## Document Details

<table>
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<tr>
<th>Title</th>
<th>Constipation Guidelines for Children and Young People Diagnosis and Management of Idiopathic Childhood Constipation</th>
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<tbody>
<tr>
<td>Trust Ref No</td>
<td>1587-33217</td>
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<tr>
<td>Local Ref (optional)</td>
<td></td>
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<tr>
<td>Main points the document covers</td>
<td>Guidance on how to treat constipation in children</td>
</tr>
<tr>
<td>Who is the document aimed at?</td>
<td>Community Paediatricians, Community Children’s Nurses, School Nurses, Health Visitors, Paediatric Psychologists, CAMHS-LD</td>
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<tr>
<td>Owner</td>
<td>Jo Winterton - Community Children’s Nurse</td>
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## Approval process

<table>
<thead>
<tr>
<th>Approved by (Committee/Director)</th>
<th>Clinical Policy Group, Medicines Management</th>
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<tbody>
<tr>
<td>Approval Date</td>
<td>14 October 2016</td>
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<tr>
<td>Initial Equality Impact Screening</td>
<td>Yes</td>
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<td>Full Equality Impact Assessment</td>
<td>No</td>
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<tr>
<td>Lead Director</td>
<td>Director of Nursing &amp; Operations</td>
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<tr>
<td>Category</td>
<td>Clinical</td>
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<td>Sub Category</td>
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<td>Review date</td>
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## Distribution

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<tr>
<th>Who the policy will be distributed to</th>
<th>Community Paediatricians, Community Children’s Nurses, School Nurses, Health Visitors, Paediatric Psychologists, CAMHS-LD Paediatric Occupational therapists.</th>
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<tbody>
<tr>
<td>Method</td>
<td>Electronically via managers / Datix, available to all staff via Trust Website and Key clinicians</td>
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## Document Links

<table>
<thead>
<tr>
<th>Required by CQC</th>
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<td>Required by NHLSA</td>
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## Amendments History

<table>
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<tr>
<td>1</td>
<td>July 2010</td>
<td>T&amp;W policy version 2.2</td>
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<tr>
<td>2</td>
<td>27.12.12</td>
<td>Updated to Trust standard</td>
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<td>3</td>
<td>Sept 2016</td>
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Contents

1 Introduction .................................................................................................................. 3
2 Purpose ......................................................................................................................... 3
3 Definitions .................................................................................................................. 3
4 Duties .......................................................................................................................... 4
  4.1 Divisional Manager, Children and Families Services ............................................. 4
  4.2 Children’s Services ................................................................................................. 4
  4.3 Health Care Professionals .................................................................................... 4
  4.4 Line Managers ....................................................................................................... 4
  4.5 Committees and Groups ....................................................................................... 4
5 Guidance ....................................................................................................................... 4
  5.1 Assessment and Diagnosis .................................................................................... 4
  5.2 Digital Rectal Examination .................................................................................. 5
6 Management .................................................................................................................. 5
  6.1 Diet and Lifestyle .................................................................................................... 5
  6.2 Medication ................................................................................................................ 7
  6.3 Non Medical Prescribing ...................................................................................... 8
  6.4 Information and Support ....................................................................................... 8
7 Consultation ................................................................................................................ 9
8 Dissemination and Implementation ........................................................................... 9
9 Advice and Training .................................................................................................... 9
10 Monitoring Compliance ........................................................................................... 9
11 Related Documents ................................................................................................ 10
12 References ................................................................................................................ 10
Appendix 1 - Referral Pathway: When a Child Has Been Identified with Constipation ............................................................................................................................. 11
Appendix 2 - Glossary .................................................................................................... 12
Appendix 3 - Key components of history taking to diagnose constipation ................. 15
Appendix 4 - Key components of history taking to diagnose idiopathic constipation 16
Appendix 5 - Key components of physical examination to diagnose idiopathic
  constipation .................................................................................................................... 17
Appendix 6 – History-taking and Physical Examination ............................................. 18
Appendix 7 - America dietary recommendations (Institute of Medicine 2005) ............ 19
Appendix 8 - Laxatives: recommended doses in NICE guidelines .............................. 20
Appendix 9 - Bristol Stool Chart ................................................................................. 22
Appendix 10 - Nurse Led Clinic .................................................................................. 23
Appendix 11 - Constipation Referral Form to Nurse Led Clinic (T&W GPs ONLY) .. 24
1 Introduction
Constipation is common in childhood; it is prevalent in around 5-30% of the child population. Symptoms become chronic in more than one third of patients.

The exact cause of constipation is not fully understood, factors that may contribute include pain, fever, dehydration, dietary and fluid intake, psychological issues, toilet training and familial history of constipation. Constipation is referred to as ‘idiopathic’ if it cannot be explained by anatomical or physiological abnormalities.

Many people don’t recognize the signs and symptoms of constipation and few relate the presence of soiling to constipation. Soiling is debilitating and many children experience social, psychological and educational consequences that require prolonged support.

Without early diagnosis and treatment, an acute episode can lead to anal fissure and may become chronic. By the time the child is seen they may be in a vicious cycle of symptoms and physical sequelae.

