The Poo Passport

IN THE COMMUNITY

From 1 year of age

Patient name: _____

Date of Birth: _____

GP Name: _____

Date of appointments:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

CONSTIPATION TREATMENT PATHWAY

Review General Practitioner

↓

Complete A, B, C section

↓

Diagnosis

Idiopathic Constipation	Underlying Cause

↓ ↓

Treatment

1. Treat for faecal impaction 2. Maintance medication 3. Weekly follow up with Poo Passport completed by family	• Refer to Paediatrician for further investigation and treatment

↓ ↓

Recurrent episodes of faecal loading, intractable constipation

↓

Refer to paediatrician For further treatment and/or investigation

Refer to specialist Paediatric Surgeon and/or Paediatric Gastroenterologist if required

PLEASE FILE PAGES 3-12 IN THE PATIENTS' MEDICAL RECORDS

Section A: Key components of history-taking

History-taking: Childhood constipation – 1 year and older		
Stool patterns and symptoms: indicate by circling the correct response for each question Stool type is based on the Bristol Stool Form Scale See page 16		
Two or more YES answers indicate constipation	YES	NO
Does the child or young person have a bowel movement fewer than three times a week (stool type 3 or 4)?		
Does the child or young person pass large hard stools?		
Does the child or young person pass 'rabbit droppings' (type 1)		
Have you noticed any soiling (very loose, very smelly stool passed without sensation) in recent days?		
Does the child or young person have poor appetite that improves with the passage of a large stool?		
Does the child or young person experience abdominal pain that comes and goes with the passage of stool?		
Is there evidence of retentive posturing (ie. typically straight-legged, tiptoed, back arching posture)?		
Does the child or young person strain when passing stools?		
Does the child or young person experience anal pain?		
Has the child or young person had any previous episodes of constipation or the present symptoms?		
Have you noticed any cracks or tears in the anal region?		
Does the child or young person bleed when passing stools?		
Total number of YES answers		

Name: _____MRN: _____

Section B: Key questions to diagnose idiopathic constipation

If the result of part 1 indicates constipation use these questions to excluding underlying causes and establish a positive diagnosis of idiopathic constipation.

Tick findings in relevant box

1. When was the onset of constipation?

After a few weeks of life	Indicates idiopathic constipation	
Birth or first few weeks of life	Indicates an underlying disorder	

2. When did the child pass meconium?

Within 48 hours after birth (in term baby)	Indicates idiopathic constipation	
More than 48 hours after birth (in term baby) or not at all	Indicates an underlying disorder	

3. Does the child or young person pass 'ribbon stools'?

Yes	Indicates an underlying disorder	

4. Are there any concerns about the growth and general wellbeing of the child?

No: generally well, weight and height within normal limits, fit and active	Indicates idiopathic constipation	
Yes: faltering growth[1]	Possible idiopathic constipation	

5. Does the child or young person have a good diet with adequate fluid intake?

No	Indicates idiopathic constipation	

6. Is the abdomen of the child or young person distended and are they vomiting?

Yes	Indicates an underlying disorder	

If any symptoms indicate an underlying disorder, refer the child or young person urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern. Do not treat them for constipation.

[1] If the history-taking and/or physical examination show evidence of faltering growth treat for constipation and test for hypothyroidism and coeliac disease. See also 'Coeliac disease: recognition and assessment of coeliac disease' (2009) NICE clinical guideline 86.

Name: _____MRN: _____

_____

Section C: Key components of physical examination to diagnose idiopathic constipation[2]

Tick findings in relevant box		
Normal appearance of anus and surrounding area	Indicates idiopathic constipation	
Abnormal appearance / position / patency of anus: fistulae, bruising, multiple fissures, tight or patulous anus, anteriorly placed anus.	Indicates an underlying disorder	

Soft abdomen: flat or distension that can be explained because of age or excess weight	Indicates idiopathic constipation	
Gross abdominal distension	Indicates an underlying disorder	

Normal appearance of the skin and anatomical structures of lumbosacral/gluteal regions	Indicates idiopathic constipation	
Abnormal: asymmetry or flattening of the gluteal muscles, evidence of sacral agenesis, discoloured skin, naevi or sinus, hairy patch, lipoma, central pit (dimple that you can't see the bottom of), scoliosis	Indicates an underlying disorder	

