Ashford and St. Peter's Hospitals
NHS Foundation Trust

Management of Paediatric Constipation

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Guideline History		
Date	**Comments**	**Approved By**
Sept 2018	Guidelines for the management of Constipation in Children – Dr Fiona MacCarthy	
April 2022	Referral Pathway for intractable constipation and Red/amber flags. Indications for imaging. Criteria for admission, contraindications, method of administration and monitoring for Klean prep. Klean prep leaflet for parents.	Paediatric Guidelines Committee
December 2025	Moviprep Regimen Guideline with review of information for whole guideline	Paediatric Guidelines Committee
May 2026	Addition of imaging guidance with US as first line	Paediatric Guideline Committee/ radiology

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Patient Presenting with Constipation

Full history and examination including:

Frequency/consistency of stool
Diet and fluid intake
Overflow, soiling, straining, holding behaviour
Social history

Weight and Height
Abdominal examination for distension
Lower limbs/neuromuscular/Spinal examination

Baseline screening as required (Thyroid function, Coeliac screen test)

Amber Flags:
- Faltering growth
- Concerns over possibility of child maltreatment

Red flags:
- Constipation from birth/neonatal period
- Failure/delay in passing meconium > 48hrs
- Ribbon stools
- Abdominal distension + /- vomiting
- Abnormal appearance of anus /sacral region **(do not do a PR)**
- Abnormal examination of spine /neuromuscular signs or abnormal reflexes
- Weakness in legs/locomotor delay
- Family history of Hirschsprungs.

YES

NO

Give general advice on management, fluids and diet. Reassure child and family.
Give written advice on constipation

Idiopathic Constipation

Start Maintenance Therapy.

Start with a Macrogol (<12yrs Movicol Paediatric, for >12 years Standard Movicol)

<1 year: 0.5-1 sachet daily
1-5 years: 1 sachet daily
6-12 years: 2 sachets daily

Reassess in 2 week (GP/clinic)

Adjust dose to produce regular soft stool (type 3 or 4*). Max 4 sachets/day as maintenance.

Add a Stimulant laxative if no response .

If Macrogol is not tolerated, addition of stimulant laxative +/- lactulose.

Faecal Impaction (LIF mass +/- soiling)

Start Disimpaction Therapy (Section B)

Explain escalation, aim and maintenance.

Warn about initial increase in soiling/abdominal pain

Reassess in 1 week (GP/clinic)

Repeat Disimpaction, check compliance.

If there is no effect after 2 weeks, Add stimulant laxative

If Macrogol not tolerated, substitute with a stimulant laxative +/- Lactulose

REVIEW overall response **6 weeks**

No Improvement

Consider appropriate limited In-Patient **enema therapy** (after counselling and consent)

Followed by re-trial of first line disimpaction course.

Ensure 3 months optimal therapy (Osmotic Laxatives + Stimulants) with adequate compliance

Improvement

After regular bowel habit is established, continue at maintenance dose for up to several months.

Do not stop medication abruptly: gradually reduce the dose over months.

Continue lifestyle changes.

Referral*

Referrals from Paeds

- Non Urgent : Paediatric Clinic Referral (RAC).
- Urgent concerns (Amber/Red Flags), escalate to On-call Consultant.
- Tertiary referral (St George's) after discussion with Gastro lead for escalation of management/Failed therapy.

Community Support

- Continence Service via One Stop Portal
- Referral can be done once Macrogol prescribed by GP/ Paediatrician and monitored for at least the first 2 weeks, but further support is required in the community.

