioural interventions suited to the child or young person's stage of development. These could include:
        - Scheduled toileting and support to establish a regular bowel habit,

        - Maintenance and discussion of a bowel diary,
        - Information on constipation,
        - Use of encouragement and rewards systems.

    - Dietary modifications to ensure a balanced diet and sufficient fluids are consumed.

- **<u>Advise parents and children and young people (if appropriate) that a balanced diet should include:</u>**
    - Adequate fluid intake (table 5). A simple rule is minimum 8-10 glasses /day
    - Adequate fibre. Recommend including foods with a high fibre content (such as fruit, vegetables, high-fibre bread, baked beans and wholegrain breakfast cereals) (not applicable to exclusively breastfed infants).
    - Do not recommend unprocessed bran, which can cause bloating and flatulence and reduce the absorption of micronutrients.

    - Provide children and their families with written information about diet and fluid intake.

    - Consider cows' milk exclusion diet only on the advice of the relevant specialist services.

    - Advise daily physical activity that is tailored to the child or young person's stage of development and individual ability as part of maintenance therapy in idiopathic constipation.

9.4 Psychological interventions

- Do not use biofeedback for ongoing treatment in idiopathic constipation.

- Referral to CAMHS and psychologists should only be considered selectively.

9.5 Antegrade colonic enema procedure

- Refer children and young people with idiopathic constipation who still have unresolved symptoms on optimum management to a paediatric surgical centre to assess their suitability for an antegrade colonic enema (ACE) procedure.

- Ensure that all children and young people who are referred for an ACE procedure have access to support, information and follow-up from paediatric healthcare professionals with experience in managing children and young people who have had an ACE procedure.

9.6 Additional notes by the author of local guidance

9.6.1 ACE Procedure

- An invasive procedure that requires a high degree of compliance and tolerance by the patient. Therefore should only be considered in the very few after considerable assessment including ruling out non-adherence (non-compliance) with medications and other potential causes of treatment failure.

9.6.2 Trans-anal irrigation treatment (TAI)

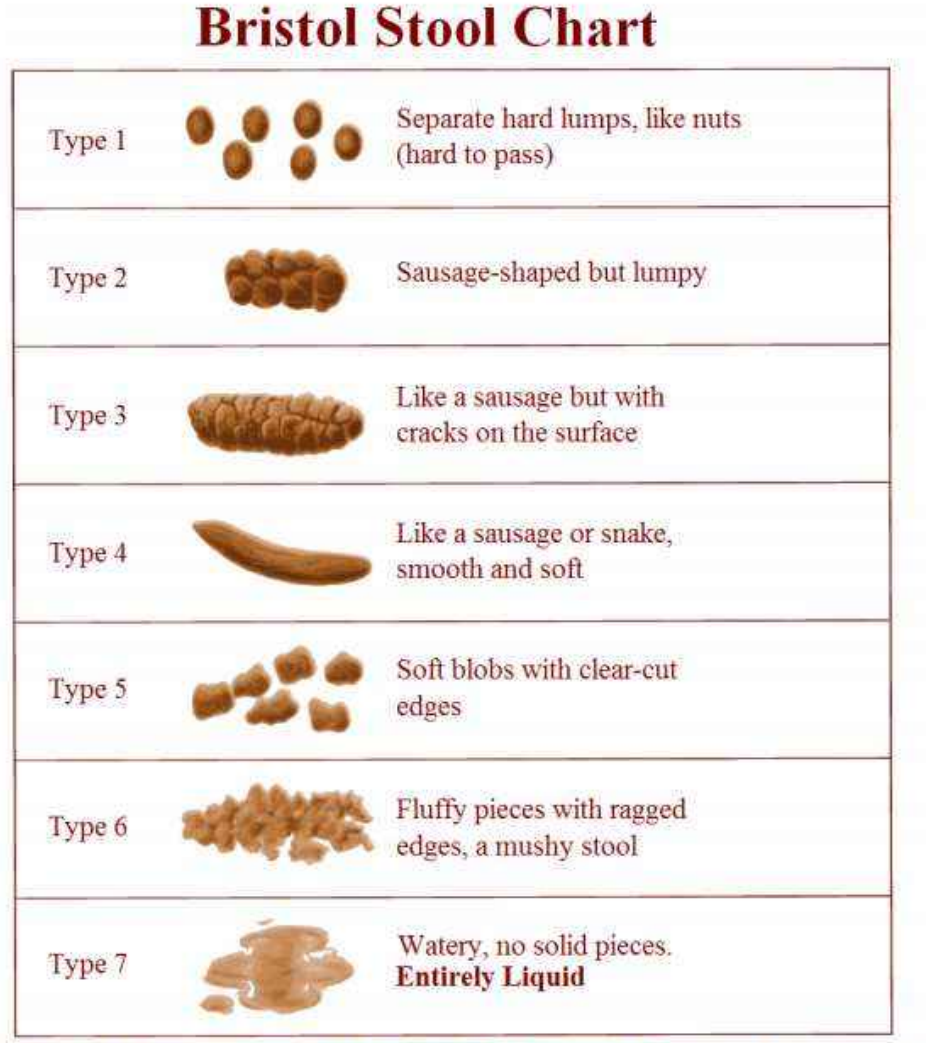
- Frequently used in Europe, but only just started to be used in the UK for adults and children with intractable constipation.
- The treatment was not referred to in NICE guidance, but appears to offer at least a non-invasive alternative to ACE procedure. With careful patient-selection, training, monitoring and support the treatment can be safe and valuable. In Merseyside several Continence Paediatric Nurse Advisory Services have good experience in its use and provide the service for carefully selected patients.
- ***Experts consensus review abstract***
  Paediatric patients with either functional or organic bowel dysfunction may suffer from constipation and fecal incontinence and represent a complex group in whom management is often difficult. Many non-invasive and invasive treatments have been proposed, with variable efficacy and adverse effects. Transanal irrigation (TAI) is now an accepted alternative, in both children and adults, for bowel dysfunction that has not responded to conservative and medical therapies. There is, however, still some uncertainty about the use of TAI in pediatric populations. Hence, a group of specialists from different nations and pediatric disciplines, all with long-standing experience of bowel management in children, performed a literature search and had round table discussions to determine the best-practice use of TAI in the pediatric patient population. Based on these findings, this article provides best-practice recommendations on indications, patient selection, important considerations before treatment, patient and family training, treatment regimens, troubleshooting, and practical aspects of TAI. We conclude that careful patient selection, a tailored approach, directly supervised training, and sustained follow-up are key to optimize outcomes with TAI in children with functional or organic bowel dysfunction.
  Reference:
  Consensus Review of Best Practice of Transanal Irrigation in Children
  Mosiello, Giovanni⁎; Marshall, David†; Rolle, Udo‡; Crétolle, Célia§; Santacruz, Bruno G.||; Frischer, Jason¶; Benninga, Marc A.#Author Information
  Journal of Pediatric Gastroenterology and Nutrition: March 2017 - Volume 64 - Issue 3 - p 343-352.
  doi: 10.1097/MPG.0000000000001483 (Open access)