Children and families are often given conflicting advice and practice is inconsistent, making treatment potentially less effective and frustrating for all concerned.

Early identification of constipation and effective treatment can improve outcomes for children.

These guidelines will ensure that children with constipation receive a standard of care/information that is evidence based and encompasses the NICE recommendations (NICE May 2010)

Implementation of this guideline will ensure that children are managed in accordance with best practice advice; it will provide a consistent co-ordinated approach and will improve outcomes for children.

Within Shropshire Community Health NHS Trust (SCHT) a referral pathway has been developed for children who have idiopathic childhood constipation and Telford & Wrekin GPs are able to access the nurse led children’s constipation clinic. For children with developmental/physical disabilities please see Appendix 1.

Children who have a Shropshire County GP should also follow the pathway. If improvements are not made after 6 months of optimum treatment Health Care Professional (HCP) can ring the children’s constipation service for advice and support. Training is also available as needed.

2 Purpose
To give clear guidelines for childhood constipation for evidence based practice and best practice and to comply with NICE guidelines. This guideline applies to all healthcare professionals who are routinely involved with children who have constipation and soiling issues.

3 Definitions
4 Duties

4.1 Divisional Manager, Children and Families Services
The Divisional Manager is responsible for ensuring managers and staff are aware of the guidelines.

4.2 Children’s Services
The Childhood Constipation Service is responsible for:
- Providing advice and guidance about the guideline
- Providing specific training for all HCPs regarding the guideline
- Keeping the policy up to date

4.3 Health Care Professionals
All HCPs to follow guidelines, and to access training as needed.

4.4 Line Managers
Line managers are responsible to ensure that:
- All staff are aware of the guidelines;
- Staff access any training needed;
- Incident reports relating to topics covered in these guidelines are raised.

4.5 Committees and Groups
The Quality and Safety Group for children and young people is responsible for ensuring any incidents relating to guidelines are actioned and followed up and these guidelines are reviewed.

5 Guidance

5.1 Assessment and Diagnosis
All practitioners should follow the flow chart – “History-taking and Physical Examination” shown in Appendix 6

Establish during history-taking whether the child has constipation. If two or more findings are identified from Appendix 3 “Key components of history taking to diagnose constipation”, with symptoms lasting for more than 1 month, this indicates constipation.

If the child has constipation, take a history using Appendix 4 “Key components of history taking to diagnose idiopathic constipation” to establish a positive diagnosis of idiopathic constipation by excluding underlying causes.

Complete a physical examination if the practitioner is competent and qualified to do so. Use Appendix 5 “Key components of physical examination to diagnose idiopathic constipation” to establish a positive diagnosis of idiopathic constipation by excluding underlying causes.

If a child has any ‘red flag’ symptoms see Appendix 4 do not treat them for constipation. Instead, refer them urgently to a HCP with experience in the specific aspect of child health that is causing concern.

If the history-taking and/or physical exam shows evidence of faltering growth, treat for constipation and test for coeliac disease and hypothyroidism.
If either the history taking or the physical examination show evidence of possible maltreatment refer to ‘When to suspect child maltreatment’, NICE clinical guideline 89 (2009).

If the physical examination shows evidence of perianal streptococcal infection, treat for constipation and also treat the infection.

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

5.12 Digital Rectal Examination
A digital rectal examination should be undertaken only by HCP competent to interpret features of anatomical abnormalities or Hirschsprung’s disease.

If a child younger than 1 year has a diagnosis of idiopathic constipation that does not respond to adequate treatment within 4 weeks, refer them urgently to a healthcare professional competent to perform a digital rectal examination and interpret features of anatomical abnormalities or Hirschsprung’s disease.

Do not perform a digital rectal examination in children or young people older than 1 year with a ‘red flag’ (see Appendices 4 & 5) in the history-taking and/or physical examination that might indicate an underlying disorder. Instead, refer them urgently to a healthcare professional competent to perform a digital rectal examination and interpret features of anatomical abnormalities or Hirschsprung’s disease.

6 Management
Written information to be given to families, leaflets utilised are:
• Talking about constipation
• Understanding childhood constipation
• Understanding toilet refusal – the child who will only poo in a nappy
http://www.disabledliving.co.uk/DISLIV/media/promocon/leaflet_only_poo_in_a_nappy.pdf
• Promoting healthy bowels. Preventing constipation in children
http://www.disabledliving.co.uk/DISLIV/media/publicationpdf/healthybowels2006.pdf

6.1 Diet and Lifestyle
Do not use dietary interventions alone as first – line treatment for childhood constipation.

6.1.1 Diet and Fluids
Advise parents and children that a balanced diet should include:
• whole grains, fruits, and vegetables. This is recommended as part of the treatment for constipation. It is also recommended for general health and promoted by the ‘five-a-day’ policy.
- A high fibre diet is recommended, but may be difficult to achieve.
- Fruits (dried or fresh) and fruit juices
- Although the effects of a high fibre diet may be seen in a few days, it may take as long as 4 weeks.
- Adequate fluid intake is important (particularly with a high fibre diet), but can be difficult for some children.
- Do not recommend unprocessed bran, which can cause bloating and flatulence and reduce the absorption of micronutrients.