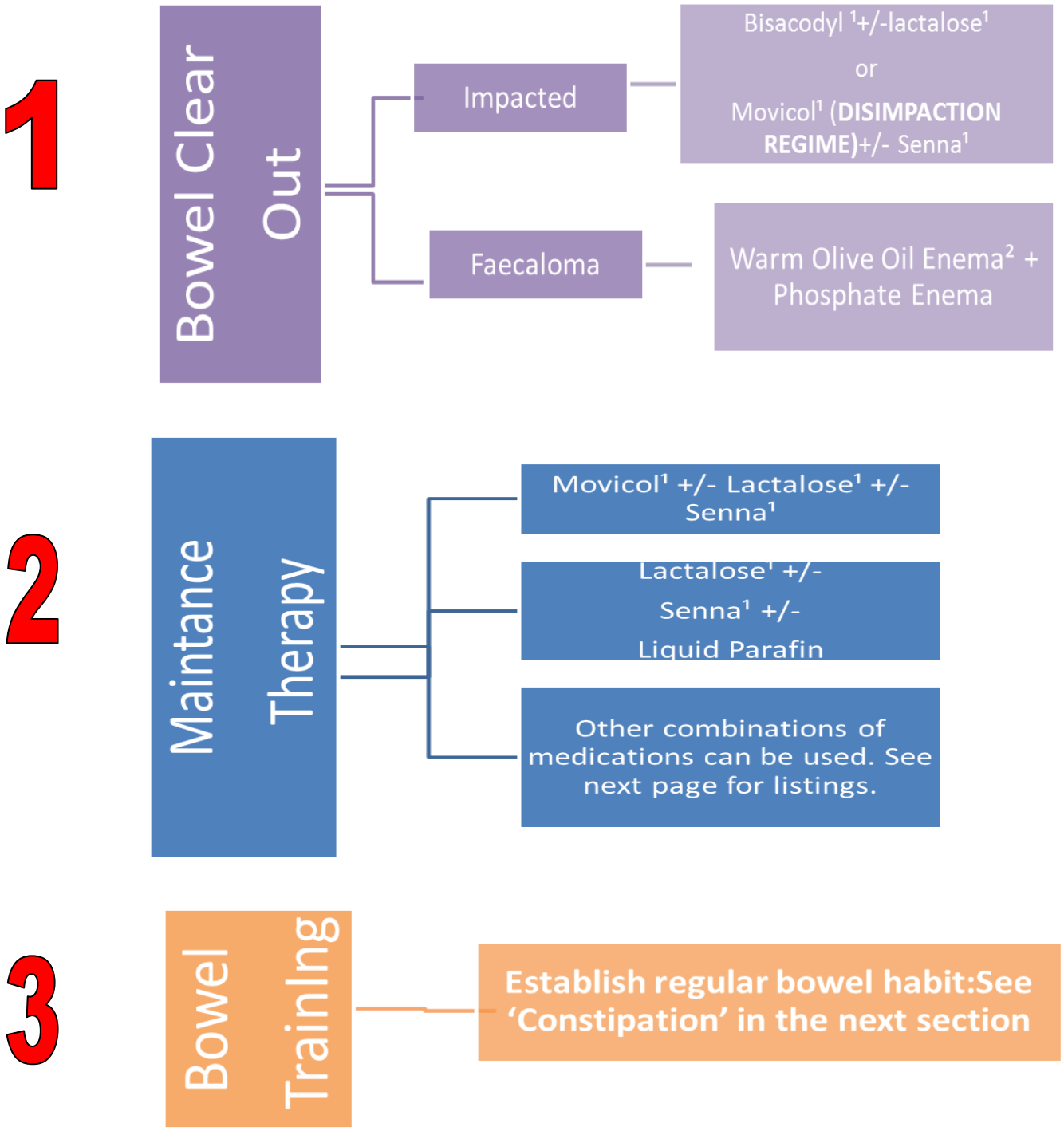
Normal gait; normal tone and strength in lower limbs	Indicates idiopathic constipation	
Deformity in lower limbs such as talipes Abnormal neuromuscular signs unexplained by any existing condition, such as cerebral palsy	Indicates an underlying disorder	

Reflexes present and of normal amplitude	Indicates idiopathic constipation	
Abnormal reflexes	Indicates an underlying disorder	

[2]: If either the history-taking or the physical examination shows evidence of possible maltreatment treat for constipation and refer to Children First National Guidance 2011

Name: _____MRN: _____

TREATMENT PLAN



[1] Please refer to next page and BNFC for dosages
[2] See Page 12 for details on Olive Oil Enema

OSMOTIC LAXATIVES

MACROGOLS

1. Polyethylene glycol 3350 + electrolytes

Paediatric formula: Oral powder: macrogol 3350 (polyethylene glycol 3350) 6.563 g; sodium bicarbonate 89.3 mg; sodium chloride 175.4 mg; potassium chloride 25.1 mg/sachet

DISIMPACTION

Child under 1 year: ½–1 sachet daily (non-BNFC recommended dose)

Child 1–5 years: 2 sachets on 1st day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily (non-BNFC recommended dose)

Child 5–12 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 12 sachets daily (non-BNFC recommended dose)

ONGOING MAINTENANCE (chronic constipation, prevention of faecal impaction)

Child under 1 year: ½–1 sachet daily (non-BNFC recommended dose)

Child 1–6 years: 1 sachet daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) (for children under 2, non-BNFC recommended dose)

Child 6–12 years: 2 sachets daily; adjust dose to produce regular soft stools (maximum 4 sachets daily)

Adult formula: Oral powder: macrogol 3350 (polyethylene glycol 3350) 13.125 g; sodium bicarbonate 178.5 mg; sodium chloride 350.7 mg; potassium chloride 46.6 mg/sachet

DISIMPACTION

Child/young person **12–18 years:** 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 8 sachets daily (non-BNFC recommended dose)

ONGOING MAINTENANCE (chronic constipation, prevention of faecal impaction)

Child/young person **12–18 years**: 1–3 sachets daily in divided doses adjusted according to response; maintenance, 1–2 sachets daily

2. Lactalose

- Child **1 month to 1 year:** 2.5 ml twice daily, adjusted according to response

Child **1–5 years**: 2.5–10 ml twice daily, adjusted according to response (non-BNFC recommended dose)

Child/young person **5–18 years**: 5–20 ml twice daily, adjusted according to response (non-BNFC recommended dose)

STIMULANT LAXATIVES

1. Sodium picosulfate[b] (Non-BNFC recommended doses)

- Elixir (5 mg/5 ml)