Imaging

1. Should be reserved for the investigation of intractable constipation (>3months of optimal therapy).
2. Where faecal impaction is suspected but a physical examination is unreliable or difficult (e.g. autistic child)

Imaging pathway for rectal faecal impaction in children

Protocol written by Dr Sylwia Niewiarowski (Consultant Radiologist) 19/3/2026

1. 1st line ultrasound: Available most days between 9am and 4 pm. Please contact US reception on extn 3630

   Normal transverse rectal diameters by age

   - 0-12 months < 2.5 cm
   - 12 months - 4 years < 3 cm
   - 4 years and above < 4 cm

   Contents – gas, formed stool, liquid

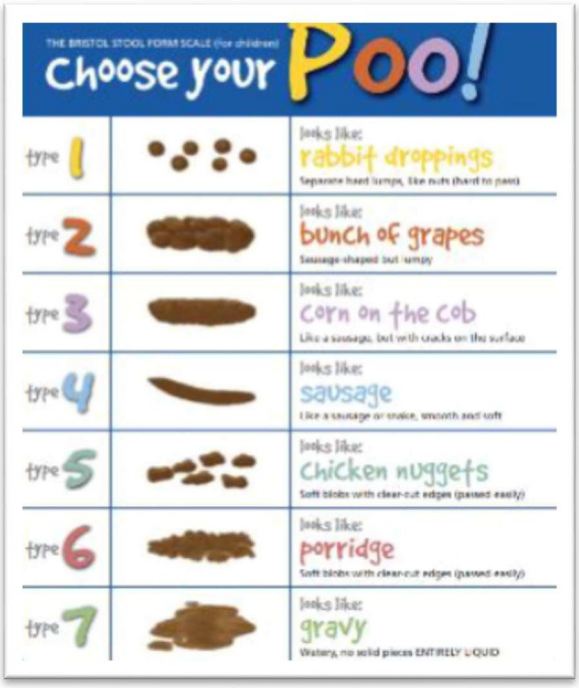
   - If rectum contains fluid or is abnormally distended with gas– consider AXR
   - If found to have rectal faecal impaction - repeat ultrasound at end of treatment.

2. 2nd line AXR: Only if US assessment is unavailable

Ensure the following key points to engage and support parents.

- Do they understand the condition?
  - Educate and give written information/sign post to appropriate online resources (pg X)
  - Advice about diet and fluids.
  - Clarify that it is a chronic condition, there is no quick fix, and treatment may be needed for months or more. A LONG term treatment, but not a 'dependency' on medications
- Are there non-medical factors involved?
  - Check about toileting issues and toilet behaviour.
  - Use reward systems such as star charts to encourage good toileting behaviour.
  - Are they withholding because school toilets not clean etc.?
  - Are there other emotional issues/difficulties at home?
  - Triggers -new school? diet? potty training
  - < 6 months: Avoid multiple feed changes, consider Infant feeding team Counsellors.
- Do they know how to make up and take the macrogols?
  - Can mix with other drinks to make it more palatable e.g. squash, or different flavours
  - 1 satchet in 60ml of fluids Paediatric Movicol, 120ml if standard Movicol.
- Don't under-medicate
  - Do not be afraid to give high doses of medication. NICE gives higher doses than BNFC.
  - Use Stimulant early for straining.
- For Disimpaction - Warn child and parents that disimpaction may initially increase the symptoms of soiling and abdominal pain. Give leaflet
- Consider patient psychological support if required. Signpost as appropriate.

Section B. Disimpaction Regimen



How to use:

- Progress along this escalation till achieve type 6-7 stools.
- De-escalate till reach a DAILY bowel output of type 3-4 stools
- Ongoing maintenance for chronic constipation - 1-4 sachets daily in divided doses
- Advise regarding focus of compliance and out of nursery/school days etc.
- Print Parent Leaflet (pg X)
- **Rectal Enema** use should be considered, alongside with oral disimpaction in moderate to severe constipation and refractory constipation **as an inpatient admission.**

< 1 year	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	½ to 1 sachet (no escalation)						
1 – 5 years	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	2 sachets	**4** sachets	**4** sachets	**6** sachets	**6** sachets	**8** sachets	**8** sachets
5- 12 years	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	4 sachets	**6** sachets	**8** sachets	**10** sachets	**12** sachets	**12** sachets	**12** sachets
> 12 years	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
	4 sachets	**6** sachets	**8** sachets	**8** sachets	**8** sachets	**8** sachets	**8** sachets
In daily Divided Doses - NICE advises higher doses than BNFC							

Section C. MoviPrep Regimen

Patient Care Notes:
Administered orally or via nasogastric tube or gastrostomy. Most children will require a nasogastric tube to achieve the desired intake per hour.
Other oral drugs should not be taken one hour before or after administration of bowel cleansing preparation because absorption may be impaired
Hypovolemia should be corrected before administration of bowel cleansing preparation and adequate hydration should be maintained during treatment
If administered via kangaroo pump the maximum pump rate is 400ml/hr which cannot be overridden
Moviprep® sachet A + sachet B should be reconstituted in 2L of water. This produces a solution that is equivalent to Klean-prep® 1 sachet in 1L of water.