High fibre foods:
- Beans, lentils and peas
- Fresh and dried fruits - particularly if the skins are eaten
- Vegetables - particularly if the skins are eaten
- Nuts and seeds
- Wholemeal and granary breads
- Jacket potatoes
- Wholegrain breakfast cereals
- Wholemeal pasta and brown rice

6.1.2 Adequate Fluid Intake
Provide children and their families with written information about diet and fluid intake. Please see Appendix 7. America dietary recommendations (Institute of Medicine 2005 (cited in NICE 2010)

6.1.3 Exercise
Advise 60 minutes of physical activity per day, which is tailored to the child’s stage of development and individual ability (NICE 2010).

6.1.4 Psychological and Behavioural Interventions
Negotiated and non-punitive behavioural interventions suited to the child’s stage of development, e.g. keeping a bowel diary, encouragement, praise and reward systems, scheduled toileting to support a regular bowel habit where appropriate.

NICE guidance recommendation¹ is that you do not routinely refer children with idiopathic constipation to the psychology service unless they have an identified psychological need. It acknowledges that a referral for psychological issues related to idiopathic constipation in children may be beneficial and cost effective where there is psychological distress related to the symptoms of constipation, and/or family difficulties that maintain or exacerbate the constipation. Psychological and behavioural interventions are effective only when the child is on effective laxative medication and when the outcome sought are negotiated with both parent and child as being achievable.

The Paediatric Psychology Service in Shropshire provide a valued service to the nurse led children’s constipation service, but do not accept referrals for constipation directly. All referrals must be directed via the Community Children’s Nursing team. Please discuss with service manager and/or Children and Adolescents Mental Health Service CAMHS for advice.

Children and adolescents with a learning disability showing toileting related behaviours (eg soiling, holding and smearing) where symptoms have persisted for

longer than 3 months, a referral to CAMHS Learning Disabilities (CAMHS LD) can be made by HCP in line with CAMHS Referral Guidelines and Care Pathway.

6.2 Medication

- Assess all children with idiopathic constipation for faecal impaction, including children who were referred because of ‘red flags’ but in whom there were no significant findings following further investigations (see Appendices 3 - 8). 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. See section 6.2.1 below

Use the following oral medication regimen for disimpaction if indicated:

- Use polyethylene glycol ‘3350’ + electrolytes using an escalating dose regimen (see Appendix 3) as the first-line treatment. Polyethylene glycol ‘3350’ + electrolytes may be mixed with a cold drink.
- Add a stimulant laxative (see Appendix 8 if polyethylene glycol ‘3350’ + electrolytes does not lead to disimpaction after 2 weeks.
- Substitute a stimulant laxative singly or in combination with an osmotic laxative such as lactulose (see Appendix 3) if polyethylene glycol ‘3350’ + electrolytes is not tolerated.
- Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain.

All drugs listed in Appendix 8 are given by mouth unless stated otherwise.

- 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 have failed.
- Do not administer phosphate enemas for disimpaction unless under specialist supervision in hospital/healthcare/clinic, and only if all oral medication and sodium citrate enemas have failed.
- Do not perform manual evacuation of the bowel under anesthesia unless optimal treatment with oral and rectal medications has failed.
- Review children and young people undergoing disimpaction within one week.

6.2.1 Maintenance Therapy

Start maintenance therapy as soon as the child's bowel is disimpacted, see Appendix 4.

Reassess children frequently during maintenance therapy 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 daily contact to contact every few weeks). Where possible, reassessment should be provided by the same person/team.

Regime

- Use polyethylene glycol ‘3350’ and electrolytes as first line treatment.
• Adjust the dose of polyethylene glycol ‘3350’ and electrolytes according to symptoms and response (see Appendix 8)
• Add stimulant laxative (see Appendix 8) if polyethylene glycol ‘3550’ and electrolytes does not work.
• Substitute a stimulant laxative if polyethylene glycol ‘3550’ and electrolytes is not tolerated by the child. Add another laxative such as Lactulose or Docusate (see Appendix 8) 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 not toilet trained should remain on laxatives until toilet training 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.

6.3 Non Medical Prescribing

• Non Medical Prescribing is supported by Trust Policy 10473 “Medicines Policy Part 6 – Non Medical Prescribing
• In England, non medical prescribers can prescribe any licensed medicine, for any medical condition, “within their own level of professional competence and expertise
• The British National Formulary for Children draws information from manufacturers’ literature where appropriate, and includes a great deal of advice that goes beyond marketing authorisations eg product licences (Paediatric Formulary Committee 2016).
• Nurse and pharmacist independent prescribers can prescribe medicines outside their licensed indications (so called “Off licence” or “off label” use), and unlicensed medicines where this is acceptable clinical practice and there is a body of evidence to support this practice. They must however, accept professional, clinical and legal responsibility for that prescribing. When prescribing ‘off label’ the prescriber should explain the situation to the patient/guardian, where possible, but where a patient is unable to agree to such treatment, the prescriber should act in accordance with best practice in the given situation and within the policy of their employing organisation (Trust Policy 10305 “Consent to Examination or Treatment Policy”).

