CHILDHOOD CONSTIPATION & SOILING

CONSTIPATION OVERVIEW

BACKGROUND

- Idiopathic constipation affects 5-30% of children and without early diagnosis and treatment can become a long term condition that is difficult to resolve (NICE 2010).

- Children and parents often experience confusion, frustration and despair when confronted with this condition and may delay seeking help through embarrassment and fear of a negative response from healthcare professionals.

- Soiling is debilitating but rarely life threatening, so it might be expected to have little impact on healthcare provision.

- Many children and young people experience social, psychological and educational consequences that require prolonged support.

- Without early diagnosis and treatment, an acute episode of constipation can lead to anal fissure and become chronic.

- 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.

Chronic Constipation in Childhood – A Hidden Disability

The impact on the child and family is enormous

- Taboo
- Ostracised
- School life adversely affected
- Social life adversely affected
- Family life adversely affected
- Cost
- Lack of understanding
- Lack of help

How constipation develops

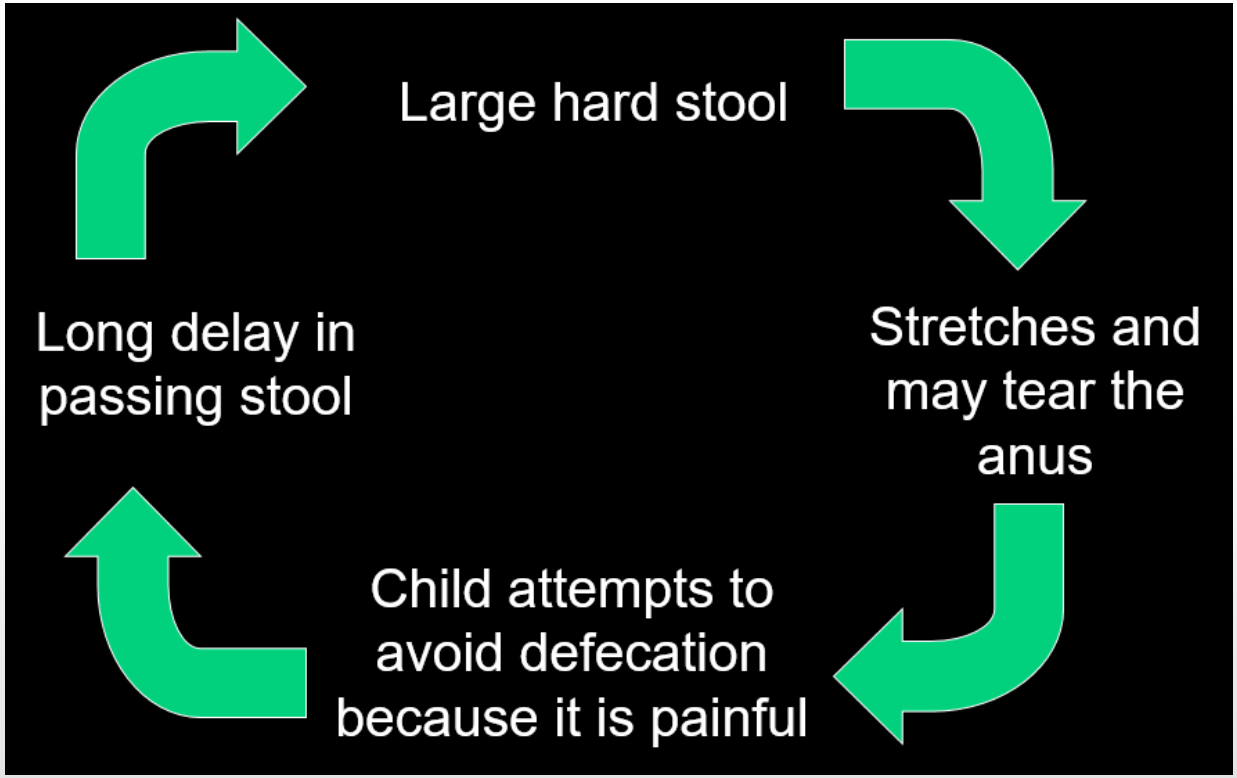
For some children, just one painful experience of pushing out hard, dry stools can cause them to become afraid of doing a poo again.

