RCPCH The Paeds Round

'Understanding and managing childhood constipation'

Transcript of podcast – November 2026

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Claire: There's just not enough resources for children who can receive support from a paediatric bladder and bowel service. 80% of children who get referred in with a bladder problem are constipated. And get the child to actually be part of that process as well.

Emma: So, I'm really excited today to welcome Claire Waters, who is our fabulous consultant specialist nurse on all things poo, and this is our PooCast. So, I'm really, really excited to talk poo with you, Claire, because this is something that I have just seen throughout my career, and it isn't till now that I really felt like I had a good way of dealing with the poo-nami.

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Emma: So, we just want to tap into all your expertise and your specialism, and welcome today to the RCPCH podcast series.

Claire: I'm Claire Waters, and I am the nurse consultant for, like Emma said, the wee and poo world. So, thank you for having me today. I look forward to answering lots of questions.

Emma: So, Claire, the first thing I wanted to ask you is why is everybody, every single child I see, constipated?

Claire: It is huge. Constipation is huge, and it's certainly increasing. There's increasing numbers. There's very high numbers of children with constipation. Bladder and Bowel UK estimate about 1.5 million in the UK. There was actually research done from NHS England which highlighted that there's 44,000 admissions to English hospitals for children with constipation.

So, I absolutely agree with what you're saying. Constipation is huge. The question why, I think there's just not enough resources for children who can receive support from a paediatric bladder and bowel service. It's just not funded enough. There's many areas without any kind of bladder and bowel service, so then you see a huge increase of children going to hospital.

Emma: Okay, Claire, I want you to tell me why are all these children constipated? Why can't everybody poo?

Claire: Do you know, it's so, so, so common. It's such a common childhood illness, and so many children get this. I think there's, like, up to 30% of children get it. And it's not that they were born that way. There's been something happened in the childhood that's resulted in constipation. So, I'll give you some clues.

If it's babies, highly likely they've had too much milk, but babies cry, and then they stop crying when you give them milk. So, you just give them lots of milk, but then they get constipated. Toilet training age is the most common age childhood constipation starts, and it's the withholding. It's the transition from the nappy to the potty or the toilet.

But then that withholding continues when they go to nursery, cause they don't want to poo at nursery, primary school, secondary school. You know what secondary school toilets are like. They can be ... They're not very private. Children can look over. So, loads of children don't poo at school, so they withhold. But withholding's a really, really common reason. Um, in diet and fluid, basic things.

Emma: Okay. Perfect, Claire. So, there's three different things. So, you started with telling me that children have too much milk, so they don't get weaned onto solids, and a diet with enough fibre and diversity and different foods. And then there's a sort of behavioural element about learning to use the potty or get toileting, and then there's access to private toilets in schools.

So that's three quite different things, and you said to me at the beginning, diet was, and fluid, was such a big thing. What is it about diet and fluid that children aren't doing right, or families and children?

Claire: Yeah. And it's not so much the child or family's fault. It's just empowering families to know what is the right amount of fluids you should be having a day, what's the correct amount of fibre you should be having a day. I didn't know all of that until I got into this role. So lots ... so the fluid is so important because, I'll not go into it too much, but the bowel, the large bowel, takes water out of the stool. So, if you're not drinking a lot of water, that bowel is clever, and it'll find water from somewhere and take the water out that stool, even if that means you're going to pass a really hard, painful poo.

So, if you can have a good fluid intake, that really, really helps, and then high fibre. That's good alongside the fluid intake because the fibre acts as a little bit of a stimulant and helps push the poo around the colon. So, the two alone are fantastic.

Emma: Perfect. So, one thing is lots of fluid in, lots of fluid out. So, fluid in means soft poo out. Not enough fluid in means hard poo out. Yep?

Claire: Absolutely

Emma: And then fibre. Fibre is the magic ingredient that actually not just keeps the poo soft but actually stimulates the bowel. What kind of foods contain fibre?

Claire: Yeah. And lots of people don't actually know that to be honest. So, there's high fibre foods, like you've got pears and blueberries and the skin off jacket potatoes and beans. But instead of just giving a few examples, I like to tell families to go to the supermarket and have a look on the nutritional information pack, and anything with five grams of fibre or more in 100 grams is good. So, there's so many options out there. And get the child to actually be part of that process as well so that they'll, they'll try the new foods.