10. Information and Support

10.1 Education

- Demystify the symptoms and provide the information leaflet.
- Not caused by psychological disturbance of the child's behaviour
- Remove negative attribution (Not the parent's or the child's fault)
- Child's refusal to sit on toilet is due to the painful defecation
- Soiling is involuntary and usually without the child's knowledge
- Aetiology is complex, and usually multifactorial.
- Explain the principles of management.
- Explain laxative's mode of action and emphasise their safety and very low rate of side effects.
- The course is likely to be protracted and subject to disappointing relapses

- Dietary advice - increasing fluid and fibre intake is important. But set achievable targets, as gradual change to healthy eating for the whole family is more likely to succeed.
- Provide tailored follow-up to children and young people and their parents or carers according to the child or young person's response to treatment, measured by frequency, amount and consistency of stools.
- Use the Bristol Stool Form Scale to assess this (Fig below).



First published: Lewis SJ, Heaton KW (1997) Stool form scale as a useful guide to intestinal transit time. Scandinavian Jorunal of Gastroenterology 32: 920–4

- Telephoning or face-to-face talks giving details on their condition and its management.
- Consider the 'Understanding NICE guidance' leaflet for this guideline giving verbal information supported by (but not replaced by) written or website information in several formats about how the bowels work, symptoms that might indicate a serious underlying problem, how to take their medication, what to expect when taking laxatives, how to poo, origins of constipation, criteria to recognise risk situations for relapse (such as worsening of any symptoms, soiling

etc.) and the importance of continuing treatment until advised otherwise by the healthcare professional.
- Provide copy of ***Trust Information Leaflet on 'Constipation and Soiling in Children'.***
- Offer children and their families a point of contact with specialist healthcare professionals, including school nurses, who can give ongoing support.
- Healthcare professionals should liaise with school nurses to provide information and support, and to help school nurses raise awareness of the issues surrounding constipation with children and young people and school staff.
- In primary care, refer children and young people with idiopathic constipation who do not respond to initial treatment within 3 months to a practitioner with expertise in the problem.

11. Additional advice by the author of the local guidance, which was not included in NICE guidance

11.1 Withdrawal of Laxatives

- May try gradual withdrawal every 6 months of regular bowel movement without soiling.
- Ensure regular and increasing fluid, cereal, fruit, vegetable and fibre intake.
- Ensure regular bowel training and follow up for at least 6 months after cessation of treatment.

11.2 Treatment Failure

- Check compliance. GP record of prescriptions over the past 6-12 months may help.
- If good compliance, consider other underlying or associated pathology.
- If good compliance, consider other treatment modalities.
- Involve other professionals: HV, GP, Continence Nurse Adviser, School nurse etc.

