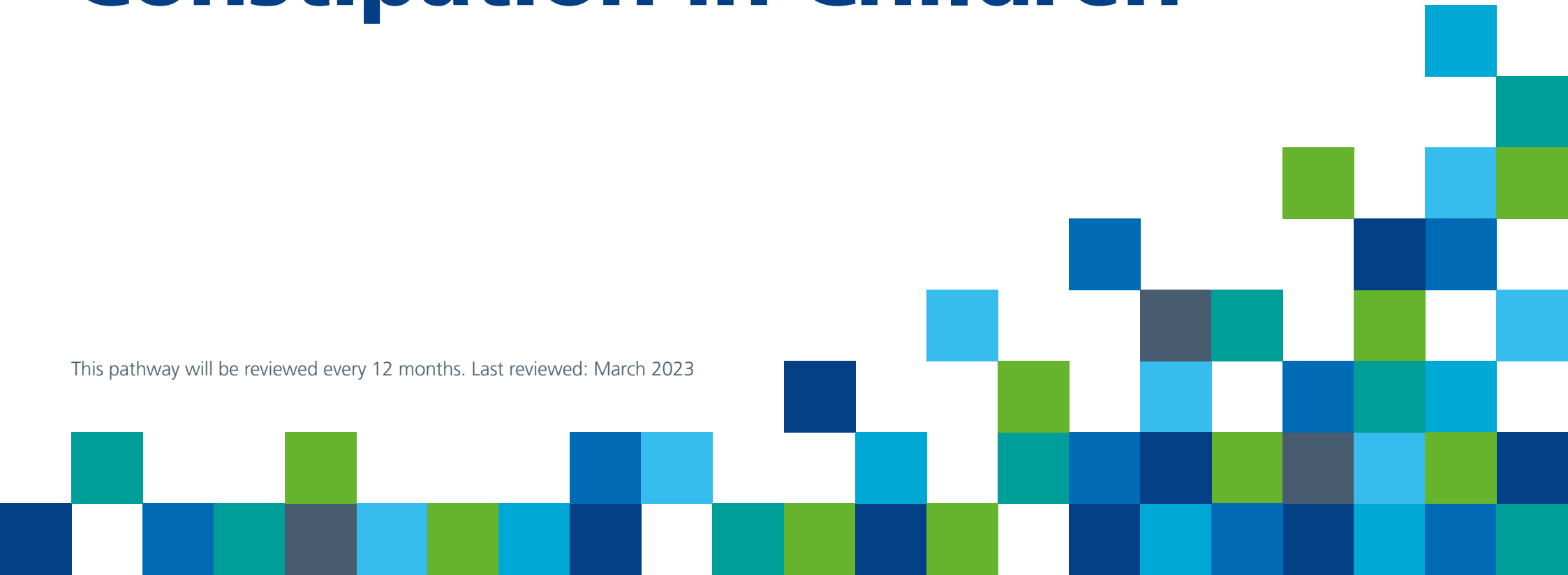
National Primary Care Clinical Pathway for Constipation in Children



This pathway will be reviewed every 12 months. Last reviewed: March 2023

Contents

National Primary Care Clinical Pathway for Constipation in Children

All families:
Safeguarding should be considered and managed as per local safeguarding procedures.

Child presents with constipation 1 or soiling (faecal incontinence)
- Undertake assessment 2 and eliminate RED FLAGS. 3

Signs of faecal impaction present?

YES

NO

Provide written and verbal information to family.
Bladder & Bowel UK
ERIC, The Children's Bowel & Bladder Charity
Consider behavioural modification, toileting regimes, physical activity, diet and fluids as treatment adjuncts.

Child presents with faecal impaction 1 4

- Disimpact 5 as per NICE guidelines. Review within 1 week.
- Ensure that parents **know how to give macrogols** (instruct to mix each sachet in 62mls of water for paediatric strength and 125mls for adult strength sachets).
- Macrogols should be used in all children including those under 2 as per **NICE** and **BNFc**.
- Do not assume soiling is part of underlying condition in children with disabilities.
- When impaction cleared treat as per child with constipation. If no improvement, see below.

