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Constipation

What is constipation?

Constipation is defined as either a decreased frequency of bowel movements or painful passage of bowel movements. Children 1–4 years of age typically have a bowel movement 1–4 times a day. If not daily, more than 90% of children go at least every other day, although these children may be constipated. When children are constipated for a long time, they may begin to soil their underwear. This fecal soiling is involuntary – the child has no control over it.

How common is constipation?

Constipation is common in children of all ages, especially during potty training and school years. Of all visits to the pediatrician, 3% are in some way related to constipation. At least 25% of visits to a pediatric gastroenterologist are due to problems with constipation. In addition, millions of prescriptions are written every year for laxatives and stool softeners.

Why does constipation happen?

Constipation is often defined as organic or functional. Organic constipation has an identifiable cause, such as colon disease or a neurological problem. Fortunately, most constipation is functional, meaning there is no identifiable cause. Functional constipation is still a problem, but there is usually no cause for worry.

In some infants, straining and difficulties expelling an often-soft bowel movement are due to an immature nervous system and/or uncoordinated defecation. Some healthy breast-fed infants also can skip several days without having a movement.

In children, constipation can begin when there are changes in the diet or routine, during toilet training, or after an illness. Occasionally, children may hold stool when they are reluctant to use unfamiliar toilet facilities. School or summer camps, with facilities that are not clean or private enough, are common triggers for withholding in children.

Once the child has been constipated for more than a few days, retained stool can fill up and stretch the large intestine (colon). An over-stretched colon cannot work properly and thus retains more stool. Defecation becomes very painful, so many children will attempt to withhold stool. Withholding behaviors include tensing up, crossing the legs, or tightening leg/buttock muscles when the urge to have a bowel movement is felt. These withholding behaviors are often misinterpreted as attempts to push the stool out. Stool withholding makes constipation worse and treatment more challenging.

How does your healthcare provider know this is a problem for your child?

- Your child has hard or small stools that are difficult or painful to pass.
- Your child consistently skips days without having normal bowel movements.
- Your child has large stools that clog the toilet.
- Other symptoms that can accompany constipation are stomach pain, poor appetite, crankiness, and bleeding from a fissure (tear in the anus from passing hard stool).

In most cases, there is no need for testing prior to treatment for constipation. However, depending on severity, your doctor may order X-rays or other tests to clarify your child's situation.

How is constipation treated?

Treatment of constipation varies according to the source of the problem and the child's age and personality. Some children may only require changes in diet, such as an increase in fiber (often fresh fruits and vegetables) or the amount of water they drink. Others may require medications, such as stool softeners or laxatives. Stool softeners are not habit-forming and may be taken for a long time without worrisome side effects.

Some children may require an initial "cleanout" to help empty the colon of a large amount of stool. This typically entails use of oral laxatives or even suppositories or enemas for a short period of time.

It is often helpful to start a bowel training/retraining routine where the child sits on the toilet for 5–10 minutes after every meal or before an evening bath. It is important to do this consistently to encourage good behavior habits. Praise your child for trying. If the child is not toilet trained yet, it is best to wait until constipation is under control.

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Constipation and Fecal Soiling

What is constipation and fecal soiling?

Constipation is defined as either a decreased frequency of bowel movements or painful passage of bowel movements. Children 1–4 years of age typically have a bowel movement 1–2 times a day, and more than 90% of children go at least every other day. When children are constipated for a long time, they may begin to pass stool in their clothing. This is called fecal soiling, and children are typically unaware that they are going to have an accident.

Another common term is encopresis, which refers to fecal incontinence that is not due to any particular disease. This form of soiling may be voluntary (passage of normal stools in clothing) or involuntary (often loose, liquid stools). Voluntary encopresis may represent significant psychological problems. Involuntary encopresis is much more common and is associated with chronic stool withholding and associated leakage.

Does behavior play a part in constipation and fecal soiling?

Children with constipation and fecal soiling have no control over these bowel movements and should not be punished for soiling episodes. They are often embarrassed by the accidents and may hide soiled underwear, which can be unpleasant for other family members. Another common upsetting behavior is refusal to change dirty clothing, even though the odor is bothersome to others. Children may also wet the bed at night or wet their clothing during the daytime, which is called enuresis. Playmates or siblings may tease children who have accidents, which can lead to embarrassment, school refusal, fighting, and other problems.