This can get the child into the habit of avoiding going to the toilet, in case it hurts. This is not the child's fault.

They start to hold in stools by tightening the muscles around the anus to keep it closed and put off the urge to poo.

The build up of stools in the rectum causes it to stretch, making it harder for the child to feel the urge to poo.

THE VICIOUS CYCLE OF CONSTIPATION



Other symptoms associated with Constipation

Abdominal pain: Vague none specific pain to very severe pain which may be diagnosed as an acute abdominal pathology

Reduced appetite: Often children with chronic constipation have a reduced calorific intake

Nausea and vomiting: Possibly as a result of disturbed peristalsis

OVERFLOW SOILING

DEFINITION OF FAECAL SOILING

(as a result of constipation or faecal impaction)

Also called: holding on, functional retentive soiling or overflow

Faecal soiling is the passage of liquid or formed stools in the child's underwear. It is often referred to as 'overflow'

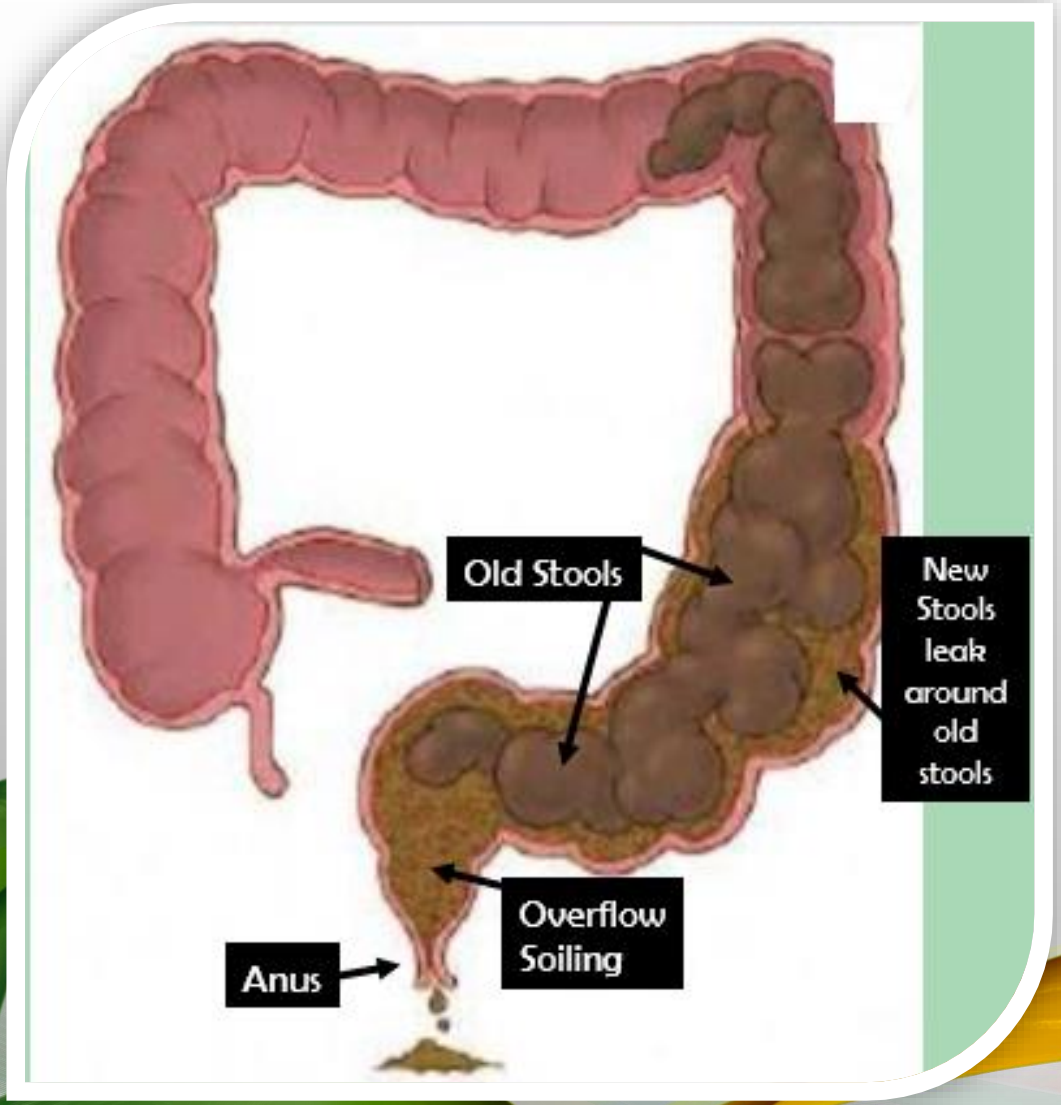
It is the inappropriate passage of stool caused by long term constipation