Child presents with Constipation 1 4

- Patient not impacted or has completed disimpaction: commence maintenance laxatives as per **NICE** guidelines. Review in 2 weeks. 6
- Ensure that parents **know how to give macrogols** (instruct to mix each sachet in 62mls of water for paediatric strength and 125mls for adult strength sachets).
- Macrogols should be used in all children including those under 2 as per **NICE** and **BNFc**.
- **Do not assume soiling is part of underlying condition in children with disabilities.**

No Improvement within two weeks of starting disimpaction or at review for maintenance, when on macrogols alone.

Add a stimulant laxative such as sodium picosulfate as per NICE Guidance and BNFc.

Review in 2 weeks.

No improvement after disimpaction or within three months of starting treatment, complex child or other concerns, refer to local community nurse-led children's bladder and bowel service and continue to provide support.

Improved:

Continue successful maintenance medication until regular bowel habit and toilet training established and symptom free.

Ensure laxatives put onto repeat prescription.

Review as required. 5

Do not stop laxatives abruptly.

Improvement sustained:

Reduce medication gradually, as tolerated. This will take weeks or months for chronic constipation.

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

Information on all of the above can be found on:

- Bladder & Bowel UK information for children and families
- Children's bowels – ERIC, The Children's Bowel & Bladder Charity
- Children with additional needs – ERIC, The Children's Bowel & Bladder Charity
- NICE Guidance constipation in children and young people
- NICE Guidance clinical management of constipation in children

Principles of management for primary care

- As per **NICE guidance** and quality standards.
- **Laxatives are always first line management** of acute or chronic constipation in children. The aim is to titrate doses to ensure the passage of soft, pain free stools and to overcome any withholding behaviours.
- **Do not use diet and fluids alone as treatment.** 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.
- When constipation has persisted for **more than four weeks it is considered chronic**. Resolution can take six months or more if the child has developed mega-rectum or mega-colon. Maintenance doses of laxatives for chronic constipation should be continued for at least three to six months after symptoms resolve and toilet training is established unless loose stools develop. They should then be slowly and cautiously titrated down as the child tolerates. The aim is to prevent relapse.
- **Children with disabilities are more prone to constipation** than their typically developing peers to constipation. It must be treated proactively to prevent long-term morbidities and potential mortality in the learning disabled young person or young adult.
- Treatment of constipation in children with disabilities should follow the same pathway. If there are complex needs, safeguarding concerns, or there is no or limited progress, consider early onward referral to specialist bladder and bowel service.
- **Continued provision of prescriptions for laxatives is essential** to allow the bowel to recover and prevent withholding due to fear of painful bowel actions.
- **Laxatives should not be stopped abruptly.**
- Acute constipation (history of less than four weeks) often needs proactive ongoing, preventative treatment so that it does not become chronic due to pain on bowel opening resulting in fear and withholding.
- If stools are too loose with macrogol alone or if macrogol alone is insufficiently effective, add a stimulant laxative (sodium picosulfate or senna). Start with a lower dose and titrate upwards until desired effect achieved.
- **Do not use rectal interventions as first line treatment.** If rectal interventions are indicated these should be prescribed under the guidance of a specialist nurse or paediatrician.
- **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.

Assessment including physical examination

- Diagnosis is largely based on history: ask about frequency and size of bowel actions, consistency of stools, soiling (in toilet trained child), pain with bowel actions, bleeding or mucous passed with stools, retentive posturing (usually straight legs, tiptoe and back arched or hiding to defecate), straining, abdominal distension or pain, appetite and fluid intake.
- Ask about previous history, including onset of symptoms, precipitating factors, passage of meconium, growth and general wellbeing.
- Physical examination: **to exclude red flags as per NICE**.
  - ☐ Include inspection of perianal area for appearance, position and patency;
  - ☐ Abdominal examination, inspection of spine/lumbosacral and gluteal regions;
  - ☐ Lower limb neuromuscular examination including tone and strength.
  - ☐ If any red flags in history or examination suggest new onset neurological impairment check lower limb reflexes.
- If not trained to examine do not delay treatment. If not making expected progress with treatment, refer to paediatrician for examination and specialist intervention.
- If faltering growth treat constipation and check for coeliac and hypothyroidism.
- Do not undertake digital rectal examination unless competent to interpret features of anatomical abnormality or Hirschsprung's disease.