As the child and family battle over the child's bowel control, the conflict may extend to other areas of the child's life as well. Schoolwork may suffer, or the child may become angry, withdrawn, anxious, or depressed, often as a result of being teased and feeling humiliated.

How are constipation and fecal soiling treated?

Treatment of constipation and fecal soiling is a three-step process that may take several months to a year to improve, if not longer.

Step 1: The Initial Cleanout removes impacted stool from the colon.

Step 2: Maintenance Therapy prevents stool build-up by keeping stool soft, thus reducing withholding behavior and allowing the colon to return to its normal shape and muscle tone. During this step, it is important to encourage regular bowel movements in the toilet.

Step 3: Counseling and Behavior Modifications may help children who are embarrassed or feel they are "bad" because of the soiling. A counselor can help structure the treatment plan and help the child cooperate.

STEP 1: Initial Cleanout

Large, rock-like stool in the colon must be softened and broken down before it can be passed. Usually the cleanout is approached from above and below.

Oral agents, such as mineral oil, magnesium citrate, polyethylene glycol (PEG 3350), and lactulose, are used to soften stool by pulling water into the stool. These agents are well-tolerated for long periods of time without developing dependence. They are not absorbed by the bloodstream and stay in the colon, though a small amount of magnesium may be absorbed from PEG 3350.

Some children do not like the taste of mineral oil or PEG 3350. Although some medicines come in flavors that your child may like, they can be expensive. These medicines can be combined with chocolate or strawberry drink mix or with Jell-O powder. Alternatively, mineral oil can be blended with orange juice concentrate, ice cream, or chocolate milk. Enemas or suppositories also can be used in the initial cleanout phase. Since they only work on the lower part of the colon, near the rectum, they help "jump-start" the process by softening withheld stool. There are many ways to achieve the initial cleanout. Your doctor will discuss the best plan with you and your child.

STEP 2: Maintenance Therapy

The objective of maintenance therapy is to prevent stool buildup, allow the colon to return to its proper shape and function, and encourage the child to have bowel movements in the toilet.

Many medications used in cleanout are also used for maintenance, only at lower doses. Maintenance therapy involves several steps:

1. Increase or decrease the medication to obtain 1–2 soft-formed daily bowel movements.
2. If the child is toilet-trained, he/she should be encouraged to sit on the toilet for 5 minutes and try to have a bowel movement, 15–30 minutes after a meal or snack. Try to do this at least twice daily.

Potty practice guidelines:

- After meals, especially after breakfast, is the best time for this "toileting practice" or "sit" – a full stomach makes most people feel the need to have a bowel movement.
- A large, warm drink also may help induce this feeling.
- After a warm bath may be another good time to attempt a bowel movement.
- Place a box or stool under the feet of smaller children to raise their knees higher than their hips, which will help them bear down.
- Very small children may feel safer if they face backwards on the toilet or use a potty chair.

3. Increase fiber intake by encouraging consumption of whole grains, fruits, vegetables, peanut butter, dried fruits, and salads. Give children at least two fiber servings every day.

Fiber serving suggestions:

- Bowl of bran cereal
- One tablespoon wheat bran mixed in food (yogurt, soup, salad)

- One tablespoon of psyllium
- Bran muffin
- Commercial fiber supplement, such as fiber cookies, or one serving of Metamucil or Citrucil in 8 ounces of water (see package directions).

4. Increase fluids in the diet, especially water and water-rich foods, which usually are fiber-rich.
5. Increase physical activity – exercise helps the colon move.
6. It is important to encourage older children to take responsibility for their own actions. An older child should be responsible for regularly taking medicine, sitting on the toilet, and cleaning up stool accidents. Each family must decide what level of responsibility to expect of the child. Having a calendar to mark doses and "sits" can help keep track.

Step 3: Counseling

The child's condition often becomes a family problem – a counselor may help reduce the tension that children and families feel because of constipation and fecal soiling. It is important to try to avoid anger or punishment around accidents, even though this may be difficult. The child may have learned to control other people by having accidents. Most often, however, the child is not misbehaving but simply cannot feel the stool coming out.

