CONDITION

Constipation in infants and children

Constipation is difficulty passing stools that are hard, painful, unusually large, or less frequent than normal.

WHAT IT IS
Hard, painful, or infrequent bowel movements in children

BODY SYSTEM
Digestive system

MAIN SYMPTOMS
Hard stools, painful bowel movements, withholding, stool leakage

WHAT CAUSES IT
Usually stool withholding; occasionally an underlying medical condition

HOW IT IS DIAGNOSED
History and examination; tests only when warning signs exist

MAIN TREATMENT
Laxatives, toilet routines, and age-appropriate diet

CAN IT BE CURED?
Sometimes - functional constipation often resolves with treatment

IS IT AN EMERGENCY?
Sometimes - green vomit with a swollen abdomen

LONG-TERM OUTLOOK
Usually good, though relapses are common during childhood

Overview

Constipation means that a child has difficulty passing stool, also called poo or a bowel movement. The stool may be hard, dry, painful, unusually large, or less frequent than normal for that child.

Frequency alone does not define constipation. Some healthy babies, especially those who are breastfed, may go several days without a bowel movement and still pass soft stool comfortably. A baby who strains and turns red before passing soft stool may have immature coordination, called infant dyschezia, rather than constipation.

Most childhood constipation is functional constipation , meaning there is no underlying disease or structural problem. It often begins when a child avoids passing stool because a previous bowel movement hurt. The longer stool remains in the bowel, the more water is removed,

making it larger and harder. This can create a cycle of pain and withholding.

Untreated stool build-up can cause pain, small tears around the anus, leakage, and toilet-training problems. Early, consistent treatment can break the cycle.

Symptoms

A child with constipation may have:

Withholding is common. A child may stiffen, cross their legs, stand on tiptoe, hide, rock, or squeeze their buttocks together. These actions may look like straining, but the child may be trying to stop stool from coming out.

When stool is stuck in the rectum, softer stool may leak around it. This is called overflow soiling . It is not usually deliberate, and punishment can worsen fear and withholding.

A small streak of bright-red blood may come from an anal fissure , a tiny tear caused by hard stool. Blood mixed through the stool, repeated bleeding, dark or black stool, or bleeding without an obvious fissure needs medical assessment.

- Hard, dry, lumpy, or very large stools
- Pain, crying, or fear when passing stool
- Fewer bowel movements than usual
- Tummy pain or bloating that improves after passing stool
- Small amounts of blood on the stool or toilet paper
- Stool leakage or soiling in a toilet-trained child
- Reduced appetite or feeling full quickly

Causes and risk factors

Functional constipation often begins after a painful bowel movement. The child holds stool back, making the next bowel movement harder and more painful.

Common triggers include:

Constipation beginning soon after birth is less likely to be functional. Less common causes include Hirschsprung disease, an underactive thyroid, coeliac disease, abnormalities of the anus or spine, and conditions affecting nerves or muscles.

A baby who did not pass their first dark, sticky stool, called meconium, within 48 hours after

birth needs medical assessment, particularly if constipation or abdominal swelling follows.

- Starting solid food or changing diet
- Toilet training before a child feels ready
- Avoiding unfamiliar or school toilets
- Changes in routine, travel, illness, or stress
- Ignoring the urge to pass stool
- Low intake of fibre-rich foods or fluids
- Limited movement because of illness or disability
- Medicines that slow the bowel, including some pain medicines or iron products

Diagnosis

Constipation is usually diagnosed from the child's symptoms, bowel pattern, growth, and physical examination. There is no single test for ordinary functional constipation.

A healthcare professional may ask about stool consistency, pain, withholding, soiling, diet, medicines, toilet training, and when symptoms began. They may examine the abdomen, anus, lower back, growth, muscle strength, and reflexes.

An internal rectal examination is not routinely needed. It may be considered if the diagnosis is uncertain or warning signs are present.

Blood tests, X-rays, scans, or specialist bowel tests are generally reserved for children who may have another condition or do not improve with appropriate treatment. An abdominal X-ray is not usually needed simply to confirm constipation.

A brief record of bowel movements, stool appearance, pain, leakage, and treatment can help. The Bristol Stool Chart may be useful for older children.

Treatment and management

Treatment aims to clear stool build-up, keep future stools soft, and help the child pass them without fear.

If a large mass of stool is stuck in the rectum, treatment may begin with disimpaction , usually using oral laxatives. Rectal treatments such as suppositories or enemas are used more selectively.

After the blockage clears, maintenance treatment keeps stools soft while the stretched bowel and normal urge to pass stool recover. This often takes months rather than days. Stopping treatment too soon can cause another build-up.

Laxatives used in children include osmotic laxatives, which draw water into stool, and stimulant like methylphenidate or lisdexamfetamine laxatives, which encourage bowel movement. Polyethylene glycol, also called macrogol, is a commonly used osmotic laxative. The choice, dose, and duration should reflect the child's age, symptoms, and clinical advice. Do not give an infant an enema, suppository, herbal remedy, or adult laxative without professional guidance.