Emma: That is actually really smart. So, you just say look for any foods that have more than five grams per 100 grams of fibre. **Claire:** Yep.

Emma: Cause the other thing is, is all those original foods you talked about, like blueberries, they're really expensive for fresh fruit and vegetables. **Claire:** Yeah.

Emma: They are obviously the best, but they are expensive, and we're in a time of a cost of living crisis. But yeah, that's such simple advice. Okay. So, we've talked about constipation and children being constipated because of diet, because of knowledge about what to eat, because of education, and because of a whole load of behavioural factors around toileting. And then the other thing that you wanted to tell me was how ... we talked about fibre, we talked about fluids, we talked about behaviours in the ... but what about education? Because without resources and education and knowledge, what you said to me, constipation is a huge problem. So what resources are available for families?

Claire: Yeah. Um, so within our service, we try and offer lots and lots of sessions. We've done some for the young person and advisory group, for young people in schools. But what's out there for people who don't have access to our service are things like Healthier Together. We also have ERIC, which is a charitable charity that...that was the wrong word. We'll do that one again. Which is a charity that's supported by NICE guidance. Bladder and Bowel UK are brilliant as well. That's a brilliant charity that supports families with constipation, and there's so many resources on there.

Emma: Fantastic. So, when you first see a child with constipation, what's the first thing that you go through with them?

Claire: Uh, honestly, clinical history is crucial, and the most important thing is to get that family and child to feel comfortable with you so that you can get them to open up. There's ... before children get referred into our service, they've already had support, such as, they've had some Movicol, they've had a stimulant, but the symptoms are not well managed.

So, you need to get them to open up about what medication they are actually taking. If you just say, "Are you taking Movicol, yes, no?" They're gonna to give a yes answer, but you have to get them to open up so that you know whether they're actually taking this medication, how often the bowel activity is occurring.

If someone said to me, "How, how many times did you poo last week?" You can't remember. You can't remember the date, the time, what they look like. So, they've got to have a seven-day bowel chart as well. That is essential, and parents can do that at home. They can, every day for seven days, write down the child's bowel movement, get the child involved, what the stool looks like, bring that to a doctor's appointment or an

appointment with a nurse, and then you'll get good support. But the most important thing is to get them to be truthful.

Emma: Okay. That's actually gold dust. So, once you've taken a good history, what investigations do children with constipation actually need?

Claire: Do you know what? Sometimes they don't need any. If you can get that brilliant history where they're open and honest, they've got a good bowel chart, you've done a physical examination, sometimes that's enough.

Sometimes it's not, but if you know that it's chronic constipation from that thorough history, then progress forward. Don't delay treatment. Some children require investigations, not all of them. Investigations such as an abdominal X-ray in accordance with Nice guidance. If you're managing the symptoms and they're just not quite improving, you could X-ray, and that can find out if the child has impaction, rectal distension, faecal loading.

So, but the, again, they don't always need that. It all goes on individual needs, basically. So, an abdominal examination, investigation. Sometimes we do bloods, um, just to rule out celiac. We'll do a full blood count, thyroid. But again, not everybody. It all depends on the, on the patient and their symptoms.

Emma: I think that's so important. So, what you're saying is the majority of children just need a good history and a, a physical examination. And I know that you have picked up all sorts of odd things, including, um, children with cerebral palsy, children with spinal defects just from an examination.

Sometimes they need some blood tests to check that their full blood count's normal because their diet, thyroid function, and a celiac screen. And the abdominal X-ray is not necessary unless they're not improving. And personally, I've sometimes found it really helpful when families keep saying to me, "I don't think they're constipated." And you show them the X-ray, and they're like, "Wow."

Claire: Yeah. Yeah, that's so true. And what we use X-rays for as well is many children get referred into our service with secondary problems with the bladder, so daytime wetting, nighttime wetting, et cetera, but parents are adamant that they're not constipated. So, you try and treat the bladder symptoms, and you get nowhere.

So, I'll say, "I'll do an abdominal examination just to rule out constipation." And there we are. We've got rectal distension, 10 centimetres, and then they get better so quickly cause you can manage the root of the problem, then the bladder problems resolve.

