Chronic constipation in childhood can result in acquired mega colon / rectum if inadequately treated leading to potential ongoing chronic problems into adulthood, including death.

Child presenting with difficulties opening bowels or with regular soiling

- Is the child passing stools / soiling more than 3 times per day?
  - Yes: Proceed with faecal impaction treatment
  - No: Proceed with maintenance dose of laxatives

Consider faecal impaction. Child to commence disimpaction laxative regime (escalating doses of macrogol as per NICE guidelines)

- Is the child passing stools at least x 3 per week with no straining or discomfort?
  - Yes: Proceed with maintenance dose of laxatives once disimpaction complete
  - No: Proceed with scheduled toileting after meals as part of bowel training programme

Advise re appropriate dietary and fluid intake and encourage regular toileting after meals

Child to be kept under regular review

- Continue laxatives for at least 6 months and cautiously reduce as necessary
- Monitor and discharge as appropriate

Is the child passing regular type 6-7 stools on Bristol Stool Form scale?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Proceed with consideration on to clinician with specific expertise in the management of constipation - for consideration of rectal laxatives (suppositories / micro enema) if tolerated and trial of transanal irrigation (TAI) if indicated

Is the child passing type 1-3 stools on Bristol Stool Form scale?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Proceed with review of laxative regime and adjust if necessary

Is the child passing type 4-5 stools on Bristol Stool Form scale?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Consider introducing laxatives (macrogols); dose to be tailored to ensure passage of regular easily passed stools

If constipation has been excluded, consider referral for further investigation e.g. test for coeliac disease

Is the child passing regular type 1-3 stools on Bristol Stool Form scale?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Proceed with review of laxative regime and adjust if necessary

Is the child passing regular type 4-5 stools on Bristol Stool Form scale?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Consider introducing laxatives (macrogols); dose to be tailored to ensure passage of regular easily passed stools

If constipation has been excluded, consider referral for further investigation e.g. test for coeliac disease

Is the child passing stool at least x 3 per week with no straining or discomfort?

- Yes: Proceed with maintenance dose of laxatives once disimpaction complete
- No: Proceed with scheduled toileting after meals as part of bowel training programme

Advise re appropriate dietary and fluid intake and encourage regular toileting after meals

Child to be kept under regular review

- Continue laxatives for at least 6 months and cautiously reduce as necessary
- Monitor and discharge as appropriate

Any progress at 3 / 12 review?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Proceed with review of laxative regime and adjust if necessary

Any progress at 3 / 12 review?

- Yes: Proceed with scheduled toileting after meals as part of bowel training programme
- No: Proceed with review of laxative regime and adjust if necessary

Review laxative regime and adjust if necessary
Constipation in children and young people with learning disabilities (LD)

Constipation is a common childhood problem affecting up to 30% of all children at any time. Identified in a timely manner, it is relatively easy to treat and once the constipation has resolved, it does not usually result in any long-term problems.

However, for those with learning difficulties, constipation is more prevalent, affecting up to 50% of individuals. In these circumstances, unless the constipation is adequately treated in the initial phase, it can go on to cause lifelong problems and in some instances even death.

For this reason, constipation should always be treated seriously and adequately treated using a laxative regime that resolves the symptoms. Macrogols are normally first-line treatment. However, an alternative laxative should be used if the child will not take or does not tolerate macrogols (as per NICE guidance). Treatment with laxatives may need to be continued for several months, if not longer; the dose should be gradually reduced over time rather than being stopped suddenly.

The child may initially present with ‘diarrhoea’ or loose stools which may mask an underlying faecal impaction. For this reason, any child presenting with an apparent bowel problem should always be assessed and an appropriate treatment programme put in place. The child’s progress should be regularly reviewed and adjusted as necessary. If, despite everyone’s best efforts, the problem does not resolve within three months of presentation, the child should be referred on to a clinician with appropriate expertise.

Failure to adequately treat and resolve the constipation can result in the development of an acquired megacolon or rectum with all the associated risks.

Stool withholding, sensory and proprioception problems can affect many children with LDs and compound the problem with constipation. It is important that these particular issues are managed appropriately and the affected child supported within an individualised behaviour modification programme.

References and further reading


