Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CHILDREN WITH FUNCTIONAL CONSTIPATION

Information booklet for parents

To be used together with advice from your doctor or nurse

Please bring the stooling charts with you when you visit the doctor or nurse

Summary:

1. Constipation is common (12% of children are constipated [Ref 1, 2]) but is not always easy to spot: infrequent hard stool passed with discomfort are the main symptoms but sometimes there could also be blood, "toilet blockers", soiling, skid marks, wetting problems and "holding behaviour".

2. Usually there is nothing structurally/physically wrong with your child's bowel (gut), i.e. there is no "blockage" as such. There is a **functional** problem however and tests like X-rays or blood tests are usually not required.

3. Your GP and PHN are your Primary Care Team to care for your medical needs, including constipation.

4. "Holding" (due to fear of discomfort) is the most common reason why children become and continue to be constipated. Temperament, toilet training, inadequate drinking and diet can also play a role, resulting in "the child loosing full control over their bowels".

5. The treatment starts with the parent(s) being fully educated about the workings of the bowels, step one. All you need to know is in this booklet. Then the parent(s) keep track of the bowel motions using a stooling chart, while the child takes plenty of laxatives for long enough periods to keep the poo really soft and the holding has stopped. The cure of the problem can only start then with a (re-) toilet training program before the medication can be weaned.

Step 1: **Parents to learn** about the bowels;

Step 2: **Clear out** the bowels;

Step 3: Take away any fear and holding behaviour by keeping the stool **really soft** and the rectum empty for many weeks or months;

Step 4: While continually keeping the stool soft with medication, the child needs to be **re-toilet trained** to acquire a bowel habit, paying attention to positioning the child correctly on the toilet;

Step 5: Only if the first three steps are successfully done, you can start **weaning** the medication.

"Man should strive to have his intestines relax all the days of his life."

Moses Maimonides. AD 1135-1204

Frequently Asked Questions

What is constipation? A child is constipated if he passes a sizable bowel motion ("poo" or "stool") infrequently (less than three times a week), which is hard and/or uncomfortable to pass. Constipation is common - 12% of children are constipated [Ref 1, 2] but isn't always easy to spot. Sometimes the child can have alternating loose and hard stool or only soiling and still be constipated. Sometimes there is blood on the toilet paper if there is a tear. I can ever appear that the child passes a stool many times a day but it is very small with intermittently passing very large stool ("Toilet Blockers", "Mega or Elephant Poos", "Cucumber size stool"). Many children with constipation also have wetting problems during the day or at night or both. Toddlers often display "holding behaviour" (going into a room or a corner, behind the couch etc or pushing up against the wall) trying not to go, which can look like straining to go.

Why do children get constipated? Why can't it be cured overnight? Very rarely there is something structurally wrong (like a blockage) with the bowels. Constipation often starts with passing a hard stool during a period when the body is a bit dry like why he drinks poorly due to illness or when it is very hot. Your doctor will know what to do by asking you questions and examining the child. Tests (X-rays and blood tests) are rarely needed. Hard stool can be painful when passed and encourages the child to hold on to their stool the next time they feel the urge to go. They can get into a self-repeating circle of → Hard stool → Passing painful stool → Being reluctant to pass a stool → More hard stool in the bowel → More painful stool …etc. The result is chronic retention or functional constipation, which is painful and upsetting for the child and affects the child's eating, behaviour and school performance. It often leads to soiling (skid marks or tire tracks in pants) and sometimes kidney infections or wetting. The chronic constipation over-stretches the bowel muscles and makes them weak (see drawings on page 12). Only when the bowels are cleared out for a long enough time, can the bowels get back into shape so it can work normally as in the three steps in the drawing. It also takes time to re-train the bowels. That's why constipation takes time to treat.

Is the constipation or soiling caused by upset emotions? No, not really. Although not all doctors fully agree, most feel that psychological factors rarely are the primary cause of the constipation. Some children's temperaments can lend itself more to react with holding following uncomfortable passing of stool, like children with autism or those who are rather anxious or stubborn. The reverse is more likely to be the case where constipation causes psychological problems and stresses. When this happens, the psychological problems can stand in the way of curing the constipation and sometimes the help of a psychologist is needed. The soiling related to constipation due to faecal retention, involves small amounts of poo in the pants ("overflow"), which is very soft. If there are really large ("scoop-able") amounts of poo in the pants (or are deposited anywhere) this might be more likely to be related to psychological issues (FNRFI). We used to call this "encopresis".

Is the constipation caused by faulty toilet training? Constipation often becomes a problem around the time of toilet training. Toilet training is NOT learning to hold; babies as young as 10 months can hold their poo and too much holding is the underlying cause of most children's constipation. **Toilet training is about the child gaining control to relax the sphincter muscles of their bottom at a time and place the child/parent(s) want it to occur.** For a child to sit on a potty/toilet and relax its muscles and let the poo come out, the child must feel confident that there will be a relief, a pleasant sensation, not discomfort. If you tell a constipated child to sit on the toilet, you in a way are telling him "to sit on the toilet and hurt yourself". No sensible child will do that; the stool has to come out without discomfort. Trying to toilet train a child who is constipated is likely to fail and worsen the holding and therefore the constipation.

