

When treatment fails, reassess compliance and review the key points. Barriers to compliance are listed below. These should be addressed specifically. In particular, there are commonly held misunderstandings and fears about laxative medicines within the community including the medical and pharmaceutical communities. The key question to ask is “was the child ever given enough medication to keep the stool as soft as wet cement for a minimum of six months?” This is required to resolve a mega rectum and to overcome a child’s previous fears of stooling.

Commonest reasons for treatment failure:

- Insufficient dose – stools not soft enough (stool texture not “wet cement”)
- Insufficient duration –treatment ceased prematurely
 - concerns about long term medication side effects
 - distaste for medication
 - medication side effects (especially non-absorbable sugars)
- Treatment not given regularly (need daily soft stools for months)
- Trigger factors recur, persist or new factors occur causing relapse
- Alternative diagnosis (eg cows milk protein intolerance)

Children who fail adequate duration medical management should be assessed for organic causes of constipation. Although the list of potential organic causes is extensive, the most common diseases that can mimic functional faecal retention include Hirschsprung disease (HD), anal achalasia (previously called ultrashort segment HD), coeliac disease, hypothyroidism, hyperparathyroidism/hypercalcaemia and food allergy (especially cows milk protein allergy). If the child fails to make progress as expected after initial treatment, screening tests should include: total IgA and celiac serology (Over 2 years old: tissue transglutaminase (TTG) IgA only; under 2 years: TTG IgA and Antigliadin IgA and IgG antibodies), thyroid function, basic biochemistry including calcium concentration. Investigations for HD are rectal biopsy (for the presence of ganglion cells) and/or anorectal manometry (the rectoanal inhibitory reflex is absent in HD).

An MRI of the lumbo-sacral spine should be considered to exclude occult spinal dysraphism. Unsuspected spinal abnormalities may be found in a small percentage of children with intractable constipation and may be present without any neurological abnormality on detailed examination, including perineal sensation and anal wink. Abdominal x-ray to evaluate faecal loading is not recommended, as interpretation is unreliable due to significant interobserver variation.

Referral to a Paediatric Gastroenterologist should be considered if constipation is medication-dependent after 6 months of adequate treatment, or if the symptoms are medication-resistant and after consideration of these organic causes.

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