Constipation in children

Keeping poo soft. Rebuilding confidence. Giving the bowel time to recover.

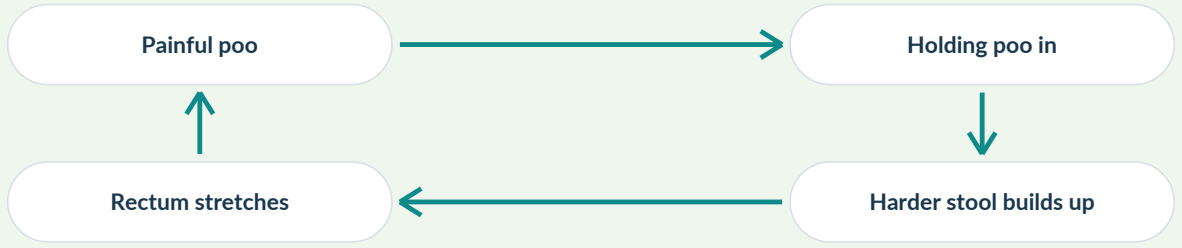
i Most childhood constipation is functional: the pattern of holding and emptying stool has become disrupted. Accidents are usually not deliberate. Treatment often takes months, rather than a few days.

How can it start?

A painful poo, toilet training, illness, a new school or avoiding unfamiliar toilets can start stool holding. Some children show this by standing on tiptoes, crossing their legs, hiding or stiffening. This may look like straining, but can be an attempt to hold poo in.

What happens in the bowel?

Stool stays longer and loses water, so it becomes harder. Repeated retention stretches the rectum, the storage space at the end of the bowel. The urge to poo can become less reliable. More pain and holding then keep the cycle going.



The cycle improves when stools stay soft and toilet habits become predictable.

Harder stool builds up Rectum stretches

Why are there runny accidents?

Soft stool can leak around retained poo. A child may have very little warning because the stretched rectum is less sensitive. Daily small poos do not always mean the bowel is emptying adequately.

Bowel rehabilitation

Treatment breaks the cycle and helps normal sensation and habits return.

1. Clear a significant build-up

Some children first need a clean-out, also called disimpaction. Oral treatment is usually preferred. Your clinician supplies a separate medicine and dose plan; this guide is not a clean-out schedule. Arrange toilet access and practical support during treatment.

2. Keep every poo soft and comfortable

Maintenance laxatives prevent repeated painful stools while the bowel recovers. The usual aim is a soft, easy stool around daily, without significant retention, withholding or accidents. The dose is adjusted to the child's response.

3. Practise relaxed toilet habits

Post-meal toilet sits use the bowel's natural response to eating. With foot support and a calm routine, children can relearn emptying without fear. Reward cooperation rather than whether a poo appears.

4. Reduce treatment gradually

Passing a few good poos is not enough to show that the storage space and sensation have recovered. Many children need several months of treatment, sometimes 6-12 months or longer. Taper with advice after sustained improvement; stopping too early often leads to relapse.

i Soft stools + no pain or holding + few or no accidents + a reliable toilet routine are the signs we are aiming for. Relapses are common and can usually be managed by reviewing the plan.

Laxatives: what do they do?

Use the child's prescribed dose and review its effect.

Macrogol / polyethylene glycol (PEG)

An osmotic laxative that holds water in stool. Products such as Movicol and Osmolax are commonly used; formulations and scoop or sachet sizes differ, so do not swap doses by volume without checking. PEG is a usual first choice for maintenance and often for clean-out treatment.

Other osmotic laxatives

Lactulose may be useful if PEG is unsuitable, although gas and bloating can occur. The best choice depends on age, acceptance, stool pattern and response.

Stimulant laxatives

Senna, bisacodyl or sodium picosulfate may be added when softening alone does not empty the bowel adequately. They encourage bowel contractions. Cramping and loose stools may occur. They should not be automatically avoided because of fears about a "lazy bowel"; use and monitoring are individualised.