How can my child have constipation if he appears to have diarrhoea and soil his pants? This is a commonly ask question by parents. As the picture on the lower right of the drawing on page 12 shows, the persistent presence of hard lumps of stool in the rectum results in the first muscle (sphincter) to stay open automatically; you have no voluntary control of this. You can wilfully keep the second muscle closed to hold your stool. When distracted or concentrating on something else (school, watching TV, playing) this second muscle could relax (open) by mistake and a bit of soft poo can escape. This is why soiling usually happens in the afternoon at home. If there were only hard lumps, nothing would come out. However in chronic constipation liquid/soft stool by-passes the lumps and end up in their pants! This is called "overflow". The child cannot help this. **It is not their fault!** Your child would tell you that he didn't feel it coming, and he is right as the three steps of normal stooling (1: empty rectum and no urge; 2 full rectum and urge; 3 relax muscle and push put) isn't working. Proper treatment of the constipation following through all five steps is the only road to cure; otherwise your child will relapse into the same pattern.

What can be done about it? A lot can be done but it will take time and hard work. Tests, X-rays and surgery are not required unless there are other health problems like not growing, vomiting or problems passing meconium at birth. Your doctor or nurse will know. A healthy diet with plenty of fruits and fibres (oranges, pineapples and avocados especially!) will help the bowels as it does in adults. See the list of fibre content in food (page 15). In children sufficient amounts of fluids (not milk, as this gives constipation) are important as well. For children with chronic functional constipation, diet advice is usually not enough to tackle the problem and medicine and committed parents and children are needed. It essentially means using laxatives constantly for a long time and to "re-train" the bowel before weaning the stool softener medication.

The management of functional constipation consists of five stages or steps [Ref 1, 2]:

"The Five Steps to Cure©"

Step 1: Education of parents and child
It is vital that the (older) child and the parent(s) understand how the bowels work, what the symptoms of constipation are, how the five-step-treatment works so you are able to adjust the dose of the stool softener and to stay motivated. The doctor or nurse will have spent time with you at the initial visit to explain the ins and outs and this handout plays an important role in this too. You are advised to study the whole handout before treating your child.

Step 2: Clearing out the large bowel
If the last part of the bowel (rectum) is not cleared out, there is no point in moving to stage three. A combination of softener(s) and stimulant laxatives is used. Rarely a hospital admission is needed to get enemas to "wash it out"; usually plenty of liquid paraffin and/or Movicol will work, which can be messy for 2-3 weeks. At any stage, but particularly at this first treatment step, it is important not to give any negative vibes (e.g. being cross with your child), because he needs to learn to relax and let it come out, not to hold it in: "*Better out then in, I always say*", says Shrek. If there is soiling, ensure the bottom is well protected with sticky barrier (water repellent) creams like Sudocream or Vaseline, so he won't get sore as this might give another reason not to go and hold. Sometimes you need to revert back to nappies/pull-ups to manage the situation (less washing buying less new underwear, no stool running down the legs etc). Once the rectum is cleared of stool, the soiling will stop. Soiling therefore usually means there isn't enough clearing out done.

Step 3: Keeping stool soft and large bowel clear of hard stool
The main aim of this stage of the treatment is to make sure the stool is consistently and really soft by using plenty of softener laxatives. The dose and type will need adjusting over time and the parent need to be able to do this. This is one of the reasons you need to know all about it and read this booklet. It doesn't matter if the child isn't going every day at first, as long as it is <u>really soft</u>. Sometimes limited use of stimulant laxatives is required. The ideal consistency of the stool in this phase – while on laxatives – is type 5, 6 or 7 (SOFT or RUNNY) on the attached Bristol stool form chart. There "should be no sausages" LOL. Types 1 to 4 are labelled as HARD (while on laxatives). In non-constipated people and after being cured of constipation, type 3 and 4, passed easily one or more times a day is normal. A stooling chart is enclosed. **Please complete this every day. Using this chart has proven to significantly increase the likelihood to cure the constipation**: it helps you understand your child stooling pattern, improves compliance giving the medication and to communicate progress to the doctor in the clinic. During step 3 the child will regain confidence so that when he/she passes a stool, he/she will not anticipate any discomfort. This learning takes time, often more than three months. If during this stage he/she has one hard stool, you are likely to be "back to square one". This is the most common reason why children never seem to get cured and become "dependant" on laxatives resulting in the laxatives to be stopped too early or given haphazardly,

resulting in having insufficiently soft stools for a long enough period. Together with stage 3 it can take up to one year to complete. Often it takes as long to get cured as it took to get constipated.

