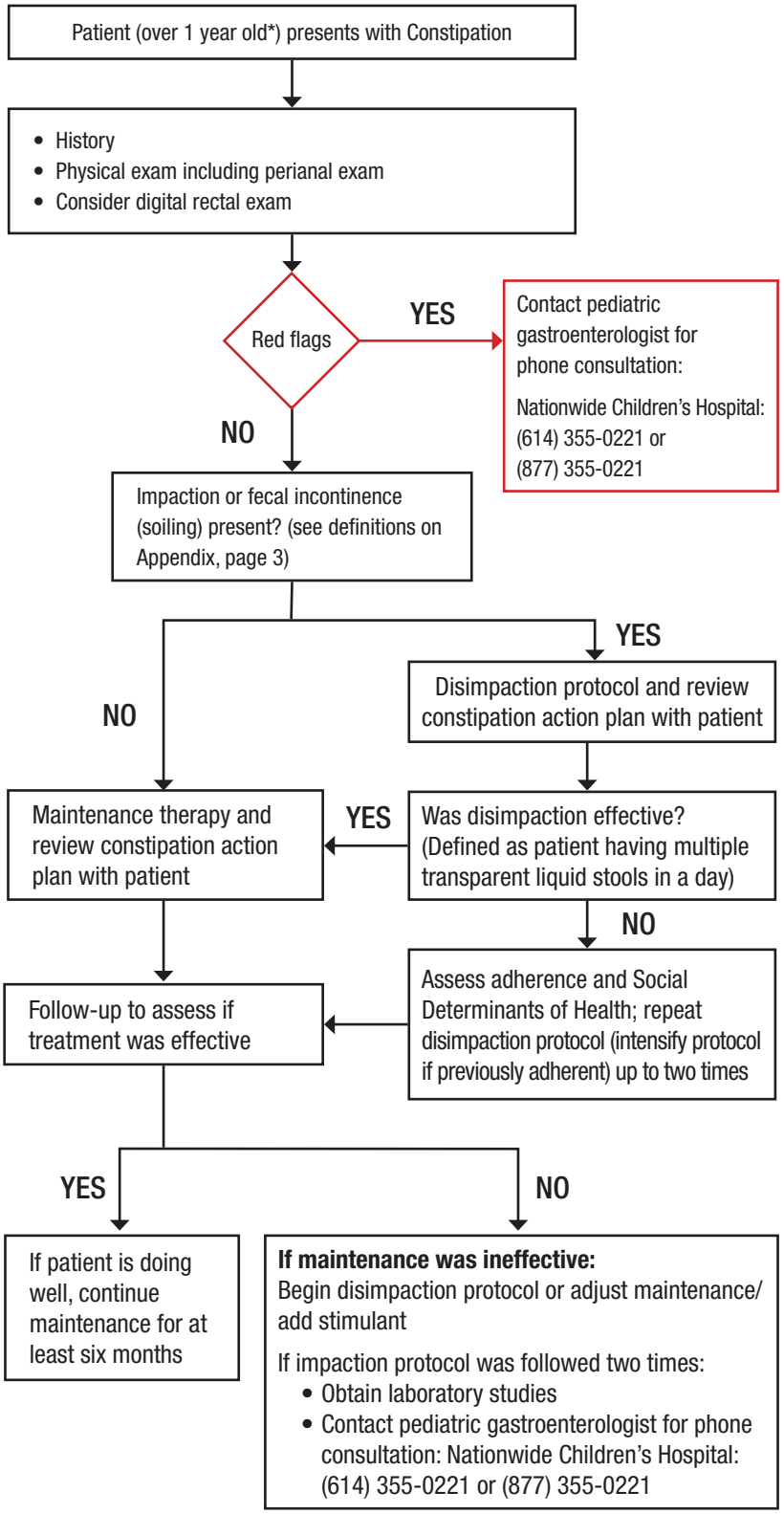
Constipation Guidelines for Primary Care Providers

PARTNERS FOR KIDS®

NATIONWIDE CHILDREN'S®

When your child needs a hospital, everything matters.

Constipation Guidelines for Primary Care Providers



History Red Flags

- Constipation in the first month of life
- Delayed passage of meconium (>48 hours)
- Family history of Hirschsprung disease or celiac disease
- Ribbon/Thin stools
- Blood in stools in the absence of anal fissures
- Failure to thrive, poor feeding
- Fever
- Bilious vomiting

Physical Exam Red Flags

- Abnormal thyroid gland
- Severe abdominal distension
- Abnormal perianal inspection
  - Perianal fistula or anal scar
  - Abnormal position of anus
  - Absent anal or cremasteric reflex
  - Gluteal cleft deviation
- Decreased lower extremity strength/tone/reflexes
- Tuft of hair on spine or sacral dimple
- Evidence of bowel obstruction

Reasons for Phone Consultation or Referral to Pediatric Gastroenterology

- Red flags present in history or physical exam
- Patient is not responding to disimpaction or recommended daily dose of laxative
- Consider labs if not improving: CBC, BMP, Thyroid studies, tissue transglutaminase IgA, total IgA level, lead level (if at risk)
- If referring, please send:
  - All growth curves
  - Lab & radiology results, radiology images on CD if those were not done at Nationwide Children's
  - Reason for referral
  - Any previous regimen attempted for condition

** For 6 month to 1 year guidelines, visit: https://naspghan.org/files/documents/pdfs/position-papers/Constipation_Feb_2014.pdf*