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**

- Treatment involves clearing out all retained faeces through administration of escalating doses of laxatives. Macrogols are used as first line unless contraindicated.

	BNFc recommended daily dose of Macrogol for disimpaction (in sachets), divide daily dose and give through the day						
Child's age	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
1-12 months (paediatric sachets)	½ - 1	½ - 1	½ - 1	½ - 1	½ - 1	½ - 1	½ - 1
1-5 years old (paediatric sachets)	2	4	4	6	6	8	8
5-12 years old (paediatric sachets)	4	6	8	10	12	12	12
12-18 years old (Adult sachets)	4	6	8	8	8	8	8

Advice for family:

- Ensure parents know how to mix and administer macrogols.
  - Bladder & Bowel UK: **Understanding Macrogol Laxatives**
  - ERIC, The Children's Bowel & Bladder Charity: **How to prepare Macrogol Laxatives**
- Advise the family to continue on the above regime until the child is passing type 7 stools with no lumps of faeces present, although there may be 'bits' from undigested food. Explain that this usually takes 5-7 days, but may take longer.

- If disimpaction is not complete within fourteen days of starting the above regime, or if macrogols are not tolerated or not taken by the child, add a stimulant laxative as per BNFc. Consider starting on low doses and titrating up to avoid excess abdominal pain. Children who are on a stimulant laxative only may benefit from the addition of an osmotic laxative such as lactulose or docusate.

Child's age	BNFc recommended daily dose of Sodium Picosulfate 5mg/5ml
1 month - 4 years	2.5 - 10mg once a day
4 - 18 years	2.5 - 20mg once a day

Child's age	BNFc recommended daily dose of Senna 7.5mg/5ml
1 month - 4 years	2.5 - 10ml once a day
4 - 18 years	2.5 - 20ml once a day

Child's age	BNFc recommended daily dose of Lactulose
1 month - 1 year	2.5ml twice daily
1 - 5 years	2.5 - 10ml twice daily
5 - 18 years	5 - 20mls twice daily

Child's age	BNFc recommended daily dose of Docusate Sodium
6 months - 2 years	12.5mg three times daily (paediatric solution)
2 - 12 years	12.5 - 25mg three times daily (paediatric solution)
12 - 18 years	Up to 500mg daily in divided doses

Maintenance guide for primary care

- First line treatment of all idiopathic constipation in children is with laxatives, usually macrogols. Prompt treatment may prevent constipation becoming chronic.
- Chronic constipation requires long-term treatment to overcome fear of painful defecation and subsequent withholding and establishment of toilet training in younger children.
- Many children require laxatives for months.

Advice for family:

- Ensure parents know how to mix and administer macrogols.
  - Bladder & Bowel UK: **Understanding Macrogol Laxatives**
  - ERIC, The Children's Bowel & Bladder Charity: **How to prepare Macrogol Laxatives**

- Adjust laxative dose according to response. Consider adding stimulants if macrogols insufficiently effective, not tolerated or refused by the child. Children who are on a stimulant laxative only may benefit from the addition of an osmotic laxative such as lactulose or docusate.
- Continue laxatives at dose required to maintain soft bowel motions for at least three to six months. Reduce doses cautiously over a long time period if initial constipation had persisted for more than four weeks.

Child's age	BNFc recommended daily dose of Macrogol for maintenance (in sachets)
1 - 12 months	½ - 1 sachets (paediatric)
1 - 6 years old	1 - 4 sachets (paediatric)
6 - 12 years old	2 - 4 sachets (paediatric)
12 - 18 years old	1 - 2 sachets (adult)

Child's age	BNFc recommended daily dose of sodium picosulfate 5mg/5ml
1 month - 4 years	2.5 - 10mg once a day
4 - 18 years	2.5 - 20mg once a day

Child's age	BNFc recommended daily dose of senna 7.5mg/5m
1 month - 4 years	2.5 - 10ml once a day
4 - 18 years	2.5 - 20ml once a day