Drug	Dose	Rate	Route	Drug Form	Frequency	Duration	Infuse Over	PRN Reason	Special Instruction/Order Comment
Moviprep® **Weight 5-10kg**	*2 sachets (A+B)*	*50mL/hour for 30 minutes, then 100mL/hour for 60 minutes, then if tolerated 125mL/hour*	*Oral/ NG*	*Liquid/dissolved powder*	*Once only*		*Maximum volume over 4 hours 100mL/kg or 3000mL*	*n/a*	*10ml/kg/hour for 30mins* *reconstitute as per instructions on sachet*
Moviprep® **Weight 10-20kg**	*2 sachets (A+B)*	*100mL/hour for 30 minutes, then 200mL/hour for 60 minutes, then if tolerated 255mL/hour*	*Oral/ NG*	*Liquid/dissolved powder*	*Once only*		*Maximum volume over 4 hours 100mL/kg or 3000mL*	*n/a*	*20ml/kg/hour for 30 mins* *Reconstitute as per instructions on sachet.*
Moviprep® **Weight 20-30kg**	*2 sachets (A+B)*	*200mL/hour for 30 minutes, then 300mL/hour for 60 minutes, then if tolerated 500mL/hour*	*Oral/ NG*	*Liquid/dissolved powder*	*Once only*		*Maximum volume over 4 hours 100mL/kg or 3000mL*	*n/a*	*Continue until 4 hours total. Maximum 100ml/kg / 3litres. If using pump continue administering until dose completed.* *Reconstitute as per instructions on sachet. If prescribed rate exceeds 400mL/hour and is being administered via pump, give at pump max (400mL/hour) until the full volume has been administered.*
Moviprep® **Weight >30kg**	*2 sachets (A+B)*	*200mL/hour for 30 minutes, then 400mL/hour for 60 minutes, then if tolerated 600mL/hour*	*Oral/ NG*	*Liquid/dissolved powder*	*Once only*		*Maximum volume over 4 hours 100mL/kg or 3000mL*	*n/a*	
Ondansetron	*100-150mcg/kg*		*oral*	*Liquid/oral dispersible tablet*	*8hours*			*As required for nausea*	*Consider prescribing ondansetron if nauseous. Max dose 8mg*

Laboratory/Monitoring Notes:
Observation every hour for first 4 hours. If these within acceptable limits then 4 hourly.
Input/output/stool charts
Medical review if any concerns or instability during Moviprep, particularly to assess signs of dehydration
Low residue/low fibre diet for 24 hours prior to commencing Moviprep
Light diet may be given in the morning and evening.
No solid food should be given whilst the infusion is being given, may consume jelly, jelly sweets, ice lollies, clear soup and a small amount of squash
Consider NG tube for administration, Care of NG tube as per local policy
Please Note: Dose of Moviprep to prescribe is automatically calculated on Cerner/FirstNet according to the weight of the patient.

Lab orders:	Pre-selected Y/N?	Scheduled order Y/N? You need to arrange at what hour you want the following tests and you need to order them.It is not automatically requested.
Urea and electrolytes, bone profile, magnesium	***No***	***Order U&E, electrolytes, bone profile, magnesium pre moviprep***
Blood sugar level	***No***	***Ordered frequency if high risk, eg less than 2 years***

Contra-indications

- Gastro-Intestinal Obstruction or Perforation *(Clinical/Radiological)*
- Gastric Retention of Contents.
- Acute Severe Colitis
- Toxic Megacolon
- Gastro-Intestinal Ulceration
- Patients with Heart Failure
- Phenylketonuria

Investigations

- Baseline Urea and electrolytes, bone profile and magnesium prior to commencement.
- Daily U+Es, bone profile, magnesium, and blood sugar levels per CLINCAL Judgement.
- Blood glucose should be monitored more closely (i.e., hourly) if the child is known to drop blood sugars levels or deemed at risk of hypoglycaemia e.g., < 2 years of age.

