Shropshire Community Health NHS
NHS Trust

Document Details	
Title	**Constipation Guidelines for Children and Young People: Diagnosis and Management of Idiopathic Childhood Constipation**
Trust Ref No.	1587
Local Ref (optional)	
Main points the document covers	Guidance on how to treat constipation in children
Who is the document aimed at?	Community Paediatricians, Community Children's Nurses, School Nurses, Health Visitors, Paediatric Psychologists.
Owner	Community Children's Nursing Team
Approval process	
Approved by (Committee/Director)	Clinical Policy Group
Approval Date	08/07/2024
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Full Equality Impact Assessment	No
Lead Director	Director of Nursing & Operations
Category	Clinical
Subcategory	
Review date	
Distribution	
Who the policy will be distributed to	Community Paediatricians, Community Children's Nurses, School Nurses, Health Visitors, Paediatric Psychologists, Paediatric Occupational therapists.
Method	Electronically via managers / Datix, available to all staff via Trust Website and Key clinicians
Document Links	
Required by CQC	
Keywords	Constipation, bowel habit,

		Amendments History
No	Date	Amendment
1	27/12/2012	Updated to Trust standard
2	September 2016	Review
3	July 2018	T&W Policy Version 2.2
4	May 2020	Reviewed & updated
5	October 2023	Reviewed & updated sections; 1,5,6,12 & Appendices 1,6 & 10.
6	June 2024	Removed community paediatrics in who the document is aimed at. Reviewed and updated sections: 1, 3 5, 6, 7, 12 & added 14. Appendices 1, 6 & 10.

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1 Introduction

Constipation is common in childhood; it is prevalent in around 5% to 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 do not recognise the signs and symptoms of constipation, and few relate the presence of soiling to constipation. The signs and symptoms of childhood idiopathic constipation 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.

Without early diagnosis and treatment, an acute episode of constipation can lead to anal fissure and become chronic. By the time, the child or young person is seen they may be in a vicious cycle. Children and young people and their 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 and young people. This guideline provides strategies based on the best available evidence to support early identification, positive diagnosis and prompt, effective management. Implementation of this guideline will provide a consistent, coordinated approach and will improve outcomes for children and young people.

These guidelines will ensure that children with constipation receive a standard of care/information that is evidence based and encompasses the NICE recommendations (NICE, 2017a)

2 Purpose

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

3 Definitions & Abbreviations used.

Term/Abbreviation	**Explanation/Definition**
Acute Constipation	Self-limiting Constipation
Term/Abbreviation	**Explanation/Definition**
Allergic proctitis	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.

Anal Stenosis	A narrowing of the anus which results in a reduced lumen & particularly a loss of the capacity to dilate with passage of faeces. Straining, passage of ribbon like faeces & constipation result.
Anal wink	The reflex contraction of the external anal sphincter.
Antegrade colonic enema (ACE) procedure	A surgical procedure in the which the channel is created into the caecum in the large intestine. This allows a catheter to be inserted & the bowel to be washed out. Sometimes known as Malone antegrade colonic enema (MACE) procedure.
Anteriorly placed anus	A congenital malformation in which the anus is mispositioned.
Biofeedback	Treatment method involving teaching the individual how to relax the external anal sphincter during straining. Treatment modalities include manometric & electromyographic biofeedback.
BeeU	Child & Adolescent Mental Health Services
BNFC	British National Formulary for Children
Chronic Constipation	Constipation lasting longer than 8 weeks
Colony – forming unit	A measure of viable (living) bacterial or fungal cells numbers.
Constipation	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.
Diarrhoea	The frequent passage of loose or watery stools, usually accompanied by abdominal cramping & urgency.
Disimpaction	The evacuation of impacted faeces.
Encopresis	Deliberate defecation in an inappropriate place. This is not to be confused with soiling.
Faecal impaction	Severe Constipation with a large faecal mass in either the rectum or the abdomen &/or overflow soiling.
Faecal incontinence	The involuntary leakage of faeces
Functional constipation	See idiopathic constipation.
HCP's	Health Care Professionals
Hirschsprung's disease	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.
Idiopathic constipation	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.
Intractable constipation	Constipation which does not respond to sustained, optimum medical management.
Kerckring folds	Circular folds projecting into the lumen of the small bowel composed of reduplications of the mucous membrane.