Emma: All right, there's two things I need to ask you. So, what do you look for on an abdominal X-ray in a child who's constipated?

Claire: The main thing, so you look to see if they're impacted and also where the root of the problem is. So, if they've got rectal faecal loading and all of the stool is sitting in the rectum, and it's distended, you think, "Right, there's the problem.

We need to tackle that part of the bowel." It might be the ascending colon, the descending colon, and you've got the problem area, and then your treatment plan would be in accordance with what we've established.

Emma: So, when you have an X-ray, you look for rectal distension, so any rectum that's bigger than three centimetres, and we quite commonly see 10-centimeter rectums. And then you look for impaction, and you look for how far back the constipation goes.

Claire: Yeah. Absolutely.

Emma: And now the second thing I wanted to say, which is a huge thing, this is the elephant in the room. You just said that wetting is caused by constipation. So, do you want to tell me more about that?

Claire: Yeah. It's, I would say in our service 80% of children who get referred in with a bladder problem are constipated, and that's because the bladder and the bowel sit so close together. And if the rectum, the bottom part of the bowel, is taking up too much space, that bladder, if you picture it like a balloon, when you...it's trying to blow up cause it's full with urine, so it's filling up with urine, and it just presses on that rectum, and you're gonna get that sudden urgency that you need to pass urine, potentially wetting accidents. You can't hold enough urine overnight to remain dry, and that's all because the bowel is taking up too much space. So, we need to get to that problem and solve it.

Emma: Clare, that sounds...I love that picture you paint. It's so simple. If the rectum's too big, there's no room for the bladder, and the bladder is like a squishy balloon and you'll, it'll try and fill with urine, but actually, as soon as it gets to any size, you'll just be, like, running to the toilet.

Claire: Yeah, absolutely

Emma: Okay. So now we've talked about how we're going to solve constipation and wetting by treating the constipation. So, what is the secret of laxatives?

Claire: The secret is getting the appropriate laxative for the individual child's symptoms, but the best laxative is the one the child will actually take. I don't think we appreciate giving daily medication to a two-year-old, five-year-old, 15-year-old, it's really challenging, so get them involved in the process. If that child needs a stool softener, say, "Okay, these are the options. You could have Movicol, you could have lactulose, you could have a tablet, Docusate sodium. What do you want?" They're all gonna do the same job. If you need a stimulant, ask them, "Would you prefer a suspension, a tablet? What do you want?" And if you get them involved in the process, then that is the perfect kind of laxative, as long as they will take it.

Emma: That's amazing, actually. So, the perfect laxative is anything that a child will actually take on a regular basis. **Claire:** Yeah. **Emma:** And it's so obvious when you say that. So, you could have a Docusate tablet, you could have Lactulose syrup suspension, or you could have Movicol, the like powder or granules. Tell me about making up Movicol?

Claire: Do you know what? So many people still get this wrong. So, the way Movicol works is it puts extra water into the colon to soften the poo. So, if you mix up the Movicol with the correct amount of water, that water that you've consumed with the Movicol in will go directly into the colon and soften that poo.

So, if you mix your Movicol with some yogurt or sprinkle it in pop, you might as well not give any, cause it's not gonna do anything. So, it's about mixing it with the correct amount of water. So, if you have one sachet, paediatric sachet, with 62.5ml of water, great. If you need two sachets, you must mix that with 125ml of water. Four sachets, 250, and so on. The more Movicol equals more water. Water only. But you can put in a splash of juice afterwards if need be.

Emma: Okay. So Movicol is just basically a water carrier, and for each sachet of Movicol, you need the equivalent about of half a cup of water. So actually, when we're saying to people take six sachets twice a day, that's like three glasses, three whole glasses, and that's a lot for a small child to take.

Claire: Yeah. Yeah, really challenging for some families to do that.

Emma: All right, so hold on. Stimulants, let's go down to stimulants. How do you know if a child needs a softener or a stimulant?

Claire: Again, it's all about the history. So, if their stools are type one, type two, but they're opening the bowels every day, then they just need a softener. If they are passing type one, type two, for example, hard poos, and they're opening the bowels once a week, then they're gonna need both. They're gonna need the softener to soften it, and the stimulant to increase the frequency of the bowel activity.