Side--effects:

Common side--effects:	Rare side--effects
Nausea Vomiting Abdominal pain (usually transient, reduced by taking more slowly) Abdominal distension	Headache Dizziness Dehydration Electrolyte disturbances

Discharge Planning

- Discuss with Paediatric Consultant with Gastro interest.
- Consider medication for discharge including adding in colonic stimulant some days *before* discharge to prevent relapse.
- Follow–up outpatient appointment within 4-6 weeks of discharge (Gastro RAC)
- Provide Appropriate Patient Information, consider Community Continence Service

Section D. Laxative Medications Commonly Used

Osmotic Laxatives – increases the amount of water in the large bowel

Polyethylene glycol 3350 + electrolytes *macrogol 3350 (polyethylene glycol 3350) 6.563 g; sodium bicarbonate 89.3 mg; sodium chloride 175.4 mg; potassium chloride 25.1 mg/sachet.* *Preparation Tips :* 1 Sachet to be mixed in 60ml of liquid (Paediatric) or 120ml for Standard Movicol	**Ongoing maintenance** (chronic constipation, prevention of faecal impaction) • **Under 1 year**: ½ to 1 sachet daily (non-BNFC recommended dose) • **1 to 6 years**: 1 sachet daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) (for ren under 2, non-BNFC recommended dose) • **6 to 12 years:** 2 sachets daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) • **12 to 18 years**: Standard Movicol 1 to 2 sachets daily in divided doses adjusted according to response for maintenance *Commercially available :* *Paediatric Movicol < 12 years . 3 flavors* *Standard Movicol >12 years* *Laxido >12 years*
Lactulose	• 1 month to 1 year: 2.5 ml twice daily, adjusted according to response • 1 to 5 years: 2.5 to 10 ml twice daily, adjusted according to response (non-BNFC recommended dose) • 5 to 18 years: 5 to 20 ml twice daily, adjusted according to response (non-BNFC recommended dose)

Stimulant Laxatives *– aim is to stimulate motility*

Sodium Picosulfate	**Elixir** (5 mg/5 ml) • 1 month to 4 years: 2.5 to 10 mg once a day • 4 to 18 years: 2.5 to 20 mg once a day **Perles** (1 tablet = 2.5mg) • 4 to 18 years: 2.5 to 20mg once a day *Non-BNFC recommended doses. Perles not licensed for use in children under 4 years. Informed consent should be obtained and documented. Note: Perles produced by Sanofi should not be confused with Dulcolax tablets which contain bisacodyl as the active ingredient.*
Bisacodyl	By mouth • 4 to 18 years: 5 to 20 mg once daily By rectum (suppository) • 2 to 18 years: 5 to 10 mg once daily Non-BNFC recommended doses
Senna	**Senna** syrup (7.5 mg/5 ml) • 1 month to 4 years: 2.5 to 10 ml once daily • 4 to 18 years: 2.5 to 20 ml once daily **Senna** (non-proprietary) (1 tablet = 7.5 mg) • 2 to 4 years: ½ to 2 tablets once daily • 4 to 6 years: ½ to 4 tablets once daily • 6 to 18 years: 1 to 4 tablets once daily
Docusate sodium (Stimulant and softener)	• 6 months to 2 years: 12.5 mg three times daily (Paediatric solution) • 2 to 12 years: 12.5 to 25 mg three times daily (Paediatric solution) • 12 to 18 years: up to 500 mg daily in divided doses