MDT	Multi-Disciplinary Team
Macrogols	A form of osmotic laxative.
Megacolon	An abnormally enlarged colon that can be congenital (as in Hirschsprung's disease) or acquired (as in chronic constipation).
Megarectum	A large rectum because of underlying nerve supply, abnormalities, or muscle dysfunction, often because 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.
Organic constipation	Constipation is termed organic when there is an identifiable physiological or anatomical cause.
Osmotic laxatives	Laxatives which increase the amount of water in the faeces thereby making them softer.
Patulous anus	Widely patent anal orifice.
Recto anal inhibitory reflex (RAIR)	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 absent in cases of congenital megacolon
Retentive Posturing	Typical straight legged, tiptoed, back arching posture.
Rome iv criteria	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. Further details can be found on the website; www.theromefoundation.org
SSCYP	Specialist Services for Children & Young People
Side effects/Adverse effects	An undesired effect resulting from treatment.
Smearing	The intentional spreading of faeces.
Soiling	Involuntary passage of fluid or semi-solid stool into clothing because of overflow from a faecally loaded bowel.
Specialist services/specialist advice/specialist care/specialist management.	Services/advice/care/management provided by health care professionals with expertise in constipation management in Children & Young People.
Stimulant laxatives	Laxatives which increase bowel motility.
SCHT	Shropshire Community Health NHS Trust

4 Duties

4.1 Committees and Groups

The Quality, Safety and Performance 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.

4.2 Divisional Manager, Children and Families Services

The Divisional Manager is responsible for ensuring managers and staff are aware of the guidelines.

4.3 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.

4.4 Childhood Constipation Service

The Childhood Constipation Service is responsible for:

- Providing advice and guidance about the guideline.
- Providing specific training for all Health Care Professionals (HCPs) regarding the guideline.
- Keeping the policy up to date.

4.5 Health Care Professionals

All HCPs to follow guidelines, and to access training as needed.

5 Guidance

5.1 Assessment and Diagnosis

All practitioners should follow the flow chart – "History-taking and Physical Examination" shown in Appendix 5

Establish during history-taking whether the child has constipation. If two or more findings are identified from Appendix 2 "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 3 "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 4 "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 (Appendix 3) do not treat them for constipation. Instead, refer them urgently to an 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 refer to the GP for testing for coeliac disease and hypothyroidism.
If either the history taking or the physical examination show evidence of maltreatment refer to 'When to suspect child maltreatment' (NICE, 2017b) and contact Trust lead for safeguarding following local safeguarding procedures.

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

Inform the child and his or her parents or carers of a positive diagnosis of idiopathic constipation and 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.

5.2 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 '(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

Direct parents or carers to information available online from the following reputable sources:

https://eric.org.uk/childrens-bowels/
https://www.bbuk.org.uk/children-young-people/resources-for-children/

6.1 Diet and Fluids

Advise parents and children that a balanced diet should include 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.
Do not use dietary interventions alone as treatment for Childhood constipation. Diet and fluid adjustments do not break down hard faeces and there is evidence that constipation is unrelated to diet and fluid intake in about 59% of affected children.

6.2 Adequate Fluid Intake

Provide children and their families with written information about diet and fluid intake. Please see Appendix 6.

6.3 Exercise

Advise daily physical activity that is tailored to the child or young person's stage of development and individual ability as part of ongoing maintenance in children and young people with idiopathic constipation. (NICE 2017a)

6.4 Psychological and Behavioural Interventions

Negotiated and non-punitive behavioural interventions suited to the child's stage of development should be recommended, e.g. keeping a bowel diary, encouragement, praise and reward systems, and scheduled toileting to support a regular bowel habit where appropriate.

NICE guidance (2017a) recommendation is that you do not routinely refer children with idiopathic constipation to the psychology service unless they have an identified psychological need. However, 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 outcomes sought are negotiated with both parent and child as being achievable.

The Paediatric Psychology Service in Shropshire provides a valued service to the nurse led children's constipation service. They do not accept referrals for constipation directly but provide an integrated service model whereby the Paediatric Clinical Psychologist is embedded in the team.

7 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 2 - 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 (refer to British National Formulary for Children BNFC. Appendix 7).

Offer the following oral medication regimen for disimpaction if indicated:

- Polyethylene glycol 3350 + electrolytes, using an escalating dose regimen as the first-line treatment. (November 2021: Not all macrogol preparations are licensed for chronic constipation and faecal impaction. Of those that are licensed for these indications, not all of them are licensed for use in children under 12, and those that may have different licence starting ages. See individual summaries of product characteristics for further detail.

