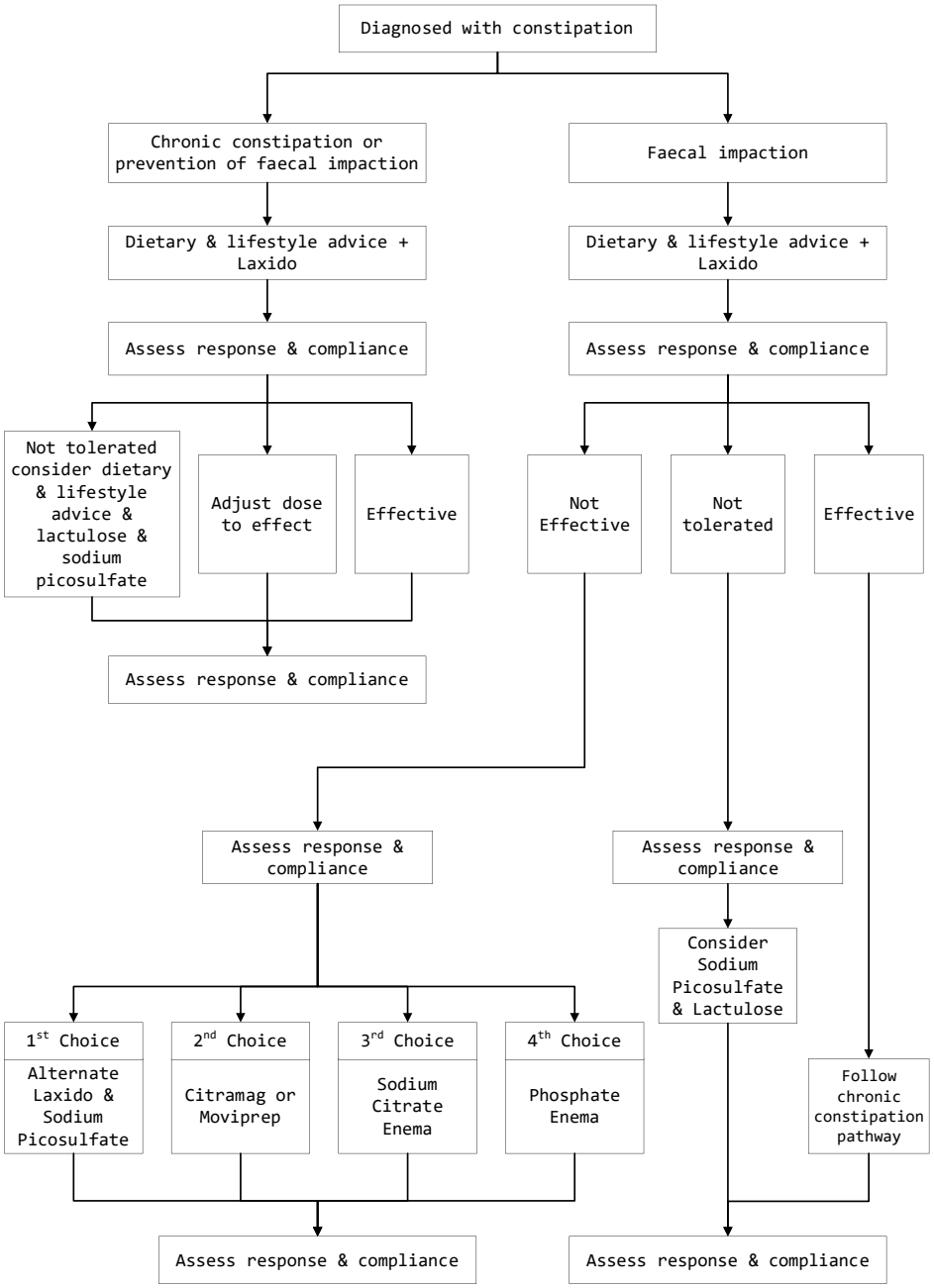
Management of Constipation in Children and Adolescents Aged 18 and Under

TARGET AUDIENCE	Paediatric patients within secondary care and where clinicians feel appropriate in primary care
PATIENT GROUP	All paediatric patients with chronic constipation

Clinical Guidelines Summary



Background

Constipation is a common childhood condition which affects between 5% and 30% of the paediatric population. Chronic constipation (symptoms lasting >8 weeks) occurs in around one third of those patients affected.