6.4 Information and Support

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, see Appendix 9). This could include:

• Telephoning or face-to-face talks.
• Giving detailed evidence-based information about their condition and its management, this might include, for example, the ‘Understanding NICE guidance’ leaflet for children with constipation (www.nice.org.uk).
• 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.
Offer children and young people with idiopathic constipation and their families a point of contact with specialist HCP, 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.

7 Consultation
This guideline was distributed to the following groups for consultation and Comment:

- Acute Paediatricians – Dr Ayub and Dr Abdu
- Community Paediatricians – Dr Ganesh
- Clinical Service Managers
  - Mrs S Crighton Children’s Community Nursing
  - Mrs G Bowyer Health Visiting
- Consultant Nurse for children with complex care – Mrs N Kular
- School Nursing Lead - Mrs K Poole,
- Community Children’s Nurses Team leaders
  - Mrs T Grocott
  - Mrs L Leather
- Community Children’s Nurses – Mrs J Winterton
- Special School Nurses
  - Mrs B Young
  - Mrs K Myles
- Paediatric Clinical Psychology – Mrs H Griggs
- Clinical Policies Group members – Dr E Peer

8 Dissemination and Implementation
These guidelines will be disseminated by the following methods:

- Divisional Managers – to disseminate to managers in all areas.
- Specialist areas – raise awareness within teams in team meetings.
- Staff - via Datix
- Published to the Trust Website

9 Advice and Training
Training will be available and advertised via the Trust web site as Paediatric Continence update.
The Childhood Constipation service is available to give advice and support on the guidelines and will arrange appropriate ad-hoc training as required; this is for all Telford & Wrekin and Shropshire. Contact details are below.

The Constipation Service
Shropshire Community Health NHS Trust
Coral House, 11 Longbow Close, Harlescott Lane
Shrewsbury, Shropshire, SY1 3GZ
Tel: 01743 450855 & Fax: 01743 450801

10 Monitoring Compliance
The Constipation Service will review these guidelines every three years, and distributed to professionals referenced in Section 7 above for approval.
Compliance Monitoring is completed periodically by Shropshire Community Health NHS Trust by Incident reporting and Audits.

11 Related Documents
The following documents contain information that relates to these guidelines:

- Non-medical Prescribing Policy
- Community Children’s Nursing Service Constipation Service leaflet.

12 References
- NICE Guidance 90 (July 2009).
- IMPACT II Paediatric Bowel Care Pathway (Sept 2008).
- Bristol Stool Form Scale produced by Dr K W Heaton, Reader in Medicine at the University of Bristol. © 2000 Norgine Pharmaceuticals Ltd.
Appendix 1 - Referral Pathway: When a Child Has Been Identified with Constipation

When a child has been identified with idiopathic constipation by a HCP (eg. GP, Paediatrician, School Nurse, Health Visitor) SCHT’s Constipation referral pathway should be followed.

**Children**

GP, School Nurse, Health Visitor, Community Children’s Nurse

Organic Constipation

Idiopathic (Functional) Constipation

Assess, Advice and Treat

Refer to School Nurse / Health Visitor

Follow up regular review

If no improvement after 6 months

Discharge

* Child with identified learning disability with additional behavioural/soiling complications, such as smearing, holding, refer to Learning Disability Team