Step 4: Re-toilet training
After the child has regained full confidence that passing a stool is a relief and not a painful affair, you have to establish a "regular bowel habit", while keeping the stool as soft as in step 3. A bowel habit can be learned and is established when you have trained your bowels to move the stool into the rectum in certain situations or at certain times resulting in an "urge" and voluntary relaxation of the muscle sphincters on the toilet: when the brain and bowel are communicating properly. The child can and needs to learn to relax their bowels and do a poo "on command" – when he/she wants it. This is not learned as easy as for doing the number ones (wees). The best time to learn to pass a stool, is half an hour after a large meal; twice a day would be ideal. Make sure the child is relaxed – stay with him or her, read a story or give them something else nice to do but don't distract too much from the job at hand. The longest a child can concentrate on this is 1 minute per year of age; a four year old can sit for only four minutes before he want to get up and go. Using an egg timer as a visual aid to indicate when the time if over, can help the smaller child. The **position on the toilet** is important to relax the muscles of the pelvic floor: (See diagram 1 on page 7 – try it yourself the next time and you can feel it relaxing!)

1. Have the child's feet supported on e.g. a stool or box so the top of the knees are slightly higher than the rest of the lower part of the body;
2. Have the child sitting comfortably and back enough on the toilet seat being of appropriate size;
3. Lean slightly forward but have the child's back straight (*hold your back like an "L"*); don't sit curved forward.
4. Have the hands/arm comfortably resting on the legs;
5. Have the tummy muscles relaxed and outwards (*hold your tummy like a "C"*).

Praise the younger child for any effort, no matter how small!!!! Reward charts can be useful, for children aged between 3 and 8 years. See an example on page 21. Any negative pressure or giving out doesn't work!

Too young for toilet training? For children who have gone successfully through step 3 but aren't ready for toilet training yet because they are too young, you skip step 4 and see how the child does while weaning the medication. Often you need to stay on some softener until the child is ready for toilet training. If you have been able to wean the child's medication, you are advised to restart a small amount of softener and follow what is said in step 4 BEFORE you start toilet training, otherwise it is likely the child will re-start holding and get constipated again.

Step 5: Weaning (reducing) the medication

The child is ready to be weaned when you have completed step 4 and the child feels an urge of stooling and goes every day, preferably on a fixed time or after a certain event (like after a meal). Only wean when the child has no holding or anxiety related to doing a poo. It can take a while before your child is ready for step 5. If you have understood the instruction above, you should have a good idea when your child is ready for weaning. If you are not sure, your doctor or nurse can advise. Reducing the medication is done gradually over 3-4 weeks while encouraging the child to sit on the toilet every day and give plenty of praise. Reduce the amount given while continue to give it twice a day. If the child is on a stimulant and softener laxative, wean the stimulant first and then the softener.

Diagram 1

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Other Important Information

What do I need to know about laxatives and diet? A good bit, because you will need to work together with the doctor or nurse to make it work. You will be instructed how to adjust some of the doses of the medicine depending on the changing condition of your child. The main laxatives that we use can be grouped into two types.

Softener laxatives: Softeners stay in the bowel and are not absorbed by the body and are therefore very safe. Often large doses are used to keep things smooth! **If the stool isn't soft enough, you need to give more softener**. The amount can be as small as 2.5 mL (half a tea spoon) and as large as 50 mL, twice a day. Softeners just make the stool soft and not necessary make the child go more often but after a while this will usually happen. The doctor suggests a starting dose. What matters is the consistency of the stool (see step 3) and not the dose. Softeners are best given twice a day.

1. **Lactulose** (brand name e.g. *Duphalac*, *Laxose*). This is an osmotic laxative and is available over the counter; i.e. it doesn't require a doctor's prescription and isn't available on the medical card. Lactulose is a long chain of sugars stuck together which the small bowel can't digest and can't absorb in your body. It is syrup and is sweet and virtually all children love it. It is dissolvable in water and you can hide it in a drink. When it arrives in the large bowel, the healthy bacteria there break it down into smaller parts and these small sugars make it more difficult for your bowel to extract water so the stool will stay soft. Lactulose will also benefit the growth of the healthy bacteria and is a "prebiotic" – check it on Wikipedia! Lactulose works a bit the same as the brown sugar you give to babies. Lactulose is very safe and can even be used during pregnancy. It sometimes gives cramps and smelly wind! Lactulose however is a relative weak laxative, especially for those toddlers who are expert holders; if you hold stool long enough, the body is stronger than the lactulose, the bacteria eat all the lactulose and the water is taken out anyway and the stool will be hard by the time it reaches the back passage.
2. **P.E.G. 3350, Poly-Ethylene Glycol (macrogols)**: This softener works a bit like lactulose and is also an osmotic laxative and requires a doctor's prescription. Instead of a sugar as in lactulose, this medication uses PEG 3350, Poly-Ethylene Glycol in a salty solution. The product in Ireland is called **Movicol Paediatric**. It is especially good to clear out the bowel in step 2, using increasing amounts of between 1 and 4 sachets twice a day, as instructed by your doctor [Ref 4]. It is also good for older children and adults to be used in step 3 to 5. When you use PEG in Toddlers it can be difficult to predict and regulate the consistency of the stool; sometimes it is too soft and leaks while on other days is too hard making it difficult to get the child confident to sit on the toilet and relax, the main aim in step 3. The powder needs to be dissolved in a liquid and taken over a short period. You can add a cordial/juice to it for taste. The salty taste and volume can be the reason children are reluctant to take it. There is a type of PEG that is not salty and tasteless and is in a tin, using scopes instead

of sachets. This product is called **Osmolax**. It comes from Australia and doesn't have a selling licence yet However your Chemist can get this after a few phone calls. One scope is approximately one sachet. Another P.E.G. product that isn't salty is **Dulcosoft** oral solution, which is flavourless but has a slight perfume like taste and is best added to a drink.