For a toilet-trained child, sitting on the toilet for several minutes after meals uses the bowel's natural response to eating. The child's feet should rest on a stool or firm surface, with the knees slightly higher than the hips. Calm praise or a reward chart can encourage sitting without making rewards depend on producing stool.

Children should have a normal, age-appropriate intake of fibre and fluids. Helpful foods include fruit, vegetables, beans, whole grains, and suitable cereals. Fibre or extra water alone usually will not clear significant stool build-up.

Babies should continue their usual breast milk or correctly prepared formula unless advised otherwise. Formula must not be diluted or mixed more strongly than directed.

Treatment should avoid blame. Withholding and overflow soiling are usually symptoms, not bad behaviour.

Complications

Ongoing constipation can cause anal fissures, pain, bleeding, and a large stool mass called faecal impaction. The rectum may stretch and become less sensitive, making the urge to pass stool harder to notice.

Overflow soiling can affect school and confidence. Constipation may also contribute to urinary urgency, daytime wetting, bedwetting, or repeated urinary tract infections because a full rectum can press on the bladder.

Severe complications are uncommon. A child who is vomiting, has marked abdominal swelling, or appears seriously unwell needs urgent assessment because the symptoms may not be ordinary constipation.

Prevention

Not every case can be prevented. Constipation caused by a structural or inherited condition, such as Hirschsprung disease, is not prevented by diet or toilet habits.

The risk of functional constipation may be reduced by responding early to painful stools and supporting regular toilet routines. Offer age-appropriate fibre and fluids, allow enough time to use the toilet, and encourage children not to ignore the urge to go.

Keep toilet training calm and flexible. If a child becomes frightened or strongly resistant, reducing pressure may prevent withholding. Treating a painful fissure and softening the stool can help stop the pain cycle.

Living with it and what to expect

Most children with functional constipation improve, but recovery may take several months. The bowel needs time to empty regularly, return toward its usual size, and regain normal sensation.

Symptoms may improve before withholding has stopped, so maintenance treatment may still be needed after bowel movements become easier. Laxatives are usually reduced gradually according to the child's progress and clinical advice.

Relapses are common during toilet training, school changes, travel, illness, or changes in routine. This does not mean treatment has failed. Recognising harder stools, skipped bowel movements, hiding, or renewed soiling early can prevent another build-up.

Children with overflow soiling may need practical support at nursery or school, including private toilet access, spare clothes, and permission to use the toilet when needed. Most can continue their usual play, school, travel, and social activities.

Children with an underlying medical condition may need longer follow-up or specialist care.

When to get medical help

Arrange a routine medical appointment if constipation is painful, keeps returning, causes soiling, or does not improve with simple measures. Seek advice if you are unsure whether an infant's bowel pattern is normal or a child needs repeated laxative treatment.

Seek prompt medical advice if constipation:

Seek emergency care if the child has green vomit, a very swollen or increasingly painful abdomen, difficulty waking, or appears seriously unwell. These signs can occur with an intestinal blockage or another urgent condition.

- Began during the first weeks of life
- Follows delayed passage of meconium after birth
- Occurs with poor growth, weight loss, fever, or repeated vomiting
- Causes ongoing blood in the stool
- Is associated with weakness, abnormal walking, or bladder problems
- Does not improve despite treatment being used as directed

Common questions

How often should my child have a bowel movement?

Normal frequency differs by age and child. Some babies pass stool after many feeds, while others go several days between soft stools. Comfort and stool consistency are more useful than frequency alone. Hard, painful stools or clear withholding suggest constipation.

Why does my baby strain if the stool is soft?

Young babies may cry, grunt, and turn red because they have not learned to relax the pelvic muscles while increasing pressure in the abdomen. If the stool is soft and the baby is otherwise well, this may be infant dyschezia. It usually improves as coordination develops.

Can changing food fix constipation?

Age-appropriate fruit, vegetables, whole grains, beans, and fluids can support regular bowel movements. Diet alone may not clear impacted stool or stop established withholding. Some children also need laxatives and a toilet routine.

Are laxatives safe for children?

Several laxatives are widely used in children when selected and monitored appropriately. The right option depends on the child's age and type of constipation. Maintenance treatment may be needed for months; this does not mean the bowel has become "lazy" or addicted.

Why is my toilet-trained child having accidents?

A full rectum can allow softer stool to leak around a hard blockage. The child may not feel or control the overflow. It is usually a medical symptom rather than deliberate behaviour. Clearing the blockage and keeping stool soft can gradually restore control.

When is blood with constipation concerning?

A small bright-red streak after a hard stool often comes from a fissure. Arrange medical assessment if bleeding keeps happening, is more than a small streak, is mixed into the stool, or

occurs with pain, diarrhoea, fever, poor growth, or dark stool.

Sources

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