Clinical review

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Chronic constipation in children

Greg Rubin, Anne Dale

Difficulty in defecation, with or without soiling, is often encountered in children. It presents a management problem for general practitioners, and parental concern is often high. Constipation accounts for about 25% of a paediatric gastroenterologist's work and is one of the 10 most common problems seen by general paediatricians.[1] We outline the epidemiology of chronic constipation in children, review the evidence base for the therapeutic interventions, and suggest strategies for management. We do not deal with the management of childhood constipation that results from an organic cause. This review is intended for general practitioners and hospital doctors who are not specialists in the management of constipation.

Sources and selection criteria

This review draws on the chapter on constipation in children in Clinical Evidence, search date April 2002,[2] supplemented by a search of Medline and the Cochrane database of systematic reviews for randomised controlled trials published in English since then. The search used the following key words: constipation, encopresis, diet therapy, diagnosis, therapy, psychology, stimulant laxatives, dietary fibre, and lactulose; it was limited to infants and children. Trials were selected for inclusion if they focused on the management of constipation or encopresis, or both.

How is constipation defined in children?

Stool frequency reduces progressively in early childhood, from more than four stools a day to 1.2 a day at age 4 years,[3] by which age 98% of children are toilet trained. Constipation is typically characterised by infrequent bowel evacuations, large stools, and difficult or painful defecation. Attempts have been made to define terms and diagnostic criteria more precisely. Soiling and encopresis are terms that lack precision and are sometimes used interchangeably. Soiling can occur in the absence of constipation and may be voluntary or involuntary. Encopresis is usually used for the passage of normal stools in socially unacceptable places. These terms have largely been replaced by the term incontinence. The Paris Consensus on Childhood Constipation Terminology (PaCCT) Group has proposed a simplified terminology that more clearly defines the criteria for chronic constipation (box 1),[4] which informs the recently published Rome III criteria for diagnosis (box 2).[5 6]

Which children get constipation?

Although organic causes for constipation are uncommon and are most likely to become apparent in the first month of life, they should be considered in making the diagnosis (box 3). For 90-95% of children with constipation the problem is functional. A family history of constipation may be present.[7] Case-control studies have shown an association between low dietary fibre and constipation (odds ratio 4.1, 95% confidence interval 1.64 to 10.32)[8] and with lower energy and nutrient intake in cases than controls.[7]

Most children with constipation are developmentally normal.[9] Pyschosocial factors are often suspected, and some studies have reported higher levels of behavioural disorders in children with constipation, with or without incontinence, though it remains unclear whether these precede the problem or are a maintaining factor.[10] Chronic constipation can lead to progressive faecal retention, distension of the rectum, and loss of sensory and motor function.

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Box 1 Terminology recommended by PaCCT Group[4]

Chronic constipation—The occurrence of two or more of the following characteristics during the past eight weeks:

- Frequency of bowel movements less than three per week
- More than one episode of faecal incontinence per week
- Large stools in the rectum or palpable on abdominal examination
- Passing of stools so large that they may obstruct the toilet
- Display of retentive posturing and withholding behaviours
- Painful defecation

Faecal incontinence—Passage of stools in an inappropriate place

Organic faecal incontinence—Faecal incontinence resulting from organic disease (neurological damage or sphincter abnormalities, for example)

Functional faecal incontinence—Non-organic disease which can be subdivided into:

- Constipation associated faecal incontinence
- Non-retentive (non-constipation-associated) faecal incontinence

Constipation associated faecal incontinence—Functional faecal incontinence associated with the presence of constipation

Non-retentive faecal incontinence—The passage of stools in an inappropriate place, occurring in children aged 4 years and older, with no evidence of constipation on history or examination

Faecal impaction—Large faecal mass in either the rectum or the abdomen which is unlikely to be passed on demand. The faecal impaction can be shown by abdominal or rectal examination or other methods

Pelvic floor dyssynergia—Inability to relax the pelvic floor when attempting to defecate

Box 2 Diagnosis of constipation in childhood

For diagnosis of functional constipation under the Rome III criteria,[5 6] symptoms must include at least two of the following:

Two or fewer defecations per week

At least one episode per week of faecal incontinence after the child has acquired toileting skills

History of excessive stool retention or retentive posturing

History of painful or hard bowel movements

Presence of a large faecal mass in the rectum

History of stools with large diameter that may obstruct the toilet

In infants and children up to a developmental age of 4 years, these symptoms must be present for at least one month; in children over 4 years old, symptoms should be present for at least two months, with insufficient criteria for the diagnosis of irritable bowel syndrome