Factors that may contribute to constipation include dietary and fluid intake, psychological issues, pain, fever, dehydration or medications. If it cannot be explained by anatomical or physiological abnormalities, it is classed as idiopathic constipation.

Signs and symptoms include infrequent bowel activity, foul smelling wind and stools, excessive flatulence, irregular stool texture, passing occasional enormous stools or frequent small pellets, withholding or straining to stop passage of stools, soiling or overflow, abdominal pain, distension or discomfort, poor appetite, lack of energy, an unhappy, angry or irritable mood and general malaise.

Constipation can be managed both pharmacologically and with lifestyle advice.

Diagnosis

Diagnosis should be carried out by an appropriate healthcare professional. Definition of terms are:

- Constipation – symptoms include hard stools, excess flatulence and abdominal pain lasting less than 8 weeks
- Chronic constipation – constipation lasting longer than 8 weeks
- Idiopathic constipation – constipation that cannot be explained by an anatomical, physiological, radiological or histological abnormalities
- Intractable constipation – constipation that does not respond to sustained, optimum medical management

Red flag symptoms are:

- Onset of constipation reported from birth or first few weeks of life
- Failure to pass meconium/delay (more than 48 hours after birth)
- 'Ribbon stools' (more likely in a child younger than 1 year)
- Previously unknown or undiagnosed weakness in legs, locomotor delay
- Abdominal distension with vomiting

Constipation Management

Treat constipation with laxatives and a combination of lifestyle advice.

Pharmacological treatment should be considered first line in addition to lifestyle advice in any of the following presentations:

- Idiopathic constipation (no physiological or anatomical cause)
- Chronic constipation (symptoms persist longer than 8 weeks)
- Risk of faecal impaction

If a patient meets one or more of these criteria they should initially be managed with Macrogols (polyethylene glycol 3350 + electrolytes) following the chronic constipation, prevention of faecal impaction regimen as per the BNF for children. The current choice of polyethylene glycol 3350 + electrolytes is Laxido® but others include Movicol® and Cosmocol®.

Some medicines contained in this document are written as their proprietary name due to the specifics of their paediatric license.

Chronic constipation, prevention of faecal impaction – First Line Treatment Option

NHS Lanarkshire recommends the use of **Laxido Paediatric/Laxido orange** sachets as per the dosing table below (Table 1/Table 2).

One Laxido Paediatric sachet should be **dissolved in 62.5ml of cold water**, keep in refrigerator after reconstitution.

One Laxido Orange sachet should be **dissolved in 125ml of cold water**, keep in refrigerator after reconstitution.

Children should be reassessed after 2 weeks to assess benefit. Adjust the dose of Laxido according to symptoms and response. If Laxido is not tolerated by the child or young person alternative laxatives such as lactulose and sodium picosulfate should be trialled. Always assess compliance with treatment. Continue medication at maintenance dose for several weeks after regular bowel habit is established.

Disimpaction – First Line Treatment Option

Assess all children with idiopathic constipation for faecal impaction, use a combination of history-taking and physical examination to diagnose faecal impaction looking for overflow soiling and/ or faecal mass palpable abdominally and/or rectally if indicated. Medication must be accompanied by lifestyle advice.

The recommended first line treatment of faecal impaction, is to increase the **Laxido Paediatric/ Laxido orange** dosage regime as per the table below (Table 3/Table 4).

One Laxido Paediatric sachet should be **dissolved in 62.5ml of cold water**, keep in refrigerator after reconstitution.

One Laxido Orange sachet should be **dissolved in 125ml of cold water**, keep in refrigerator after reconstitution.