3. **Liquid paraffin:** Liquid paraffin is used a lot because it is particularly good for those young children who hold their stool, it's cheap, it can be obtained without a prescription, and it is safe even when used for long periods [Ref 3]. It should not be used in children under the age of 12 months or those with swallowing/vomiting difficulties in case it ends up in their lungs. It is not uncommon to have some leaking of the orangey looking oil into the child's underwear (anal seepage) which improves when the amount required is reduced.
4. **Diet and other fibre softener products:** Natural softener can be found in health food shops like linseed (it has oil in it like liquid paraffin) or fibres found in food or other products. No diet on its own in a toddler is likely to fix retention constipation. A constipated child usually has a low appetite and introducing healthy "all-bran" fibre food won't be easy anyway. Long term improving the child's diet however is important in reducing the risk of relapsing later. Once he/she starts eating better introduce new and fibre food as per enclosed diet sheet on page 15-16. Health food shop stool softeners can be used to keep the poo soft once cured, like linseed or some (less natural) fibre additives like "**Fibre Clear**" (dissolvable tasteless fibre [Ref 1]).

Some non-fibre foods are more constipating than others, like rice and bananas but the effect is usually minimal, unless you have particularly noticed this to be the case in your child. Avoid large amounts of milk but dairy products are not bad for constipation as long as you don't give too much of it.

Stimulant laxatives: These medicines stimulate the muscle in the bowel to "make you go". Regular bowel movement is a good to prevent hard stool. If the stool is large and hard, sometimes stimulants on their own don't work and can cause cramps. In general, you need to give more stimulant laxative if the child does not go often enough (this is at least once a day). Unlike the softener and lubricant laxatives, the dose of stimulant laxatives has strict maximum allowed doses, duration and frequencies of use. Stimulant laxatives for children need a prescription and are to be taken as instructed by your doctor. The stimulant laxatives we use are senna products (*Senokot syrup*), sodium picosulfate (*Picolax, Dulcolax Pico Liquid/Perles*), and bisacodyl (*Dulcolax tablets, Toilax*).

Guidance on medication doses [Ref 5]

Starting dose softeners (dose to be titrated to response):

Medication	< 1mo	1-12mo	1-5yr	5-10yr	>10yr
Lactulose	1mL/kg/d	2.5mL BD	5mL BD	10mL BD	15mL BD
Liquid paraffin	Don't use	Don't use	1-2mL/kg/day		
Movicol sachet	Don't use	0.5/day	1-2 sachets per day		

Stimulants:

Medication	< 1mo	1-12mo	2-6yr	6-12yr	>12yr
Senokot	Don't use	Don't use	2.5-5mL	5-10mL	10-20mL
Picolax	Don't use	2.5-10 mg/day		2.5 – 20 mg/day	

Bowel clear-out:

Bisacodyl

1-5 years old	5mg per day for 3-5 days
5 years old	10mg per day for 3-5 days

OR

Movicol Paediatric Plain
(in sachets per day, divided in two or three doses)

	Day of treatment						
	1	**2**	**3**	**4**	**5**	**6**	**7**
2-4 years old	2	4	4	6	6	8	8
5-11 years old	4	6	8	10	12	12	12

How do I give the laxatives? It is recommended not to hide the laxatives if at all possible – the child usually will find out you are hiding it anyway. It is easier in the long run and most children will take it neat. Softeners are best given twice a day to get a more consistent response but some do well when given all in one go, once a day. Especially liquid amounts over 5 mL of Lactulose and Liquid paraffin are best given using a small measuring cup. You get these 30 mL measuring cups free of charge from your chemist.

Diagram 2

What if my child doesn't want to take the medicine? Most children don't take tablets so most medication is in liquid form. Some children seem to take no medication at all. This can be a challenge and firmness without being forceful is required as most children will quickly acquire a taste for medication. Praise the child for taking any mediation and give them a small reward or treat afterwards (See the use of Reward Charts on page 22). Try not to bribe them with promising the "moon and the stars" in advance.

Tips to take Lactulose: Most children take the sweet lactulose, so you have a good start. If this is impossible you can:

1. Take it neat and take a drink afterwards **or**
2. Dissolve the lactulose in a small drink with the child's knowledge.
3. Hide it in a drink. Be sure your child finishes the whole drink otherwise he doesn't get the full dose of the medication.

Tips to take Liquid paraffin: Liquid paraffin is an oil and doesn't dissolve in drinks (based on water). If this medication is required but is difficult to take, the following tricks can be tried:

1. Mix some liquid paraffin with the pure lactulose in the measuring cup, if he is able to take the lactulose. Then gradually increase the liquid paraffin and decrease the amount of lactulose.
2. Take it neat and take a drink or yoghurt afterwards **or**
3. Mix the liquid paraffin in a small amount of yoghurt or ice-cream, preferably with the child's knowledge.
4. Put the bottle of liquid paraffin in the fridge. This makes it less oily and the cold liquid paraffin tastes better.