Some children have behavioral and emotional difficulties that interfere with the treatment program. Psychological counseling can help these children deal with issues such as peer conflicts, academic difficulties, and low self-esteem, all of which can contribute to constipation and soiling.

Children respond well to a carefully planned, consistent system of rewards for appropriate behaviors. Parents can develop behavior modifications or reward systems that encourage a child's proper toilet habits. It is the child's responsibility, however, to take medicine and attempt regular toileting.

Success!

Constipation and fecal soiling are curable! Although it may take several months or longer for bowel function to become normal, children who follow the treatment plan will be able to control their bowel movements. Further, many children may benefit from long-term medication, especially if the child is regularly taking other medications that can cause constipation. Relapsing is not uncommon – repeating the initial cleanout, followed by maintenance therapy, will bring back control. Some children will continue to have constipation into adult life, although a continued high-fiber diet and use of stool softeners as necessary can help. Alternatively, some less common diseases have symptoms similar to constipation and fecal soiling. If a child does not respond to treatment, testing may be recommended.

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Fluid and Fiber

Fiber is normally ingested in the diet, and part of fiber cannot be broken down. A diet rich in fiber produces soft and more frequent stool and can help with constipation. There are two types of fiber, both of which are important in your child's diet:

1. **Soluble**
   - Creates larger, softer stool
   - Good sources: beans, fruit, oat products
2. **Insoluble**
   - Increases stool bulk
   - Good sources: whole-grain products and vegetables

Daily fiber recommendations:

Use this formula to figure out how much fiber your child needs daily:

Minimum: *Child's age + 5 = grams of fiber needed per day*

Maximum: *Child's age + 10 = grams of fiber needed per day*

Example: Eric is 10 years old. The amount of fiber he needs daily is:

10 (his age) + 5 = **15** grams per day, minimum
10 (his age) + 10 = **20** grams per day, maximum
Eric needs **15–20** grams of fiber per day.

Tips to encourage and increase fiber intake:

- Include a variety of food sources at meal times that contain fiber, such as fruits, vegetables, whole grains, and nuts.
- Slowly increase the amount of fiber your child eats over the course of a few weeks to meet his/her fiber goal. Rapid increase may make the constipation worse or cause gas, cramping, bloating, or diarrhea.
- Drink plenty of fluids. Fiber works best with adequate fluids, which will help soften the stool and make it easier to pass.
- On certain occasions, your physician may recommend over-the-counter fiber supplements (Benefiber, Metamucil, etc.) if dietary fiber is insufficient.

Ways to incorporate fiber at meal and snack times:

Meal	Choose
Breakfast	• Original rolled oats instead of instant oats • Whole grain cereals or bran • Add sliced apples, peaches, or berries to cereal or oatmeal; keep the skin on for extra fiber • Whole wheat flour when making muffins, pancakes, and waffles
Lunch and dinner	• Brown or wild rice instead of white rice • Whole wheat breads for sandwiches • Whole wheat pasta instead of white pasta • Add vegetables to pizza, tacos, and pasta • Add beans to soups
Snacks	• Popcorn, whole grain pretzels, whole grain fruit and granola bars, and whole grain crackers • Dried fruit (prunes, raisins, and cranberries) • Add fruits and vegetables to smoothies • Puree black beans or chickpeas to make dips

Choose high-fiber fruits and vegetables at all meal times:

- Eat raw fruits and vegetables with the skin on.
- Choose fresh fruits and vegetables instead of juices.
- Fruits, including green kiwis, dates, figs, pears, apples with skin, prunes, and raisins are helpful for constipation management.

Reading food labels:

Nutrition Facts

8 servings per container

Serving size **2/3 cup (55g)**

Amount per serving

Calories **230**

	% Daily Value*
Total Fat 8g	**10%**
Saturated Fat 1g	**5%**
Trans Fat 0g	
Cholesterol 0mg	**0%**
Sodium 160mg	**7%**
Total Carbohydrate 37g	**13%**
Dietary Fiber 4g	**14%**
Total Sugars 12g	
Includes 10g Added Sugars	**20%**
Protein 3g	**10%**
Vitamin 2mcg	10%
Calcium 260mg	20%
Iron 8mg	45%
Potassium 235mg	6%

*The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

When grocery shopping, read the labels to see how much fiber a product contains. It will list the amount of fiber per serving. The first ingredient listed should be whole grain or whole wheat.