Children should be reassessed after 2 weeks to assess benefit and compliance.

If patients fail to respond to the increased Laxido Paediatric dosage regimen, then the following alternative options should be considered.

Disimpaction – Second Line Treatment Options

Second line treatment options, following failure to respond to Laxido Paediatric/Laxido orange treatment regime:

- 1st line – Laxido + sodium picosulfate liquid
- 2nd line - Citramag or Moviprep
- 3rd line - Sodium citrate enemas only if oral treatment has failed
- 4th line - Phosphate enemas only if all oral medications and sodium citrate enemas have failed

Note: Treatment option may depend on stock availability and tolerability. Substitute sodium picosulphate liquid and lactulose if Laxido is not tolerated.

<u>Sodium Picosulfate</u>
Sodium picosulfate is a first line option, dose should follow BNF for children guidance using the 5mg/5ml oral solution. Dosing as per Table 5.

<u>Citramag</u>
One Citramag sachet should be **dissolved in 200mls of hot water** in a large jug. Allow the mixture to cool for around half an hour before drinking. It can be flavoured with juice after cooling. The mixture should be drunk as quickly as can be managed but in less than half an hour. A new sachet should be made up for each dose. Dosing as per Table 6.

Moviprep

Reconstitute ONE Moviprep® sachet A in **2000ml of water** and discard Moviprep® sachet B and set pump to deliver dose as per the weight recommendation below until the bowel is emptied or the maximum volume delivered. Moviprep is unpalatable and often needs to be delivered by NG tube. Oral medication taken within 1 hour before, during or 1 hour after Moviprep may be flushed from GI tract and not absorbed. Consider monitoring baseline and post-treatment electrolytes, renal function and ECG in patients with significant renal impairment, arrhythmia or in those at risk of electrolyte imbalance. Dosing as per Table 7.

Sodium citrate

Sodium citrate enemas only if oral treatment has failed. Dosing as per Table 8.

Phosphate enema

Phosphate enemas only if all oral medications and sodium citrate enemas have failed. Dosing as per Table 9.

Review

- Review children and young people undergoing disimpaction within 1 week.
- Start **Laxido Paediatric/Laxido orange maintenance therapy** (Table 1 or 2) as soon as the patient is disimpacted.
- Provide a copy of the ERIC information leaflet https://eric.org.uk/childrens-bowels/parents-guide-to-disimpaction/
- Always consider compliance with treatment before changing regimens.
- Reassess frequently (base on child's individual needs) during maintenance treatment to ensure they do not become reimpacted.
- Chronic constipation/prevention of faecal impaction therapy should be continued for several weeks after a regular bowel habit has been established.
- Do not stop medication abruptly, gradually reduce over a period of months in response to stool and frequency.
- The child's consultant may wish to change the plan based on response and compliance with treatment.

Lifestyle Advice

- Dietary interventions should not be used alone as a first line treatment for idiopathic constipation.
- Ensure adequate fluid intake.
- Ensure adequate fibre intake for example fruit, vegetables, high-fibre bread, baked beans and whole grain breakfast cereals.
- Do not recommend unprocessed bran which can cause bloating and flatulence and reduce absorption of micronutrients.
- In idiopathic constipation, cow's milk exclusion should only be started on the advice of a specialist.
- Supply ERIC advice for children with constipation leaflet
    - https://eric.org.uk/wp-content/uploads/2025/09/Constipation_factsheet_Sept2025.pdf

Medication Dosing

Table 1: Laxido Paediatric Dosage Regime for Chronic constipation, prevention of faecal impaction regimen

Age	Laxido Paediatric chronic constipation, prevention of faecal impaction regimen
1-11 months	0.5–1 sachet daily
12-23 months	1 sachet daily, adjust dose to produce regular soft stools; maximum 4 sachets per day
2-5 years	1 sachet daily, adjust dose to produce regular soft stools; maximum 4 sachets per day
6-11 years	2 sachets daily, adjust dose to produce regular soft stools; maximum 4 sachets per day

Table 2: Laxido Orange for Chronic constipation

Age	Laxido Orange chronic constipation
12-17 years	1–3 sachets daily in divided doses usually for up to 2 weeks; maintenance 1–2 sachets daily.