- Polyethylene glycol 3350 + electrolytes may be mixed with a cold drink.
- Add a stimulant laxative 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 if polyethylene glycol '3350' + electrolytes 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 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 anaesthesia unless optimal treatment with oral and rectal medications has failed.
- Review children and young people undergoing disimpaction within one week.

7.1 Maintenance Therapy

Start maintenance therapy as soon as the child's bowel is disimpacted.

Regular follow up improves outcomes. Family should be contacted one week after commencing disimpaction, two weeks after commencing maintenance, then within a further four weeks and then within eight weeks. Further follow up should continue as appropriate to the child and family.

- If no improvement within four weeks in children under one year, refer urgently to a paediatrician.
- If no or limited improvement after three months, in children over one year old, or additional concerns refer to specialist service.
- If soiling resumes, consider if over or under treated and consider referral to specialist service.
- Consider involving other members of the multidisciplinary team as appropriate.
- Where possible, reassessment should be provided by the same person/team.

Regime (Refer to BNFC for further advice)

- Use polyethylene glycol '3350' and electrolytes as first line treatment.
- Adjust the dose of polyethylene glycol '3350' and electrolytes according to symptoms and response.
- Add stimulant laxative 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 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. (NHS England Southwest, 2023)

7.2 Non-Medical Prescribing

Non-Medical Prescribing is supported by the Trust through the Non-Medical Prescribing Policy.
In England, non-medical prescribers can prescribe any licensed medicine, for any medical condition, "within their own level of professional competence and expertise."
The BNFC draws information from manufacturers' literature where appropriate and includes a great deal of advice that goes beyond marketing authorisations e.g. product licenses (British National Formulary, 2020).
Nurse and pharmacist independent prescribers can prescribe medicines outside their licensed indications (so called "Off license" 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 Trust's Consent to Examination or Treatment Policy.

7.3 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 using the Bristol Stool Form Scale to assess (Appendix 8). This could include:

- Telephoning, face-to-face consultation in clinic or Attend Anywhere video consultation clinics.
- 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 https://www.nice.org.uk/guidance/cg99/resources/constipation-in-children-and-young-people-pdf-318120904645
- 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 consult with schools to provide information and support, and to help raise awareness of the issues surrounding constipation with children and young people and school staff.

8 Consultation

This guideline was distributed to the following groups for consultation and comment:

Dr Preetha Raveendran – Specialist Doctor, Community Paediatrician

Steph Moore – Community Children's Continence Nurse

Katie Williams – Community Children's Nurse

Di Kitching - Lead Pharmacist for Children's Community Services and Governance

9 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

10 Advice and Training

The Continence 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.

Children & Young Peoples Continence Service
Shropshire Community Health NHS Trust
Coral House, 11 Longbow Close, Harlescott Lane
Shrewsbury, Shropshire, SY1 3GZ
Tel: 01743 450855 emails: shropcom.continenceforpaediatrics@nhs.net

11 Monitoring Compliance

There will be no formal monitoring of compliance as the intended use of this document is for guidance. The Continence Service will review these guidelines following any new national documents published or at the latest every three years to ensure the information is consistent with best practice advice.

Compliance Monitoring is completed periodically by Shropshire Community Health NHS Trust by Incident reporting and Audits.

12 Related Documents

The following documents contain information that relates to these guidelines:

Non-medical Prescribing Policy

Consent to examination and treatment policy.

Safeguarding Children and Young People

13 References

- NHS England Southwest (March 2023) National Primary Care Clinical Pathway for Constipation in Children https://www.england.nhs.uk/wp-content/uploads/2023/03/B1416-National-clinical-constipation-pathway-for-primary-care-for-children.pdf
- NICE (2017a) Clinical Guideline 99: Constipation in children and young people: diagnosis and management of idiopathic childhood constipation in primary and secondary care https://www.nice.org.uk/guidance/cg99/resources/constipation-in-children-and-young-people-diagnosis-and-management-pdf-975757753285
- NICE (2017b) Child maltreatment: when to suspect maltreatment in under 18s https://www.nice.org.uk/guidance/cg89/resources/child-maltreatment-when-to-suspect-maltreatment-in-under-18s-pdf-975697287109
- Paediatric Formulary Committee (2020) BNF for Children (2019-2020). London: BMJ Group, Pharmaceutical Press, and RCPCH Publications.

