



CHILDHOOD CONSTIPATION

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Rome III diagnostic criteria – in absence of organic pathology ≥ 2 occur

Child with a developmental age <4 years

- 2 defecations per week
- At least 1 episode of incontinence per week after the acquisition of toileting skills
- History of excessive stool retention
- History of painful or hard bowel movements
- Presence of a large fecal mass in the rectum
- History of large-diameter stools that may obstruct the toilet

Child with a developmental age 4 years and above







- 2 defecations in the toilet per week
- At least 1 episode of fecal incontinence per week
- History of extensive retentive posturing
excessive volitional stool retention
- History of painful or hard bowel movements
- Presence of a large fecal mass in the rectum
- History of large-diameter stools that may obstruct the toilet



Bristol stool chart

THE BRISTOL STOOL FORM SCALE (for children)

Choose your Poo!

type 1		looks like: rabbit droppings Separate hard lumps, like nuts (hard to pass)
type 2		looks like: bunch of grapes Sausage-shaped but lumpy
type 3		looks like: corn on the cob Like a sausage, but with cracks on the surface
type 4		looks like: sausage Like a sausage or snake, smooth and soft
type 5		looks like: chicken nuggets Soft blobs with clear-cut edges (passed easily)
type 6		looks like: porridge Soft blobs with clean-cut edges (passed easily)
type 7		looks like: gravy Watery, no solid pieces ENTIRELY LIQUID



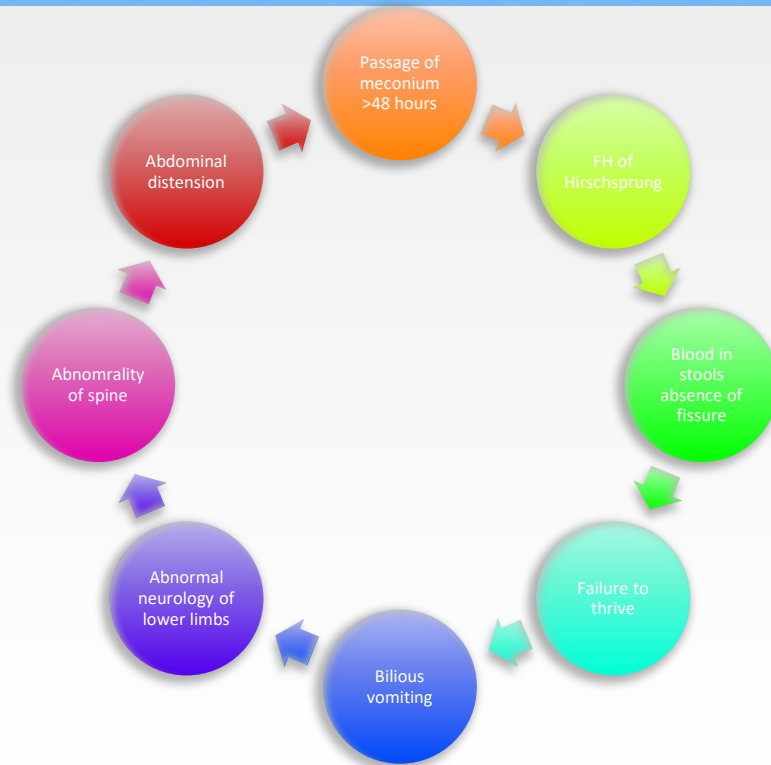
Clinical presentation

- History and examination is very important
 - Symptoms as per Rome III criteria
 - Some children present with abdominal pain and rarely rectal bleeding
 - Meconium at birth
 - Neurology examination of spine and lower limbs





Red flags in history and examination – referral to tertiary service





Primary Investigation

- Coeliac disease antibodies
- Thyroid function tests



Management

Age < 6 months

- Increase water
- Breast feeding counsellor
- Avoid multiple feed changes
- Lactulose accordingly
- Avoid stimulants

Age > 6 months

- Increase water
- Diet – fibre
- Macrogol
- Use stimulant early for straining
- Toilet training



Faecal Impaction

- Presence of a large faecal mass in rectum or abdomen
– occurs in 50% of children with FC
- Plain AXR may be used in whom faecal impaction is suspected
- Polyetheylene glycol (PEG) and enema are equally effective for fecal impaction