**Telford & Wrekin**

Nurse led constipation clinic (CCN) only T&W (Appendix 10 & 11) *

Review within nurse led service

Refer to secondary care, if no improvement or red flags

Discharge

**Shropshire**

Ensure child has had optimum treatment and advice for full 6 months

Ring Children’s constipation Service for advice

Refer to secondary care if no improvement or red flags

Discharge
<table>
<thead>
<tr>
<th>Term / Abbreviation</th>
<th>Explanation / Definition</th>
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<tr>
<td>Acute constipation</td>
<td>Self-limiting constipation.</td>
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<tr>
<td>Allergic proctitis</td>
<td>Proctitis is an inflammation of the rectum. Allergic proctitis is inflammation attributed to allergic causes. The causes of the allergies have been attributed mostly to dietary proteins.</td>
</tr>
<tr>
<td>Anal stenosis</td>
<td>A narrowing of the anus which results in a reduced lumen and particularly a loss of the capacity to dilate with passage of faeces. Straining, passage of ribbon-like faeces and constipation result.</td>
</tr>
<tr>
<td>Anal wink</td>
<td>The reflex contraction of the external anal sphincter</td>
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<tr>
<td>Antegrade colonic enema (ACE) procedure</td>
<td>A surgical procedure in which a channel is created into the caecum in the large intestine. This allows a catheter to be inserted and the bowel to be washed out. Sometimes known as Malone antegrade colonic enema (MACE) procedure.</td>
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<tr>
<td>Anteriorly placed anus</td>
<td>A congenital malformation in which the anus is malpositioned.</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Treatment method involving teaching the individual how to relax the external anal sphincter during straining. Treatment modalities include manometric and electromyographic biofeedback.</td>
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<td>CAMHS</td>
<td>Children and Adolescents Mental Health Services</td>
</tr>
<tr>
<td>Chronic constipation</td>
<td>Constipation lasting longer than 8 weeks.</td>
</tr>
<tr>
<td>Colony - forming unit (CFU)</td>
<td>A measure of viable (living) bacterial or fungal cells numbers. Results are given as CFU/ml (colony-forming units per millilitre) for water, and CFU/g (colony-forming units per gram) for soil or other porous material.</td>
</tr>
<tr>
<td>Constipation</td>
<td>A term to describe the subjective complaint of passage of abnormally delayed or infrequent passage of dry, hardened faeces often accompanied by straining and/or pain.</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>The frequent passage of loose or watery stools, usually accompanied by abdominal cramping and urgency.</td>
</tr>
<tr>
<td>Disimpaction</td>
<td>The evacuation of impacted faeces.</td>
</tr>
<tr>
<td>Encopresis</td>
<td>Deliberate defecation in an inappropriate place. This is not to be confused with soiling.</td>
</tr>
<tr>
<td>Faecal impaction</td>
<td>Severe constipation with a large faecal mass in either the rectum or the abdomen, and/or overflow soiling.</td>
</tr>
<tr>
<td>Faecal incontinence</td>
<td>The involuntary leakage of faeces.</td>
</tr>
<tr>
<td>Term / Abbreviation</td>
<td>Explanation / Definition</td>
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<td>--------------------</td>
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<tr>
<td>Functional constipation</td>
<td>See idiopathic constipation.</td>
</tr>
<tr>
<td>HCPs</td>
<td>Health Care Professionals</td>
</tr>
<tr>
<td>Hirschsprung’s disease</td>
<td>A congenital abnormality in which the nerve cells in a section of the bowel are not present. As a result, faeces can become trapped in the bowel.</td>
</tr>
<tr>
<td>Idiopathic constipation</td>
<td>Constipation is termed idiopathic when it cannot (currently) be explained by any anatomical, physiological, radiological or histological abnormalities. The exact aetiology is not fully understood but it is generally accepted that a combination of factors may contribute to the condition.</td>
</tr>
<tr>
<td>Intractable constipation</td>
<td>Constipation which does not respond to sustained, optimum medical management.</td>
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<tr>
<td>Kerckring folds</td>
<td>Circular folds projecting into the lumen of the small bowel composed of reduplications of the mucous membrane.</td>
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<tr>
<td>MDT</td>
<td>Multi-disciplinary Team.</td>
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<tr>
<td>Macrogols</td>
<td>A form of osmotic laxative. PEG 3350 and PEG 4000 are examples of macrogols.</td>
</tr>
<tr>
<td>Megacolon</td>
<td>An abnormally enlarged colon that can be congenital (as in Hirschsprung’s disease) or acquired (as in chronic constipation).</td>
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<tr>
<td>Megarectum</td>
<td>A large rectum as a result of underlying nerve supply, abnormalities or muscle dysfunction, often as a result of chronic faecal loading which remains after disimpaction of the rectum. The cause of the megarectum is unknown, but onset in childhood may be the result of chronic stool holding by the child, leading to progressive distension of the rectum and eventual loss of awareness of rectal distension. Once this has occurred the patient can no longer recognize when stool is present in the rectum; the distension of the rectum causes chronic inhibition of the resting tone of the internal anal sphincter. This leads to the loss of control of liquid or semisolid stool that passes by the faecal impaction without the patient being aware of it.</td>
</tr>
<tr>
<td>Organic constipation</td>
<td>Constipation is termed organic when there is an identifiable physiological or anatomical cause.</td>
</tr>
<tr>
<td>Osmotic laxatives</td>
<td>Laxatives which increase the amount of water in the faeces thereby making them softer.</td>
</tr>
<tr>
<td>Patulous anus</td>
<td>Widely patent anal orifice.</td>
</tr>
<tr>
<td>Rectoanal inhibitory reflex (RAIR)</td>
<td>Relaxation of the internal anal sphincter in response to increased pressure of stool, gas or liquid entering the rectum. If voluntary muscle action occurs, the rectum empties through the anal canal. This reflex is...</td>
</tr>
<tr>
<td>Term / Abbreviation</td>
<td>Explanation / Definition</td>
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<tr>
<td>absent in cases of congenital megacolon.</td>
<td></td>
</tr>
<tr>
<td>Retentive posturing</td>
<td>Typical straight legged, tiptoed, back arching posture.</td>
</tr>
<tr>
<td>ROME (II &amp; III) criteria</td>
<td>The Rome criteria is a system developed to classify functional gastrointestinal disorders (FGIDs): disorders of the digestive system in which symptoms cannot be explained by the presence of structural or tissue abnormality, based on clinical symptoms. Some examples of FGIDs include irritable bowel syndrome, functional dyspepsia, functional constipation, and functional heartburn. The most recent revision of the criteria, the Rome III criteria, was published in 2006. Further details can be found on the website: <a href="http://www.romecriteria.org">www.romecriteria.org</a> <a href="http://www.romecriteria.org/assets/pdf/19_RomeIII_apA_885-898.pdf">http://www.romecriteria.org/assets/pdf/19_RomeIII_apA_885-898.pdf</a></td>
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<tr>
<td>SSCYP</td>
<td>Specialist Services for Children &amp; Young People</td>
</tr>
<tr>
<td>Side effects / adverse effects</td>
<td>An undesired effect resulting from treatment.</td>
</tr>
<tr>
<td>Smearing</td>
<td>The intentional spreading of faeces.</td>
</tr>
<tr>
<td>Soiling</td>
<td>Involuntary passage of fluid or semi solid stool into clothing as a result of overflow from a faecally loaded bowel.</td>
</tr>
<tr>
<td>Specialist services / specialist advice / specialist care / specialist management</td>
<td>Services/advice/care/management provided by health care professionals with expertise in constipation management in children and young people.</td>
</tr>
<tr>
<td>Stimulant laxatives</td>
<td>Laxatives which increase bowel motility.</td>
</tr>
<tr>
<td>SCHT</td>
<td>Shropshire Community Health NHS Trust</td>
</tr>
</tbody>
</table>
### Appendix 3 - Key components of history taking to diagnose constipation

