Constipation

What is it?

Constipation is the inability to pass stools regularly or empty the bowels completely.
It is referred to as idiopathic, if there are no underlying anatomical or physiological abnormalities.
The prevalence of idiopathic constipation is 5%- 30%.
Factors which contribute to idiopathic constipation include inadequate dietary fibre and fluid intake, toileting habits and psychological factors.

What should I do?

History:
Rome IV Diagnostic criteria for functional constipation: Must include 2 or more criteria for at least 1 month

1. ≤2 stools/week
2. History of retentive posturing or excessive volitional stool retention (i.e. withholding or incomplete evacuation)
3. History of painful or hard bowel movements
4. History of large-diameter stools
5. Presence of a large faecal mass in the rectum
6. At least 1 episode per week of soiling/incontinence after the acquisition of toileting skills
   After appropriate evaluation, the symptoms cannot be fully explained by another medical condition.

History and Examination	Diagnostic features of Idiopathic constipation vs Non-idiopathic constipation	NOT Idiopathic constipation 'Red flag' findings that indicate an underlying condition
Time of onset and potential precipitating factors	Starts after a few weeks of life Obvious precipitating factors: change of diet, timing of potty/toilet training or acute events such as infections, fissure, moving house, starting nursery/school, fears and phobias, major change in family.	Reported from birth or within first few weeks of life
Passage of meconium	Normal (within 48 hours after birth in term baby)	Failure/ delay to pass meconium (more than 48 hours after birth in term baby)
Stool patterns	Fewer than three complete stools per week Hard large stool 'Rabbit droppings' Overflow soiling	'Ribbon stools' (more likely in a child younger than 1 year)
Growth and wellbeing	Generally well, weight and height within normal limits, normal physical activity	Growth faltering, tiredness, frequent falling
Diet and fluid intake	History of poor diet and/or insufficient fluid intake	Vomiting
Inspection of perianal area	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, non-distended abdomen.	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 neurology	Normal gait, normal tone, power and reflexes in lower limbs,	Deformity in lower limbs such as talipes Abnormal neuromuscular signs unexplained by co-existing conditions like cerebral palsy

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C) INVESTIGATIONS: not routinely indicated.

- Coeliac screen and thyroid function tests: In refractory constipation, not responsive to medical management.
- X ray abdomen and Ultrasound abdomen are not indicated in idiopathic constipation.

D) MANAGEMENT:

- 3 key interventions are:
  - Laxatives
  - Dietary optimisation of fibre and fluid intake *(see Birmingham Community dietetics link below)*
  - Behavioural interventions including scheduled toileting and use of rewards systems.
- Provide tailored follow-up, verbal and written information and signposting to **www.eric.org.uk.**
- Early diagnosis and treatment are important to prevent chronic constipation with continence problems (including soiling), which can have a significant emotional impact on children and young people and carers.

LAXATIVE TREATMENT:

A) <u>MAINTENANCE REGIME:</u> is used in children without faecal loading or soiling and after successful disimpaction

1) First-line treatment: Macrogols (Movicol)

(Substitute with a stimulant laxative (Senna or Sodium Picosulfate or Docusate) if Macrogol is not tolerated)

2) Second line treatment: Add a stimulant laxative (Senna or Sodium Picosulfate or Docusate).

3) Third line treatment: Add another osmotic laxative such as lactulose

Continue medication at maintenance dose for several weeks after regular bowel habit is 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. Reassure parents and carers that laxatives do not lead to a 'lazy' bowel. Children who are toilet training should remain on laxatives until toilet training is well established.

B. <u>DISIMPACTION REGIME:</u> is used in Faecal impaction
Movicol or alternative Macrogol

When should I refer?

- Symptoms from birth or first few weeks of life
- Failure/delay to pass meconium (more than 48 hours after birth in a term baby)
- Abnormal perianal examination
- Abnormal lower limb neurology
- Abnormal lumbo-sacral spine examination
- Severe abdominal distension
- Faltering growth
- Lower limb weakness or motor delay
- Significant concern about a possible underlying cause such as coeliac disease
- Infant under 1 year failing to respond to treatment within 1 month*
- Children over 1 year failing to respond after 3 months of treatment*
- Failure to respond after 2 weeks of disimpaction treatment*

*** poor compliance is the most common reason for treatment failure**

Resources:

- NICE Clinical guideline updated July 2017: Constipation in children and young people: diagnosis and management (CG99)
- www.eric.org.uk: excellent resource for parents and young people
- British Dietetic Association https://www.bda.uk.com
- www.bhamcommunity.nhs.uk/patients-public/adults/nutrition/links-and-resources/#paediatric-leaflets