Laxatives

Osmotic	Stimulant	Rectal
PEG 3350/4000	Sodium picosulfate	Phosphate enema
Lactulose	Senna	Sodium citrate (micralax)
Docusate sodium	Bisacodyl	Bisacodyl enema and supp
Milk of magnesia	Docusate sodium	Glycerol supp



When to refer to tertiary service

- Red flag symptoms and signs
- Refractory to macrogols and stimulants
- Recurrent disimpaction required



When to wean medications if child has responded

- Approximately 50 % of children with FC can stop medication within 6–12 months after initiation of treatment
- Weaning can be considered when symptoms are stable under maintenance treatment, which means
 - children have a defecation frequency of ≥ 3 times per week and do not fulfill any any Rome III criteria
- Medication should be gradually reduced, rather than abruptly discontinued
 - If child responded to stimulants wean osmotic laxatives first – do not stop gradually wean

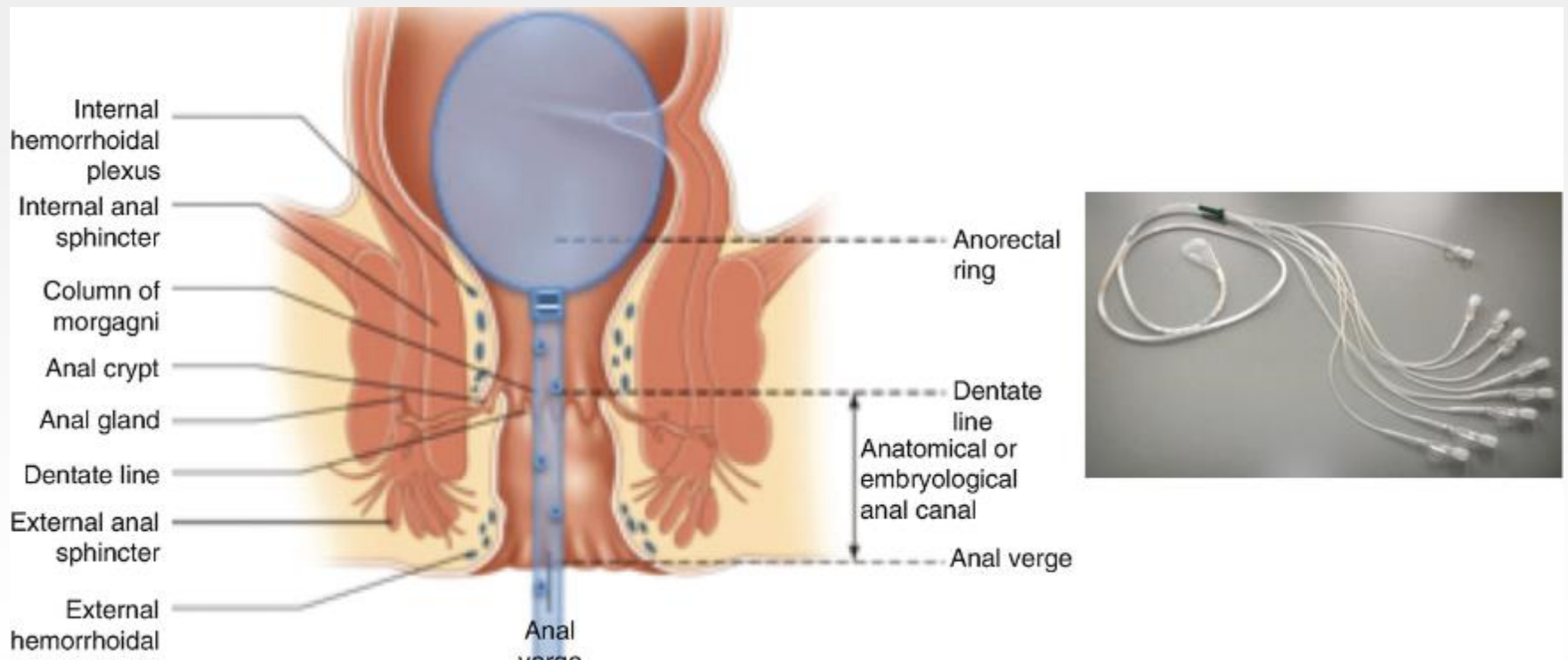


Specialist Investigations – transit marker study





Specialist Investigation – Anorectal manometry





Trans anal irrigation