<table>
<thead>
<tr>
<th>Key Components of History Taking</th>
<th>Potential findings in a child younger than 1 year</th>
<th>Potential findings in child/young person older than 1 year</th>
</tr>
</thead>
</table>
| **Stool patterns**              | ▪ Fewer than three complete stools per week (type 3 or 4, see Bristol Stool Form Scale – appendix 6) (this does not apply to exclusively breastfed babies after 6 weeks of age)  
▪ Hard large stool  
▪ Rabbit droppings (type 1, see Bristol Stool Form Scale – appendix 6) | ▪ Fewer than three complete stools per week (type 3 or 4, see Bristol Stool Form Scale – appendix 6)  
▪ 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 – appendix 6)  
▪ Large, infrequent stools that can block the toilet |
| **Symptoms associated with defaecation** | ▪ Distress on stooling  
▪ Bleeding associated with hard stool  
▪ Straining | ▪ Poor appetite that improves with passage of 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 |
## Appendix 4 - Key components of history taking to diagnose idiopathic constipation

<table>
<thead>
<tr>
<th>Key components of history taking</th>
<th>Potential findings and diagnostic clues that indicate idiopathic constipation</th>
<th>Potential findings and diagnostic clues in a child/young person older than 1 year</th>
</tr>
</thead>
</table>
| 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 and 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]) | Red Flag: Failure to pass meconium/delay (more than 48 hours after birth [in term baby]) |
| Stool patterns | | Red Flag: ‘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

**Growth and general wellbeing:**
- Faltering growth (see recommendation on faltering growth, below)

**Personal/familial/social factors:**
- Disclosure or evidence that raises concerns over possibility of child maltreatment (see recommendation on possible maltreatment, below)
## Appendix 5 - Key components of physical examination to diagnose idiopathic constipation

<table>
<thead>
<tr>
<th>Key components</th>
<th>Findings and diagnostic clues that indicate idiopathic constipation</th>
<th>‘Red flag’ findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection of perianal area: appearance, position, patency, etc</td>
<td>Normal appearance of anus and surrounding area</td>
<td>Abnormal appearance/position/patency of anus: fistulae, bruising, multiple fissures, tight or patulous anus, anteriorly placed anus, absent anal wink</td>
</tr>
<tr>
<td>Abdominal examination</td>
<td>Soft abdomen. Flat or distension that can be explained because of age or overweight child</td>
<td>Gross abdominal distension</td>
</tr>
<tr>
<td>Spine/lumbosacral region/gluteal examination</td>
<td>Normal appearance of the skin and anatomical structures of lumbosacral/gluteal regions</td>
<td>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</td>
</tr>
<tr>
<td>Lower limb neuromuscular examination including tone and strength</td>
<td>Normal gait. Normal tone and strength in lower limbs</td>
<td>Deformity in lower limbs such as Talipes Abnormal neuromuscular signs unexplained by any existing condition, such as cerebral palsy</td>
</tr>
<tr>
<td>Lower limb neuromuscular examination: reflexes (perform only if ‘red flags’ in history or physical examination suggest new onset neurological impairment)</td>
<td>Reflexes present and of normal amplitude</td>
<td>Abnormal reflexes</td>
</tr>
</tbody>
</table>
Appendix 6 – History-taking and Physical Examination

Establish constipation
Two or more symptoms from Appendix 3 indicate constipation

Establish idiopathic constipation and exclude underlying causes
Take a history to exclude or identify any red flags from Appendix 4
Do a physical examination to exclude or identify any red flags from Appendix 5

Amber flag found (page 6)
No red or amber flags found

Inform about diagnosis of idiopathic constipation
Inform the child/young person and his/her carers that underlying causes have been excluded by the history and/or physical exam
Reassure them that there is a suitable treatment but it may take several months for the condition to be resolved