Faeces are often loose and could be mistaken as 'diarrhoea'

It is an involuntary action over which the child has no control

Large stools get stuck and block the child's bowel. Liquid stools above the blockage flow around it and the child may leak watery stools into their underwear. This happens without them doing anything - it is not their fault!

A closer Look...



When stools first join the large intestine, they do so as a soup like mixture. As they travel around the large intestine, more and more water is absorbed from them.

The longer they have been present inside the bowel, the drier / harder / smellier they will become.

As new stools enter the large intestine, they meet the "faecal mass" present within the bowels. Because the large intestine has not had time to absorb much water from the stools, they can leak around the faeces that are sitting within the bowel. This is often mistaken for diarrhoea.

We have so many parents saying "My child cannot be constipated as they have diarrhoea..." It may look that way, however the likelihood is that what their child is experiencing is actually overflow soiling.

DIFFERENCE BETWEEN OVERFLOW SOILING AND DIARRHOEA

OVERFLOW SOILING	ACCIDENTAL SOILING
• Easily mistaken for diarrhoea • Child has no sensation • Poo can be dry crumbly, gloopy • Poo can be constantly leaking • Sticks to child and needs scrubbing off • Will not wash out of underwear	• Usually is diarrhoea • Child has sensation • Poo is usually wet • Single episode • Easily washed off child • Easily washes out of underwear

TREATMENT

1

3

2

The THREE main components of treatment are :

1. **Education**
2. **Disimpaction**
   a. Oral
   b. Rectal
   c. Manual
3. **Maintenance therapy**
   a. Dietary interventions
   b. Toileting programmes
   c. Laxatives
   d. Follow up

1 EDUCATION

Aims: To alleviate blame

To enlist co-operation

- Parents should be positive and supportive
- Explain why constipation happens
- A child CANNOT help faecal soiling
- NEVER EVER reward clean underwear
- Always reward bowel action
- It may take some time to improve things

2 DIS-IMPACTION

When a child has been diagnosed with faecal impaction, the first treatment would be to commence a dis-impaction regime.

You would follow the guidelines on the next page, depending on the age of the child.

MOVICOL PAEDIATRIC PLAIN

Faecal impaction dosage

Age	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Number of sachets (daily dose to be taken over a 12 hour period)							
5 – 11 years	4	6	8	10	12	12	12
2 – 4 years	2	4	4	6	6	8	8
12 months – 23 months	2	4	4	6	6	8	8
1 – 11 months	0.5 – 1 sachet daily						

HOW TO DIS-IMPACT

Stay on Movicol Dis-impaction schedule until type 7 stools are reached

Stay on this dose for 3 full days to fully dis-impact

There is no need to complete full schedule once 3 days at type 7 stools have been reached

After this, reduce Movicol by 2 sachets a day until type 5 stools are reached

Medication will need to be titrated according to stool type, to achieve maintenance dosage

DO NOT STOP TAKING MOVICOL. MAINTAINENCE DOSE MUST BE CONTINUED FOR A MINIMUM OF 6 MONTHS OR THE CHILD WILL BECOME IMPACTED AGAIN