Choosing foods with at least 3 grams of fiber per serving will help your child meet his/her daily fiber goal.

Fiber-containing foods:

Breads/muffins

1 slice whole wheat, rye, or pumpernickel bread: 1-2 grams
1 small corn tortilla: 1-2 grams
1 small bran muffin: 3-4 grams

Cereals

1 cup Corn Flakes or Fruit Loops: 1-2 grams
1 whole-grain Pop-Tart: 3 grams
1 cup Cheerios: 3-4 grams
½ cup Quaker old fashioned oats: 3-4 grams
1 cup Kashi: 9 grams

Fruits

10 grapes or 1 cup cantaloupe or pineapple: 1-2 grams
1 medium-size banana, kiwi, peach, or plum: 1-2 grams
1 cup blueberries or strawberries: 3 grams
6–8 prunes or 1 medium pear: 4-5 grams
1 cup raspberries: 8 grams

Vegetables

1 cup raw spinach or ½ cup broccoli, green beans, corn, or raw carrots: 1–2 grams
½ cup green peas, brussels sprouts: 3-4 grams
1 medium sweet potato with skin: 3-4 grams
½ cup lima beans: 8 grams

Pasta/rice

½ cup whole wheat pasta: 3-4 grams
1 cup brown rice: 3-4 grams

Dried beans/nuts/peas

1 ounce nuts or ½ cup seeds: 3-4 grams
½ cup kidney beans, pinto beans, or chickpeas: 5-6 grams

Snack foods

1 serving whole-grain goldfish: 1-2 grams
6 Triscuit crackers: 3-4 grams
3 cups popcorn: 3-4 grams
Kashi granola bar: 4 grams

Fluids

Fluid helps soften stool and make it easier to pass. Adequate fluid is important when increasing fiber in the diet. Water is the best source, but fluid can also come from healthy beverages and even some foods. Clear or pale urine is a good sign that your child is hydrated.

Daily fluid recommendations:
Note: 1 cup = 8 ounces

Age	Ounces/day	Cups/day
1-3 years	45-50 ounces	5.5-6 cups
4-8 years	55-60 ounces	7-7.5 cups
9-13 years	**Males:** 80-85 ounces **Females:** 70-75 ounces	**Males:** 10-10.5 cups **Females:** 8.5-9 cups
14-18 years	**Males:** 100-110 ounces **Females:** 75-80 ounces	**Males:** 12.5-14 cups **Females:** 9.5-10 cups

Types of fluid:

1. **Water**
   - This is the recommended source of fluids.
2. **Juice**
   - Choose 100% fruit juice – apple, pear, and prune juices can help with constipation.
   - Substitute half of juice with water to increase overall fluid intake.
   - Limit to the following:
     - 1-3 years old: up to 4 ounces daily.
     - 4-6 years old: up to 4-6 ounces daily.
     - 7-18 years old: up to 8 ounces daily.
3. **Milk**
   - 1–2 years old: 2 cups daily
     - Offer whole milk.
     - Reduced fat (2%) milk is recommended if obesity is of concern or if there is family history of obesity, dyslipidemia, or cardiovascular disease.

- 2–8 years old: 2 cups daily
  - Offer low-fat (1%) or fat-free (skim) milk.
- 9+ years old: 3 cups daily
  - Offer low-fat (1%) or fat-free (skim) milk.

4. **Sports drinks**
   - Use only with prolonged, vigorous physical activity (>90 minutes).
5. **Soda/energy drinks**
   - Not recommended for children or adolescents.

Ways to increase fluid intake:

- Flavor water with cut-up fruit, vegetables, or herbs.
- Offer fruits and vegetables that are high in fluids, such as grapes, watermelon, cucumbers, oranges, celery, strawberries, blueberries, and kiwis.
- Include low-sodium broths and soups at meal times.
- Snack on fruit popsicles, Jell-O, or Italian ice.