Child **1 month to 4 years**: 2.5–10 mg once a day

Child/young person **4–18 years**: 2.5–20 mg once a day

Perles[c] (1 tablet = 2.5mg)

Child/young person **4–18 years**: 2.5–20mg once a day

2. Bisacodyl (Non-BNFC recommended doses)

- By mouth (5mg tablet)

DISIMPACTION

<5 years old – 1 tablet a day for 3 – 5 days

>5 years old – 2 tablets a day for 3 – 5 days

By rectum (suppository)

Child/young person **2–18 years**: 5–10 mg once daily

3. Senna[d]

- Senna syrup (7.5 mg/5 ml)

Child **1 month to 4 years**: 2.5–10 ml once daily

Child/young person **4–18 years**: 2.5–20 ml once daily

Senna (non-proprietary) (1 tablet = 7.5 mg)

Child **2–4 years**: ½–2 tablets once daily

Child **4–6 years**: ½–4 tablets once daily

Child/young person **6–18 years**: 1–4 tablets once daily

4. Docusate sodium[e]

Child **6 months–2 years**: 12.5 mg three times daily (use paediatric oral solution)

Child **2–12 years**: 12.5–25 mg three times daily (use paediatric oral solution)

Child/young person **12–18 years**: up to 500 mg daily in divided doses

BULK-FORMING LAXATIVES

ISPAGHULA HUSK

1.Fybogel

Adequate fluid intake should be maintained to avoid intestinal obstruction

Child **6-12 years:** ½ - 1 level 5ml spoonful in water twice daily, preferably with meals

Child **12-18 years:** 1 sachet (or 2 level 5ml spoonful's) in water twice daily, preferably with meals

STOOL SOFTENER

1. Liquid Parafin (Non-BNFC recommended doses)

Short term use. Do not give before bedtime. Store in fridge (also improves the taste). May affect absorption of fat soluble vitamins.

N.B: should not be given to child with swallowing difficulties or impaired neurodevelopment because of risk of pulmonary aspiration.

Child **over 3years of age**: 1ml/kg. the dose is increased in 10ml increments every

3 -5 days until the child is having soft stools that are easy to pass. Maximum 40mls/24hours

All drugs listed above are given by mouth unless stated otherwise.

Unless stated otherwise, doses are those recommended by the British National Formulary for Children (BNFC) 2009. Informed consent should be obtained and documented whenever medications/doses are prescribed that are different from those recommended by the BNFC.

a At the time of publication (May 2010) Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that includes electrolytes. It does not have UK marketing authorisation for use in faecal impaction in children under 5 years, or for chronic constipation in children under 2 years. Informed consent should be obtained and documented. Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that is also unflavoured.

b Elixir, licensed for use in children (age range not specified by manufacturer). Perles not licensed for use in children under 4 years. Informed consent should be obtained and documented.

c Perles produced by Dulcolax should not be confused with Dulcolax tablets which contain bisacodyl as the active ingredient

d Syrup not licensed for use in children under 2 years. Informed consent should be obtained and documented.

e Adult oral solution and capsules not licensed for use in children under 12 years. Informed consent should be obtained and documented

Olive Oil Enema

THE PURPOSE OF THE WARM OLIVE OIL ENEMA IS TO LUBRICATE THE STOOL

0-3 years: 60mls
3-7 years: 90mls
7-12 years: 120ml

Equipment:

Rectal catheter Size 12
Catheter tip syringe
Lubricant
Warmed Olive Oil
Incontinence Sheet

Method:

- Allow child to go to the toilet before procedure
- Explain procedure to child
- Warm Olive Oil by placing the bottle in a bowl of warmed water (Olive oil should be body temp)
- Attach syringe and catheter
- Draw up olive oil
- Lubricate tip of catheter
- Insert catheter into rectum approx.10 cm
- Insert olive oil
- Never force in the fluid, if resistance is met- reposition catheter
- After oil is inserted, elevate feet if possible
- Give pain relief if any cramps are experienced