14 Appendices

Appendix 1 - Referral Pathway: When a Child Has Been Identified with Constipation

Appendix 2- Key components of history taking to diagnose constipation.

Appendix 3 - Key components of history taking to diagnose idiopathic constipation.

Appendix 4 - Key components of physical examination to diagnose idiopathic constipation.

Appendix 5 – History-taking and Physical Examination.

Appendix 6 – Fluid intake guidelines.

Appendix 7 – Laxatives.

Appendix 8 - Bristol Stool Chart.

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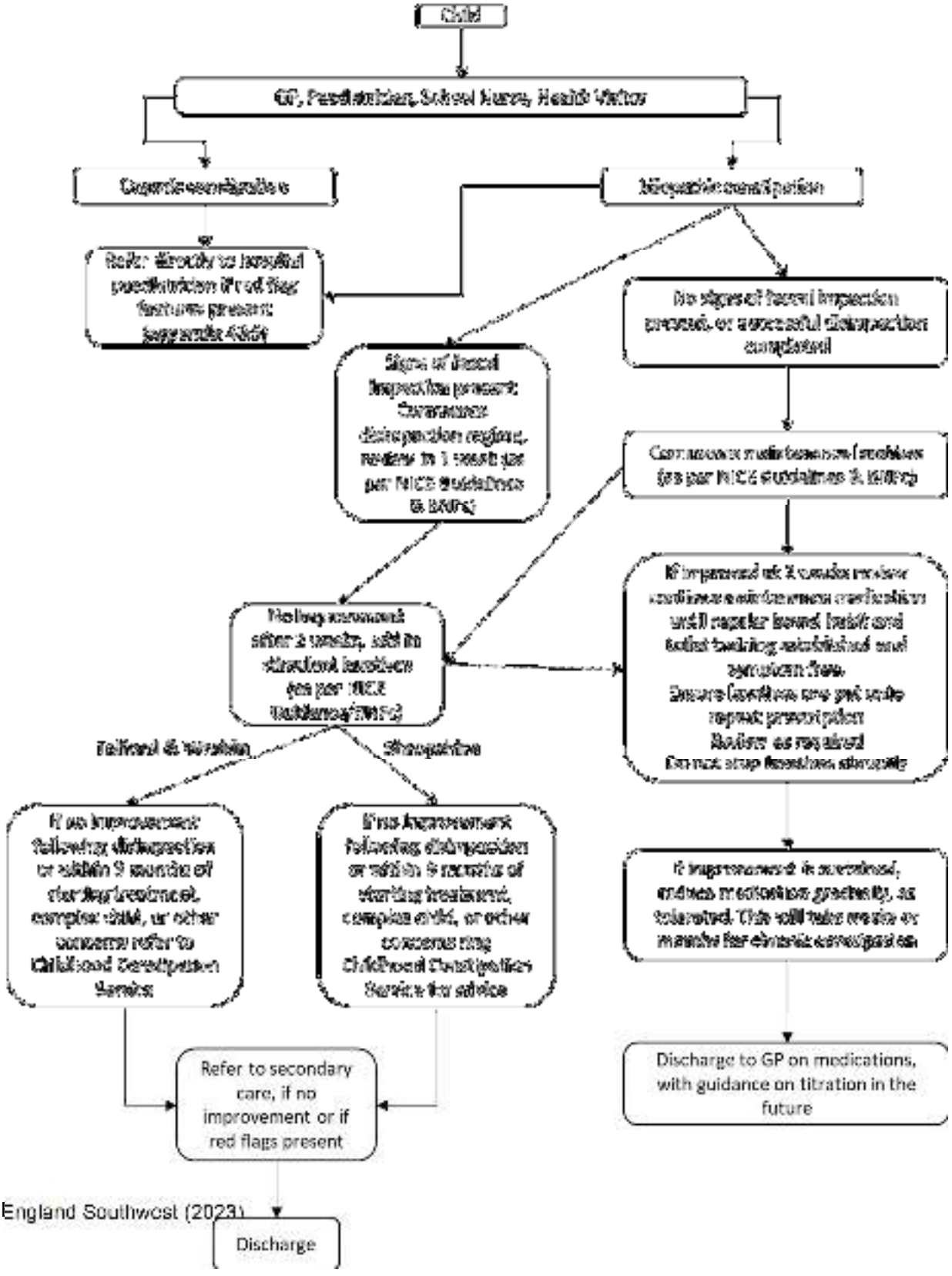
Appendix 10 - Constipation Referral Form to Nurse Led Clinic (T&W GPs ONLY).