Tips to take Senokot syrup (senna): This is bitter and can be difficult to take so mixing it with a more tasty substance would be helpful.

Are laxative dangerous? When used as instructed, the use of laxatives is safe. Even when used for long periods (months-years) there is no risk of the bowels becoming "lazy", especially with the use of softeners. Long term use of stimulants might have effects on the tone of the muscles in the bowels.

Which doctor deals with my child's constipation?

With you reading this handout, your own GP can manage most children with functional constipation. Some children however have a bowel disease or concerning symptoms requiring special tests or treatments not available in primary care. When your GP is concerned about this, you might need to be referred to a Consultant Paediatrician's outpatient clinic. **In the clinic you will be asked if you have read this handout** and a lot of questions from birth to current symptoms and the child will be examined. In a small number of cases, a rectal examining, blood tests, an X-ray, Ultra sound or referral to a surgeon in the children's hospital in Dublin is required before a treatment plan is made. In addition to the treatments outlined in this handout, the Paediatrician might also use other methods like briefly mentioned in the next paragraph.

Other treatment methods: Apart from medication by mouth as outlined above there are other methods to help regulating and emptying the bowel in children. It would be uncommon to use these and usually the Paediatrician is involved at that stage and the use will be explained:

1. Other oral softeners: Bulk forming laxatives
2. Other oral stimulant laxatives
3. Suppositories: bullet shaped medication put in the child's bottom
4. Enemas
5. Micro enemas
6. Bowel Washouts

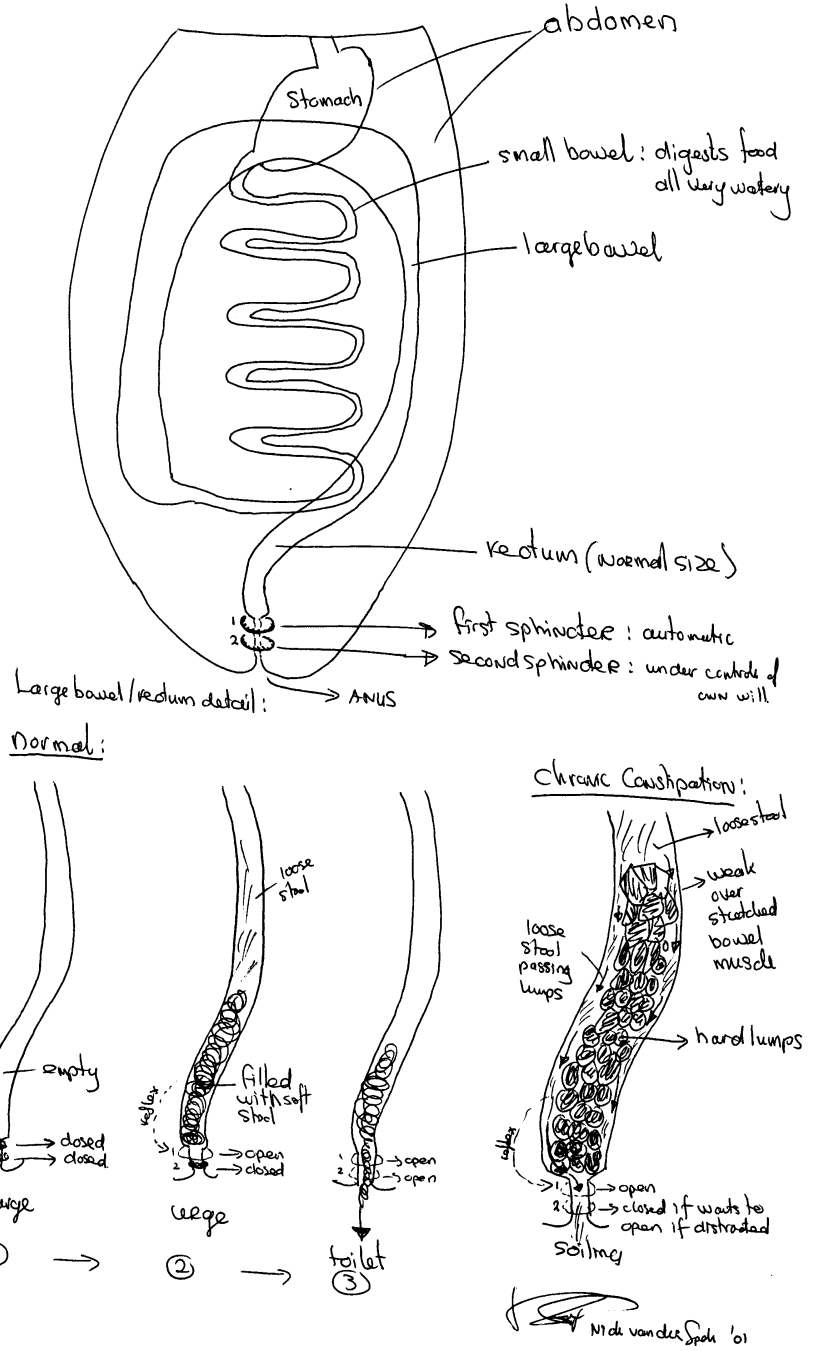
abdomen
Stomach
small bowel: digests food all very watery
large bowel
rectum (normal size)
first sphincter: automatic
second sphincter: under control of own will
Large bowel/rectum detail:
ANUS
Normal:
empty
closed
closed
No urge
①
loose stool
filled with soft stool
relax
open
closed
urge
②
open
open
toilet
③
Chronic Constipation:
loose stool
weak over stretched bowel muscle
loose stool passing lumps
hard lumps
relax
open
closed if wants to
open if distracted
soiling
Nicki van der Spek '01