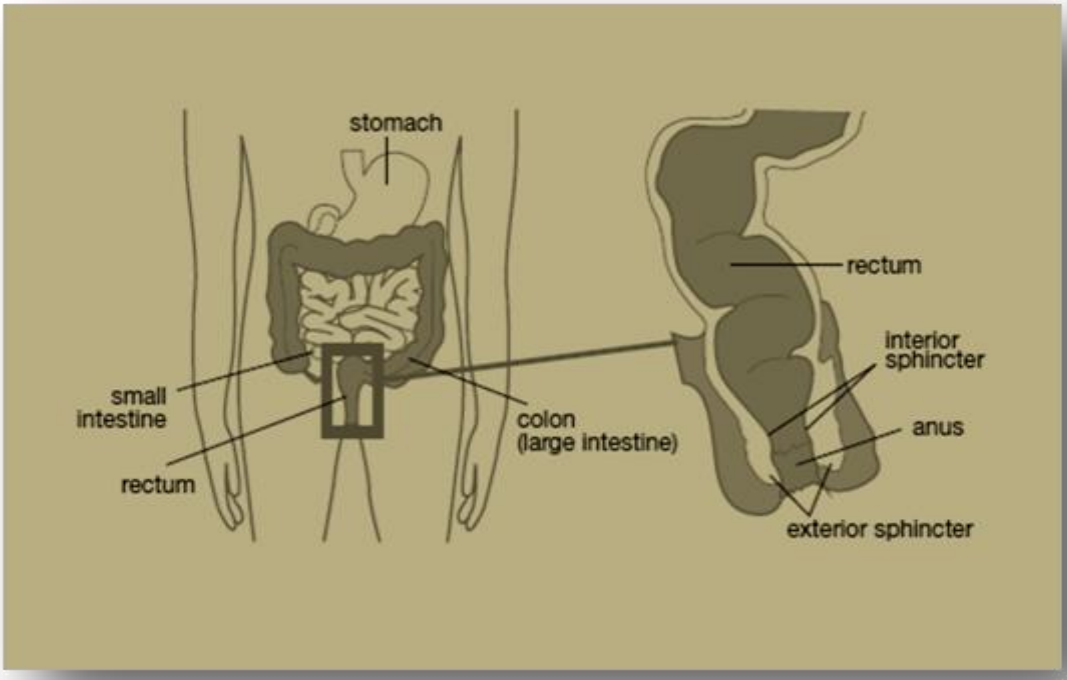
NORMAL BOWEL FUNCTION

Defaecation (having a poo) is a complex process that we sometimes take for granted – until there is a problem! The process involves your abdominal and pelvic muscles and also your anal sphincters.

When the rectum is full of poo the internal sphincter is told to relax to let the poo out. However the external sphincter will hold in poo until we have found a toilet and then we relax this muscle to let the poo out.

We also have what is called the 'gastrocolic reflex'. When we eat a meal, the stomach distends and sends a signal to the rectum to contract. This is why we feel like making a poo after a meal. The reflex can take up to 30 minutes to work. This is the reason you are told to bring your child to the toilet 20-30 minutes after eating their main meals.

Infants will defaecate without realising until they reach Toilet Training age – approximately 2 and half or 3 years of age.



CONSTIPATION

Constipation is a very common condition in children and occurs when your child does not pass a stool often enough. Your child has been diagnosed with Idiopathic Constipation. This means there is no known cause for it. However, there are a number of risk factors:

RISK FACTORS FOR CONSTIPATION

- Poor diet and/or low fluid intake
- Avoidance of passing stool (often a consequence of the fear of pain when passing stool or embarrassment)
- Not enough exercise
- Change in daily routine
- Medications (eg. cough medicines, anticonvulsants, antihistamines)

It is reassuring to know that there is nothing structurally amiss and that it can be treated. However, it will **take time, effort and patience**. Medication may need to be used for what seems like a long length of time **but this is necessary**. Your child may initially need a 'clear out' dose of medication. This means that the back log is being cleared out. Once this is done it is extremely important to stay on medication as directed by your doctor. **Do not stop giving medication unless you speak with your doctor.**

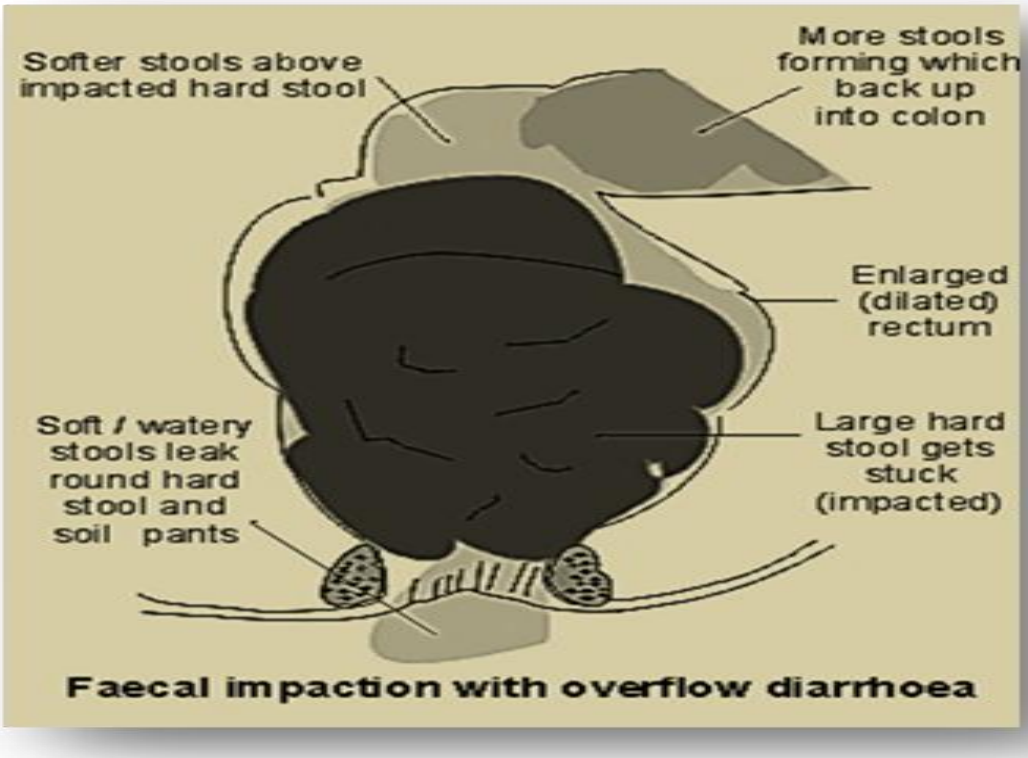
It is a common misconception that long term use of medication is harmful- **it is not**. In order for your child to gain control of their bowel motions it is important that the stool is kept soft and moving. It is sometimes necessary to repeat the 'clear out' medication at certain intervals. This again may become frustrating but it is common for stool to build up again. Medications may need to change and/or doses adjusted until the correct formula is reached for your child. This is why it is so important that you and your child keep a diary of what is happening.

