Management of Functional Constipation

1.0 Introduction

This pathway is for use with children aged 1-18 years old with no underlying disease or comorbidity who have been diagnosed with functional constipation. Patients are to be removed from this pathway if there is a change in diagnosis.

1.1 Target Users: physicians, nurse practitioners and nurses hospital wide, physicians and nurse practitioners in the community

2.0 Definitions

Functional constipation - constipation without objective evidence of a pathological
condition

**PEG3350**- polyethylene glycol 3350

**Disimpaction** - removing fecal mass prior to starting maintenance therapy

**Rome III Criteria** - criteria used as a diagnostic aid for functional constipation

**Osmotic agent** - medicine that helps draw water into the stool and make it softer

**Stimulant laxative agent** - medicine that stimulates the bowel to function

**Encopresis** - fecal soiling

### 3.0 Clinical Practice Guideline

This pathway was developed by an interdisciplinary clinical team from SickKids and the Greater Toronto Area using research knowledge, clinical experience and consensus agreement. This pathway is a general guideline and does not represent a professional care standard governing providers' obligations to patients. Care is revised to meet individual patient needs.

### 4.0 Decision Tree/Algorithm
5.0 Definition of Constipation

5.1 Delay or difficulty in defecation present for two or more weeks, and sufficient to cause significant distress to the patient.
5.2 Rome III diagnostic criteria for functional constipation
(criteria fulfilled at least once per week for at least two months before diagnosis):

Must include two or more of the following in a child with a developmental age of at least four years, with insufficient criteria for the diagnosis of irrritable bowel syndrome.

1. Two or fewer defecations in the toilet per week
2. At least one episode of fecal incontinence per week
3. History of retentive posturing or excessive volitional stool retention
4. History of painful or hard bowel movements
5. Presence of large fecal mass in the rectum
6. History of large diameter stools that may obstruct the toilet

6.0 Differential Diagnosis of Constipation

6.1 Non-Organic

- Developmental - cognitive handicaps, attention-deficiet disorders
- Situational - coercive toilet training, toilet phobia, school bathroom avoidance, excessive parental interventions, sexual abuse, other
- Depression
- Constitutional - colonic inertia, genetic presdisposition
- Reduced stool volume & dryness - low fibre in diet, dehydration, underfeeding/malnutrition

6.2 Organic

- Anatomic malformations - imperforate anus, anal stenosis, anterior displaced anus, pelvic mass (sacral teratoma)
- Metabolic & Gastrointestinal - hypothyroidism, hypercalcemia, hypokalemia, Cystic Fibrosis, Diabetes Mellitus, Multiple Endocrine Neoplasia type 2B, Celiac disease
- Neuropathic conditions - spinal cord abnormalities, spinal cord trauma, Neurofibromatosis, static encephalopathy, tethered cord
- Intestinal nerve or muscle disorders - Hirschsprung disease, Intestinal Neuronal Dysplasia, visceral myopathies, visceral neuropathies
- Abnormal abdominal musculature - Prune Belly, gastroschisis, Down syndrome
- Connective tissue disorder - Scleroderma, Systemic Lupus Erthhematosus, Ehler-Danlos syndrome
- Drugs - opioids, phenobarbital, sucralfate, antacids, antihypertensives, anticholinergics, antidepressants, sympathomimetics, iron supplements, calcium channel blockers
- Other - heavy metal ingestion (lead), Vitamin D intoxication, Botulism, Cows Milk Protein(or other food) intolerance

6.3 Physical Findings Distinguishing Organic Constipation from Functional Constipation

- Failure to thrive
- Abdominal distention
- Lack of lumbo-sacral curve
- Pilonidal dimple covered by tuft of hair
- Midline pigmented abnormalities of the lower spine
- Sacral agenesis
- Flat buttocks
- Anteriorly displaced anus
- Patulous anus
- Tight empty rectum in presence of palpable abdominal fecal mass
- Gush of liquid stool and air from rectum on withdrawal of finger
- Occult blood in stool
- Absent anal wink
- Absent cremasteric reflex
- Decreased lower extremity tone and/or strength
- Absence or delay in relaxation phase of lower extremity deep tendon reflexes

7.0 When to Consult

7.1 Gastroenterology

- When child fails therapy
- When there is a concern for organic disease
- When management is complex

7.2 General Surgery

- Infants with significant constipation or enterocolitis
- Older children only if they present with failure to thrive or very atypical, intractable constipation and have been referred by a pediatric gastroenterologist
- At SickKids refer through ARMS

8.0 Medications
Polyethylene glycol (PEG-3350) is a safe and effective medication for the treatment of functional constipation in children and adults alike. Studies have shown that it is as effective in treating constipation and better tolerated than other osmotic agents, specifically milk of magnesia and lactulose. PEG-3350 does not cause dependency, unlike stimulant laxative agents, and is safe to use over an extended period of time.

8.1 Disimpaction or treatment of encopresis (Goal: the colon has been emptied - disimpaction continues until child is having 1-3 soft bowel movements per day)

- **Polyethylene glycol 3350**: 1-1.5g/kg/day with a maximum of 100g/day for 3-6 days
- **PICO Salax**: 0.5-1 sachet/day for 2 days (with appropriate fluid intake as per instructions on the box)

8.2 Maintenance therapy (Goal: having smooth, easy to pass, large bowel movement at least daily)

- **Polyethylene glycol 3350**: 0.5 - 1g/kg/day. Dose may be titrated until desired effect is achieved

8.3 Preventative therapy for patients on medications that may cause constipation (Goal: prevention of anticipated constipation)

- **Polyethylene glycol 3350**: 0.5 - 1g/kg/day. Dose may be titrated until desired effect is achieved

9.0 If Disimpaction Doesn't Work

- Titrate PEG3350 to effect (increase to maximum disimpaction dose)
- Consider weekly administration of Pico-Salax until soiling resolves (in conjunction with maintenance PEG3350)
- Referral to a pediatric Gastroenterologist
- Consider admission to hospital for lavage therapy
- Consider manual disimpaction under general anesthetic
- **Disimpaction with enemas or suppositories is not recommended, notably in children with developmental delay or autism**

10.0 Community Pediatrician Referral

The list below is comprised of pediatricians in the Greater Toronto Area who have an interest in managing constipation, however child should be followed by primary physician until appointment is made.
11.0 Development Process

11.1 Development Process & Statement of Evidence

This pathway was developed by an interdisciplinary clinical group from SickKids using research knowledge, clinical experience and consensus agreement. A literature search was completed using OVID using key words: children and constipation. This pathway is a general guideline and does not represent a professional care standard governing providers' obligations to patients. Care is revised to meet individual patient needs. Level C: Expert Opinion

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<tr>
<th>Grades of Recommendation</th>
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<td>A</td>
<td>Recommendation supported by at least one randomized controlled trial, systematic review or meta-analysis.</td>
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<td>B</td>
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<td>C</td>
<td>Recommendation supported by expert opinion or experience of a consensus panel.</td>
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11.2 Guideline Group and Reviewers
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12.0 Related Documents

SickKids Formulary
www. aboutkidshealth.ca
Functional Constipation: Your Child's Treatment Plan
Pain Management Clinical Practice Guideline -->

13.0 References

18. Hardikar W, Cranswick N, Heine RG. Macrogol 3350 plus electrolytes for chronic


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