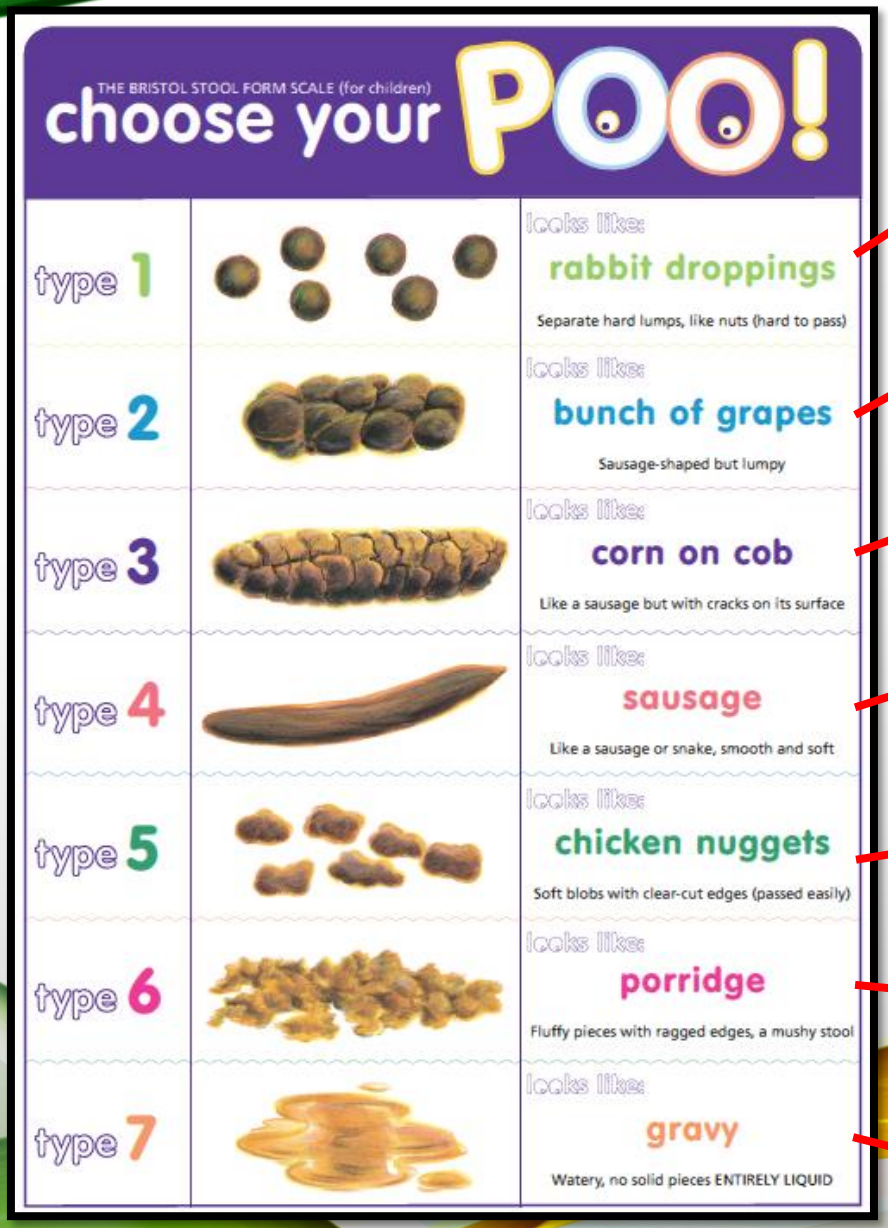
3 MAINTENANCE THERAPY

Once the faecal impaction has been cleared, the treatment then focuses on the prevention of a recurrence of impaction.

The purpose of maintenance therapy is to help the muscles and nerves of the rectum recover sensitivity and strength by promoting regular toileting and preventing further stool impaction.

The goal is to achieve one soft stool (Type 5 on Bristol Stool Chart) per day

BRISTOL STOOL CHART



Increase dose

Increase dose

Increase dose

Maintain/increase dose

Maintain/decrease dose

Decrease dose

Decrease dose

GENERAL POINTS

DISIMPACT, THEN MAINTAIN

Follow the oral route of disimpaction rather than the anal route – it's better tolerated by everyone concerned!