Diagram 3

A model of how the bowels work (see Diagram 3)

Big picture in top half:

Your bowels (or guts) are in your abdomen (tummy) to digest your food. It starts with your stomach which receives the food from your mouth via the gullet (oesophagus). The stomach works as a reservoir and passes small amounts of its content into the next part, the small bowel (duodenum, jejunum and ileum) where the actual digestion takes place. Digestion means the breaking down of food in very small particles, small enough to be absorbed into the blood and used to build-up and feed the rest of your body. The small bowels have no germs; it's sterile. Not all food can be digested and the watery remnants or slack is passed into the next part of the gut, the large bowel (colon). The large bowel does not do any digestion but is there to re-absorb water and thicken the content, so you don't have to go and pass loose poo every 20 minutes like the cows! The large bowel has lots of germs doing a good job and helping us. The end of the large bowel is called the rectum and anus (=back passage). It has two muscles, which keep it closed. They are very sophisticated, enabling us to pass wind without solids even when we have diarrhea. The (1) first sphincter muscle is normally closed unless there is a substantial amount of poo in the rectum. This opening and closing happens automatically – the child has no control over this. When this muscle relaxes, a message is sent to your brain, which is translated in the feeling of having an urge of going. This urge gradually becomes stronger and stronger every 15-20 minutes if you hold the stool. The (2) second sphincter muscle is also closed normally but can be opened (relaxed) voluntarily as it is under your mind's control. You can also keep it tightly closed if you are afraid to go, like when a child displays "holding behaviour".

Large bowel/rectum details:

Smaller three pictures in left lower corner ("**normal**"):

(1) In a normal person, the lower part of the rectum is virtually empty. Poo that is finished waits in the sigmoid, just before the rectum. See picture (1). If you have a bowel habit, it waits there until you are ready to use the toilet. At this stage both sphincters are closed and you feel no urge.

(2) When the poo moves from the sigmoid down towards the child's back passage there is automatic relaxation of the first sphincter. At this stage you feel an urge of going. To prevent poo coming out, you need to "hold" by keeping your second sphincter closed;

(3) Normally you would then go to the toilet and relax the second sphincter (so both muscles are open) and with a little push you empty the rectum completely. The urge resolves and you feel a satisfactory relieved sensation.

Smaller picture in right lower corner ("**chronic retention constipation**"):

In chronic constipation, several things have gone wrong. The initial problem is holding stool in the rectum (retention). The rectum gradually becomes larger and larger, over-stretching the rectum muscles in its wall while the first sphincter muscle remains open all the time. This open sphincter results in:

1. The "urge" signal from the rectum stops from being sent to the brain. That is why the child doesn't know he has to poo.
2. The second problem is that watery poo from higher up often by-passes the lumps in the rectum, and because the first sphincter is always open it can "sneak out" when you aren't careful. In this situation, your child is constantly holding (keeping the second sphincter closed) but the **sneaky poos** come out when the second sphincter is also relaxing; this happens when he/she relaxes, usually in the evening at home. Because there is no urge, he doesn't know these sneaky poos are coming out. It is not his or her fault!

Stool Form Scale Chart

Diagram 4

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While on laxatives:
Type 1, 2, 3 & 4 are labelled as HARD stool
Type 5 & 6 are SOFT
Type 7 is RUNNY

Fibre Calculations

FRUITS	SERVING	FIBRE (gm)
Apple with skin	1 medium size	3.7
Apple without skin	1 med	2.4
Applesauce	½ cup	2.0
Apricots	3 med	2.5
Banana	1 med	2.7
Blueberries (raw)	1 cup	4.0
Cantaloupe	1 cup pieces	1.3
Cherries	10 cherries	1.3
Fruit salad/fruit cup	½ cup	1.3
Grapefruit	½ med	1.3
Grapes	1 cup	1.2
Honeydew melon	1 cup pieces	1.0
Mandarin oranges	½ cup	1.0
Nectarine	1 med	2.2
Orange	1 med	3.0
Peach	1 med	1.7
Pear	1 med	4.0
Pineapple	1 cup pieces	2.0
Plum	1 med	1.0
Prunes (dried)	10 prunes	6.0
Raisins (seedless)	2/3 cup	4.0
Raspberries	1 cup	8.4
Strawberries	1 cup	3.4
Tangerine	1 med	2.0
Watermelon	1 cup pieces	0.8
VEGETABLES	**SERVING**	**FIBRE (gm)**
Artichoke, boiled	1 medium	6.2
Asparagus, boiled	½ cup, 6 spears	1.4
Baked beans	1 cup	14.0
Broccoli, boiled	½ cup	2.3
Brussels sprouts, boiled	½ cup	2.0
Carrots	1 medium	2.0
Cauliflower, boiled	½ cup	1.7
Celery	1 stalk (7 inch)	0.7
Coleslaw	½ cup	1.0
Corn, on the cob	1 ear	2.0
Cucumber	½ cup of slices	0.5
Eggplant, boiled	½ cup	1.0
Green beans, boiled	½ cup	2.0
Lima beans, boiled	1 cup	13.2
Lettuce	½ cup of pieces	0.5
Mushrooms	½ cup pieces	0.4
Onions, boiled	½ cup	1.0
Peas, green	½ cup	4.0