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Nutrition for Constipation in the First 12 Months

Age of child	Foods to offer	Foods to avoid
Birth–6 months	• Breast milk or infant formula	• Do not switch to a low-iron formula; ask your doctor or dietitian before making any formula changes
6–8 months	• Continue breast milk or infant formula • Can start sips of water from a cup; this does not replace breast milk or infant formula • 0.5 – 1 ounce of undiluted prune, pear, or apple juice • High-fiber strained fruits and vegetables: apricots, prunes, peaches, plums, spinach, sweet potatoes, and carrots	• Do not give cereal in a bottle unless directed by healthcare provider • Avoid large quantities of: • Low-fiber cereal (rice)

8–12 months	• Continue breast milk or infant formula
	• Can offer 1–2 ounces undiluted prune, pear, or apple juice
	• Add mashed foods, such as cooked beans; offer high-fiber solids 3 times per day
	• Add finger foods to diet:
	  • Whole wheat toast, crackers
	  • Cooked whole wheat noodles, cooked brown rice
	  • Soft, peeled fruit slices (apricots, pears)
	  • Solid foods that dissolve easily, such as dry cereal containing oats
	• After 10 months, add finely diced table foods to diet
		• Avoid large quantities of:
		  • Low-fiber grains (white rice, white bread, white pasta, puffs)
		  • Fruit juices
		• Do not start dairy milk until child is 1 year old

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Toilet Training Tips

18 months

- Begin identifying toileting with appropriate words: "poop," "pee," "potty," or whatever words you determine fit your family.
- Make diaper-changing a pleasant experience.
- Encourage your child to come to you when the diaper is wet or soiled – this will enforce "staying dry" as good.
- Avoid using negative terms, such as "yucky" or "nasty," to describe bowel movements. Instead, say, "You are wet, we need to change you," or "Your pants are soiled, and we need to fix that."
- Point out that everyone has to potty.
- Model appropriate toileting behavior for your child – letting them see you use the restroom is part of toilet training.

21 months

- Identify an appropriate potty chair, and explain that it belongs to your child and is special.
- Practice sitting on the toilet while your child sits on the potty chair.
- Start to develop the prerequisite skills for toilet training: sitting for up to 2–3 minutes, following directions, getting on and off the toilet, and raising and lowering pants and underwear.

2.5 - 3 years

- Use toileting tools, books, and videos to teach the components of toilet training.
- Have your child potty train a doll or stuffed animal.
- Begin talking about wearing underwear – it is "special" and a "privilege."
- Begin practice runs to the potty – do this when you begin to see signs of needing to use the bathroom.
- Encourage sitting on the potty for about 1 minute at a time.
- Dress your child in clothing they can easily pull up and down.
- Optimal practice times are about 30 minutes after meals and after naps.

- Most children will need to urinate about every 60–90 minutes.
- Use positive reinforcement for sitting on the potty and using the potty – positive reinforcement can be praise, high fives, stickers, or small treats.
- Accidents happen – deal with them in a non-judgmental way.

General Guidelines for Good Toilet Hygiene

- Toilet training for typically developing children usually occurs between 18 months to 4 years of age. Each child is different.
- Urine training typically occurs before bowel training.
- Try to avoid starting toilet training around the time of major life changes (birth of a sibling, death of a loved one, move or relocation, school entry, etc.).
- Help discourage obvious retention behaviors (squeezing legs together, clenching buttock, grabbing privates, etc.) when they are witnessed.
- Use of osmotic laxatives may be needed to keep stools soft if constipation is noted.
- The best time to attempt toilet sitting for defecation is within 2 hours of awakening and/or 30 minutes after large snack or meal.
- Allow unhurried use of toilet in a calm, non-threatening environment.
- For those with toilet aversion, doing pleasurable activities (reading, listening to music, etc.) is acceptable to help overcome the fear of sitting on the toilet. However, for those not aversive to toilet sitting and working specifically on defecation, time sitting on the toilet should be spent focusing on defecation, not reading books, using electronic devices, etc.
- Try having child blow up party blowers, bubbles, or balloons if no latex allergies (always under direct supervision due to choking hazard risk) to help strengthen and train pelvic floor muscles.
- If feet don't touch the floor, use a footstool for added leverage during defecation.
- If behavioral problems or anxiety are impacting toilet training, seek help from a professional.
- Make sure your child is getting adequate fiber in their diet. To calculate the fiber (grams per day) needed in their diet for children over 2 years of age: age in years + 5 = ___ grams per day. (i.e. 4 year old child needs 4 + 5 = 9 grams fiber per day).
- Untreated constipation is likely to delay or complicate toilet training. Limit dairy intake to no more than 16-24 ounces a day maximum. Make sure your child is getting the adequate amount of fluids (see guidelines below). Water is optimal.

