key points

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Constipation is the most common childhood gastroenterological problem, affecting 5-30% of children. Up to a third of these children will develop chronic constipation. The signs and symptoms of constipation in children are seldom clear and there is frequently a delay in seeking help in either a primary or secondary care setting.

The underlying cause of childhood constipation is unclear. The initial problem may be an acute episode of constipation that results in painful defecation. This may lead to the development of an anal fissure and the child may become scared of the process of defecation. Often they will hold on to the faeces which become harder and when they are passed cause pain and so the vicious cycle is repeated. The key to the effective management of childhood constipation is establishing the diagnosis of idiopathic constipation by taking a thorough history.

Up to 29% of children with daytime urinary incontinence may have chronic constipation and 34% of children with chronic constipation older than five years may have problems with bedwetting. Chronic constipation is often a risk factor for recurrent UTIs in children. Urinary retention and vulvovaginitis have also been described in children with chronic constipation.

The NICE guidelines recommend only carrying out a DRE in a child under a year old who has not responded to optimum treatment after four weeks. In a child older than a year, only perform a DRE if there are red flags in the history that would suggest a diagnosis of Hirschsprung's disease and you are competent to interpret the signs of the examination. Once a positive diagnosis of idiopathic constipation has been made by history and examination, further investigations are not necessary.

It is important to explain to the patient and parents that the symptoms have a medical explanation and that the child has not been soiling or having 'accidents' because of bad behaviour. Once the child has been diagnosed with idiopathic constipation, it is important to assess him or her for faecal impaction as this will determine the next therapeutic step. Faecal impaction can be diagnosed by history taking and examination. Overflow soiling and a faecal mass palpable abdominally are suggestive of faecal impaction. The maintenance regimen for faecal impaction is PEG 3350 plus electrolytes as first-line treatment. If disimpaction has not occurred after two weeks and the child has been taking the medication, a stimulant laxative may be added.

Once the child has been disimpacted, the next stage is to start maintenance therapy. The length of treatment depends on the individual case. It can take time for the bowel and rectal function to revert to a more normal state. The most common reason for treatment failure is stopping the medication too soon.