Appendix 1 - Referral Pathway: When a Child Has Been Identified with Constipation

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



NHS England Southwest (2023)

Appendix 2 - Key components of history taking to diagnose constipation.

Key Components of History Taking	**Potential findings in a child younger than 1 year**	**Potential findings in child/young person older than 1 year**
Stool patterns	▪ Fewer than three complete stools per week (type 3 or 4, see Bristol Stool Form Scale – appendix 8) (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 8)	▪ Fewer than three complete stools per week (type 3 or 4, see Bristol Stool Form Scale – appendix 8) ▪ 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 8) ▪ 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 3 - Key components of history taking to diagnose idiopathic constipation.

Key components of history taking	**Potential findings and diagnostic clues that indicate idiopathic constipation**	**Potential findings and diagnostic clues in a child/young person older than 1 year**
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

'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 maltreatment, below)

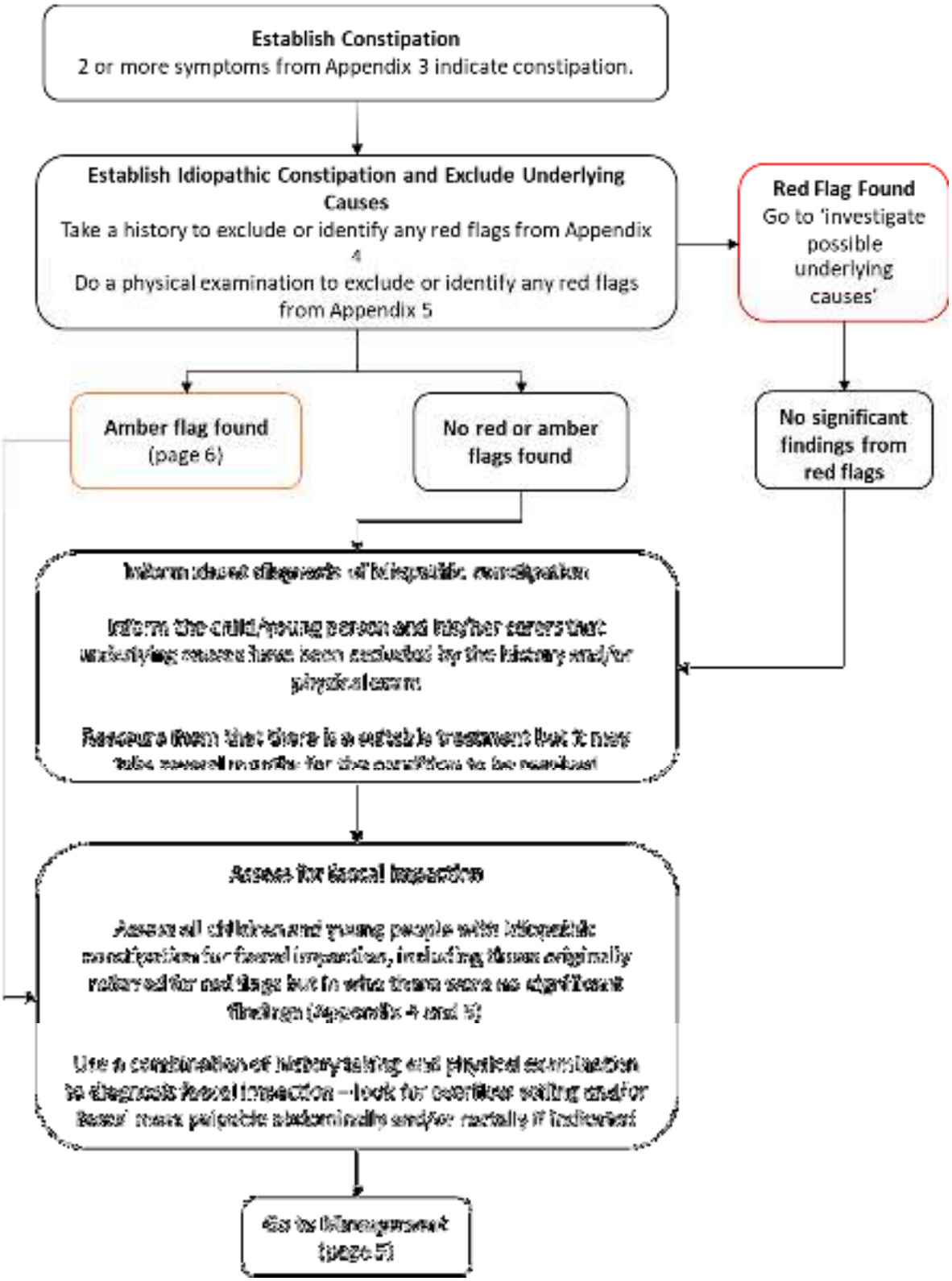
RED FLAGS – for immediate referral to paediatrician