What does the evidence support?

Paediatric guidance supports laxatives combined with toilet retraining. PEG has the strongest routine support among oral maintenance options. Extra water, probiotics or extra fibre alone are not proven substitutes for treating significant stool retention.

> **i** Appropriately prescribed laxatives support recovery; they are not a punishment. Persistent watery stool or accidents can mean a dose issue or ongoing retention. Ask for review rather than assuming the problem is solved or stopping everything.

Suppositories and enemas

These are not routine daily home treatment for most children. Use only on a clinician's plan. Never use an adult or phosphate enema in a child without explicit medical advice.

The toilet routine

Calm, comfortable and consistent.

Set up a comfortable position

Use a stable footstool: feet supported, knees slightly higher than hips, leaning a little forward. Encourage a relaxed tummy and bottom rather than prolonged straining. Make the toilet feel safe and private.

Time it after meals

For a toilet-trained child, try a roughly five-minute sit after breakfast and another main meal. A timer, book or blowing bubbles may help. Stop before it becomes a battle. Delay pressured toilet training while poos are painful.

Reward what the child can control

Praise sitting, taking medicine and following the routine. Do not punish accidents or reward only a “successful” poo. Parents and schools should respond to soiling discreetly and without blame.

Food, fluid and movement

Offer a normal age-appropriate intake of fruit, vegetables, grains and fluids, plus daily activity. Extra-large amounts of fibre can worsen bloating, and forcing excessive water does not cure stool retention. A strict low-FODMAP diet is not constipation treatment and may unnecessarily reduce fibre and variety.

When can physiotherapy help?

A child-experienced continence or pelvic-floor physiotherapist may help selected children with posture, relaxation, awareness or persistent soiling. It complements adequate medical treatment. Routine biofeedback is not needed for every constipated child.

i At school: provide easy toilet access, a private change of clothes if needed, and time for an agreed sit. Avoid requiring the child to hold on until a scheduled break.

When to review and where to get help

Most children do not need scans or invasive tests.

When do we investigate?

Diagnosis is usually based on history, growth and examination. Abdominal X-rays are not routinely useful. Tests are targeted if another cause is suspected or a well-delivered treatment plan is not helping. Endoscopy is not a routine constipation test.

Concerning features

Tell the clinician about constipation from early infancy, first meconium passed after 48 hours, poor growth, persistent swelling, unusual leg weakness or walking changes, abnormal spinal or anal findings, or blood not explained by a fissure. These may need specialist assessment.

! Urgent care: green vomiting, marked or increasing abdominal swelling, severe pain, significant bleeding, dehydration or a very unwell child.

Keep a simple diary

Record stool consistency, pain or holding, accidents, toilet sits and laxative doses. Bring it to review so the plan can be adjusted. A printable diary follows. Phone apps are optional; their automated advice does not replace clinical care.

Continence Health Australia - constipation in children ↗

Pooficient AI - optional stool diary (Apple App Store) ↗

Plop - optional stool tracker (Apple App Store) ↗

Check privacy settings before entering health information or stool photographs. Paper is equally suitable.

TRUSTED INFORMATION AND SOURCES

RCH - paediatric constipation guidance ↗

Children's Health Queensland - constipation ↗

7-day bowel diary

Bring this page to follow-up or use it while treatment is being adjusted.

Describe poo as hard pellets, large/hard, formed/soft, loose or watery. Note pain, withholding and accidents, even on a day when your child passes poo.

Day / date	Poo & consistency	Pain / holding	Accidents	Toilet sits	Laxative & dose
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					
Sun					

i Also note appetite, tummy pain, missed doses or a change in routine. Treatment goal: soft, comfortable stools without holding or soiling.



Your feedback is welcome

If you would like to leave a Google review about your experience, scan the QR code.

Please avoid including your child's name or private health information in a public review.