CONSTIPATION WITH SOILING

Some children with long-term constipation may also have a soiling problem. When your child has been constipated for some time, the poo builds up and starts to stretch the rectum or lower bowel. This can mean your child loses the 'need to go' feeling because the rectum is always stretched. Poo can then leak out because your child has no control. Your child is therefore unable to control the soiling.

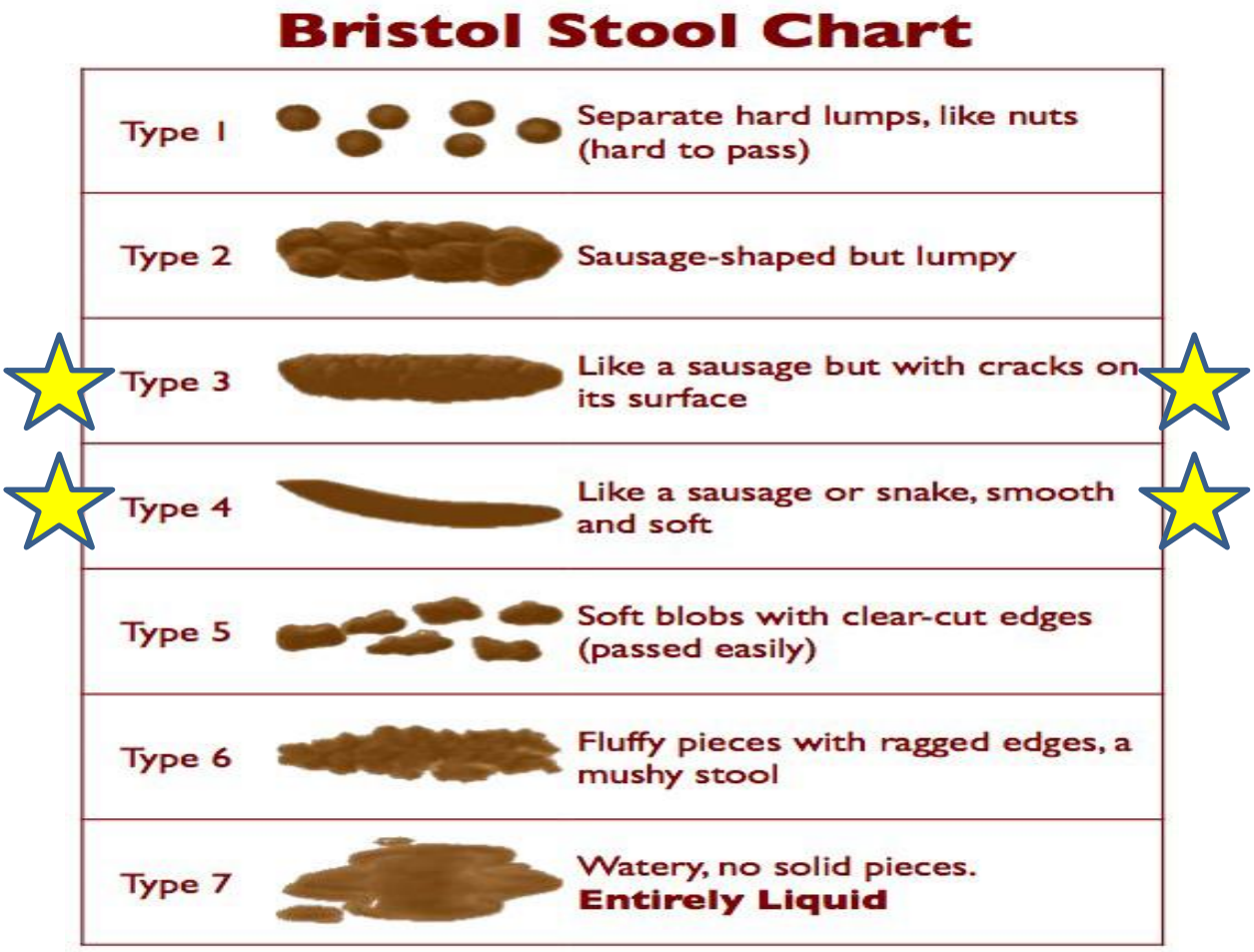
Soiling is usually because of constipation.

Soiling is a source of major tension within a family where the parents believe that the soiling is intentional and that the child is just misbehaving. The child, through shame or fear, may hide the soiled underwear thus confirming the parent's impression of bad behaviour. By emptying out the rectum with the 'clear out' medication and maintance medication this problem should resolve over time



DIFFERENT TYPES OF POO

The bristol stool chart is used to describe the type of stool your child is passing. It is important that you know what type of poo that is being produced as it can tell your doctor a lot. For instance, type 1 can indicate constipation as they are generally hard little lumps that look like rabbit droppings. Also some children will pass type 7 poo along with type 1 and this can be overflow diarrhoea with constipated stool. Involve your child with deciding what their poo looks like and keep it recorded in the diary section.
Type 3 & 4 are the ideal poo as they are soft and easy to pass.



TREATMENT PATHWAY

Medication alone will not cure constipation. We must look at the risk factors contributing to the problem and fix these issues too.

Solving constipation takes time – it is a marathon, not a sprint.

