OHSU Pediatric Gastroenterology

CONSTIPATION IN CHILDREN – MEDICAL MANAGEMENT

Constipation is a common pediatric problem that can be managed at the primary care provider level. The goal is for the child to have a regular, soft stool daily. Medications should be given on a regular basis to ensure that this occurs, particularly children with encopresis and soiling where the goal is to stop soiling. It is important in assessment to ensure the child has a normal rectal exam.

Families also should understand it may take over a year for this problem to resolve, and that some individuals with slow motility require stool softeners and laxatives throughout their lives.

Recommended management approach

- Maintenance stool softeners and/or laxatives should be in sufficient amounts to elicit a daily, mushy bowel movement. Most children require this aggressive approach for 9-18 months to break the cycle of fear of pain with defecation and stool withholding. Tapering the medications too soon is often unsuccessful. Plan a therapy for 6-12 months before a trial of weaning/tapering. Polyethylene glycol (Miralax) is the mainstay of therapy, with nighttime dose of senna product such as Ex-Lax squares for encopretics or neurologically impaired patients with slow bowel motility.
- Behavior modification includes sitting on the toilet for 10-15 minutes after breakfast (to stool before school) and after dinner with a book – no video games on the toilet. We do not suggest toilet sitting for young children not yet toilet trained.
- While fiber plays a minor role in the management of constipation in children, modest increases in fiber help decrease vascillation in stool consistency; breads and cereals should have at least 2 gm of fiber per serving. In older children we use Benefiber; try the chewable tablets.
- Bowel cleanouts, when the child is backed up with stool, can usually be managed at home by doubling medications for 3-4 days. If there is a large rectal plug, the child may also need a daily glycerin suppository for 4 days while oral laxatives are stepped up. Occasionally, with large rectal masses, enemas are also required. Avoid rectal medications in children who have been sexually abused. Miralax can be used for cleanouts at 1.5 gm/kg/day for 4 days (up to 6 capfuls per day) then drop back to maintenance dosing of 0.4 gm/kg/day. Enemas and suppositories may be necessary in older children who are impacted with stool. Do not give more than one phosphate containing enema in a day. Fleet's phosphate enemas should not be given to infants, and monitored carefully if used in young children due to possibly fatal fluid & electrolyte shifts.

Adjuncts to therapy

Sugar-free gum has sorbitol or xylitol. These sugar alcohols act as laxatives, and may help in the therapy of older children who are non-compliant with medication.

Useful tips

If an encopretic patient presents with persistent soiling despite medication, and if not apparent by abdominal exam, perform a rectal exam to see if there is a large plug of stool that may necessitate more aggressive therapy or dialing back the medication. Medical non-compliance is best addressed by a behavioral therapist or adolescent specialist.

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