Discuss the available treatments and gain approval from the child and their parents / carers for improved compliance.

BEHAVIOURAL CHANGES AND REWARDS

- Rewards should be small, instant and manageable.
- Star charts and stickers. Family charts…
- Pennies!
- Always praise the poo *never ever* praise clean underwear.
- Reinforce good behaviour with treat.

NICE GUIDELINES

CONSTIPATION IN CHILDREN AND YOUNG PEOPLE

NICE
OVERVIEW OF THE MAIN RECOMMENDATIONS

Take a history to establish whether the child is constipated

If constipation is present, exclude any underlying cause and establish a diagnosis of idiopathic constipation. If findings and diagnostic clues indicate the possibility of an underlying condition/disorder ("red flag" symptoms) refer the child urgently

Carry out a physical examination and urgently refer children with red flag symptoms

RED FLAGS –

Does the child meet any of the following? If yes to any answer, please refer without delay.

- Symptoms from birth or first few weeks of life? Y ☐ N ☐
- Failure/delay to pass meconium? (more than 48 hours after birth in a term baby) Y ☐ N ☐
- Abnormal perianal examination? Y ☐ N ☐ Not Examined ☐
- Abnormal lower limb neurology? Y ☐ N ☐
- Abnormal lumbo-sacral spine examination? Y ☐ N ☐
- Severe abdominal distension? Y ☐ N ☐
- Faltering growth? Y ☐ N ☐
- (Significant concern about a possible underlying cause such as coeliac disease)

Inform the child and family if idiopathic constipation is diagnosed. Reassure them that there is a suitable treatment but it may take time to work

Assess for faecal impaction and treat with an oral medication regimen. Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain. Children undergoing disimpaction should be reviewed within *one week.*

If the bowel is not impacted, or when disimpaction is complete, start maintenance therapy and continue ongoing treatment. Children should be reassessed regularly, preferably by the same person or team, to ensure impaction does not recur.

Any questions, please contact us on:

Tel:

01322 428 550.

Email:

dgn-tr.dvh-childhoodconstipation@nhs.net

Constipation Knowledge Recap:

Constipation Overview:

Do you know how chronic constipation develops and can you effectively explain the viscous cycle of constipation?

Overflow Soiling:

Can you explain what overflow soiling is and how it becomes present and can you distinguish the differences between overflow soiling and diarrhoea?

Treatment:

Can you remember the 3 components of treatment?

Dis-Impaction:

Are you comfortable with the Dis-Impaction treatment regime and can you effectively use the NICE Faecal Dosage chart?

Diagnosing:

Are you comfortable with the red flags you are required to be aware of when diagnosing constipation?

Maintenance:

Can you remember when the Dis-Impaction regime ends and maintenance begins and can you effectively identify the types of stools within the Bristol Stool Chart?

Diagnosing:

Could you effectively diagnose constipation based on the NICE guidelines?

Case Study 1:

Six year old Bella has presented in A&E with abdominal pain and her parents tell you she hasn't had a bowel motion for 3 days and is very lethargic. On examination, you feel that her tummy is quite distended.

How would you move forward with Bella's treatment?

Case Study 2:

You have taken a phone call from a trainee health care professional, who is unsure if their patient has the symptoms of overflow soiling. They would like you advice on what to look out for. The patient's parent is adamant that constipation is not possible because their child is passing stools several times per day.

What would you tell the health care professional?

Case Study 3:

Lucas has suffered with constipation for a while and embarked on a dis-impaction regime 4 months ago, and is 9 years old. Recently, he has welcomed a baby sister and now mum has noticed he has began to with-hold his stools. He hasn't opened his bowels for a couple of days and currently takes 1 x sachet of Movicol daily. Mum is worried as Lucas has been sick today, and is very upset.

What would you tell the health care professional?

Case Study 4:

Megan needs fully dis-impacting. She is 4 years old and red flags have been ruled out. Mum is unsure how to begin dis-impacting Megan and would like a detailed explanation of why she has to dis-impact, along with what dosage is safe for her to take.

How would you help Megan's mum to commence dis-impaction?