See next page for more …

Pinto beans, boiled	1 cup	14.7
Potato, baked w/skin	1 medium	5.0
Potato, boiled	1 medium	2.0
Potato salad	½ cup	1.6
Pumpkin, canned	½ cup	5.0
Spinach, boiled	½ cup	2.2
Spinach, raw	½ cup	0.8
Squash, winter	½ cup	3.0
Sweet potato, baked	1 medium	3.0
Tomato, raw	1 medium	1.0

CEREALS	**SERVING**	**FIBRE (gm)**
All-Bran, Kellogg's	½ cup	10.0
Alpha-Bits	1 cup	1.0
Banana Nut Crunch	1 cup	4.0
Bran Buds, Kellogg's	1/3 cup	12.0
Cheerios	1 cup	3.0
Corn Pop	1 cup	0.0
Cracklin' Oat Bran, Kellogg's	¾ cup	5.6
Cream of Wheat	1 pack	1.0
Fibre One, General Mills	½ cup	13.0
Frosted Mini-Wheats	5 biscuits	5.0
Honey Nut Cheerios, GMills	1 cup	2.0
Instant Oatmeal	1 pack	3.0
Multi-Grain Cheerios	1 cup	3.0
Quaker Shredded Wheat	3 biscuits	7.3
Raisin Bran, General Mills	¾ cup	3.0
Raisin bran, Kellogg's	1 cup	8.2

BREADS/GRAINS	**SERVING**	**FIBRE (gm)**
(Check the packages!! Many brands have different fibre amounts)		
Bagel (most bagels)	1 Bagel	1.5
English Muffin	1 muffin	1.5
French bread	1 slice	0.5
Italian, Bakery Light	1 slice	2.5
Multi-grain	1 slice	1.5
Pancakes	1 med-large	1.0
Pita, white	1 6" diameter	1.0
Seven grain, Bran'ola	1 slice	3.0
Wheat, Bakery Light	1 slice	2.5
White	1 slice	1.0
Whole wheat	1 slice	2.0

PASTA		
Macaroni	1 cup	1.8
Macaroni, whole wheat	1 cup	4.0
Spaghetti, whole wheat	1 cup	6.3
Brown rice, long grain	1 cup	3.5
White rice	1 cup	1.0

Stooling chart for (Name): ……………………………………

Month: ………………………………

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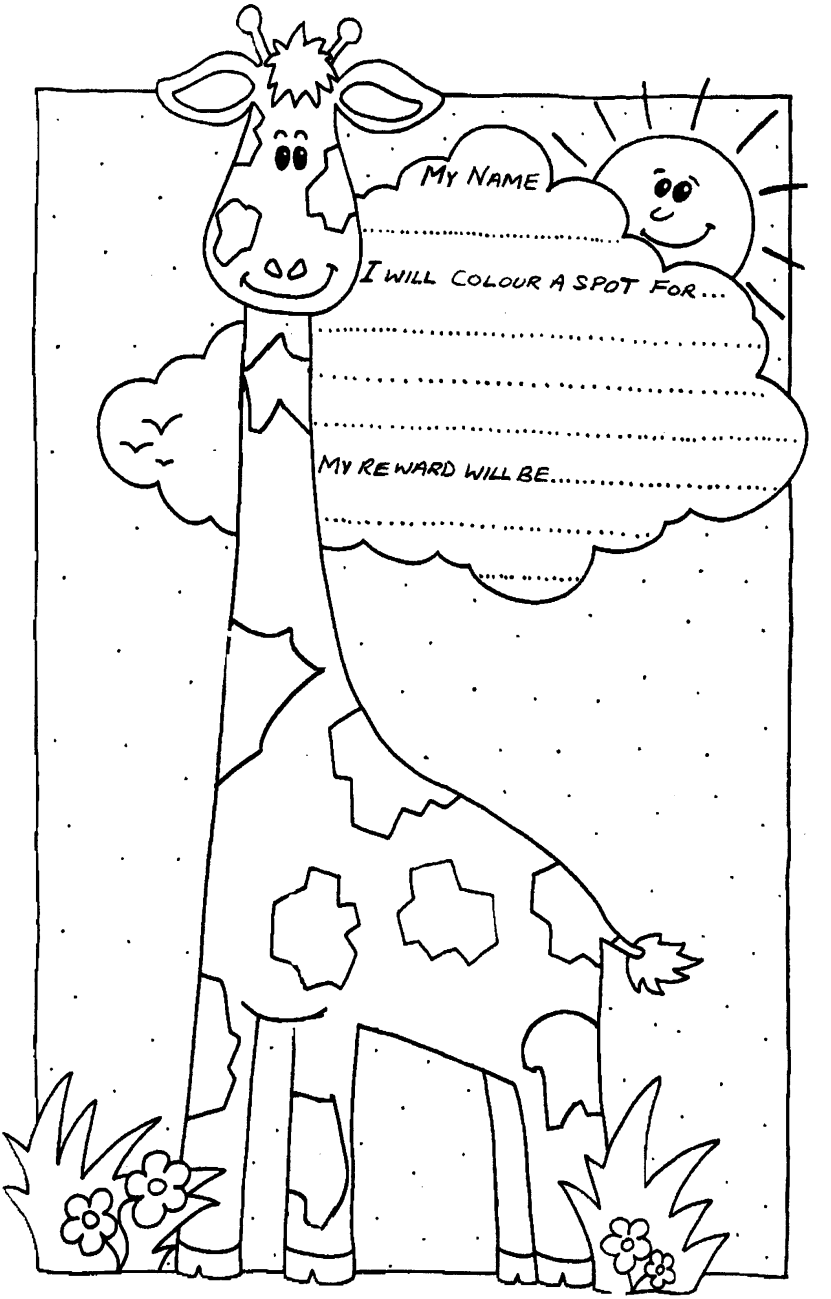
Diagram 5