STEP 1: Diagnose Idiopathic Constipation

STEP 2: Empty out the build-up of poo – DISIMPACTION

STEP 3: Identify areas of daily routine that need modification, i.e. – fluid and dietary intake, toileting pattern, exercise.

STEP 4: Keep on medication until such time that your child is passing poo without problem and has stopped soiling **AND** only after discussing this with your doctor.

STEP 5: Keep a record of intake, poos passed and medication taken each day.

MEDICATONS FOR CONSTIPATION

There is a variety of medications/laxatives that the doctor may prescribe for your child to help treat their constipation. These medications may need to be taken regularly for some time before your child's bowels return to normal. They will not make your child's bowel "LAZY".
The types of laxatives available for children are divided into different groups depending on how they work:

BULK-FORMING LAXATIVES

- Used if fibre intake is low
- Increase size of stool so stimulating peristalsis
- Must have an adequate fluid intake
- Do not take before bedtime
- Once mixed with water , drink immediately
- Used in management of haemorrhoids & anal fissures
- E.G: Fybogel (over 6years of age only)

STIMULANT LAXATIVES

- Stimulant laxatives which stimulate contractions of the muscles in the bowel, shortening the time it takes stool to pass through the bowel.
- Some can take 8-12 hours to work
- E.G: Senna (Senokot), Bisacodyl (Dulcolax), Docusate Sodium, Glycerol, Sodium Picosulphate

STOOL SOFTENERS

- As the name suggests, these products ease the process of passing stool by softening the stool and lubricating its passage through the anus.
- E.G. Liquid Paraffin, Olive Oil Enema

OSMOTIC LAXATIVES

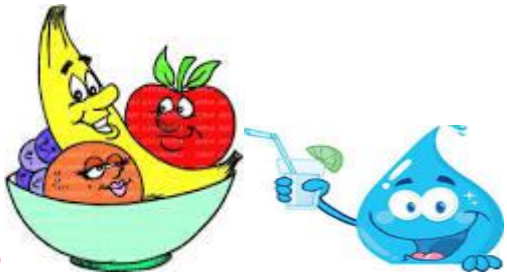
- This group of medications work by drawing fluid from the body into the bowel or by retaining the fluid it is taken with, so softening and increasing the bulk of the stool.
- Some of these medications can take 24-48 hours to act.
- E.G: Lactalose, Macrogols (Movicol), Magnesium Salts, Phosphates (Fleet), Sodium Citrate (Micolette Micro-Enema)

PLEASE KEEP MEDICATIONS LOCKED AWAY FROM CHILDREN IN A SAFE PLACE

IF YOU ARE CONCERNED ABOUT THE EFFECT OF LAXATIVES ON YOUR CHILD AT ANY TIME YOU SHOULD CHECK WITH YOUR DOCTOR.

DO NOT STOP MEDICATIONS WITHOUT CONSULTING YOUR HEALTHCARE PROVIDER

FLUIDS & FIBRE



What goes in must come out!

It is imperative that your child has a healthy well balanced diet. Take note over a few days of what your child is eating and drinking – are they honestly reaching the recommend fluid and fibre intake for their age? It can be difficult to achieve this but make small changes every day and gradually habits will change.

FLUIDS

Age	Sex	Total drinks per day
4-8 years	Female Male	1000-1400mls 1000-1400mls
9-13 years	Female Male	1200-2100mls 1400-2300mls
14-18 years	Female Male	1200-2500mls 2100-3200mls

TIPS FOR INCREASING FLUIDS

- ❖ Encourage plenty of non-fizzy drinks for example, water, fruit juice and squash.
- ❖ Avoid excessive milk consumption as children can easily fill up with milk resulting in a poor dietary intake.
- ❖ For children who find it difficult to increase the amount they drink, try to include foods that contain high fluids e.g. gravy, sauces, soups, custard, jelly, ice lollies and fruit
- ❖ For babies, try giving cooled boiled water between feeds

FIBRE

HOW TO CALCULATE HOW MUCH FIBRE YOUR CHILD NEEDS:

Childs age in years + 5 grams for children over 2 years of age.

E.g: if your child is 7 years old, then you calculate it as

7 + 5 = 12.

Therefore a 7 year old should be eating 12 grams of fibre a day

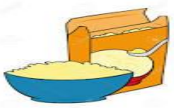
TIPS FOR INCREASING FIBRE

Try to include some of the following fibre containing foods at each meal/snack:-

- **Add linseed to breakfast cereals and yogurts (drink plenty of water if adding linseed to cereal)**
- **Wholemeal bread or Best of Both breads**
- **Wholemeal pasta and brown rice**
- **High fibre biscuits such as digestive, fig rolls, cereal and muesli bars**
- **Homemade muffins with wheatbran added**
- **Fruit and vegetables**
- **Pulses e.g. baked beans, kidney beans, chickpeas and lentils. These can often be added to Bolognese, soups, sauces, stews, casseroles for example.**
- **Potatoes and jacket potatoes with skin left on**

A HIGH FIBRE AND FLUID DIET IS A HEALTHY DIET AND IS SUITABLE FOR ALL THE FAMILY.YOU SHOULD ENCOURAGE A REGULAR MEAL PATTERN AND INCREASE THE WHOLE FAMILY'S FIBRE AND FLUID INTAKE AT EVERY MEAL. BY DOING THIS YOU WILL INCREASE THE WATER CONTENT OF STOOLS MAKING THEM SOFTER AND EASIER TO PASS.