Assess for faecal impaction
Assess all children and young people with idiopathic constipation for faecal impaction, including those originally referred for red flags but in who there were no significant findings (Appendix 4 and 5)
Use a combination of history taking and physical examination to diagnosis faecal impaction – look for overflow soiling and/or faecal mass palpable abdominally and/or rectally if indicated

Red flag found
Go to “investigate possible underlying causes”
No significant findings from red flags

Go to Management (page 5)
### Appendix 7 - America dietary recommendations (Institute of Medicine 2005)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total water intake per day, including water contained in food</th>
<th>Water obtained from drinks per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants 0–6 months</td>
<td>700 ml assumed to be from breast milk</td>
<td></td>
</tr>
<tr>
<td>7–12 months</td>
<td>800 ml from milk and complementary foods and beverages</td>
<td>600 ml</td>
</tr>
<tr>
<td>1–3 years</td>
<td>1300 ml</td>
<td>900 ml</td>
</tr>
<tr>
<td>4–8 years</td>
<td>1700 ml</td>
<td>1200 ml</td>
</tr>
<tr>
<td>Boys 9–13 years</td>
<td>2400 ml</td>
<td>1800 ml</td>
</tr>
<tr>
<td>Girls 9–13 years</td>
<td>2100 ml</td>
<td>1600 ml</td>
</tr>
<tr>
<td>Boys 14–18 years</td>
<td>3300 ml</td>
<td>2600 ml</td>
</tr>
<tr>
<td>Girls 14–18 years</td>
<td>2300 ml</td>
<td>1800 ml</td>
</tr>
</tbody>
</table>
### Appendix 8 - Laxatives: recommended doses in NICE guidelines

<table>
<thead>
<tr>
<th>Laxatives</th>
<th>Recommended Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Macrogols</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Polyethylene glycol 3350 + electrolytes | **Paediatric formula:** oral powder: macrogol 3350 (polyethylene glycol 3350) 6.563g; sodium bicarbonate 89.3mg; sodium chloride 175.4mg; potassium chloride 25.1mg/sachet.  
**Disimpaction**  
| Child under 1 year: ½ to 1 sachet daily  
| Child 1–5 years (treat until impaction resolves) 2 sachets on 1st day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily  
| Child 5–12 years: (treat until impaction resolves) 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 12 sachets daily  

Administration: Mix each sachet in quarter of a glass (approx 60-65mL) of water: total daily dose to be taken over a 12 hour period.  
**Ongoing maintenance** (chronic constipation, prevention of faecal impaction)  
| Child under 1 year: ½ to 1 sachet daily  
| Child 1–6 years: 1 sachet daily; adjust dose to produce regular soft stools (maximum 4 sachets daily)  
| Child 6–12 years: 2 sachets daily; adjust dose to produce regular soft stools (maximum 4 sachets daily)  

Administration: Mix content of each sachet in quarter of a glass (approx 60-65mL) of water.  
**Adult formula:** oral powder: macrogol 3350 (polyethylene glycol 3350) 13.125g; sodium bicarbonate 178.5mg; sodium chloride 350.7mg; potassium chloride 46.6mg/sachet (unflavoured).  
**Disimpaction**  
| Child/young person 12–18 years: 8 sachets daily usually for a maximum of 3 days  

Administration: Mix contents of 8 sachets in 1 litre of water and drink within 6 hours. After reconstitution the solution should be kept in a refrigerator and discarded if unused after 6 hours.  
**Ongoing maintenance** (chronic constipation, prevention of faecal impaction)  
| Child/young person 12–18 years: 1–3 sachets daily in divided doses usually for up to 2 weeks; maintenance, 1–2 sachets daily.  

Administration: Mix contents of each sachet in half a glass (approx 125mL) of water.  
**Osmotic Laxatives**

<table>
<thead>
<tr>
<th>Lactulose (May take up to 48 hours to act)</th>
<th></th>
</tr>
</thead>
</table>
|                                           | **Child** 1 month to 1 year: 2.5ml twice daily, adjusted according to response  
|                                           | **Child** 1–5 years: 2.5–10ml twice daily, adjusted according to response  
|                                           | **Child/young person** 5–18 years: 5–20 ml twice daily, adjusted according to response                |

**Stimulant Laxatives**

| Sodium picosulphate b | Elixir (5 mg/5 ml)  
|-----------------------|-------------------|
|                       | **Child** 1 month to 4 years: 2.5–10mg once a day  
|                       | **Child/young person** 4–18 years: 2.5–20mg once a day  

Perles® (1 tablet = 2.5mg)  
<table>
<thead>
<tr>
<th></th>
<th><strong>Child/young person</strong> 4–18 years: 2.5–20mg once a day</th>
</tr>
</thead>
</table>
| Bisacodyl             | By mouth  
|                       | **Child/young person** 4–18 years: 5–20mg once daily, adjusted according to response |