Enemas - *Although rectal administration of laxatives may be effective, this route is frequently distressing for the child and may lead to persistence of withholding –* ***Most cases MUST be INPATIENT***	
Sodium Citrate *Micolette/Relaxit/Micralax*	3–17 years: 5 mL for 1 dose.
Sodium Phosphate	3–6 years: 45–65 mL once daily. 7–11 years : 65–100 mL once daily. 12–17 years: 100–128 mL once daily.
Glycerine Suppository	1–11 months: 1 g as required. 1–11 years : 2 g as required. 12–17 years: 4 g as required.
Bowel Prep Solutions *– after consultation with GI Lead/Tertiary Centre*	
Picolax	https://bnfc.nice.org.uk/drug/magnesium-citrate-with-sodium-picosulfate.html#indicationsAndDoses

SECTION E. Parent Leaflets and Websites

1. General Advice for Constipation
   - **ERIC**
   - **BBUK Infants and Toddlers**
   - **BBUK Children**
   - **BBUK Children with Learning Difficulties**
   - **ERIC Child Friendly Leaflet**
2. ERIC Disimpaction Regime and Guidance
3. Bristol Stool Chart
4. Poo Diary | ERIC
5. How To Prepare Macrogols
6. Preparation for Admission for Klean-Prep
   - SPH Leaflet (on Intranet)
7. Children with Toilet Refusal
8. More Fibre Tips
9. More Fluids tips How to Encourage my Child to Drink More Water by BBUK

Websites to signpost to

- https://www.eric.org.uk/Pages/Category/bowel-problems
- https://www.bbuk.org.uk/bowel-resources/
- The Poo Nurses- https://www.thepoonurses.uk/

2. Supporting References

1. STPN Meeting Draft for Management of Constipation in Children 2022.
2. https://www.nice.org.uk/Guidance/CG99
3. SGH/Evelina Guidelines
4. BNFC/https://www.medicinesforchildren.org.uk/
5. Tabbers, M M et al. "Evaluation and treatment of functional constipation in infants and children: evidence-based recommendations from ESPGHAN and NASPGHAN." Journal of pediatric gastroenterology and nutrition vol. 58,2 (2014): 258-74.

3. Supporting relevant trust guidelines

1. Guidelines for the management of Constipation in Children 2018 – On TrustNet

2. Guideline Governance

a. Scope

This guideline is relevant to all staff caring for all ren from 0-18 years old across the emergency department, inpatient ward and outpatient department.

b. Purpose

i. This guidelines aims to facilitate a common approach to the management of ren. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant.

ii. This guideline is subject to regular review to ensure ongoing evidence based practice.

c. Duties and Responsibilities

All healthcare professionals responsible for the care of all ren 0-18years should be aware of practice according to this guideline.

d. Approval and Ratification

This guideline will be approved and ratified by the Paediatric Guidelines Group.

e. Dissemination and Implementation

i. This guideline will be uploaded to the trust intranet 'Paediatric Guidelines' page and thus available for common use.
ii. This guideline will be shared as part of ongoing education within the Paediatric Department for both medical and nursing staff.
iii. All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

f. Review and Revision Arrangements

a. This policy will be reviewed on a 3 yearly basis by the appropriate persons.
b. If new information comes to light prior to the review date, an earlier review will be prompted.
c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Paediatric Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

g. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Author and the supervising consultants.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
All groups of staff and patients were taken into consideration and there is no bias towards or against any particular group.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups

There is no evidence of discrimination.
Conclusion • Provide a summary of the overall conclusions
There is no evidence of discrimination.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
This guideline is appropriate for use.

h. Document Checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Management of Paediatric Constipation

Policy (document) Author: Dr Alka Thakur

Executive Director: N/A

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Y	

		Yes/No/ Unsure/NA	Comments
	Is the purpose of the document clear?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Y	
	Who was engaged in a review of the document (list committees/ individuals)?	Y	Dr Michael Aninwene, Guidelines committee
	Has the policy template been followed (i.e. is the format correct)?	Y	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are local/organisational supporting documents referenced?	Y	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	Y	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	

		Yes/No/ Unsure/NA	Comments
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Y	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Y	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Y	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

Committee Approval (Paediatric Guidelines Group)	
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner	
Name of Chair **Alexandra Jones**	**Date** **03/12/2025**
Ratification by Management Executive (if appropriate)	
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner	
Date: 6/01/2026	