The next few pages detail the amount of fibre in common popular foods. Try at least one new food a week and give it a few tries, don't give up after the first refusal, it can take a few attempts to develop a taste.

BREAKFAST CEREALS 

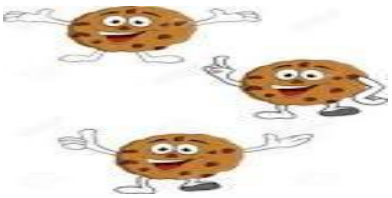
Type	Portion	Fibre g's
All- Bran	Small bowl	7.2
Bran buds	Small bowl	6.6
Mini shredded wheat	Small bowl	3.4
Bran flakes	Small bowl	2.6
Raisin splitz	Small bowl	2.3
Muesli	Small bowl	2.0
Sultana bran	Small bowl	2.0
Weetabix	1 biscuit	1.9
Fruit 'n' fibre	Small bowl	1.4
Country store	Small bowl	1.2
Corn flakes	Small bowl	0.2

NUTS 

OVER 5'S ONLY DUE TO RISK OF CHOKING!

Type	Portion	Fibre g's
Peanut butter	Thickly spread	1.4
Almonds	6	1.0
Peanuts	10	0.8
Brazils	3	0.6

BISCUITS & PASTRIES



Type	Portion	Fibre g's
Wholemeal scone	1	2.6
Cereal bar	1	1.0
Oat cakes	1	0.7
Jacobs fig roll	1	0.7
Cracker	1	0.4
Rich Tea	1	0.4
Digestive biscuits	1	0.3

BREAD

Type	Portion	Fibre g's
Wholemeal pitta	1 mini	1.8
Wholemeal	1 small slice	1.5
Brown	1 small slice	0.9
High fibre white	1 small slice	0.8
Hovis	1 small slice	0.8

VEGETABLE

Type	Portion	Fibre g's
Broad beans	2 tablespoons	7.8
Red kidney beans	2 tablespoons	4.3
Butter beans	2 tablespoons	3.7
Peas	2 tablespoons	3.0
Baked beans	2 tablespoons	3.0
Chick-peas	2 tablespoons	2.9
Potatoes(baked with skin)	1 small	2.7
Corn-on-the-cob	1	2.7
Broccoli Tops (raw)	2 spears	2.4
Carrots	2 tablespoons	2.0
Spinach	2 tablespoons	1.7
Lentils split (boiled)	2 tablespoons	1.5
Potatoes (new)	2	1.2
Oven chips	Small portion	1.2
Cabbage	2 tablespoons	1.1
Leeks	Stem	1.1
Sweetcorn (canned)	2 tablespoons	0.9
Turnip	1 tablespoon	0.8
Beetroot	4 slices	0.8
Tomatoes (Raw)	1 small	0.7

RICE&PASTA

Type	Portion	Fibre g's
Wholemeal spaghetti	3 tablespoons	3.1
Brown boiled rice	2 heaped tablespoons	0.6

FRUIT

Type	Portion	Fibre g's
Pear	1 medium	3.3
Dates (dried)	5	3.0
Avocado	½	2.6
Prunes (dried)	5	2.3
Orange	1 small	2.0
Blackberries	10	1.5
Melon-cantalope	1 slice	1.5
Apple	1 small	1.3
Fruit cocktail	Small bowl	1.2
Kiwi fruit	1 medium	1.1
Banana	1 medium	1.1
Peach	1 medium	1.1
Raspberries	10	1.0
Pineapple	1 large slice	1.0
Grapefruit	½	1.0
Mango	1 slice	1.0
Strawberries	5	0.7
Grapes	10	0.6
Raisins	1 tablespoon	0.6
Tangerine	1 small	0.6
Plum	1 small	0.5

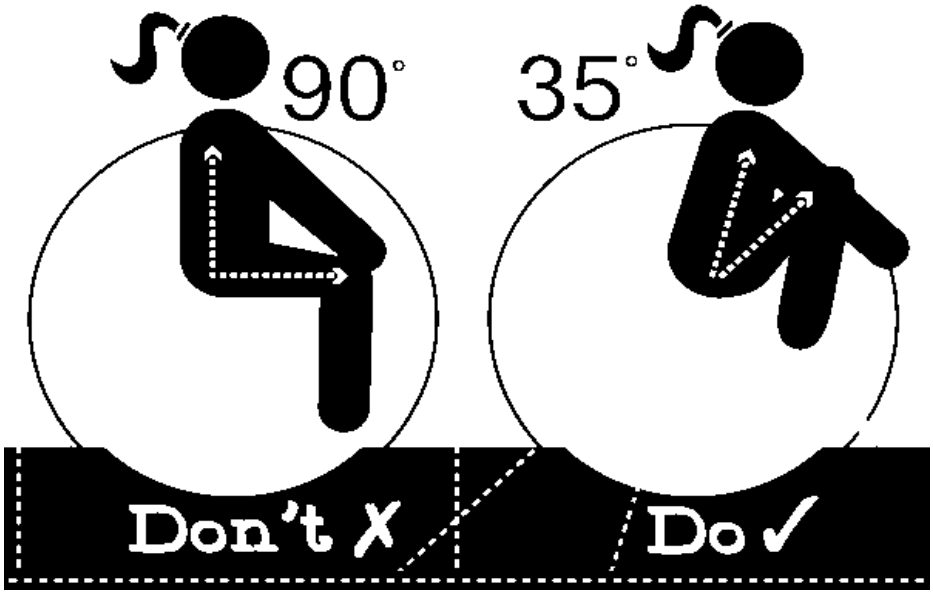
TOILETING TIPS

It can prove difficult to get your child to sit on the toilet, let alone correctly!
Children tend to find that they haven't the time to spend on the toilet and so quickly hop on and off it without concentrating on what they should be doing! Correct positioning can help to empty the bowel more efficiently- here are a few tips on achieving this.