- Symptoms that commence from birth or in the first few weeks
- Failure or delay (>first 48 hours at term) in passing meconium.
- Ribbon stools, leg weakness or locomotor delay
- Abdominal distension with vomiting
- Abnormal examination findings including:
- Abnormal appearance of anus
- Gross abdominal distension
- Abnormal gluteal muscles, scoliosis, sacral agenesis, discoloured skin, naevi or sinus, hairy patch, or central pit
- Lower limb deformity including talipes.
- Abnormal lower limb reflexes or neuromuscular signs unexplained by existing conditions
- Other symptoms that cause concern that cannot be explained by existing conditions
- Other symptoms that cause concern

Appendix 4 - 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 overweight child	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

Appendix 5 – History-taking and Physical Examination



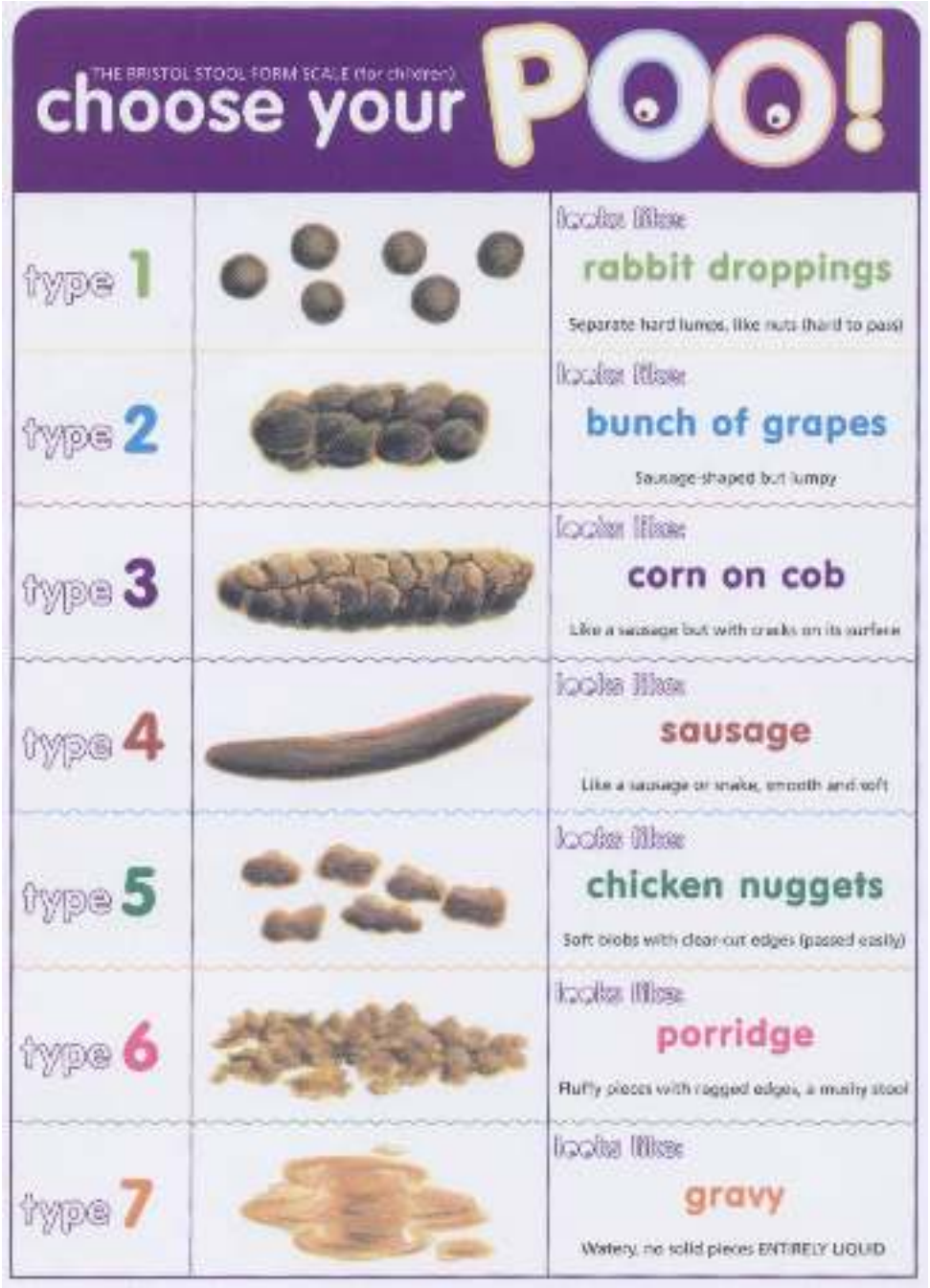
NHS England Southwest (2023)

