CONSTITUTIONAL (FUNCTIONAL) IN INFANTS AND CHILDREN

I. DEFINITION:

Functional Constipation in children refers to constipation which has no underlying medical disease characterized by having fewer than 2 bowel movements a week or having stools that are hard, dry, small, and accompanied by straining and/or pain.

II. ETIOLOGY:

A. True constipation is very rare. If a child does not have a bowel movement daily, this is not a sign of constipation. A hard stool with difficulty every third day should be treated as constipation.

B. There are numerous causes of true acute or chronic constipation. Typically the common causes of constipation in children and adolescents are low fiber diet, poor fluid intake, ignoring the urge to have a bowel movement, and high intake of dairy products. Other functional causes include coercive toilet training, and reluctance to use a public restroom or school bathroom avoidance.

C. Constipation is the most prevalent cause of chronic abdominal pain in children and adolescents and is easily diagnosable with a careful history.

III. CLINICAL FEATURES:

A. Children with a developmental age <4 years* must have ≥2 of the following criteria present without organic pathology for at least 1 month to meet the definition of functional constipated as determined by both the European and North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition.

1. At least 1 episode of incontinence per week after the acquisition of toilet training skills
2. ≤ 2 defecations per week
3. History of excessive stool retention
4. History of painful or hard bowel movements
5. Presence of a large fecal mass in the rectum
6. History of a large diameter stool that might obstruct the toilet

Accompanying symptoms may include irritability, decreased appetite, and/or early satiety, which disappear immediately following passage of a large stool.

B. Children with a developmental age of ≥4-18** years who do not meet the criteria for irritable bowel syndrome must have ≥2 of the following criteria present for at least 2 months.

1. ≤ 2 defecations in the toilet per week
2. ≥ 1 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 a large fecal mass in the rectum
6. History of a large-diameter stool that might obstruct the toilet

* Criteria fulfilled for at least 1 month.
** Criteria fulfilled at least once per week for at least 2 months before diagnosis.

IV. MANAGEMENT PLAN:

A. Review diet. If solids started early, may want to stop solids or reduce the amount and type of solids taken. Evaluate diet for balanced nutrition, adequate fluid and fiber intake.

B. Encourage a diet rich in whole grains, fruits and vegetables.

C. Teach parents about normal bowel patterns and expectations of toileting habits. Encourage a toileting routine that dedicates time of a few minutes (3min.-10min depending on the age of the child) once or twice a day within an hour after meals to promote regular stooling habits.

D. Discourage the chronic use of stool softeners, laxatives, enemas, and suppositories.

E. Increase fluid intake of water. Children should drink fluids throughout the day.

F. Discourage use of honey and Karo syrup.

G. Encourage exercise or play.

H. Encourage good bowel habits, such as prompt response to urge to defecate.

I. Consultation/Referral:

Refer to APRN or physician for any of the following: Complete ODH 399 Referral Form per instructions on all referrals made.

1. If child has recurrent fecal impactions, abdominal pain, vomiting, weight loss or encopresis.

2. Suspicion of anal fissures.

3. Failure to respond to treatment.

J. Follow-up:

1. If no improvement, refer.

2. Determine tracking priority utilizing professional judgment.
## SUGGESTED LIQUIDS/FOODS

<table>
<thead>
<tr>
<th>AGE</th>
<th>JUICE</th>
<th>NECTAR</th>
<th>STRAINED FRUIT</th>
<th>INITIAL DILUTION</th>
<th>DAILY AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants - Under 4 months</td>
<td>Prune</td>
<td>Pear</td>
<td>Or Apricot</td>
<td>3 oz water</td>
<td>Water: 2 oz two times/day between feedings. If not effective, give juices/nectar.</td>
</tr>
<tr>
<td>Infants - 4 - 6 months</td>
<td>Prune</td>
<td>Pear</td>
<td>Or Apricot</td>
<td>3 oz water</td>
<td>As indicated.</td>
</tr>
<tr>
<td>Infants - Over 6 months - 1 year</td>
<td>Prune</td>
<td>Pear or Apple</td>
<td>Prunes, peaches, plums, apricots, peas, green beans</td>
<td>None</td>
<td>Formula 24-32 oz daily. May increase fluids or fruit juices</td>
</tr>
<tr>
<td>Over 1 year</td>
<td>1 – 1 ½ cups of fresh, frozen, canned, or dried fruit and 1-2 cups cooked vegetables with edible skins</td>
<td>High Fiber Fruits</td>
<td>Substitutions</td>
<td>Increase all fluids <strong>EXCEPT</strong> Milk. Milk should not exceed 2-3 cups (16-24 oz) daily. WIC recommends not exceeding 16 ounces per day for 2 &amp; 3 year olds and 24 ounces per day for 4 year olds</td>
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**WIC** recommends not exceeding 16 ounces per day for 2 & 3 year olds and 24 ounces per day for 4 year olds.
REFERENCES:


Hockenberry, MJ; Wong, DL Nursing Care of Infants and Children 8th ed 2007.

MD Consult: AAP Patient Education [www.mdconsult.com](http://www.mdconsult.com) *Access to website is available through your local Advanced Practice Nurse*