Child's age	BNFc recommended daily dose of Lactulose
1 month - 1 year	2.5ml twice daily
1 - 5 years	2.5 - 10ml twice daily
5 - 18 years	5 - 20mls twice daily

Child's age	BNFc recommended daily dose of Docusate Sodium
6 months - 2 years	12.5mg three times daily (paediatric solution)
2 - 12 years	12.5 – 25mg three times daily (paediatric solution)
12 - 18 years	Up to 500mg daily in divided doses

- Reassess as appropriate to the child and family. If no improvement after three months refer to specialist service (local children's bladder and bowel service if there is one or to a paediatrician)

Health & wellbeing reviews and contacts 0-5 years

Guided by:
Health visiting and school nursing service delivery model, May 2021i
Making Every Contact Count (MECC) April 2016ii

Health Promotion:

Identifying, understanding and feeling confident to promote good bladder and bowel health is the responsibility of all professionals and organisations supporting families from before birth to 5 years old.

This includes but is not exclusive to the: community midwife, heath visitor, family nurse partnership, enhanced special services for vulnerable families, 0-19 services, GP practice, third sector partners.

Antenatal health promotion: 28 weeks +

Antenatal health promotion:

At this stage professionals and organisations supporting families should feel confident to:
1) provide information; 2) answer parent/carer questions; 3) sign-post to on-line resources;
4) identify when things don't seem quite right (red flags) and refer to GP services.

What do parents-to-be need to know:

- What should my baby's poo look like and how often should they pass a stool?
- What should my babies wee look like and how often should they have a wee?
- How will I know if there is a problem and what should I do?
- Is there any advice or top tips on deciding which type of nappies to use, particularly to fit with our lifestyle?
- Potty training: Why it's good to be prepared.

Information on all of the above can be found on **ERIC, The Children's Bowel & Bladder Charity** and **Bladder & Bowel UK**

- **Children's Bowels – ERIC, The Children's Bowel & Bladder Charity**
- **Children's Bladders – ERIC, The Children's Bowel & Bladder Charity**
- **Understanding Constipation in Infants and Toddlers – Bladder & Bowel UK**
- **Sore bottoms caused by disposable nappies – Bladder & Bowel UK**

i www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model

ii www.makingeverycontactcount.co.uk/

Health & wellbeing reviews and contacts 0-5 years

6-8 week development assessment

New baby review 10-14 days after birth

3 month contact

New baby review, 6-8 week assessment and 3 month contact:

Building confidence, understanding and skills of parents and caregivers:
At this stage, the health visitor, community nursery nurse and any other professional/organisation supporting the family will want to reinforce the importance of keeping the bladder and bowel healthy and to know what to do if things are not as they should be. This is also the time to encourage, build confidence and motivate parents and carers to prepare for potty training.

What parents and carers need to know:

- What should my babies wee and poo look like?
- How often should they pass a stool or have a wee?
- What are the signs to look out for that might indicate something is wrong (possible red flags)?
- How will I know if there is a problem and what should I do?
- How to prevent nappy rash/sore bottoms
- Is there any advice or top tips on deciding which type of nappies to use, particularly to fit with our lifestyle?
- Potty training: Why it's good to be prepared.

Information on all of the above can be found on **ERIC, The Children's Bowel & Bladder Charity** and **Bladder & Bowel UK**

- **Children's bowels – ERIC, The Children's Bowel & Bladder Charity**
- **Constipation in children: symptoms, causes and relief – ERIC, The Children's Bowel & Bladder Charity**
- **Potty training: how to start & best age to potty train – ERIC, The Children's Bowel & Bladder Charity**
- **Resources for children – Bladder & Bowel UK**
- **The impact of diet on constipation in children – Bladder & Bowel UK**

One year assessment: 9-12 months

6 month contact

6 month contact, 9-12 month assessment:

Building confidence, understanding and skills of parents and caregivers:
At this stage, the health visitor, community nursery nurse and any other professional/organisation supporting the family will want to reinforce the importance of keeping the bladder and bowel healthy and to know what to do if things are not as they should be. This is also the time to encourage, build confidence and motivate parents and carers to prepare for potty training.