Weight in Pounds/Fluids per day

10 pounds = 16 ounces (2 cups)
20 pounds = 30 ounces (3-3/4 cups)
30 pounds = 40 ounces (5 cups)
40 pounds = 48 ounces (6 cups)
50 pounds = 52 ounces (6 ½ cups)
60 pounds = 55 ounces (7 cups)
80 pounds = 61 ounces (7 ½ cups)
100 pounds = 67 ounces (8 ¼ cups)
120+ pounds = 73-82 ounces (9-10 ¼ cups)

References: *Contemporary Pediatrics, Vol. 21, No. 3; American Academy of Pediatrics; HealthyChildren.org; www.GIkids.org; Clinical Handbook of Pediatric Gastroenterology, Second Edition.*

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Water Tracker

Cups	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Mon														
Tue														
Wed														
Thu														
Fri														
Sat														
Sun														

Drink your water!

Guidelines by age *(1 cup = 8 oz)*:

1 – 3 years: 5–6 cups/day (45–50 oz

4 – 8 years: 7–8 cups/day (55–60 oz)

9–13 years: males, 10 -11 cups/day (80-85 oz); females, 8 - 9 cups/day (70 - 75 oz)

14 –18 years: males, 12-14 cups/day (96-112 oz); females, 9 –10 cups/day (72–80 oz)

The amount of water recommended is a general guideline – water needs may vary based on individual needs. Please consult your physician/dietitian if you have concerns.

Your fluid goal is: _____ **. Fill in the cups to keep track of how much you drink during the day!**

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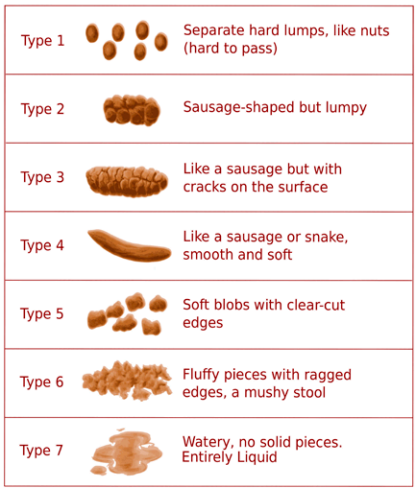
Bowel Management Tool

WEEK _____

AM (morning)	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Sit on toilet							
Bowel movement							
Accident code							
Accident timing							
Osmotic laxative							
Stimulant laxative							
Rectal therapy							
PM (afternoon)	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Sit on toilet							
Bowel movement							
Accident code							
Accident timing							
Osmotic laxative							
Stimulant laxative							
Rectal therapy							

Bristol Stool Chart



Instructions:

Use check marks to indicate daily toilet sitting whenever this occurs (morning= anytime prior to 12pm noon. Evening= anytime after 12pm noon)

Please mark bowel movements when they occur using the numbers (1-7) indicated by stool consistency on the provided Bristol Stool Chart Please indicate any accident should one occur with the following codes: S= streak or smear or the corresponding numbers (1-7) indicated by stool consistency on the Stool Chart

Briefly describe details of accident timing (ie: playing, in a car, at school, etc)

Indicate the medications used (if any):

Osmotic laxatives: Polyethelene glycol (PEG 3350) measured in teaspoon increments or capfuls, lactulose in ml or teaspoons, mineral oil or Magnesium based laxatives in ml or teaspoons

Stimulant laxatives: Senna measured in teaspoons, or tablets, Bisacodyl measured in tablets

Rectal therapy: S= Suppository, E= Enema

http://www.vertex42.com/ExcelTemplates/kids-chore-schedule.html

Locate a Pediatric Gastroenterologist

IMPORTANT REMINDER: *This information from the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) is intended only to provide general information and not as a definitive basis for diagnosis or treatment in any particular case. It is very important that you consult your doctor about your specific condition.*

NASPGHAN
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