Table 3: Laxido Paediatric Dosage Regime for the Treatment of Faecal Impaction

Age	Laxido Paediatric Treatment Dose
1-11 months	0.5–1 sachet daily
12-23 months	2 sachets on first day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily, total daily dose to be taken over a 12-hour period, after disimpaction, switch to maintenance laxative therapy (Table 1).
2-4 years	2 sachets on first day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily, total daily dose to be taken over a 12-hour period, after disimpaction, switch to maintenance laxative therapy (Table 1).
5-11 years	4 sachets on first day, then increased in steps of 2 sachets daily, maximum 12 sachets per day total daily dose to be taken over a 12-hour period, after disimpaction, switch to maintenance laxative therapy; (Table 1)

Table 4: Laxido Orange Dosage Regime for the Treatment of Faecal Impaction

Age	Laxido Orange Paediatric Treatment Dose
12-17years	4 sachets on first day, then increased in steps of 2 sachets daily, maximum 8 sachets per day total daily dose to be drunk within a 6 hour period, after disimpaction, switch to maintenance laxative therapy if required; (table 2).

Table 5: Sodium picosulfate Dosage Regime for Constipation

Age	Sodium Picosulfate Dose
1 month -3 years	2.5-10mg daily dose to be adjusted to according to response.
4-17 years	2.5-20mg daily dose to be adjusted to according to response.

Table 6: Citramag Dosage Regime for Treatment of Faecal Impaction

Age	Citramag Dose
5-9 years	66mls of reconstituted sachet single dose repeated if required after 6 hours
10-12 years	100mls of reconstituted sachet as single dose repeated if required after 6 hours
12-17 years	200mls of reconstituted sachet as single dose repeated if required after 6 hours

Table 7: Moviprep (sachet A) Dosage Regime for Treatment of Faecal Impaction

Weight (kg)	Moviprep (sachet A in 2000ml) dose given over 4 hours	Pump rate (ml/hr)
5-10	100ml/kg	50mL/hour for 30 minutes, then 100mL/hour for 60 minutes, then if tolerated 125mL/hour
10-20kg	100ml/kg	100mL/hour for 30 minutes, then 200mL/hour for 60 minutes, then if tolerated 255mL/hour
20-30kg	100ml/kg	200mL/hour for 30 minutes, then 300mL/hour for 60 minutes, then if tolerated 500mL/hour
>30kg	3000ml	200mL/hour for 30 minutes, then 400mL/hour for 60 minutes, then if tolerated 600mL/hour

Table 8: Sodium citrate enema Dosage Regime

Age	Sodium Citrate Dose
3-17 years	5ml for 1 dose

Table 9: Sodium acid phosphate with sodium phosphate enema

Age	Phosphate Enema Dose
3 - 11years	On doctor's advice only
12-17 years	118ml once daily

References

NICE Guideline Constipation in children and young people: diagnosis and management (2017). Available at: www.nice.org.uk/guidance/cg99

Constipation | Treatment summaries | BNFC | NICE

https://apps.nhslothian.scot/files/sites/2/Guidelines-for-Management-of-Idiopathic-Childhood-Constipation.pdf

https://eric.org.uk/childrens-bowels/parents-guide-to-disimpaction/

Appendices

1. Governance information for Guidance document

Lead Author(s):	Lynsay McAulay & Alice Deasy
Endorsing Body:	ADTC
Version Number:	V1
Approval date	**Nov 25**
Review Date:	Nov 28
Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	Dr T Jordan, Dr H Isikli, Dr A Sullivan
Consultation Process / Stakeholders:	
Distribution	

CHANGE RECORD

Date	Lead Author	Change	Version No.
9/10/25	Lynsay McAulay	*Preparation of guideline*	1
			2
			3
		.	4
			5