Constipation can be present at three common stages of childhood: in infants at weaning, in toddlers acquiring toilet skills, and at school age. Painful defecation is one of the most common triggers to faecal retention, precipitated by the passage of a faecal mass and leading to a cycle of fear and further retention. Constipation can be difficult to treat and often requires prolonged support, explanation, and medical treatment. In a series of long term follow-up studies of children presenting under the age of 5 years to a specialist clinic in Iowa, 50% recovered within one year and 65-70% recovered within two years; the remainder required laxatives for daily bowel movements or continued to soil for several years.[10] In a longitudinal study of 418 children with a median age of 8.0 years at enrolment, a third of those followed up beyond puberty continued to have severe constipation.[11]

Box 3 Organic causes of constipation and diagnostic tests[29]

Anorectal malformation:
- Physical examination

Chronic constipation:
- Physical examination and history*
- No tests necessary*
- At times: x ray of kidneys, urether, and bladder; colonic transit

Non-retentive faecal incontinence:
- Physical examination and history*
- X ray of kidneys, urether, and bladder
- Colonic transit

Hirschsprung's disease:
- Rectal biopsy*
- Anorectal manometry
- Barium enema

Neuroenteric problem:
- Colonic transit
- Colonic motility*
- Rectal biopsy?

Spinal cord problem:
- Physical examination
- Magnetic resonance imaging*
- Anorectal manometry?

Pelvic floor dyssinergia:
- Anorectal manometry*

Metabolic, systemic problems:
- Thyroxine, thyroid stimulating hormone*
- Tests for coeliac disease*
- Calcium*
- Sweat test*

Toxic (lead, drugs):
- Lead level, toxic screen*

Cows' milk allergy:
- Elimination diet
- Allergy testing

*Investigations of choice.

Making the diagnosis

It is important to establish that the child's problem is indeed constipation by careful questioning of the parent about the frequency of defecation, consistency of stool, and associated behaviour. The Bristol stool form chart is a useful aid (figure). Parents may mistake incontinence for diarrhoea. In infants under 6 months, dyschezia (episodes of straining and crying lasting for at least 10 minutes before the passage of soft stools in an otherwise healthy baby) may be mistaken for constipation. Physical examination includes palpation of the abdomen for a faecal mass. The rare possibility of developmental abnormalities such as anal stenosis or ectopia and of sacral anomalies should be considered at this stage. A plain x ray of the abdomen may show a rectal faecal mass that is not palpable in the abdomen, though the evidence for an association between the clinical and radiological diagnosis of constipation is conflicting[12] and routine radiography is not recommended.[13] Practitioners disagree about the value of rectal examination. It may sometimes be helpful, but some practitioners never do it. Good rapport with the patient and parents should be established before it is done. Other investigations are unnecessary in the initial assessment.

What treatments work?

The evidence for effectiveness of treatments is weak. Therapeutic trials have used a range of outcome measures; those of greatest clinical relevance are the number of defecations per week, use of laxatives, stool consistency, pain, difficulty in defecation, and number of soilings per month.

Osmotic laxatives

No randomised controlled trials have compared osmotic laxatives versus placebo in children. Two small randomised trials found no significant difference in

Type 1 - Separate hard lumps, like nuts

Type 2 - Sausage-like but lumpy

Type 3 - Like a sausage but with cracks in the surface

Type 4 - Like a sausage or a snake, smooth and soft

Type 5 - Soft blobs with clear-cut edges

Type 6 - Fluffy pieces with ragged edges, a mushy stool

Type 7 - Watery, no solid pieces

Bristol stool form chart.[30] Reproduced with permission

Additional educational resources

Clayden GS, Keshtgar AS, Carcani-Rathwell I, Abhyankar A. The management of chronic constipation and related faecal incontinence in childhood. *Arch Dis Childhood (Educ Pract)* 2005;90:58-67.

Baker SS, Liptak GS, Colletti RB, Croffie JM, DiLorenzo C, Ector W, et al. Constipation in infants and children: evaluation and treatment. A medical position statement of the North American Society for Pediatric Gastroenterology and Nutrition. *J Pediatr Gastroenterol Nutr* 1999;29:612-26.

Rubin G. Constipation in children. In: *Clinical evidence concise. Issue 15*. London: BMJ Publishing Group, 2006:85-6.

Gordon J, Reid P, Thompson C, Walford C. *"Tough going." Childhood idiopathic constipation management pathway: a resource for health professionals*. Edinburgh: Royal Hospital for Sick children, 2001. www.nhslothian.scot.nhs.uk/quicklinks/RHSC_CONSTIPATION2.PDF

stool frequency or consistency between lactulose and lactitol after two to four weeks in children aged 8 months to 16 years, both having benefit.[14 15] One of the trials found that lactulose increased abdominal pain and flatulence more than lactitol. A third randomised trial in non-breastfed constipated infants found no difference between different strengths of lactulose.[16]