By rectum (suppository)  
|                       | **Child/young person** 2–18 years: 5–10mg once daily, adjusted according to response |

| Senna c               | Senna syrup (7.5mg/5ml)  
|-----------------------|-------------------------|
|                       | **Child** 1 month to 4 years: 2.5–10 ml once daily  
|                       | **Child/young person** 4–18 years: 2.5–20 ml once daily |
|                       | **Senna (non-proprietary) (1 tablet = 7.5 mg)  
|                       | **Child** 2-4 years: ½ to 2 tablets once daily, adjusted according to response  
|                       | **Child** 4-6 years: ½ to 4 tablets once daily, adjusted according to response  
|                       | **Child/young person** 6–18 years: 1–4 tablets once daily, adjusted according to response |
Shropshire Community Health NHS Trust

Laxatives | Recommended Doses
--- | ---
Docusate sodium | • Child 6 months–2 years: 12.5 mg three times daily, adjusted according to response (use paediatric oral solution)
• Child 2–12 years: 12.5–25 mg three times daily, adjusted according to response (use paediatric oral solution)
• Child/young person 12–18 years: up to 500 mg daily in divided doses, adjusted according to response

Unless stated otherwise, doses are those recommended by the British National Formulary for Children (BNFC) 2011-2012. Informed consent should be obtained and documented whenever medications/doses are prescribed that are different from those recommended by the BNFC.

a At the time of NICE publication (May 2010) Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that includes electrolytes. It does not have UK marketing authorisation for use in faecal impaction in children under 5 years, or for chronic constipation in children under 2 years. Informed consent should be obtained and documented. Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that is also unflavoured.

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. Perles produced by Dulcolax should not be confused with Dulcolax tablets which contain bisacodyl as the active ingredient.

c Syrup not licensed for use in children under 2 years. Informed consent should be obtained and documented.

d Adult oral solution and capsules not licensed for use in children under 12 years. Informed consent should be obtained and documented.

- 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 have failed.
- Do not administer phosphate enemas for disimpaction unless under specialist supervision in hospital/healthcare/clinic, and only if all oral medication and sodium citrate enemas have failed.
- Do not perform manual evacuation of the bowel under anesthesia unless optimal treatment with oral and rectal medications have failed.
- Review children and young people undergoing disimpaction within one week.
Appendix 9 - Bristol Stool Chart

Concept by Professor DCA Candy and Emma Davey, based on the Bristol Stool Form Scale produced by Dr K W Heaton, Reader in Medicine at the University of Bristol. © 2000 Norgine Pharmaceuticals Ltd.
Appendix 10 - Nurse Led Clinic

Referral Criteria

Patients with Telford & Wrekin GPs ONLY

- Constipation treatment pathway has been followed by GP/HV/SN - If no improvement from original assessment with optimal treatment after 6 months of the child’s constipation/soiling.

- Infants and children from 6 months up to their 18th birthday who have idiopathic constipation.

- Following discussion with Advanced Nurse Practitioner to consider individual circumstances in the event they do not meet the referral criteria.

Exclusion Criteria

Patients with a Shropshire County GP

- Infants under the age of 6 months.

- Newborns, infants and children who have constipation with a known cause.

- Children with an identified learning disability, who have additional behavioural or toileting complications associated with their learning disabilities such as smearing, holding then refer to the Learning Disability Team for assessment and management.

Nurse Led Constipation Clinic provides

- Specialist nurse to assess, advice, treat.

- Support children and their families regularly within the clinic, in their homes and telephone support.

- Advice and support for HCP.

- Training for other HCP.

- Regular Multi Disciplinary Team MDT meeting for caseload supervision with consultant Paediatrician.

- Dietetic and psychological support.
### Appendix 11 - Constipation Referral Form to Nurse Led Clinic (T&W GPs ONLY)

<table>
<thead>
<tr>
<th>Name :</th>
<th>NHS Number :</th>
<th>DOB :</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address :</th>
<th>Telephone No :</th>
<th>Mobile No :</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Parent / Carer :

<table>
<thead>
<tr>
<th>GP :</th>
<th>GP Address &amp; Telephone Number :</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical History :

<table>
<thead>
<tr>
<th>Current Medication (including laxatives/stimulants) :</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Medication used (including dose and frequency) :</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Current School :

<table>
<thead>
<tr>
<th>Has constipation treatment pathway been followed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

Identify which Health Professional(s) involved with constipation/soiling management :

- GP □
- Health Visitor □
- School Nurse □
- Other □

<table>
<thead>
<tr>
<th>Is the child’s family aware of this referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the child aware of this referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there a safeguarding protection plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there a Common Assessment Framework (CAF)/Team Around the Child (TAC) in progress?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

Date : ........................................
Telephone No : ..............................
Name : ........................................
Signature : ....................................

**Constipation Referral Form – Referral Method**

In **writing** using Constipation Service Referral Form.

By **fax** to Community Children’s Nursing Services (CCN) on 01743 450801.

By **post** to Community Children’s Nursing Services, SCHNT, SSC&YP, Coral House, 11 Longbow Close, Harlescott, Shrewsbury, SY1 3GZ.

Form available from The Constipation Service on telephone 01743 450855

Once referral received, the Constipation Service will respond to the client and referrer within 5 working days. The first appointment will be issued within 2 weeks of referral to service.