Reward chart example. You can make your own.
Please read instruction on the next page.



My colour-in reward chart – 12 steps

This chart can help your child with taking medication or overcome toilet training problems. The chart will be a record of progress over one week.

How to use this chart:

1. It is suitable for children between 5 and 9 years of age, depending on how smart they are.
2. If the child is able, let him/her fill in his/her name on the top of the chart.
3. Decide with the child on the goals to achieve. For example this could be: Helping to change the pants when dirty, sitting on the toilet without moaning, drinking an extra glass of water or fibre food, taking medicine or telling parent when he wants to/has gone to toilet or, of course, you can choose your own goals. You might even be able to aim for clean pants every day. Discuss this with your child. **It is important that the goal is achievable: no matter what the child can do right now, the chart will be completed after a week and the reward obtained. (The child doesn't know that)**
4. Let the child fill in what he/she is going to try to achieve every day (SMART goal) in the space at the front of the chart.
5. Everyday when the child achieves what was planned, colour in a shape.
6. Decide with your child what reward he/she will receive for each shape coloured and fill this reward in on the front of the chart. Also decide what reward he/she will receive when all shapes are completed. The reward should be simple and cheap (e.g. extra story at bed time, game of football with granddad etc).
7. Remember to complete the chart every day the child achieves his/her goal.
8. When he/she has finished the chart, congratulate him/her! The child could now try changing (upping) his goals and he/she could use another colour-in chart, which you can draw yourself.
9. The doctor may want to see the progress and charts, so bring them to the surgery or clinic.

Good Luck!

Treatment plan:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

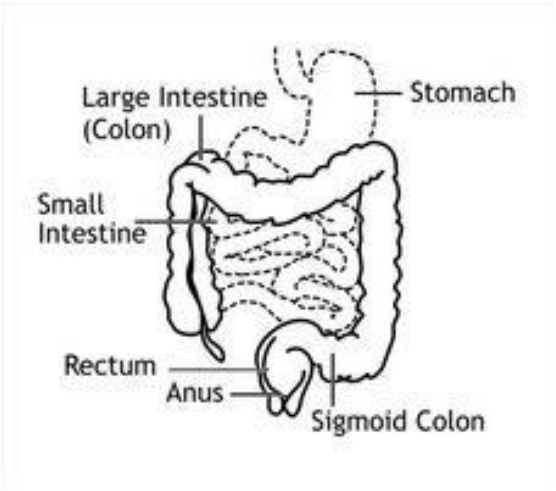


Diagram 6

(Space for drawing by child)

References:

1) Management of functional bowel disorders in children, Rosa E. Burgers et al; International Children's Continence Society Standardization guideline, July 2013.
2) The Prevalence of Symptoms of Constipation in an Irish school-aged population - A dissertation prepared during studies for the MSc. in Community Paediatrics. N van der Spek. UCL London, September 2003. Accessible on: http://www.lenus.ie/hse/bitstream/10147/301885/1/ConstipationDissertation090903.pdf
3) Liquid paraffin: a reappraisal of its role in the treatment of constipation. F Sharif, E Crushell, K O'Driscoll, B Bourke Arch Disease of Childhood 2001;85:121–124.
4) Constipation in infancy: A practical approach. Prof Billy Bourke, Consultant Paediatric Gastroenterologist, Our Lady's Children's Hospital, Crumlin. Paediatrics Ireland Journal. Issue 2 April 2013.
5) The Poo passport. Stephanie Orr and Ann Costigan, colorectal/stoma CNS, Our Lady's Children's Hospital, Crumlin, Dublin 12. November 2014

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