What parents and carers need to know:

Now that my baby is weaning:

- Will their wee and poo look different?
- Is it likely they will poo more often or less?
- Will their diet affect their poo?
- What happens if they don't poo for more than 3 days?
- What should I do if my child's poo changes e.g. frequency/consistency
- How will I know if there is a problem and what should I do?

Now that my baby can sit up and is starting to move around:

- Would it harm my baby if I sat them on the potty?
- What can I do to get ready for potty training?
- How will I know my child is ready to start potty training?
- What happens if it all goes wrong?

Information on all of the above can be found on **ERIC, The Children's Bowel & Bladder Charity** and **Bladder & Bowel UK**

- **Understanding constipation in infants and toddlers – Bladder & Bowel UK**
- **Constipation in Children & Young People: Diagnosis and management – NICE guidance**

Health & wellbeing reviews and contacts 0-5 years

2 to 2.5 year review:

2 to 2.5 years assessment:

Building confidence, understanding and skills of parents and caregivers:

At this stage the health visitor, community nursery nurse and any other professional/organisation supporting the family will want to reinforce the importance of keeping the bladder and bowel healthy and know what to do if things aren't as they should be. This is also the time to encourage, build confidence and motivate parents and carers to prepare for potty training – if not already started.

What parents and caregivers need to know:

- How will we know when it is time to start potty training?
- What do we need to do to prepare?
- How can I help my child start to use the potty or toilet?
- Are there any tips on how to keep them interested and motivated?
- At what point do I stop using nappies?
- How long will it take and should we expect accidents?
- Should my child also be clean and dry at night?
- What do we do if it all goes wrong from 2 years up to 5 years?
- My child has additional needs so I'm not sure this is something we need to be thinking about just yet.

- **Potty training: how to start & best age to potty train – ERIC, The Children's Bowel & Bladder Charity**
- **Children with additional needs – ERIC, The Children's Bowel & Bladder Charity**
- **Toilet training information – Bladder & Bowel UK**
- **Toilet training children with autism – Bladder & Bowel UK**
- **Toilet training children with additional needs – Bladder & Bowel UK**
- **Constipation in children and young people: diagnosis and management - NICE guidance**

Principles of management when child presents in hospital

Children should not attend A&E for treatment of constipation unless acutely unwell:

i) **Increasing abdominal pain**
ii) **Increasing abdominal distention**
iii) **Vomiting, unable to tolerate oral fluids**
iv) **Reduced urine output**

- Child may present to A&E or be diagnosed during an in-patient stay.
- Assess child to rule out an urgent medical emergency.
- Complete assessment 2 to confirm diagnosis of constipation.
- Explain diagnosis to family including correct treatment pathway – i.e. in primary care.
- Provide information using varied media – printed, by sending a link to parent's mobile and by showing QR code.
- Give sufficient Macrogol laxatives to last 1/52 (unless they already have a supply at home).
- Refer to GP, emphasizing that the child must be reviewed within 1/52 to monitor progress with disimpaction and prescribe more laxatives.
- DO NOT routinely prescribe PR interventions in A&E.
- If admission is deemed necessary, constipation management may include:
  - Administration of macrogol laxatives via nasogastric tube; stimulant laxatives added as required.
  - Kleen prep or Picolax may be prescribed if macrogol laxatives + stimulants + enemas/suppositories are not effective.
  - Manual evacuation should only be used as a last resort, and must always be performed under general anaesthetic and with guidance from a paediatrician/paediatric surgeon.

Indication for PR intervention
– distressed child, in significant pain, unable to pass any stool.

Consider Sodium Citrate micro-enema/Bisacodyl suppository as first line PR treatment.

Consider Phosphate enema if Sodium Citrate/Bisacodyl ineffective, titrating dose according to age and considering dilution.

PR medication to be cautiously administered in A&E department. Child to be observed to ensure effective result, pain settled and clinical urgency resolved.

YES

Child to be discharged home with disimpaction information, oral laxatives and referral to GP as above.

NO

Child to be admitted.

This pathway was produced in collaboration with

NHS England – South West

ERIC, The Children's Bowel & Bladder Charity

Bladder & Bowel UK

Academic Health Science Network – South West

National Network of Parent Carer Forums – South West

NHS England South West, March 2023

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