Provincial Pediatric Constipation Primary Care Clinical Pathway

Suspect constipation if child presents with:
- Dry, hardened stools (Bristol type 1 or 2), which may be painful, of large diameter, and/or associated with straining;
- Stools occurring < 3 times per week, except in breastfed infants; and/or
- Excessive stool retention by history or physical exam +/- retentive posturing and fecal incontinence after the acquisition of toileting skills

1a. Key history and physical exam
- Symptoms and age of onset
- Assess for growth, behaviour and development
- Systemic exam – if unwell, sick, febrile
- Abdominal, perianal +/- rectal exam
- Spine and neurological exam
- Medication review
- Consider bloodwork/other investigations only if indicated by clinical features or family history

1b. Alarm features / red flags
- URGENT assessment in ED if any of the following:
  - Unwell, fever > 38°C, bilious vomiting, severe abdominal distention
- Referral to Pediatric Surgery if any of the following:
  - Ribbon-like stool, abnormal position of the anus, perianal fistula, stenosis
- Referral to Pediatrics if any of the following:
  - Onset < 1 month of age or passage of meconium > 48 hours
  - Blood in stool in absence of anal fissures
  - Malnutrition or hypothyroidism concern
  - Abnormal spinal or lower extremities neurological exam suggestive of spinal abnormalities
  - Developmental delay or behavioural or mental health concerns
  - Anal scars or suspicion of abuse

No

2. Normal variations in healthy infants?
- Infrequent BMs in exclusively breastfed infant more than two weeks old
- Infant dyschezia (>10 minutes of straining/crying before passage of soft stools)

Yes → Provide education, reassurance, reassess in 2-4 weeks. No rectal stimulation or laxatives.

No

3. Functional constipation diagnosis (Rome IV criteria, see link above for details)
- 2 or more symptoms present for > 1 week (treatment can be initiated earlier)
- Assess triggers and risk factors, including nutrition to guide management

4. Management principles
- Family education
- Monitoring, diary of symptoms, and interventions
- Toilet training and behavioural modification (as age appropriate)
- Laxatives (oral route preferred) and fluid intake
- Dietary modifications - not a substitute for laxatives; implement only **after** normal stool patterns are re-established

< 6 months of age → **5. Management (< 6 months of age)**
- Verify diet/formula preparation (modify intake, as needed)
- If no improvement in 2-4 weeks:
  - First line approach: 100% undiluted prune, pear, or apple juice (if > 4 months) in addition to normal feeding. Start with 2 tbsp and slowly increase as needed to a max of 8 tbsp/day. Reduce dose to minimum required to maintain soft stools
  - Second line approach: Lactulose (1/2 g/kg/day) in 1-2 doses
  - Occasional 1/2-1 pediatric glycerine suppository, if needed
- Once normal stool is established, maintain for 1-2 months, maintain for 1-2 months, then wean from juice and/or laxatives and observe for 1 month

Non responsive/relapse → Seek advice or refer to Pediatrics

> 6 months of age

6. Is fecal impaction present?
- Assess functional retention by history (large stools that may plug up the toilet, fecal incontinence, and/or incomplete/infrequent evacuation)
- Assess for excessive amount of stool in the colon by abdominal exam

No

Yes

7. Bowel cleanout/disimpaction
- PEG 3350 orally 1-1.5 g/kg/day x 3-6 days (until passage of clear, watery stools)
- If PEG ineffective, add oral stimulant (e.g. Senna, Bisacodyl) as additional cleanout agent

** Rectal therapies are considered second line*

Assess in 5-7 days if clean out achieved

Yes → **8. Laxatives and fluid intake**
- Initial goal is BM Bristol stool 4-5
- Ensure adequate fluid intake
- PEG 3350: 0.5-1 g/kg/day or
- Lactulose: 1-2g/kg/day in 1-2 doses or
- Mineral oil (lubricant laxative) if painful BMs*

** do not use below 1 year of age*

No → Assess in 5-7 days if clean out achieved

Response in 2-4 weeks?

No → **11. Optimize management**
- Reassess / re-educate
- Query fecal impaction (if yes, return to #7)
- Ensure adherence
- Change laxatives / optimize dosing
- Query behavioural / mental health factors

Non responsive/ need advice → Seek advice or refer to Pediatrics

Yes → **9. Maintenance therapy for 6-12 months**
- **Essential for long term success**
- Reinforce family understanding of management concepts and the need for long-term intervention
- Maintain laxatives, slowly transition to BM Bristol stool 3-4
- Add dietary modifications

Relapse?

Yes → **11. Optimize management**

No → **10. Wean and observe for 6-12 months**
- Decrease laxatives by 25% every 1-2 months
- Reinforce high risk of recurrence and importance of early intervention as needed