One randomised controlled trial has compared polyethylene glycol (PEG 3350) with lactulose in 100 children aged 6 months to 15 years, using a composite measure of success comprising defecation three or more times per week and encopresis once or less every week after eight weeks.[17] Treatment was significantly more successful in the PEG group than in the lactulose group (56% *v* 29%), and adverse effects were fewer. A second study confirmed the clinical and biological tolerance of PEG in children treated for three months and found it better than lactulose in respect of vomiting and flatulence side effects.[18]

Stimulant laxatives

A Cochrane review (search date 2001) found no randomised controlled trials that adequately met the selection criteria, and it concluded that there is insufficient evidence on the use and effectiveness of stimulant laxatives for the treatment of childhood constipation.[19] The studies identified were all comparative, used multiple interventions, and had small sample sizes. One quasi-randomised study in 37 children (aged 3-12 years) with chronic constipation found that after six months senna was significantly less effective than mineral oil concentrate in achieving daily bowel movements or reducing involuntary soiling.[20] We found no subsequent placebo controlled randomised trials of the effects of stimulant laxatives in children.

Biofeedback and other psychological interventions

Two types of biofeedback have been widely studied, pressure biofeedback and electromyography biofeedback. In both, an audio or visual display is generated of the child's efforts to consciously contact and relax the muscles around the anus. This is compared with the pattern of someone doing the same thing normally, and the child then practises to replicate that pattern. One systematic review (search date 2006; eight randomised controlled trials all of children with functional faecal incontinence)[21] found higher rather than lower rates of persisting faecal incontinence after up to 12 months when biofeedback was added to conventional treatment (odds ratio 1.11, 0.78 to 1.58). One small trial of behaviour modification as an adjunct to laxatives found a significant reduction in soiling episodes at three and 12 months (odds ratio 0.20, 0.06 to 0.65). In the systematic review, sample sizes were generally small, and interventions and outcomes varied among trials. Other interventions, such as positive reinforcement and skills building, and interactive parent-child family guidance, have been the subject of descriptive studies and case reports only.

Increased dietary fibre

No systematic reviews or randomised controlled trials of increasing dietary fibre in children with constipation have been reported.

Management plan

The Childhood Constipation Working Group of the British Society of Paediatric Gastroenterology, Hepatology, and Nutrition recently reported that, on the basis of a systematic review of available treatments, there was insufficient evidence to allow any recommendations for practice and that guideline development would need to be based on a synthesis of clinical experience, evidence, and consensus.[22]

The following is a synthesis of current guidelines from the United Kingdom[23] and North America.[10]

Initial rapport

A critical first step is to manage the anxiety of both parent and child, to deal with attitudes of guilt or blame if they exist, and to develop a treatment plan. The child may be fearful of painful defecation and parents need to understand that coercive toilet training in this situation will be ineffective. In older children, faecal incontinence and its social consequences needs a non-accusatory, sympathetic management approach. A positive approach on the part of the clinician and a carefully explained management plan with the assurance of continued involvement over an extended period of time all contribute to an effective therapeutic relationship.

The objectives of treatment are to remove faecal impaction, to restore a bowel habit in which stools are

Information resources for patients

Constipation in children. Best Treatments. 2006. www.besttreatments.co.uk/btuk/conditions/17264.html

An excellent, highly professional website with lots of links that give visitors additional detail. The content is based on that in *Clinical Evidence*

Constipation in childhood. CORE. www.digestivedisorders.org.uk/Default.aspx?docname=doc_childhoodconstip

A patient information leaflet that contains easily understood explanations of the causes, patients' experience, and treatment of constipation

soft and passed without discomfort, and to ensure self toileting and passing stools in appropriate places.

Disimpaction

The objective of disimpaction is to fully clear the rectum of retained faeces. High doses of mineral oil or polyethylene glycol 3350 (1-1.5 g/kg/day for three days[24]) have been shown to be effective. Although many of the other available laxatives have also been used, evidence of their effectiveness is lacking. The use of suppositories, enemas, and manual evacuation is more contentious and a careful balancing of physical and psychological benefits and harms is necessary. Many paediatricians avoid rectal treatments if at all possible. Glycerol suppositories are suitable for infants and bisacodyl suppositories for older children. Phosphate, saline, or mineral oil enemas are effective; soap and water, and magnesium enemas are potentially toxic and should be avoided. In rare circumstances disimpaction under anaesthetic is indicated.

Maintenance therapy

It is sensible to use laxatives over an extended period, which may be months or years, in order to establish a normal bowel habit and improve rectal awareness. This seems preferable to frequent attempts to wean off treatment, followed by the repeated need for disimpaction. Osmotic laxatives have the best evidence for effectiveness, and PEG is less likely to produce side effects than lactulose. The dose should be adjusted to achieve the passage of soft, formed stools. The chronic use of stimulant laxatives is contentious. They have been widely used in clinical practice, usually in combination with an osmotic laxative, though prolonged use can precipitate an atonic colon and hypokalaemia. As a result, intermittent use for avoiding a recurrence of impaction has been advocated. Adequate intakes of fluids and fibre should be encouraged, and specialist dietetic advice may be needed. The child and its parents can be asked to keep a bowel chart or diary, such as that contained in the *Tough Going* guide, to provide an objective record of progress.