Emma: So you're talking about the Bristol Stool Chart, which actually I love and I show children all the time.

Claire: Yes. **Emma:** And I like the one where it says, um, type one is gra- sorry, type six is gravy, type five is fluffy, type four is chicken nuggets so forth, cause they really enjoy looking at it. So, type one are those hard little raisin ball stools, and type two is, is it corn on the cob, I think?

Claire: Yeah. Well, that might be three. I can't remember, but it's like a hard, a big hard poo, basically.

Emma: Okay. So hard stools, you need softeners. Not enough stools, you need stimulants. Which brings me back to, Claire, what's normal?

Claire: What's a normal bowel pattern? Well, the NICE guidance says between three poos a day and three poos a week, as long as they're soft and formed. If children come into the service and they've got secondary problems, like the daytime wetting, we need them to be pooing more frequently. Daily would be ideal to keep that bowel away from the bladder and get that bladder function to get bigger and stronger and be able to hold more urine. So, it does...it's about the frequency of the bowel movements, but also about what the bowel movements look like.

Emma: Which brings me onto my second favourite topic, overflow diarrhoea. Talk to me about over- we always have so many problems with overflow diarrhoea because it's really hard for families to realise that this is constipation.

Claire: Yeah, that's true. Families will get referred in and say there's no way they're constipated; they're pooing 10 times a day. You think, "It's not normal", and it is overflow. And that's just, there's just so much poo in the bowel, that the bowel's so distended that the leaky, watery poo is leaking out. Cause if you think with the colon, as soon as the poo goes into the colon, it's just a watery substance, and the job of the colon is to take water out of the stool, and that happens as it moves along the colon. But if your bowel's so distended, that leaky poo is just gonna leak out, and it's not even gonna have...it's not gonna be able to form into some kind of soft-formed bowel movement, cause the bowel is too distended.

Emma: Okay, so if you are so constipated that your whole bowel is completely full, it can't do its job, you're going to end up with overflow diarrhoea. And that just, that is that classic thing. It's what you said, if you take a good history, they come in saying they're doing soft, runny poos up to 10 times a day. They've got a bit of poo in their underpants, so they have a little bit of incontinence. That's overflow. And I, I guess that was your point about if you've got secondary problems and people don't believe it, this is a time where it's really good to do an X-ray and prove it to families so they can see it.

So, we've talked about all my favourite things. So, we've talked about diet, we've talked about behaviour, we've talked about access to a good, clean, private toilet in school and at home. We've talked about taking a good history. We've talked about not really doing many investigations but doing a good examination. The secret of laxatives, so softeners and stimulants. We've talked about what's normal. What other things do you see going wrong with children when they come into your practice?

Claire: Yeah. Um, the things that go wrong is, when you haven't got...I keep talking about clinical history, but it's so important is if they haven't been truthful and they feel like they're being judged when you're asking if they've been having the medication.

So, what goes wrong is when you're trying to escalate a plan from, say, oral medication to rectal intervention, and it's not required. It's just they're not taking the oral medication. So, it's getting, building up that rapport with the family and not judging them. It's hard to get a child to take medication every day. I think that's when things go wrong, when you, you can't get that clear history. You need to work with them.

Emma: All right. So, I think that's really important that actually having that rapport and having that trust and being honest about what's been prescribed and what you've taken is fundamental to all treatment, but particularly to constipation because it does carry a certain stigma. And then what I wanted to ask you is about; you suddenly said other things that you can do. So, when is it that it's good to use something like, um, pessaries?

Claire: That's, that's a really, really good question, and I think this is what healthcare professionals need to be aware of. If that child has rectal distension or they've been constipated for all of their life and they're now 16, it's highly likely that they're gonna need some kind of rectal intervention such as suppositories, enemas or rectal irrigation.

We've had ... There's many, many case studies I could talk about, but oral medications alone just are not enough for some of our patients with rectal distension and a 10-year history or five-year history of constipation, and they need that rectal intervention of rectal irrigation, daily enemas. And although it sounds quite invasive, there hasn't been one family who's declined it. The symptoms and the effects of that daily soiling and wetting and bullying and poor quality of life, they will do anything. And so, they will progress onto the next level of the appropriate treatment plan, and they have excellent success rates.