Appendix 6 - Fluid intake guidelines; American dietary recommendations (Institute of Medicine 2005)

	Total water intake per day, including water contained in food	**Water obtained from drinks per 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

Appendix 7 - Laxatives: dosage information is now given in the BNFC. BNFC (British National Formulary for Children) | NICE https://bnfc.nice.org.uk/

Appendix 8 - 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 9 - Nurse Led Clinic

Referral Criteria

Patients with Telford & Wrekin GPs ONLY

- GP/HV/SN has followed constipation treatment pathway - If no improvement following disimpaction or within 3 months of starting treatment, complex child, or other concerns refer to Children & Young People's Continence Service
- 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 CCG GP.
- Infants under the age of 6 months.
- Newborns, infants, and children who have constipation with a known cause.

Nurse Led Constipation Clinic provides.

- Specialist nurse to assess, advise, treat.
- Support for Children/Young People and their families regularly within the clinic; either Face-to-Face or via telephone.
- Advice & support for schools.
- Advice and support for HCP.
- Training for HCP's.
- Dietetic and psychological support.

Appendix 10 - Constipation Referral Form to Nurse Led Clinic (T&W GPs ONLY)

<table>
<tr><td>Name:</td><td>NHS Number:</td><td>DOB:</td></tr>
<tr><td>Address:</td><td colspan="2">Telephone
Number:</td></tr>
<tr><td colspan="3">Name of Parent / Carer:</td></tr>
<tr><td>GP:</td><td colspan="2">GP Address & Telephone Number:</td></tr>
<tr><td colspan="3">Medical History:</td></tr>
<tr><td colspan="3">Current Medication (including laxatives/stimulants):</td></tr>
<tr><td colspan="3">Previous Medication used (including dose and frequency):</td></tr>
<tr><td colspan="3">Current Nursery/School:</td></tr>
<tr><td colspan="3">Has constipation treatment pathway been followed?

Yes ☐ No ☐</td></tr>
<tr><td colspan="3">Identify which Health Professional(s) involved with constipation/soiling management:
GP ☐ Health Visitor ☐ School Nurse ☐ Other ☐</td></tr>
<tr><td colspan="2">Is the child's family aware of this referral? Yes ☐ No ☐</td><td rowspan="2">Is there a safeguarding protection plan? Yes☐ No☐
Is there a Common Assessment Framework (CAF)/Team Around the Child (TAC) in</td></tr>
<tr><td colspan="2">Is the child aware of this referral?
Yes ☐ No ☐</td></tr>
<tr><td colspan="3">Date……Name: ……
Telephone Number: ……Signature……</td></tr>
</table>

Constipation Referral Form – Referral Method in **writing** using Constipation Service Referral Form-
By **post** to: Children & Young People's Continence Service
Community Children's Nursing Team, Coral House,
11 Longbow Close, Harlescott, Shrewsbury, SY1 3GZ.
By **email**: shropcom.continenceforpaediatrics@nhs.net

Form available via telephone 01743 450855 from the Continence Service on request.
Once we receive the referral, the Continence Service will invite the Child, Young Person & Parent/Carer to a Face-to-Face Clinic appointment;
We request a Bladder & Bowel diary is completed & they bring it along to their clinic appointment.