Disimpaction Protocols*

Time of day	Age 1-2 (15 to 22 pounds)	Age 2-4 (22 to 44 pounds)	Age 5-10 (45 to 88 pounds)	Age 10+ (over 88 pounds)
Morning	Take 0.5 chocolate senna laxative square (7.5 g)	Take 1 chocolate senna laxative square (15 g)	Take 1.5 chocolate senna laxative squares (22.5 g)	Take 2 chocolate senna laxative squares (30 g)
Throughout the day	Mix 2.5 capfuls (42.5 g) of PEG3350 powder in 16 ounces of fluid Drink it all over 4-8 hours	Mix 4 capfuls (68 g) of PEG3350 powder in 20 ounces of fluid Drink it all over 4-8 hours	Mix 7 capfuls (119 g) of PEG3350 powder in 32 ounces of fluid Drink it all over 4-8 hours	Mix 14 capfuls (238 g) of PEG3350 powder in 64 ounces of fluid Drink it all over 4-8 hours
Evening	Take 0.5 more senna chocolate laxative square (7.5 g).	Take 1 more senna chocolate laxative square (15 g).	Take 1.5 more senna chocolate laxative square (22.5 g).	Take 2 more senna chocolate laxative squares (30 g).

Keep on clear liquids the day of the clean-out.

Note: An enema may be needed to start if there is a large stool mass.
Bisacodyl is available over the counter but may be covered under insurance plans.
< 20 kg/44 lb: 5 mg or 15 mL Bisacodyl
> 20 kg/44 lb: 10 mg or 30 mL Bisacodyl

Maximum two enemas per clean-out. Can be given eight hours apart.

** For more information on medication coverage, see page 3.*

Maintenance Therapy – Must Maintain All Steps

1. Balanced diet: whole grains, fruits and vegetables
2. Fluids; consider prune juice and age-appropriate water intake.
   Ages 1 to 2: Three to four cups of water
   Ages 2 to 4: Four cups of water
   Ages 5 to 10: Six cups of water
   Ages 10+: Eight cups of water
3. Behavioral modification including daily toilet sitting
4. Daily maintenance laxative therapy at an appropriate dose

Maintenance Therapy – Must Maintain All Steps

Osmotic laxatives: TO BE GIVEN EVERY DAY
PEG 3350 (MiraLAX): 0.2-0.8 g/kg/day; 1 capful (17g) should be mixed in 8 oz clear fluid. Adjust dose to ensure one to two soft bowel movements per day.
or
Lactulose (10 g packets or 10 g/15 mL syrup)
1-2 g (1.5-3 mL)/kg/day divided into one to two doses.
Up to 60 mL per day for initial dose.

If maintenance therapy with stool softeners is not effective, add daily dose of stimulant laxatives.
Refer to morning disimpaction protocol and to the constipation action plan for dosing of stimulant.

Tips for Disimpaction

- For school-aged children, start bowel clean-out on Friday after school.
- If unsatisfactory results, repeat up to three days. Parents should call their provider if still not clear.
- Make sure the child is on a clear liquid diet for the duration of the clean-out; otherwise, the clean-out will take too long.

What to Tell Families

- Give parents written home instructions.
- The child should sit on the toilet two to three times daily, five to 10 minutes each time, for "protected time to have a bowel movement."
- Ensure that smaller children have a footstool or other object so that they have a solid base to push off.
- Parents should use positive reinforcement, not punishment.
- Explain encopresis to the parent and child.
- Although the role of cow's milk after age 1 is controversial, a trial of stopping milk for two to four weeks might be considered in children not responding to bowel therapy.
- Explain the importance of a balanced diet with five servings of fruits and vegetables per day and age-appropriate amounts of fluids.
- Set a follow-up appointment within several weeks to assess progress and provide encouragement and guidance. Encourage follow-up phone calls to remain on track.
- Do not stop medications without contacting your child's provider.

Tips for Maintenance Therapy

- Daily dose of osmotic laxatives should be adjusted so the patient is having daily bowel movements that are approximately oatmeal consistency.
- If stopping stimulant laxatives that have been given consistently, the dose needs to be slowly weaned off to prevent re-impaction.
- If not improving despite following clean-out and maintenance recommendations, consider referral to pediatric GI.
- MiraLAX smushes and Senna pushes.

Appendix

Is this a fecal impaction?

- Fecal impaction is a significant amount of stool in the rectum and colon in the setting of either:
  – Constipation-associated fecal incontinence or encopresis
  – Incomplete or infrequent evacuation

Diagnostic Criteria for Fecal Impaction:

- One or more of the following is present:
  – A hard mass in the lower abdomen identified on physical exam
  – A dilated rectum filled with a large amount of stool on rectal examination
  – Excessive stool in the distal colon on abdominal radiography

History

- Did the child pass meconium within the first 48 hours?
- When was the onset of constipation?
- How frequently do they have a bowel movement?
- What is the consistency of the stool according to the Bristol Stool Chart?
- How large are the stools in caliber? Do they clog the toilet?
- Do they have pain with passage or blood present?
- Is the child having stool accidents (streaks or smears in the underwear or full bowel movements outside the toilet)?
- Do they need to strain to pass stool?
- After passing stool, do they feel like they were able to get everything out?
- What medications have been used in the past?
- Have they ever needed to do at home or hospital clean-outs in the past?
- Is there a family history of anorectal malformation or Hirschsprung disease?

Unified Preferred Drug List (UPDL)

- This condensed version was compiled by Partners For Kids to focus on common pediatric diagnosis.
- View the Unified Preferred Drug List by visiting PartnersForKids.org/Resources and selecting "Prescribing Resources."
  – The UPDL is developed by ODM and implemented by the single Pharmacy Benefit Manager, Gainwell Technologies.
  – This information is intended for use by providers to select cost-effective medications for their patients. It is not a substitute for individual patient factors and clinical judgment.

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