Emma: That's so interesting. So, the first thing you would give them, would that be a suppository or an enema? And which ones do you use?

Claire: So, depending on the age, if they're just young and they've come into the services, a baby under three years of age, we'll use suppositories. Once they're three years or older, we would start with Microlax enemas, which are just, they're tiny, it's only 5ml of solution. But then if that 5ml of solution is not having the desired effect, then we'd progress to rectal irrigation. But rectal irrigation, it does not look medical at all. It looks like a little baby bottle, a small baby bottle with a teat on the end, and you insert water into the rectum, and it clears out the rectum and the bottom part of the bowel, depending on the volume of water that you insert. And it takes less than a minute of the day to do that. Sit on the toilet, empty the bowel, then they can go out and enjoy the day knowing that they're not gonna soil.

Emma: That's amazing. That's so simple. So rectal irrigation, which you just do with a soft bottle, so it's not that invasive, and they just wash out their rectum. So, you know what it sounds just like what they do in ENT with sinuses.

Claire: Mm-hmm. That's what it's like but in the bottom.

Emma: And how often do you get them to do rectal irrigation?

Claire: So, they would do it daily to start with, then when symptoms have been well managed for six to eight weeks, meaning they're opening the bowels daily, they're not solely relying on irrigation to do a bowel movement. They're actually pooing outside of irrigation time, and they're not soiling for six to eight weeks, then we'll gradually reduce it. So, it's not forever. So, six to eight weeks, and then they'll have one day off a week. We'll monitor it again for six to eight weeks. If symptoms remain well managed, then we'll reduce it by another day, and so on.

Emma: How long do children need to have laxatives for?

Claire: Yeah. So that'll just depend on the clinical symptoms, to be honest. But the most important thing is not to, not to just suddenly stop them. Sometimes people think, "symptoms are well managed now, so I'll just stop everything." But no, they're only well managed because they've got the medication on board. Once you stop that medication, their symptoms will start all over again, so you only ever gradually reduce it down in accordance with their symptoms. So, if bowel movements become too loose, reduce the stool softener by a tiny bit and monitor bowel pattern. If they become too frequent, gradually reduce the stimulant by a mil and monitor bowel patterns, and then we've got a plan for the rectal irrigation that it's reduced by one day every six to eight weeks.

Emma: So, I think another of the interesting things is this actually can be done by the parents. It shouldn't be prescriptive. So, you're saying that they should be able to increase or decrease the laxatives, but they do need to understand that they need to carry on, and they may need to carry on for months and months. I often say you'll need to have laxatives as long as you've been constipated.

Claire: Yeah. They will need it for a very long time, and when we've established a maintenance dose, and if they're not on rectal intervention, we'll discharge them, but we'll make sure that they feel empowered to be able to adjust that medication independently, and the GP will also be there for support too.

Emma: Claire, why is constipation so terrible for families? What are the impacts on children, young people, and families?

Claire: Yeah, that's a really good question, and it's because sometimes chronic constipation doesn't get the true recognition that it deserves. If a child has chronic constipation, they can end up incontinent, they can end up having pooing accidents every day, wetting accidents every day, and that's really hard to grow up in this society with soiling and wetting. You know, children get bullied. They don't want to go to school, then parents get penalised because they're not at school, and then this can go on for years.

So, they really need to get that appropriate support so that they can manage the symptoms effectively. Once the right treatment plan is in place, the soiling, the wetting can resolve within a few weeks. It's a treatable condition. It's just getting it right first time and understanding the effects chronic constipation can have on a family. So, we do really all of us need to get it right first time.

Emma: I think that's so important what you say, and it's really interesting. If I walk past the bowel and bladder team, that's you and, uh, Paula Drummond, I see all the cards and flowers that you get, and you get a lot more than all the other teams. So, I can see that it's so important to families, and they're really, really grateful.

Claire: Uh, I feel privileged to be in this job, that I can see them at the start of the journey when they are really down and the quality of life's poor. And then at the end of the journey when symptoms are well managed, I really am in a privileged position.

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