11.3 Prognosis and Outcome

- Up to 20% of patients may require laxatives for less than 6 months
- Up to 50% may achieve normal bowel habit without laxatives by 1 year
- Up to 70% may achieve normal bowel habit without laxatives by 2 years
- The rest may continue to relapse and require treatment for many years.

12. Training

What aspect/s of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Statutory & Mandatory Training Policy?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
	No training requirements specific to this guideline.					

13. Monitoring Compliance

13.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1.	Ensure monitoring of compliance with this guideline
2.	Investigate any adverse incidents related to this guideline
3.	Review the management of Constipation and Soiling via Audit

13.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Ensure monitoring of compliance with this guideline	Matron, Paediatric	Review of Datix reports	Monthly	Paediatric Clinical Governance Meeting. Children's & Neonatal Nurses Meeting MCG Integrated Governance	Lead Consultant for Gastroenterology
Investigate any adverse incidents related to this guideline	Matron, Paediatrics	Trust policies and Protocols for investigations of adverse incidents and serious incidents requiring investigation	As required	Paediatric Clinical Governance Meeting. Children's & Neonatal Nurses Meeting MCG Integrated Governance	Clinical Director and Directorate Manager, Paediatrics
Review the management of Constipation and Soiling via Audit	Consultant Paediatrician with special interest in gastroenterology	Audit	Within 2 years (by end of 2023)	Paediatric Audit Meeting	Consultant Paediatrician with special interest in gastroenterology

14. References/Bibliography/Relevant Legislation/National Guidelines

No	Reference
1.	Constipation in Childhood – NICE Guidelines 2010 (updated 2017). NG 99
2.	IMPACT – Constipation in Childhood Resource Management Package 2004
3.	*Consensus Review of Best Practice of Transanal Irrigation in Children Mosiello, Giovanni⁎; Marshall, David†; Rolle, Udo‡; Crétolle, Célia§; Santacruz, Bruno G.‖; Frischer, Jason¶; Benninga, Marc A.#Author Information Journal of Pediatric Gastroenterology and Nutrition: March 2017 - Volume 64 - Issue 3 - p 343-352. doi: 10.1097/MPG.0000000000001483 (Open access)*
4.	Trust Audit data "Constipation in children"

15. Related Trust Documents

No	Related Document
1.	Information Leaflet on 'Constipation and Soiling in Children'
2.	Multi-Agency Standard Operating Procedure for the Identification, Assessment and Management of Faltering Growth in Babies and Children

16. Equality Analysis Screening Tool

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Head of Patient Inclusion and Experience for monitoring purposes via the following email, cheryl.farmer@sthk.nhs.uk. If the assessment is related to workforce, a copy should be sent to the workforce Head of Equality, Diversity and Inclusion for workforce equality&diversity@sthk.nhs.uk

If this screening assessment indicates that discrimination could potentially be introduced, then seek advice from either the Head of Patient Inclusion and Experience or Head of Equality, Diversity (Workforce) and Inclusion.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	Paediatric Clinical Guideline for Constipation and Soiling in Childhood.
Brief description of function to be assessed	Guideline to ensure that children and young people with constipation and/or soiling are diagnosed and managed appropriately to achieve optimal outcomes.
Date of assessment	24/06/2024
Lead Executive Director	Medical Director
Name of assessor	Paeds Clinical Governance Guidelines Group
Job title of assessor	

Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to or will in practice, discriminate against equality groups
2) Promote equality of opportunity, or foster good relations between equality groups?
3) Where there is potential unlawful discrimination, is this justifiable?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Age	No	Yes	This guideline relates specifically to children and young people
Disability	No	No	
Gender reassignment	No	No	
Pregnancy or maternity	No	No	
Race	No	No	
Religion or belief	No	No	
Sex	No	No	
Sexual orientation	No	No	

Human Rights

Is the policy/proposal infringing on the Human Rights of individuals or groups?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Right to life	No	No	
Right to be free from inhumane or degrading treatment	No	No	
Right to Liberty/security	No	No	
Right to privacy/family life, home and correspondence	No	No	
Right to freedom of Thought/conscience	No	No	
Right to Freedom of expression	No	No	
Right to a fair trial	No	No	

Health Inequalities

Is the policy/proposal addressing health inequalities and are there potential or actual negative impact on health inequality groups, or positive impacts? Where there is potential unlawful impacts is this justifiable.

	Negative Impact	Positive Impact	Justification/ evidence and data source
Deprived Populations	No	No	
Inclusion health groups	No	No	
5 child clinical areas	No	No	
5 adult clinical areas	No	No	

Outcome

After completing all of the above sections, please review the responses and consider the outcome.

Is a full EIA required?	Yes ☐ No ☒ Please include rationale:

Sign off

Name of approving manager	Susan Thong
Job title of approving manager	Directorate Manager Paediatrics
Date approved	24/06/2024

17. Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		No		
Will the procedural document lead to the collection of new information about individuals?		No		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive?		No		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		No		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		No		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		No		
Will the implementation of the procedural document compel individuals to provide information about themselves?		No		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author **Consultant Paediatrician** **Date** **15/02/2024**