Behaviour modification

Behaviour modification can be an important element of management and can be effectively delivered in a specialist, nurse led clinic. Regular toileting and unhurried time on the toilet should be encouraged. A reward system, especially one that is geared toward successful use of the toilet as opposed to clean pants is important. A diary of stool frequency can be helpful, and it can be linked to a system of reward as well as being a focus for positive reinforcement at surgery visits.

Dealing with incontinence

Both child and parents need a careful explanation of the involuntary process that leads to faecal incontinence as an essential first step. Rectal contractions occur regularly even in constipation, and are associated with transient relaxation of the internal sphincter. This allows loose or liquid stool in the vicinity to leak out. The child can be helped to focus on regular defecation and checking/changing of underclothes as positive actions to prevent the problem. Involving the school nurse can help with access to toilet facilities and make teachers aware of the child's problems. Though several studies have shown associations between encopresis, soiling, or incontinence and psychological and behavioural problems, good evidence of the effectiveness of psychological interventions in these children does not exist.

Summary points

- Explicit criteria for the diagnosis of constipation and a defined terminology now exist
- The evidence for effectiveness of treatments in childhood constipation is weak; management is based largely on clinical experience and consensus
- Children with constipation and faecal incontinence benefit from regular support and guidance, particularly in establishing a regular and more normal toilet routine
- Childhood constipation is often a long term problem requiring treatment over months or years

When to refer for specialist care

Assessment by a specialist with an interest in childhood constipation is necessary if an organic cause is suspected, if treatment is unsuccessful, or when management is complex. Treatment failure may be early, when attempts at disimpaction fail, or late, if there is difficulty maintaining remission. If an underlying problem is suspected, the general practitioner can instigate blood tests for inflammatory markers, hypothyroidism, hypercalcaemia and coeliac disease before the child attends outpatients.

Further investigation is usually not required, but support by the specialist nurse, psychology department, or child and adolescent mental health team can be provided as appropriate, sometimes over months or years. Assessment of colonic transit time is used by some specialists to separate those children with soiling but normal transit time (who may benefit from behavioural modification or psychological evaluation) from those with constipation and a delayed transit time, in whom treatment outcomes are poorer.[25] Other investigations and their indications are listed in box 3.

Specialist follow-up typically takes place in a nurse led clinic at intervals of one to three months, depending on progress, with medical review as required. Families can be provided with a contact number in case they need help urgently. Multidisciplinary team meetings are particularly valuable for those children with associated family or psychological problems.

Surgery for functional constipation

In rare instances, continued failure to respond to treatment may require surgical intervention. Formation of a caecostomy and antegrade continence enemas can reduce frequency of soiling and abdominal pain in children with slow transit constipation, though stoma complications (stenosis, leakage, pain related to the catheter) are common.[26] More recently, botulinum

toxin has been used, with variable results, on the basis of the concept that some patients have a short aganglionic segment above the pectinate line, sometimes called "ultra-short Hirschsprung's disease."[27] Anal dilatation has no benefit in functional constipation.[28]

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A memorable patient

Fear of onward travel

We had had a patient on the ward for several weeks whom we could not get to leave. He was almost bed bound but had come in with an acute deterioration, which turned out to be gout in his knee. However, despite this improving, he would not accept the possibility either of going home or of placement in a nursing home. A good friend of his, whose home he lived in, visited every day, and she was involved by him in all conversations about management decisions.

Whatever suggestion for onward travel was made was rebutted by either him or his friend. Eventually a case conference was called, and it was agreed that a nursing home would be the best place to serve his needs. However, his friend continued to try and keep him on the ward by rejecting all possible nursing home placements, with his agreement. The situation continued, and every day, as the senior house officer, I would go and talk to them both to try and elicit their fears and try to find a way forward.

One day, the patient's friend came on to the ward looking flustered, and as usual I was seated at the reception desk doing paper work. I offered her a cup of tea because I was about to have one anyway and asked if she wanted to sit at the desk with me. She gratefully accepted. Over the next 25 minutes, while I was signing off results and updating notes, this woman told me of her concerns about removing her friend from the hospital, and explained to me the experiences she had previously had with her mother in the same situation. One by one, we were able to allay her fears as she tackled them at her own pace. As we drained our cups together, she shook my hand and said thank you.

Within two weeks our mutual charge was in a suitable nursing home. This reminded me that sometimes we forget to allow people to speak to us on their own terms, and, until we do, we cannot expect to form a good relationship. Of course, it also reminded me of the value of a cup of tea to facilitate a proper conversation.

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