- Make sure the bathroom is warm and inviting! Close the windows and maybe put up some posters for your child to look at.
- Take advantage of the body's natural 'gastrocolic reflex'. This is strongest in the morning and about 20-30 minutes after main meals.
- Try to keep to a routine, using the toilet around the same times every day and also when your child says they feel the need to go – always respond to the body's urge to poop!
- Stay with your child. Do not leave the child sitting on the toilet by themselves for long periods of time.
- Ensure the toilet is comfortable to sit on. Some children fear that they will fall into the toilet and so it is important to get an add-on seat for smaller children.
- A footstool is very important to ensure your child has good support for their feet.

- Put some toilet paper into the bowl first so that there is no splash back when a pooh is passed. Some children get a fright if there is a splash!
- When sitting on the toilet your child should be able to lean forward and rest their elbows on their knees with their knees higher than the hips
- Your child should be relaxed when sitting on the toilet and not straining.
- Talk to your child when following these steps so that they know what you are trying to achieve.

CORRECT TOILET POSITION



MAKE IT FUN

The success or failure of the whole treatment programme rests with the child's adherence to this sitting regime so <u>make it as fun as possible</u>

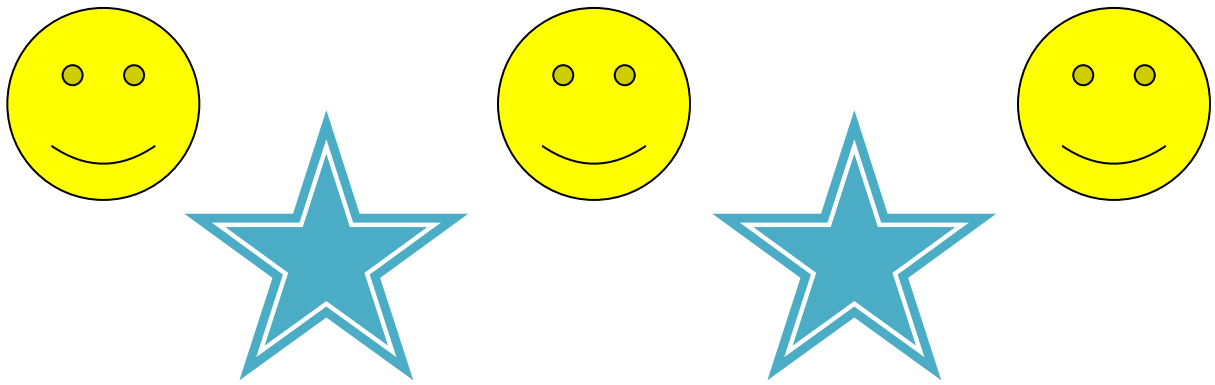
- Allow your child to blow bubbles or blow up a balloon so to increase their inter-abdominal pressure.

- Encourage your child to flush the toilet as part of the process of going to the toilet. You can put some food colouring into the cistern and your child can guess what colour the water will be as a way of making a game of it.

- Teach your child how to wash their hands after using the toilet.

- Use a sticker reward chart to praise positive behaviour

- Avoid letting your child use anything that may distract them while on the toilet eg computer games/mobile phones as this may prevent them from concentrating on making a poo.



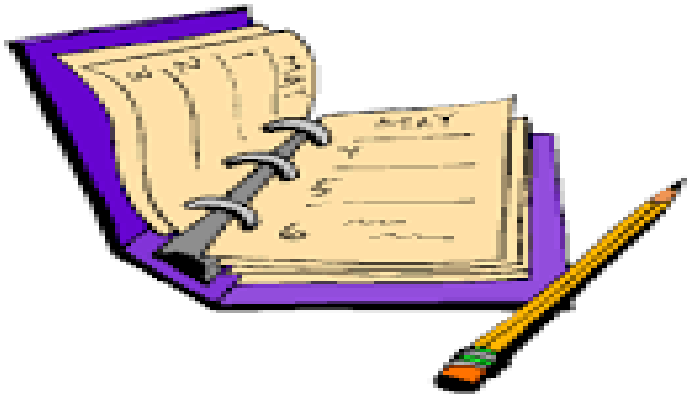
EXERCISE

20-30 minutes a day of daily exercise is recommended for your child. Make it a family activity and as part of your child's daily routine. Allow an hour after eating big meals to allow food to digest fully. Make it fun and Interactive by getting the whole family involved.

Try a few of the following ideas:

- Skipping
- Playing a game outside, running around
- A walk
- Cycling
- Swimming

DIARY



☺Update diary daily with your child, encouraging them to participate

☺It is easier to see a change in pattern when it is written down

☺Be truthful about how much they are drinking and eating

☺Use the Bristol Stool Chart to document types of poo.

DAY

TIME	FIBRE AMOUNT	FLUID AMOUNT	TYPE OF POOH

MEDICATION

TIME	MEDICATION	AMOUNT

DAY

TIME	FIBRE AMOUNT	FLUID AMOUNT	TYPE OF POOH

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MEDICATION

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